SEXUAL AND REPRODUCTIVE JUSTICE AS THE VEHICLE TO DELIVER THE NAIROBI SUMMIT COMMITMENTS

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2022 Report of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up

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Lead for the High Level Commission Secretariat & Global Coordinator ICPD25 Follow-up: Saskia Schellekens

Lead author: Professor Terry McGovern, JD, Harriet and Robert H. Heilbrunn Professor and Chair, Population and Family Health at Columbia University Mailman School of Public Health and Director, Global Health Justice and Governance Program

Lead author team members: Malia Maier, MPH, Senior Program Officer, Columbia University Global Health Justice and Governance Program; Nicolette Naylor, LLM, LLB, Columbia University Global Health Justice and Governance Program; Alexanne Neff, MPH, Columbia University Global Health Justice and Governance Program; Clare McNerney MPHc, Columbia University Global Health Justice and Governance Program

Copy Editor: Gretchen Luchsinger

Leads development of the Global Commitments Monitoring Framework, Country Profiles and Methodological Note (Annexes A, B & C): Nadia Carvalho and Kristin Bietsch, Avenir Health

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The Co-Chairs of the High-Level Commission on the Nairobi Summit on ICPD25 extend their appreciation to all Commissioners in the release of this second report. We commend your partnership in the continuous advocacy for the implementation of the Nairobi Summit on ICPD25 commitments and the call to action and recommendations from our first report – No Exceptions, No Exclusions: Realizing Sexual and Reproductive Health, Rights and Justice for All, along with your simultaneous collaboration in producing our 2022 report. We thank the Commission's Secretariat, under the leadership of Ms. Saskia Schellekens, Global Coordinator, ICPD25 Follow-up, and the author of the report, Professor Terry McGovern and associates, who prepared the text with the inputs of the Commissioners and in close coordination with the Secretariat. We further thank Ms. Gretchen Luchsinger, who edited the report. We extend appreciation as well to Avenir Health for developing the Global Commitments Monitoring Framework to track progress against key indicators for the global Nairobi commitments, and the associated Country Profiles, which is a new addition to this year's report.

In this report, we continue to highlight progress against the Nairobi commitments, particularly by applying a sexual and reproductive health, rights, and justice framework to our mandate as a Commission. We hope that the report will complement the efforts of so many others, especially those close to the ground, as we collectively seek to continue to leverage the momentum of ICPD25 as we move forward towards ICPD30. We commend your efforts and are grateful for your good practices and successes, which have been shared with us, even if only a few can be presented in this concise report. Our confidence that every action contributes to making the ICPD Programme of Action a reality in people's lives is unwavering and we will collectively continue to move forward.

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Foreword

We are pleased to present this second report of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up. One year after the Commission's first report, *No Exceptions, No Exclusions: Realizing Sexual and Reproductive Health, Rights and Justice for All*, we have seen progress in implementing its call to action. Yet its recommendations remain relevant and urgent today. With that in mind, this year's report explores the concept of sexual and reproductive justice – what it means and how it can be applied in diverse places. As an organizing framework, sexual and reproductive justice is fundamental to realizing the 12 global commitments of the Nairobi Summit. The Commission is tasked with advocating for action on these as well as annually reporting on progress.

As the Commission launches this report, our world is on the cusp of being home to 8 billion people. This is a remarkable achievement, reflecting striking achievements in health care and reductions in poverty over many decades. It brings challenges and opportunities for further advances. One issue already in sharp focus is that all people need to exercise rights and choices as key to their resilience, never more so than now, at a moment of profound change and crisis. The COVID-19 pandemic is in its third year. The war in Ukraine has sent shock waves throughout the world, threatening food security and raising the cost of living. Climate change threatens the very existence of our planet. And widening inequalities and widespread polarization undermine hopes for sustainable development.

Realizing the global promises and ideals embodied in the 2030 Agenda for Sustainable Development, the ICPD Programme of Action and the Nairobi commitments depends on sexual and reproductive justice. It encapsulates a spectrum of rights underpinning bodily autonomy and agency, and applies the notion of intersectionality to reach individuals and groups facing multiple forms of discrimination – and often the worst breaches of their rights. From this perspective, realizing sexual and reproductive rights is about health care as well as decent work, a safe environment, a voice in decision-making and freedom from any form of marginalization. Sexual and reproductive justice in essence will be key to unleashing the full potential of all human beings to create a future that is more equitable, secure and sustainable.

The work of the Commission provides a bridge between the global Nairobi commitments and the upcoming ICPD30 review and commemorative event by the United Nations General Assembly, both slated for 2024. With national and regional reviews about to begin in preparation for ICPD30, the Commission hopes its reports provide sound grounds and inspiration for intensified advocacy to put sexual and reproductive justice for *all* at the forefront.

And as we continue on this journey, we must also honour the life and legacy of the late Dr. Nafis Sadik, who passed away in August 2022. The former Executive Director of UNFPA, she was the first woman to direct a United Nations organization, serving in that role from 1997 to 2000. As Secretary-General of the International Conference on Population and Development in Cairo in 1994 and architect of its groundbreaking Programme of Action, Dr. Sadik made enduring contributions to advancing sexual and reproductive health and rights, women's leadership and global development.

In the words of Dr. Natalia Kanem, the current Executive Director of UNFPA, "Dr. Sadik helped the world understand that people are at the heart of development and that when we remove obstacles in their path and uphold their rights, they and their societies flourish – women especially." Since Cairo, millions of girls and young women have grown up knowing that their bodies belong to them and that their futures are theirs to shape, a lasting testimony to Dr. Sadik's determination, courage and conviction.

As she herself once said, "Reproductive rights involve more than the right to reproduce. They involve support for women in activities other than reproduction, in fact liberating women from a system of values which insists that reproduction is their only function."

This visionary understanding was at the foundation of the ICPD agenda. It galvanized renewed commitment at the Nairobi Summit. It is central to our work as a Commission and torchbearer for sexual and reproductive justice and making rights and choices a reality for all.

By protecting rights and advancing justice, we can unlock the boundless potential of human beings. As 8 billion people, we have the power to alter the course of our shared world so that it works for everyone.

Jakaya Mrisho Kikwete

Co-Chair & Former President of the United Republic of Tanzania

Michaëlle Jean

Co-Chair & Former Governor General and Commander-in-Chief of Canada; and former Secretary-General of the International Organization of la Francophonie


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Introduction

The year since the High-Level Commission on ICPD25 Follow-up published its first report, *No Exceptions, No Exclusions: Realizing Sexual and Reproductive Health, Rights and Justice for All*, has aptly illustrated the centrality of sexual and reproductive health, rights and justice to the well-being of humanity. The COVID-19 pandemic demonstrated the harm done by the failure of many governments to craft a gender-informed response. This undermined sexual and reproductive health and rights through the restriction and interruption of services deemed unessential, unequal access to digital technology, and structural barriers to care faced by diverse women, adolescents, persons with disabilities, low-income individuals, refugees and persons of diverse sexual orientation and gender identity. Financial insecurity, lockdowns, and constrained health, social and legal services allowed gender-based violence to proliferate. Numerous governments hesitated to enact additional protections for victims and survivors.

New COVID-19 variants now suggest that the virus will continue to spread even as violations of sexual and reproductive rights persist in many parts of the world. The global monkeypox outbreak, which the World Health Organization (WHO) has declared a public health emergency of international concern,[1] poses another threat and showcases a lack of learning. Similar to COVID-19, HIV and other outbreaks, the virus has outpaced the response, which has been plagued by systemic racism and homophobia.

Two events in the Global North in 2022 – the war in Ukraine and the reversal of *Roe v. Wade* by the Supreme Court in the United States of America – have had a disproportionate impact on global well-being with far-reaching ramifications for justice. In Ukraine, the war has internally displaced more than 6.6 million people; 6 million more have fled the country.[2] The crisis contributed to the record high number of people affected by humanitarian crises in the last decade, from Afghanistan to Sudan to Syria. The unprecedented scale, frequency and duration of emergency situations and the need for humanitarian assistance in fragile settings due to conflicts or climate-related disasters requires urgent attention. According to the United Nations Office for the Coordination of Humanitarian Affairs, approximately 1.8 billion people live in fragile settings worldwide.[3] The number of people in humanitarian need reached 274 million in 2022.[4]

In June, the United States Supreme Court overturned *Roe v. Wade*, stripping citizens of a constitutional right to abortion. Abortion is currently banned in 17 states, with additional states expected to enact restrictions.[5] In many states, exceptions do not exist for abortion in cases of rape or incest, violating international law.[6] Black and brown people and individuals below the poverty line – who already face limited access to sexual and reproductive health services like contraception while experiencing inequities across broader social and economic dimensions – are likely to bear the burden of these restrictions as they make up the majority of those who obtain abortions in the United States.[7] The Commission remains concerned about the effects of this decision, as it fears it will only increase the number of unsafe abortions and result in more maternal deaths. It will likely strengthen anti-abortion and conservative movements seeking to restrict progress on sexual and reproductive rights worldwide.[8]

What has transpired in the United States contrasts with recent progress in Latin America and Africa, which has become an inspiration for the fight for sexual and reproductive justice worldwide. On the heels of successful advocacy by women's movements in Mexico and Argentina, Colombia legalized abortion in 2022. In November 2021, Benin's Parliament voted to legalize abortion in most circumstances,[9] a groundbreaking move on the African continent, where 92 percent of women of reproductive age live under restrictions.[10] The Democratic Republic of the Congo, the first country in Francophone Africa to broaden access to abortion care, endorsed guidelines to implement the directives of the African Protocol on the Rights of Women (the Maputo Protocol).[11] In July 2022, Sierra Leone took steps to overturn colonial-era abortion laws following decades of advocacy by the women's movement and government officials. Parliament will debate a draft bill decriminalizing abortion that has drawn high-level political support; it is expected to pass before the end of 2022.

Other fallout from the last several years has indelibly impacted the social, political and economic environment that determines sexual and reproductive health. A shrinking civic space combines with misinformation, disinformation and political polarization associated with the COVID-19 pandemic, among other factors. These are linked to a rise in authoritarianism, far-right rhetoric and populist movements.[12] Food insecurity, compounded by the war in Ukraine and inflation, is on the rise.[13] Climate change is driving disaster-related displacement and forced migration worldwide as communities face increased drought, flooding, cyclones and other climate-related events.[14]

In 2019, the Nairobi Summit celebrated the twenty-fifth anniversary of the landmark 1994 Programme of Action of the International Conference on Population and Development (ICPD). Governments and civil society actors, businesses and a diverse array of other stakeholders presented over 1,300 commitments to action and endorsed the Nairobi Statement, which defines 12 core global commitments to achieve the ICPD goals for everyone, everywhere.

The commitments focus on five overarching goals:

1
Achieving universal access to sexual and reproductive health and rights as a part of universal health coverage

2
Addressing sexual and gender-based violence and harmful practices

3
Mobilizing the required financing to finish the ICPD Programme of Action and sustain the gains already made

4
Drawing on demographic diversity to drive economic growth and achieve sustainable development

5
Upholding the right to sexual and reproductive health services in humanitarian and fragile contexts

Achieving these goals depends on combating intersecting forms of oppression that impede sexual and reproductive justice. As stated in the Commission's 2021 report, sexual and reproductive health and rights are integral to an agenda for justice and development that is universal in its reach. As such, the Commission endorsed the adoption and implementation of a sexual and reproductive justice framework as essential to success in delivering the Nairobi commitments.

While the framework of sexual and reproductive justice that our first report outlined has resonated, this second report will elaborate on its principles and demonstrate how it applies to diverse stakeholders, settings and contexts. The Commission intends for this report to illuminate a path to achieve ICPD and Nairobi Summit commitments through the sexual and reproductive justice framework.

What's in this report

Chapter 1 introduces the sexual and reproductive justice framework and how it helps understand and respond to the specific contexts, structures and relationships that shape bodily autonomy, agency and choice. The Commission highlights how the sexual and reproductive justice framework takes us beyond a narrow focus on individual access to services, which has often excluded women and girls at the margins of society, and instead provides an intersectional analysis that reinforces implementation and accountability for the Nairobi commitments.

Chapter 2 places the sexual and reproductive justice framework in the context of other justice agendas and concepts. Sexual and reproductive justice is a prerequisite for achieving justice more broadly. It creates opportunities for actors in diverse movements to build solidarity and form the broad power base necessary to effect change.

Chapter 3 demonstrates how the sexual and reproductive justice framework is essential to achieving sustainable development and addressing humanitarian crises.

In **Chapter 4**, the Commission considers examples of how sexual and reproductive justice has contributed to progress in realizing the Nairobi commitments, and the challenges that remain. The Commission draws on the latest reporting of the Global Commitments Monitoring Framework and a new set of country profiles to underscore what the latest data reveal while highlighting emerging good practices.

In its **concluding section**, the Commission reflects on the continuing relevance of its 2021 Call to Action. It suggests actions that, if adopted, will accelerate change and ensure accountability for sexual and reproductive health and rights, justice and development, in line with the Nairobi Statement, the ICPD Programme of Action and the 2030 Agenda for Sustainable Development.

Annexes A, B and C present the 2022 update of the Global Commitments Monitoring Framework, a select set of country profiles and an accompanying methodological note. The Global Commitments Monitoring Framework, building on the scorecards of the 2021 report, presents the most recent available data to track key global indicators by region. Select country profiles take deeper dives on the data. Where possible, data are disaggregated to deepen understanding of realities on the ground and drive targeted investments in line with the Nairobi commitments. The methodological note accounts for the Commission's process in developing the monitoring framework and profiles.

The Nairobi Statement: 12 Global Commitments

Recognizing our different capacities and responsibilities, our way forward is to focus in particular on those actions, expressed in specific commitments and collaborative actions, that will deliver on the promise of the ICPD Programme of Action, the Key Actions for the Further Implementation of the Programme of Action of the ICPD and the outcomes of its reviews, and the 2030 Agenda for Sustainable Development.

In that context, we will:

1 NAIROBI GLOBAL COMMITMENT

Intensify our efforts for the full, effective and accelerated implementation and funding of the ICPD Programme of Action, Key Actions for the Further Implementation of the Programme of Action of the ICPD, the outcomes of its reviews, and Agenda 2030 for Sustainable Development.

Achieve universal access to sexual and reproductive health and rights as a part of universal health coverage (UHC), by committing to strive for:

2 NAIROBI GLOBAL COMMITMENT

Zero unmet need for family planning information and services, and universal availability of quality, accessible, affordable and safe modern contraceptives.

3 NAIROBI GLOBAL COMMITMENT

Zero preventable maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national UHC strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.

4 NAIROBI GLOBAL COMMITMENT

Access for all adolescents and youth, especially girls, to comprehensive and age-responsive **information, education and adolescent-friendly comprehensive, quality and timely services** to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood.

Address sexual and gender-based violence and harmful practices, in particular child, early and forced marriages and female genital mutilation, by committing to strive for:

5 NAIROBI GLOBAL COMMITMENT

Zero sexual and gender-based violence and harmful practices, including zero child, early and forced marriage, as well as zero female genital mutilation; and **elimination of all forms of discrimination against all women and girls**, to realize all individuals' full socioeconomic potential.

Mobilize the required financing to finish the ICPD Programme of Action and sustain the gains already made, by:

Using national budget processes, including gender budgeting and auditing, increasing **domestic financing** and exploring new, participatory and innovative financing instruments and structures to ensure full, effective, and accelerated implementation of the ICPD Programme of Action.

Increasing **international financing** for the full, effective and accelerated implementation of the ICPD Programme of Action, to complement and catalyze domestic financing, in particular of sexual and reproductive health programmes, and other supportive measures and interventions that promote gender equality and girls' and women's empowerment.

Draw on demographic diversity to drive economic growth and achieve sustainable development, by:

Investing in the education, employment opportunities, health, including family planning and sexual and reproductive health services, of adolescents and youth, especially girls, so as to fully **harness the promises of the demographic dividend.**

Building peaceful, just and inclusive societies, where no one is left behind, where all, irrespective of race, colour, religion, sex, age, disability, language, ethnic origin, sexual orientation, and gender identity or expression, feel valued, and are able to shape their own destiny and contribute to the prosperity of their societies.

Providing quality, timely and disaggregated data, that ensures privacy of citizens and is also inclusive of younger adolescents, investing in digital health innovations, including in big data systems, and improvement of data systems to inform policies aimed at achieving sustainable development.

Committing to the notion that nothing about **young people's** health and well-being can be discussed and decided upon without their **meaningful involvement and participation** ("nothing about us, without us").

Uphold the right to sexual and reproductive health services in humanitarian and fragile contexts, by:

Ensuring that the **basic humanitarian needs and rights** of affected populations, especially that of girls and women, are addressed as critical components of responses to humanitarian and environmental crises, as well as fragile and post-crisis reconstruction contexts, through the provision of access to comprehensive sexual and reproductive health information, education and services, including access to safe abortion services to the full extent of the law, and post-abortion care, to significantly reduce maternal mortality and morbidity, sexual and gender-based violence and unplanned pregnancies under these conditions.


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1 Defining the Sexual and Reproductive Justice Framework

Key Messages

- Sexual and reproductive justice is a universal concept that includes the right to have or not have children, the right to parent one's children in safe and sustainable environments, and the right to sexual autonomy and gender freedom.
- The sexual and reproductive justice framework builds on the platform of sexual and reproductive rights, recognizing structural inequalities and intersecting systems of oppression that impact sexual and reproductive decision-making, including economic, social and health factors.
- Realizing sexual and reproductive justice requires challenging the unequal distribution of power in society and ending marginalization and exclusion.
- The sexual and reproductive justice framework is universal in application and key to organizing and building broad and intersecting social movements.
- The framework is crucial to reinforcing implementation and accountability for the Nairobi commitments and the Sustainable Development Goals (SDGs) as it extends analysis to overlapping structural barriers to progress at the community, country, regional and global levels.

In 1994, the year that saw the adoption of the historic ICPD Programme of Action, a collective of 12 Black feminists coined the term "reproductive justice", transforming the narrow "pro-life versus pro-choice" debate dominating reproductive, economic and social rights discourse in the United States of America.[15] Mainstream reproductive rights movements put privileged, white, cisgender and heterosexual women at the centre. Such movements were perceived as undermining the lived experiences of women of colour and other marginalized groups by failing to address the intersecting forces affecting these communities.[16]

While references to reproductive justice first appeared in the United States, the concept of sexual and reproductive justice is universal. Many stakeholders from all parts of the world have long recognized the importance of addressing intersecting oppressions to achieve sexual and reproductive justice and gender justice. The concept allows a critical analysis of reproductive as well as civil, economic and social rights. It has three primary tenets: the right to not have a child, the right to have a child and the right to parent one's child(ren) in safe, sustainable environments. The decade following the creation of the reproductive justice framework saw the inclusion of a fourth tenet: the human right to sexual autonomy and gender freedom.[17]

Sexual and reproductive justice illuminates the experiences of those who have often gone unheard while permitting a systematic analysis of the power and privilege that punitively regulate reproduction. Issues of gender, class, race, sexual orientation, age, disability, migration status and ethnicity are central to sexual and reproductive justice and used to evaluate barriers associated with the criminal justice system, law enforcement, economic participation, political representation, education, housing, health, child welfare, public assistance, sexual autonomy and gender freedom.[18]

Sexual and reproductive justice builds on the sexual and reproductive rights framework, which is grounded in a constellation of fundamental human rights guarantees, including the rights to life, health, privacy, information, freedom of expression, freedom from violence and discrimination, and freedom from torture, cruel, inhuman and degrading treatment. These rights are embedded in national laws and constitutions as well as in foundational and universally accepted human rights documents. They are defined and elaborated in international and regional human rights treaties, interpretive statements and political consensus documents.[19]

While the rights-based framework takes an individualistic approach to reproductive freedom, affirming and protecting an individual's rights to services like contraception and maternal health care, the justice framework goes further.[20] Beyond access to services, it considers the concurrent social conditions that promote or impede one's ability to enjoy sexual and reproductive freedom.

Professor Loretta Ross, one of the pioneers of reproductive justice globally, underlines how questions of reproductive autonomy lie not only in effective access to and choice in contraception, abortion and antenatal and obstetric care, but also in understanding the barriers that marginalized women face in bearing and raising children. These include

the criminalization of reproduction, coerced pregnancy or sterilization, the stigmatization of teenage mothers, the effects of environmental degradation on fertility and limited access to reproductive technology.

Reproductive autonomy must be contextually understood in interpersonal and structural terms, with women's reproductive choices located within "a broader analysis of the racial, economic, cultural, and structural constraints on women's power".[21] Bodily autonomy is based on individual rights to privacy, confidentiality, informed consent and choice, freedom of expression, and freedom from discrimination, harassment and violence. Individual autonomy is also made possible by constructive relationships and undermined by destructive ones, not only in "intimate [and family] relationships but also in more distant relationships and social structural relationships such as gender, economic relations, and forms of governmental power."[22] This contextual and relational interpretation recognizes that autonomy differs across groups of women and girls, despite a common vulnerability to gendered subordination.

A history of discriminatory sexual subordination and population control, coupled with complex and specific socialization around sexuality and childbearing, means that racial and ethnic minorities, among other groups, often have experiences distinct from those of dominant groups. Universally, poverty and inequality, histories and experiences of population control and abortion access, HIV vulnerability and epidemic levels of gender-based violence affect women differently based on race, class, sexuality, age and disability. Putting intersectionality and interlocking mechanisms of subordination and oppression at the centre of analysis focuses attention on women and girls pushed to the margins of society by combinations of race, ethnicity, class, sexuality, age, disability, poverty, migrancy, rural location and many other bases of oppression. For them, the reality is often little or no choice in their sexual and reproductive lives.

Realizing sexual and reproductive justice requires challenging the unequal distribution of power in society and striving to restore people's dignity, a pivotal principle permeating a human rights approach.

It calls for connecting a contextual, relational and intersectional understanding of a person's autonomy and self-determination with substantive equality and socioeconomic rights. Realizing rights and bodily autonomy is a foundational step in transforming patriarchal, racist, ageist, ableist, homophobic and transphobic cultures and structures.

The kinds of change envisaged by sexual and reproductive justice requires removing structural obstacles, oppressive systems and conditions that make people vulnerable to human rights violations. Intersectionality must be employed within a justice framework to reshape research, inform policies and programmes and analyse the global health architecture and its interface with justice.

Activists and movements worldwide have embraced the sexual and reproductive justice framework, demonstrating its universality and adaptability. South Africa explicitly adopted a justice framework in 1996 when Parliament legalized abortion under the Choice on Termination of Pregnancy Act. In 2015, South Africa's Cabinet included sexual and reproductive health and rights as a population policy priority and recommended that a reproductive justice approach guide the Government's work in all spheres. The Government is now collaborating with civil society and academic stakeholders on a cross-country seminar series on sexual and reproductive justice and how it relates to governance, service delivery (especially to underserved groups), migration and mobility, tradition, culture and language, poverty and inequality and demography. A national conference on sexual and reproductive justice in 2023 will highlight national priorities requiring intensified interventions.

In the Republic of Korea, a disability rights group joined forces with doctors' organizations, feminist groups, youth activists and religious groups in 2017 to frame abortion as a social justice issue. Their collective advocacy ultimately led to the decriminalization of abortion last year.[23] Abortion rights activists in Ireland used sexual and reproductive justice concepts linking maternal mortality, economic oppression and reproductive justice to repeal an abortion ban in 2018. Similarly, Latin American feminists have adopted a sexual and reproductive justice framework to mobilize grass-roots movements and create political space for new conversations broadening perspectives on abortion. In Argentina, the feminist movement wove the struggle for abortion into other feminist struggles, such as those against domestic violence, the gendered pay gap and murders of female environmental and indigenous activists. [24]

The sexual and reproductive justice framework is crucial to reinforcing the implementation and accountability for the Nairobi commitments and the Sustainable Development Goals, in particular SDG 3 (good health and well-being) and SDG 5 (gender equality), while also impacting SDG 4 (education), SDG 10 (reducing inequalities), SDG 13 (climate action), SDG 16 (peaceful and inclusive societies), SDG 17 (partnerships) and ultimately SDG 1 (ending poverty). The framework also aligns with the 2030 Agenda principles of human rights, universality, leaving no one behind and endeavoring to reach the furthest behind first.

An example of how to apply the sexual and reproductive justice framework can be found in ICPD25 Global Commitment 3, on zero preventable maternal deaths and maternal morbidities. Simply providing access to maternal health care will not achieve this goal, since disrespect and abuse during childbirth can have a negative impact on health outcomes.[25] Poor treatment can stem from the sociopolitical environment and be associated with factors like racism[26] and practices that prevent patients from giving

birth with dignity.[27] Similarly, health-care professionals from diverse racial, ethnic or indigenous backgrounds tend to face degrading treatment in their professional settings. Health systems often give less value, pay and recognition to midwives and other traditional and customary health workers, who are mostly women.

Environmental injustice and exposures to risk can also play a role in maternal mortality. Further, when a woman dies giving birth, the lasting economic and social consequences touch children, households and entire communities. These include financial instability resulting from the loss of income combined with health-care and funeral costs, an increased childrearing burden on other family and community members, loss of educational and life opportunities for surviving children, and higher child mortality.[28]

In sum, a sexual and reproductive justice lens extends analysis to overlapping structural barriers at the community, country, regional and global levels. In rectifying these, it centralizes the importance of social movements and grass-roots efforts as well as the responsibilities of States as duty-bearers for human rights.

sexual and reproductive justice

2 A Sexual and Reproductive Justice Framework Breaks Down Silos

Key Messages

A sexual and reproductive justice framework requires:

- Adopting intersectional analysis of the impact of multiple and intersecting forms of oppression
- Building alliances and networks of allied social justice and human rights organizations that integrate a reproductive justice agenda into their work at the local, regional and global levels
- Recognizing and supporting the leadership and power of the most excluded groups, particularly marginalized women and girls, and standing behind the efforts of women and their communities to build and claim social, political and economic power
- Integrating issues and constituencies that are gender expansive, multiracial and multigenerational, and recognizing the leadership of disability activists, environmental activists, indigenous movements, and racial and ethnic minority women and girls in creating a powerful, relevant sexual and reproductive justice movement

Sexual and reproductive justice is at the centre of the most critical social and economic justice issues facing marginalized communities, such as workers' rights, environmental justice, immigrant rights and disability justice, and the rights to protection from violence and discrimination based on race, ethnicity, age, sex, migration status, HIV status, sexual orientation and gender identity. The sexual and reproductive justice framework addresses the fact that reproductive oppression results from the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights.

The framework uses a model grounded in organizing for change in terms of broader structural power inequalities. Structural analysis of problems, strategies and envisioned solutions must be comprehensive and focus on interconnecting social justice and human rights issues that affect the bodies, sexuality and reproduction of women, girls and gender-diverse people, as displayed in the figure above. The framework requires addressing a lack of power, resources and control because its central focus is on the control and exploitation of women's bodies, sexuality and reproduction as a way to dominate women, girls and communities, particularly the most marginalized.

Historically and currently, a woman's lack of power manifests through the multiple oppressions of race, ethnicity, class, gender, sexuality, ability, age and migration or refugee status. Yet funding and movements for sexual and reproductive health and rights have traditionally operated in isolation from other actors for human rights and justice. Of more than 27,000 human rights grants made by private US foundations to 44 countries in 2018, only 22 per cent sought to benefit more than one population and just 21 per cent addressed more than one

issue. Grants for persons with disabilities and persons of differing sexual orientation and gender identity were the most siloed funding streams.[29]

This compartmentalization of injustices by the donor community has made it difficult for organizations, particularly grass-roots ones, to work on intersectional, interdependent issues. It has proven difficult to connect work on sexual and reproductive justice to that on racial justice, climate justice and economic justice. This is despite evidence showing that climate change, for example, negatively impacts nearly all sexual and reproductive health and rights outcomes.[30] Approximately 80 per cent of those displaced by climate-related disasters are women at risk of discrimination, harassment and gender-based and sexual violence during transit and in shelters and refugee camps.[31] At the same time, the climate justice movement, led by youth leaders, acknowledges that poor and racial and ethnic minority communities around the world do not drive climate change yet are bearing the brunt of its impacts.

This is where the sexual and reproductive justice framework is powerful as an organizing frame and a "broad and capacious movement".[32] It breaks down silos and builds solidarity and a more diverse power base comprising climate justice, racial justice, economic justice, and sexual and reproductive justice movements as well as funders and policymakers to effect lasting change. Indigenous women in the United States, for example, have used a sexual and reproductive justice framework to articulate the environmental contamination of Native land as a reproductive health hazard.[33]

The separation between the sexual and reproductive justice and economic justice movements is particularly stark, even as economic empowerment is critical to reproductive decision-making and justice. Financial opportunity and security afford women and people who can become pregnant greater agency in deciding if, when and how to raise children. Reciprocally, the extent to which a person can attain sexual and reproductive freedom and well-being influences the level and nature of their participation in the economy. Expanding contraceptive use and reducing adolescent childbearing increases the likelihood of participation in the formal labor market.[34] Adolescent pregnancy, by contrast, can lead to school dropouts, resulting in a loss of potential job opportunities and increased societal costs.[35] Without gender justice-informed workplace protections and policies, women and people giving birth are forced to choose between caring for their child or losing their job. In many contexts, the double burden of childrearing and participation in the labor market pushes women out of the workforce or relegates them to the informal sector, which lacks safeguards for equal pay and fair working conditions.[36]

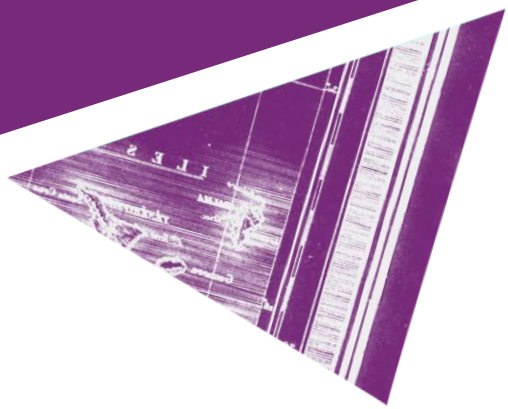
The sexual and reproductive justice framework envisions combined strategies for tackling interlocking concepts of economic empowerment and sexual and reproductive freedom. It advocates for universal health coverage, including all components of sexual and reproductive health services, alongside the right to education; fair and equal pay; social protection systems, including paid parental leave; family benefits; shared parenting responsibility and decent conditions and pay for care work. It also prioritizes resources and opportunities

for women with disabilities as their full participation in political, economic and public life is a gateway to sexual and reproductive justice.

Both gender justice and sexual and reproductive justice prioritize women's equal participation and leadership in political and public life. Despite evidence that involving women in political processes is beneficial for all, women are underrepresented at all levels of decision-making worldwide. Just 10 countries currently have a woman head of State and 13 have a woman head of Government; only 26 per cent of national parliamentarians are women. Based on data from 133 countries, women constitute 36 per cent of elected members in local deliberative bodies.[37]

The interdependence and indivisibility of rights

The African Commission on Human and Peoples' Rights in its General Comment No.2[38] on the Protocol on the Rights of Women in Africa[39] underscores the interdependence and indivisibility of rights. It stipulates that the civil and political rights components of sexual and reproductive rights cannot be separated from the socioeconomic components. All States are obligated to respect, protect, promote and fulfil rights guaranteed to women by the Protocol. The obligations to promote and fulfil are particularly important as many States presently lag behind in implementing existing laws and policies. States must attend not just to barriers in law and policy but also the cultural, social, religious and economic obstacles to women fulfilling their rights.[40]



Justice across generations

IInterwoven with climate justice, economic justice and sexual and reproductive justice is intergenerational justice. It holds that present generations have certain obligations to each other as well as to future generations. There is a growing understanding of the importance of social integration and intergenerational solidarity, rooted in interdependence among generations during the life course. This stems from a critical recognition of the impacts of climate change across generations as well as the intergenerational transmission of poverty. Ways to prevent the latter depend on investing in children and young people so they can reach their full potential.

An intergenerational justice perspective requires considering the power relations between current generations as well as the conditions of generations to come,[41] including the social and physical environment and the legacies of oppression they inherit. This notion is central to sexual and reproductive justice, which seeks to create and sustain safe and dignified contexts in which current generations may raise their children, and that future generations will eventually inhabit. Further, sexual and reproductive injustices – such as forced pregnancy, forced sterilization, forced abortions, broken child welfare systems, prenatal environmental exposures and lack of access to reproductive technologies – have direct impacts in shaping future generations.

Intergenerational justice demands acknowledging the perpetration of sexual and reproductive injustices in generations with restricted social, economic and political power. Elderly people have been largely neglected in sexual and reproductive health and rights agendas, for instance, despite rapidly ageing populations worldwide.[42] Approximately one in six older adults have experienced abuse in a community setting, including sexual abuse.[43] Policies, funding and services frequently ignore their specific sexual and reproductive health needs,[44] however, since individual, community and societal factors tend to disempower older adults.[45]

Adolescents face many barriers to care and decisions about their own sexual and reproductive health. The Committee on the Rights of the Child stated that "all adolescents should have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education," and emphasized the ability of adolescents to make informed decisions about their own care.[46] In 21 per cent of countries with laws protecting access to contraceptive services, statutes also require the involvement of a third party, typically medical, parental or judicial, to access those services. [47] This has a particular impact on adolescents, who are often prevented from reaching care without the consent of a parent, presenting a significant barrier. In some countries, providers cannot offer family planning services without the written consent of a parent or guardian.[48]

The Nairobi commitments underscore the importance of the meaningful involvement and participation of young people. While youth have traditionally been underrepresented in political institutions,[49] youth movements will be important partners in advancing sexual and reproductive justice worldwide. The sexual and reproductive justice framework allows for a deeper analysis of how and why older and younger generations have been restricted in their ability to access social, economic and political power and the specific impact of those restrictions on their sexual and reproductive rights. It explores the impact of sexual and reproductive injustices on generations to come.

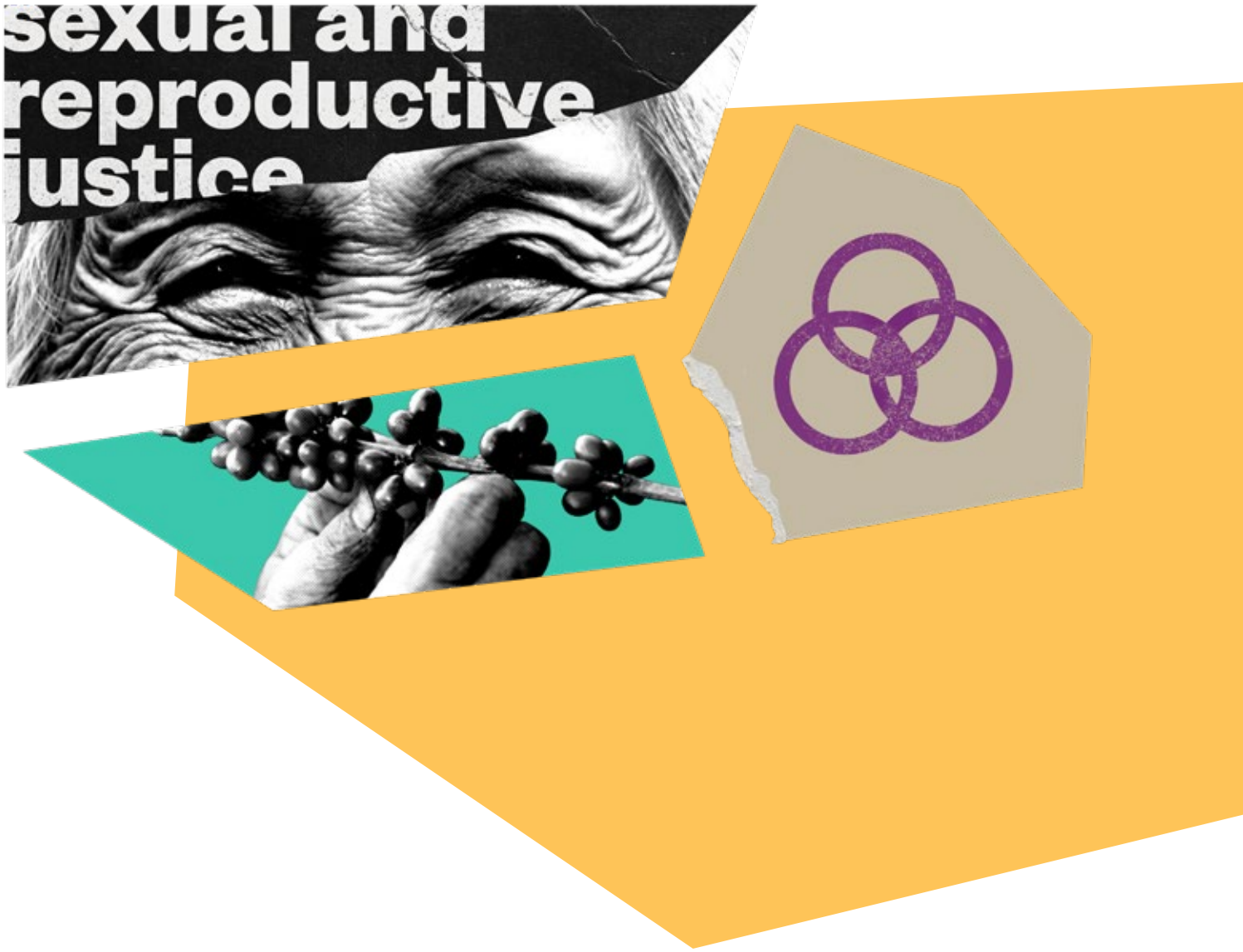
A closer look at racial, ethnic and indigenous justice

Like racial and ethnic minorities around the world, indigenous communities and their intersectional identity, including their culture, sex, gender, ethnicity, socioeconomic status and language, face systemic and intersectional discrimination.[50] The Committee on the Elimination of Discrimination against Women in its General Recommendation No. 34 warned about the dangers of compartmentalizing the issues faced by women and girls who are indigenous and/or of African descent. It stated that "States parties should recognize that rural women are not a homogenous group and often face intersecting discrimination" and that "[m]any indigenous and afro-descendent women live in rural settings and experience discrimination based on their ethnicity, language and traditional way of life".[51]

Sexual and reproductive justice is critically important for indigenous communities and racial and ethnic minorities given structural economic, social, political and cultural marginalization coupled with historical patterns of exclusion and discrimination, including through slavery, colonialism, exploitation and violence. Despite the United Nations Declaration on the Rights of Indigenous Peoples, the lack of recognition of indigenous status and indigenous peoples' specific, collective and territorial rights compound other barriers. Violence against indigenous women and girls is closely linked to the continuing colonial dispossession of their peoples' lands and most commonly involves discriminatory and coercive practices, including acts of sexual abuse and rape against indigenous women human rights defenders. Sexual and reproductive justice approaches require governments to honour the collective rights of indigenous peoples and the principle of free, prior and informed consent.

Globally, systemic racism drastically undercuts sexual and reproductive justice. Racial, ethnic and indigenous disparities in maternal mortality persist in many areas of the world, for instance. In Ecuador, the maternal mortality rate for women of African descent is triple the overall maternal mortality rate. In Colombia, the rate for women of African descent is 1.8 times higher; in Brazil, it is 36 per cent higher.[52] Black women in the United Kingdom are four times more likely to die in pregnancy than White women. Asian women are almost twice as likely to die.[53] Systemic racism is also apparent in the fact that 86 per cent of global maternal deaths occur in sub-Saharan Africa and South Asia.[54, 55]

Indigenous peoples experience disproportionately high rates of maternal and infant mortality.[56] Australia has a more than three-fold difference in maternal mortality for Aboriginal and Torres Strait Islander women compared to non-indigenous women.[57] In Canada, the indigenous maternal mortality rate is more than twice that of the general population.[58]



Case study: Alyne da Silva Pimentel v. Brazil

A 2007 case before the Committee on the Elimination of All Forms of Discrimination against Women addressed sexual and reproductive justice and systemic racism. *Alyne da Silva Pimentel v. Brazil* involved an Afro-Brazilian woman (Ms. Pimentel) who died at age 28 due to pregnancy complications after a Rio de Janeiro health centre failed to provide appropriate and timely access to emergency obstetric care. The complainant argued that this was not an isolated case, citing a WHO survey revealing that "4,000 maternal deaths occur each year in Brazil, representing one-third of all maternal deaths in Latin America."[59] The complainant also relied on the Committee's previous finding that a disproportionately high number of victims in Brazil are women of African descent.

The Committee found Brazil in violation of the Convention on the Elimination of All Forms of Violence against Women in that its policies failed to meet the standard of "being action- and result-oriented as well as adequately funded"[60] with maximum available resources being mobilized to ensure women's right to safe motherhood and emergency obstetric services. The Committee was prepared to go beyond the priorities the State had set out in its National Plan to examine barriers faced on the ground by specific groups. The inclusion of structural factors affecting access to health services, such as poverty and race, was a milestone in the development of an intersectional understanding of sexual and reproductive justice.[61]

Here the sexual and reproductive justice framework illuminates the gap between rights on paper and lived realities, and the need to develop and adequately fund policies paying specific attention to marginalized groups. The case highlights that "reproductive rights are meaningless without addressing the social contexts in which these rights are exercised, including historically oppressive structures of racial and economic inequality." [62] It also provides guidance for addressing issues of anti-racism through sexual and reproductive justice. For example, four things would be required to reduce maternal mortality:

1
Addressing the most prevalent, life-threatening conditions for all pregnant women (haemorrhage, eclampsia and sepsis)

2
Applying the lens of anti-racism and any other forms of discrimination to maternal mortality, with a focus on improving hospital teams' understanding of structural racism and social vulnerabilities

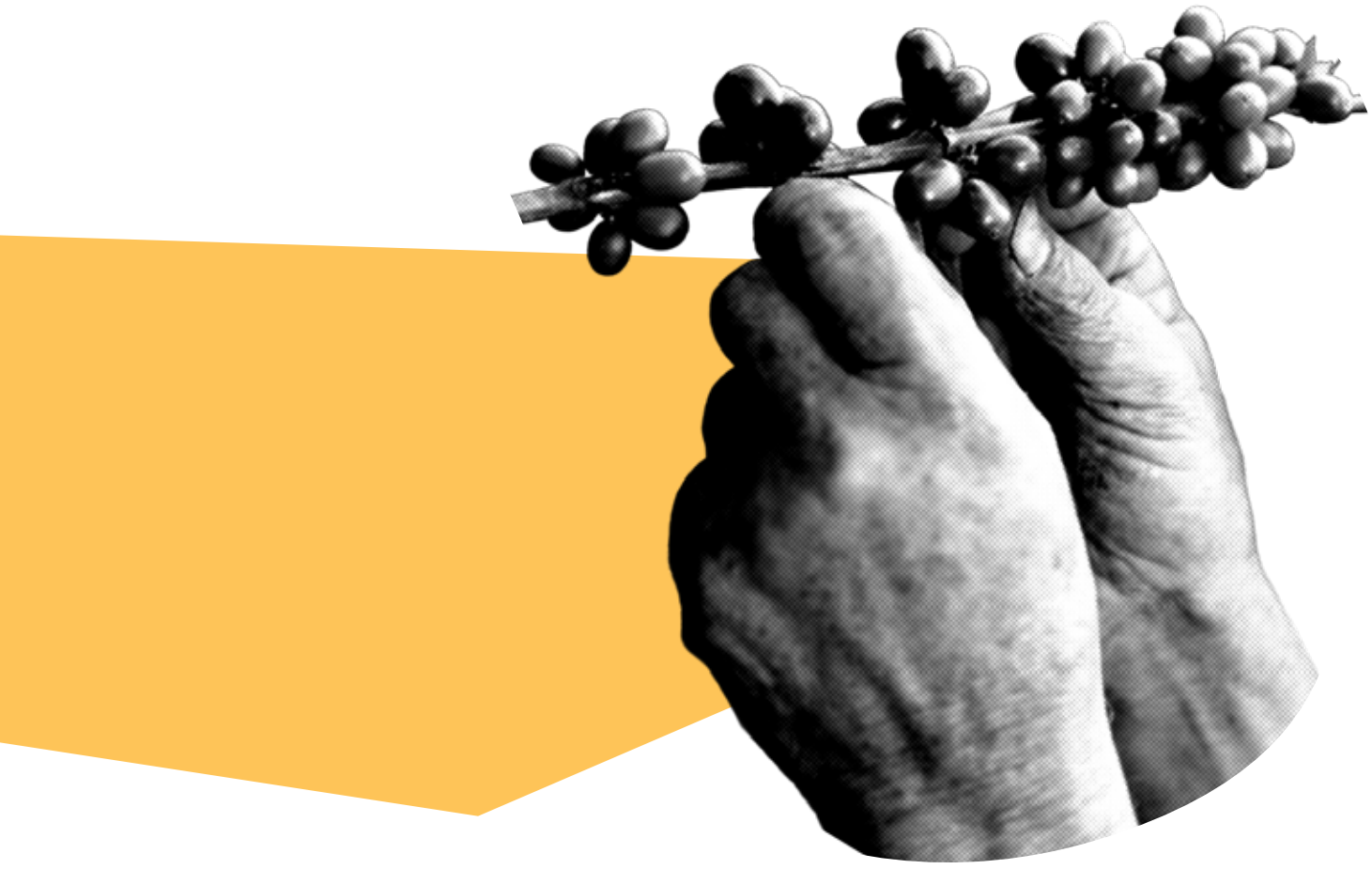
3
Documenting and disaggregating data by race and ethnicity to adequately capture the lived experiences of racial and ethnic minority communities

4
Acknowledging that those on the margins, like Black and indigenous mothers, tend to have little or no decision-making power, and examining how power can be (re)distributed to improve the system and ensure the participation of those who are primarily concerned in programme design and service delivery.

Although *Alyne v. Brazil* was decided over a decade ago, its legacy justifies its inclusion in this report. It was the first maternal mortality case decided by an international human rights body and resulted in the first global decision to uphold sexual and reproductive justice.[63] In 2013, Brazil launched an agenda to address systemic racism in the public health-care system.[64] The case has also helped advance recognition of reproductive rights in Latin America and globally by establishing States' immediate and enforceable human rights obligation to address and reduce maternal mortality.[65]

In an interagency statement, the United Nations Office of the High Commissioner on Human Rights (OHCHR), UNFPA, UN Women, the WHO and other United Nations entities[66] highlighted that indigenous peoples and ethnic minorities are particularly vulnerable to acts of violence, including forced/coercive sterilization, and that it is critical to consider an intersectional perspective on this issue, as is also the case for women with disabilities and women living with HIV.[67] In 2021, Peru heard testimonies from women and men, mostly from indigenous communities, who were forcibly sterilized between 1996 and 2000 as part of government-run poverty alleviation programmes. The hearings were held to determine whether former President Fujimori could be charged for the forced sterilizations of hundreds of thousands of women and men.[68]

In a recent report, OHCHR noted that Uyghur women and other ethnic and religious minority groups in the Xinjiang region of China have experienced coercive enforcement of family planning policies since 2017 in the form of forced sterilizations, abortions and birth control.[69] The United States has a long history of sterilization targeting communities of color, immigrant communities and people with disabilities (often labelled "undesirable").[70] At the same time that Roe v. Wade was decided in the 1970s, approximately 25,000 Native American women were forcibly sterilized by the Government of the United States, a stark demonstration of why an intersectional perspective is fundamental to claiming sexual and reproductive justice.[71]



Forced sterilization in sub-Saharan Africa: Namibia, South Africa and Kenya

Forced and coerced sterilization has been a widespread problem in Botswana, Kenya, Namibia, South Africa and Uganda as well as other parts of sub-Saharan Africa, including in relation to disability, and HIV status.[72] In November 2014, the Namibian Supreme Court[73] decided a case involving three women who had been forcibly sterilized. It unequivocally rejected medical paternalism, emphasizing that individual autonomy and self-determination are overriding principles of the law. The decision had far-reaching consequences for women living with HIV throughout Africa, with similar cases brought in Kenya and South Africa.[74]

In 2020, the Commission for Gender Equality in South Africa released a report after an investigation into the forced sterilization of Black women with HIV.[75] This investigation came about after women's rights activists mobilized behind a call for investigation and government action.[76] The report found that forced sterilization violated the rights to equality and dignity as well as freedom and security over one's body and the right to the highest attainable standard of health care. Clear and specific recommendations were flagged for amending laws relating to sterilization and recognizing the legacy of apartheid laws and infringements on Black women's bodies. Recommendations to the Health Professions Council of South Africa and the Nursing Council aimed to eradicate the practice of forcibly sterilizing women and girls with HIV.

Dalit women in India's caste system

Despite the Indian Government's quota system to guarantee access to jobs, education and political participation for excluded groups,[77] caste-based discrimination remains a pressing issue when considering sexual and reproductive justice. More than 46 per cent of Dalit or so-called "untouchable" women receive no antenatal care, and the average lifespan of Dalit women is 15 years less than for women from higher castes.[78] Access to sexual and reproductive health-care for low-caste women is shaped by the availability of health-care services, transportation costs and experiences of discrimination at points of care.[79]

Widely reported cases of rape and sexual violence against Dalit women evince the reality that gender-based violence is a tool of oppression and control.[80] Few cases of sexual violence against these women are reported; those that are reported often see little recourse to justice.[81]

Dalit activists stress that a lack of legal protections for women in the workplace and education jeopardizes their abilities to support their families and raise their children with dignity, a key facet of sexual and reproductive justice. Gaps in protection directly influence sexual and reproductive health outcomes.

Applying a sexual and reproductive justice framework in Nepal

Women and girls seeking access to modern contraceptives in Nepal face numerous barriers. Those in rural and marginalized communities have access to fewer hospitals and clinics and are therefore less likely to obtain modern contraceptives. Such stumbling blocks effectively deny Nepali women the right to contraceptive information and services, exposing them to a high risk of unintended pregnancy (see also the country profile in Annex B).

In *Lakshmi and Others v. Government of Nepal and Prakashmani Sharma and Others v. Government of Nepal*, the Supreme Court recognized women's reproductive rights and acknowledged women's right to self-determination in relation to their reproductive functions, which encompass abortion, pregnancy and childbearing.[82] The Court ordered the Government to make necessary legal and policy changes to ensure that all women, including those who are marginalized and impoverished, have access to a full range of contraceptives, and to ensure effective implementation of these changes. In 2021, the Government agreed to decriminalize abortion and protect the sexual and reproductive health and rights of women and girls. The move came with Nepal's acceptance of the Report of the Working Group of the Universal Periodic Review on Nepal[83] before the United Nations Human Rights Council.

Indigenous women and girls with disabilities in Nepal struggle with distinct challenges, forms of discrimination and human rights violations. They grapple with multiple identities related to gender, sexuality, age, disability and ethnicity and their intersections. Around 85 per cent of indigenous women and girls with disabilities face forms of violence that are distinct from those faced by indigenous women without disabilities and non-indigenous women with disabilities.[84] Amid prevailing racism, prejudice and inequalities in access to power, a striking 95 per cent of indigenous women and indigenous women with disabilities reported increased violence during the COVID-19 pandemic.

Under the sexual and reproductive justice framework, an intersectional lens permits a collective look at issues affecting indigenous, rural,

disabled women and girls without compartmentalizing multiple intersecting identities. Nepal is making efforts to prioritize the concerns faced by marginalized women, decentralize power and control over resources, create meaningful engagement in decision-making, and strengthen the capacity of marginalized women to access information and comprehensive sexual and reproductive health services.

Disaggregated knowledge production and processes of knowledge production centred on marginalized women and others are urgent under a sexual and reproductive justice framework. Nepal's Nairobi ICPD+25 commitments acknowledge these issues and commit to ensuring that marginalized groups, particularly adolescents and youth, can exercise their reproductive rights. The commitments encompass universal access to quality family planning services, including modern contraception; the upscaling of adolescent-friendly health services; and the full integration of comprehensive sexuality education, consistent with the evolving capacities and needs of young people, in the formal and non-formal education system, with the goal of reducing the adolescent birth rate to 30 per 1,000 women.[85]

Towards cultural relevance

Although patriarchal oppression is universal, the field of global health, and by extension, sexual and reproductive health, retains discriminatory colonial vestiges and practices. The sexual and reproductive justice framework illustrates how colonialism and its enduring aftermath have been tools of discrimination, violence and oppression dependent on the control of the bodies of women, girls and gender-diverse peoples.[86] It considers the historical context of marginalization and discrimination while looking at issues of racism, the legacy of colonialism in Western medical systems[87] and other forms of discrimination, and the need for culturally relevant health services.[88]

Cultural relevance requires developing and incorporating health models and practices that bridge customs by indigenous and other local communities and modern medicine, that treat diverse approaches as complementary, and that avoid patronizing and discriminating against indigenous medicine.[89] A sexual and reproductive justice approach recognizes that the cultural views of indigenous peoples need to be respected, protected and fulfilled to ensure the realization of their sexual and reproductive health and rights. It requires the empowerment of women, especially women from racial and ethnic minorities and indigenous groups, as partners and leaders

in medical practice, and the recognition that systemic racism as well as gender-based discrimination and devaluation in educational and health-care institutions continue to constrain them. The Constitution of Ecuador specifically recognizes and incorporates the right to intercultural health care.[90] Colombia, Guatemala and Peru have similarly adopted programmes to address continuing colonial, Western biases in reproductive health-care services.

Many people lose the choice to have children or not and a safe environment in which to parent due to colonial and post-/neo-colonial systems of power and privilege.[91] In apartheid South Africa, birth control was used as a tool to control the non-White population.[92] In the Caribbean, labour shortages were an impetus for maternal health programmes.[93] Many countries retain colonial-era exemptions from the criminalization for marital rape[94] and still enforce colonial-era penal codes that criminalize homosexuality.[95] Hostility towards sexual minorities has remained even in places that accepted them before colonization.

A decolonizing frame requires deconstructing relations of power and conceptions of knowledge that reproduce racial, gender and geo-political hierarchies. Decolonization is therefore a process of shifting and unravelling tangled colonial relations of power and privilege. As an emergent process, it looks back at history and requires an interrogation of paths to decolonization that draws on anti-colonial movements, anti-racist movements, transnational feminist movements, indigenous movements and Pan-African feminist movements.

Sierra Leone takes a new stance on abortion

In 2022, Sierra Leone's President and Cabinet backed a bill to decriminalize abortion and overturn a pre-independence, colonial-era law dating back to 1861.[96] The bill is due to be debated and signed into law before the end of 2022. This victory came from the massive mobilization of women's groups who have long drawn attention to how colonial-era laws result in high maternal mortality rates.[97] The proposed bill will address not only maternal mortality but also a broad range of reproductive health services. It gives effect to the African Protocol on the Rights of Women (the Maputo Protocol), which explicitly calls out histories of colonization on the continent and the harmful impact of the crime and punishment model of abortion laws when it comes to maternal mortality.[98]

3 Applying the Sexual and Reproductive Justice Framework to Achieve Sustainable Development and Address Humanitarian Crises

Key Messages

- Achieving sexual and reproductive justice is essential to fulfilling the Nairobi commitments and ultimately the SDGs; towards that end, financial systems and data collection mechanisms need more support.
- The humanitarian context offers a particularly critical opportunity to apply a sexual and reproductive justice framework, as shown in Colombia, Uganda and Ukraine.

Seeing the issues, funding the solutions

The realization of sexual and reproductive rights is a fundamental aspect of achieving sustainable development and addressing humanitarian crises. A sexual and reproductive justice framework is essential to success. The SDGs emphasize addressing intersecting oppressive forces that are harming people – the precise approach of the sexual and reproductive justice framework. The Nairobi commitments and the newly adopted UNFPA Strategic Plan 2022-2025 also centre on addressing intersecting oppressions.[99]

The Commission affirms that achieving sexual and reproductive justice is an essential component in fulfilling the Nairobi commitments and ultimately the SDGs. It calls on countries to craft – and fund – an intersectional response addressing economic, social and legal barriers, and obstacles posed by multiple forms of discrimination. The Commission also encourages clearer and more concrete understanding of the vast disparities among various populations.

Both the ICPD25 and Beijing+25 [100] outcome documents endorse intersectionality. As a basis for informed and responsive policies and other interventions, both encourage the continued strengthening of data collection systems.[101] Data disaggregation in particular allows analysis of how intersectional barriers impact access to sexual and reproductive health and rights. While the SDGs and other global monitoring frameworks disaggregate data by sex (along with age, wealth, rural/urban residence and other factors such as level of education), important axes of discrimination, including race and ethnicity, migratory status, disability and sexual orientation and gender identity could be better understood.

A sexual and reproductive justice framework allows countries to ensure that laws and policies that support sexual and reproductive rights are implemented fairly and benefit all. United Nations organizations have important roles in backing this shift, in partnership with women's movements and organizations. Support can comprise undertaking complementary analyses applying a sexual and reproductive justice framework with clearer guidance on the components of the approach.

A closer look at community-developed interventions, gaps in data collection and the aggregate impacts of intersecting forces will create stronger understanding of how to close shortfalls in health care. Midwives, when properly trained and supported, offer one of the most culturally sensitive and cost-effective means to achieve universal care. They could help avert roughly two thirds of all maternal and newborn deaths while delivering 87 per cent of all essential sexual, reproductive, maternal and newborn health services. Yet midwives are in short supply in many developing countries. They often lack the skills and supportive environment to perform their jobs well. Deficits are highest in areas where needs are greatest. Despite their enormous responsibilities, midwives frequently endure poor pay, low status and gender discrimination.[102]

Governments have made multiple international commitments to finance and promote sexual and reproductive

health, gender equality and women's empowerment,[103] including in the ICPD Programme of Action, the Beijing Platform for Action, the SDGs[104] and regional agreements such as the Maputo Protocol. This encompasses domestic resources for development, trade, private capital flows, official development assistance, debt and other systemic issues related to the international financial system. Yet many commitments remain unrealized with no clear accountability frameworks in place to rectify gaps.[105] The Commission highlights the importance of financing to achieve the commitments.

Towards justice in humanitarian action

A sexual and reproductive justice framework is integral to successful humanitarian responses and must be embedded in existing humanitarian coordination and governance systems. As captured in the 2021 High-Level Commission report, humanitarian crises reduce access to abortion, antenatal care, family planning, and other sexual and reproductive health as well as mental health services. This increases rates and consequences from unintended pregnancies, unsafe abortions, sexually transmitted infections including HIV, pregnancy complications, miscarriage, post-traumatic stress disorder, depression, suicide, intimate partner violence, gender-based and sexual violence, and maternal and infant mortality.[106]

Crisis-affected women and girls can experience higher levels of unwanted pregnancies due to unmet needs for contraception and a lack of access to safe abortion.[107] Pregnancy in crises can be life-threatening: Over half of all maternal deaths occur in humanitarian and fragile settings, as do 53 per cent of deaths under age 5 and 45 per of neonatal deaths globally.[108] Over the past two years, needs to respond to gender-based violence in humanitarian settings increased by 120 per cent but only 20 per cent of responses are funded.[109] Recent trends show an increase in the number and extent of humanitarian emergencies, posing major threats to achieving the Nairobi commitments, the ICPD Programme of Action and the SDGs.

Despite notable progress, sexual and reproductive health services in humanitarian settings remain variable. Midwives can play a vital role given the high burden of preventable maternal and neonatal death but factors including security and safety concerns, culture and gender norms and a lack of infrastructure and supplies prevent midwives from delivering essential services.[110] A 2015 study from three crisis-affected settings in sub-Saharan Africa that spanned a 10-year period found that only 5 of 63 assessed health facilities provided adequate emergency obstetric and newborn care, and only 3 provided elements of the clinical management of rape. Safe abortion was unavailable across settings, despite unsafe abortion causing an estimated 25–50 per cent of maternal deaths in refugee settings.[111]

Moreover, most humanitarian policy and programmatic efforts are tailored towards heterosexual, cis-gendered women of reproductive age. Certain groups, such as adolescents and older women, male survivors of sexual violence, sex workers, people living with disabilities, and those of diverse sexual orientation and gender

identity and/or expression, continue to face significant obstacles in accessing information and services in humanitarian settings. Deficient health systems, shortages of skilled health providers, supply stock-outs and restrictive policy environments hinder effective sexual and reproductive health service provision. The application of local discriminatory laws instead of internationally accepted standards also plays a role in allowing third-party consent requirements to block access to sexual and reproductive health services for women and girls.[112]

Deprioritization of sexual and reproductive health and rights by some health and protection actors, political resistance, leadership and coordination challenges, and scarce research are additional barriers in humanitarian and crisis settings. These challenges, alongside inconsistent monitoring, are compounded by inadequate mechanisms to hold humanitarian actors accountable for fulfilling the sexual and reproductive health and rights of crisis-affected populations.

New and emerging threats further jeopardize progress and risk considerable pushback. The climate crisis already contributes to forced displacement, with women and girls accounting for more than half of the 200 million people affected annually. The gendered impacts of climate change are aggravated in settings impacted by armed conflict, political instability and economic strife. Additionally, the rise of authoritarianism and the reinvigoration of nationalism, xenophobia, homophobia, transphobia and antifeminism are eroding funds and creating environments hostile to sexual and reproductive health and rights and women's rights. Socioeconomic and cultural barriers, gender inequality and a dearth of information about the availability and benefits of care also impede service uptake.

National and international humanitarian and development organizations could benefit from applying a sexual and reproductive justice lens to address major gaps and shortcomings in equitably meeting the specific needs of crisis-affected communities. Along with pregnant women, adolescents, older women, female and male sexual violence survivors, persons with diverse sexual orientation and gender identity/expression, sex workers and those living with a disability should be prioritized. This requires partnering with crisis-affected communities and prioritizing the involvement and leadership of marginalized groups, especially local and community-based organizations, in preparing, implementing and monitoring humanitarian response programmes and efforts to increase resilience.

Multiple crisis settings have shown a tendency to prioritize the restoration of political order and physical rebuilding above the timely and reliable delivery of sexual and reproductive health assistance. This neglect is evident in the distribution of funding. Sexual and reproductive health services constitute only a small part of official development assistance to conflict-affected countries, with most funding going to narrowly defined services such as HIV-related care rather than comprehensive care.[113] This reflects the imperative to dismantle unequal patterns of resource distribution and power in the quest for sexual and reproductive justice.

A sexual and reproductive justice framework sheds light on how matters of sexuality

and reproduction gain political meaning in the context of war. It helps to make links between democracy, peace and sexual and reproductive health, and to use that analysis to develop inclusive and comprehensive security agendas, including through sustained humanitarian and development support and finance for local groups promoting sexual and reproductive health. Further, it is not enough to simply make normative assertions that women, girls and marginalized communities are entitled to exercise choice and autonomy over their reproductive functions. Positive conditions must exist to exercise choice meaningfully. This requires steps such as designing humanitarian and transitional justice strategies that address structural barriers to accessing sexual and reproductive health care, such as in indigenous or rural communities, or those imposed due to poverty or illiteracy.

Embedding a sexual and reproductive justice approach more strongly within truth-seeking, accountability and reparations processes gives explicit visibility to sexual and gender-based violence, to the social conditions in which sexual and reproductive rights and agency are exercised, and to the ways these intersect with and impact women's and girls' lives. Sexual and reproductive justice provides a framework to develop transitional justice mechanisms that can disrupt the gendered normalization of control over women's bodies and their reproductive functions.

Politically motivated strategies to control bodily autonomy and reproductive capacity have occurred in many places, with grave consequences. During the conflict in the former Yugoslavia, evidence emerged of detained women being raped and forcibly impregnated to ensure they would give birth to children of the perpetrator's ethnicity, a means of ethnic cleansing.[114] Similarly, during the genocide in Rwanda, many women and girls became pregnant as a result of rape, while women who were already pregnant suffered miscarriages after being raped and beaten by Hutu militia.[115] In the eastern region of the Democratic Republic of the Congo, armed groups perpetuate the systematic use of sexual violence amid mass population displacement.[116] There are many distressing reports of criminal organizations terrorizing neighbourhoods in Haiti's capital, Port-au-Prince, including through the mass rape of women and children.[117]

Practices of forced marriage, with couples being coerced into having intercourse under threat of punishment, have been employed to increase birth rates and ensure the continued existence of a particular group in a number of contexts, for instance, by the Khmer Rouge in Cambodia and by the Lord's Resistance Army, a non-state armed group active in northern Uganda and neighbouring countries. The Russian Federation has recently moved to ostracize "child-free people" as anti-Russian in the context of military incursions in Ukraine.[118]

These examples illustrate how beyond the purposeful politicization of sexual and reproductive health and rights, women's health has suffered from the collateral damages of war. In conflict and humanitarian settings, the most marginalized women have been particularly affected by a discriminatory nexus of poverty, ethnicity and geographic inequality

Wide-ranging consequences from the crisis in Ukraine

The invasion of Ukraine by the Russian Federation has forced millions of women and girls to flee their homes.[119] This has subjected them to acts of sexual violence, such as gang rape and coercion, and put them at increased risk of human trafficking for sexual exploitation and transactional sex.[120] The invasion has also created serious challenges and barriers to accessing sexual and reproductive health care.[121] The WHO has documented over 500 confirmed attacks that impacted health-care facilities.[122] An OHCHR report verified damage or destruction to 182 medical facilities, 111 of which were hospitals, including 10 perinatal centres and maternity hospitals and 17 children's hospitals.[123]

Certain population groups, such as people living with disabilities, persons of diverse sexual orientation or gender identity, and people belonging to certain racial, ethnic and religious minorities, face particularly acute dangers to their lives, safety and health, including sexual and reproductive health.[124] For persons with disabilities, for example, the situation is appalling. They often lack access to bomb shelters and evacuation trains, and many long-term care facilities confront insufficient supplies of food, medication and hygiene products.[125]

Sexual and reproductive health concerns affect not only those in conflict-affected areas of Ukraine but also the millions of people who are now refugees in neighbouring countries. By April 2022, over 1 million people had sought refuge in other countries, with many fleeing next door to Poland. While abortion is legal in Ukraine, Poland is now one of the most restrictive countries for abortion access.

Colombia makes links to transitional justice

Recent developments in international law suggest that greater sensitivity to links between sexual and reproductive health and rights and a transitional justice agenda are emerging. One significant development is in Colombia, where the Constitutional Court in 2019 issued a decision on forced abortion and forced contraception within the Revolutionary Armed Forces of Colombia. The decision was one of the first to directly address reproductive violence in the context of a transitional justice process.[126]

The Constitutional Court held that forced contraception and forced abortion amounted to gender-based violence and that: "The State should ensure specialized care and assistance for women and girls of all ages who have survived sexual violence committed by armed actors, which includes the obligation to provide victims with immediate, comprehensive, and specialized assistance, with a differential approach and as long as necessary to recover from the physical and psychological harm resulting from the abuse they suffered." [127]

This case brought sexual and reproductive justice within the realm of transitional justice and the Truth Commission of Colombia, which opened the door to wide-ranging relief, including reparations and a broader historical and contextual analysis of reproductive coercion and violence in conflict. The case shows that adopting a sexual and reproductive justice approach helps examine how best to respond to reproductive harm during periods of conflict and large-scale violence. Further, it has potential to disrupt the gendered inequalities that make individuals vulnerable to such violence in the first place.

The International Criminal Court and Uganda

In 2021, the International Criminal Court convicted Dominic Ongwen, a Ugandan Lord's Resistance Army commander, of the forced impregnation of women and girls, among other charges. Many women and girls abducted by the Lord's Resistance Army became pregnant through rape and were confined and monitored closely to ensure they did not miscarry. Others who did not become pregnant were punished.

During the trial, witnesses testified to reproductive harms attached to forced pregnancy, including those embedded within cultural and gendered norms around family life. Both mothers and their children experienced stigma and challenges to reintegration upon returning to their communities. Some women were rejected due to their perceived affiliation with the Lord's Resistance Army, meaning their children were viewed as the children of army commanders. This also meant that children fell outside social and economic kinship structures, negatively affecting their economic security and access to health, education and employment.

As a result of rejection by communities or new partners, some women were separated from their children, causing them significant emotional distress. Due to gender norms placing sole responsibility for the care of children on mothers, witnesses also described the broader impacts on their lives of being forced to parent a child at a young age, including obstacles to educational opportunities, professional ambitions and livelihoods. This kind of contextual analysis beyond the original act of violence allowed for a more structural and systemic analysis of harm, its causes and consequences, and available remedies with a strong emphasis on reproductive autonomy and choice.

In February 2021, the Trial Chamber endorsed this analysis, concluding that "the crime of forced pregnancy is grounded in the woman's right to personal and reproductive autonomy and the right to family". The Chamber emphasized the importance of fair labelling, distinguishing forced pregnancy from other crimes of sexual and gender-based violence partly on the basis that one of its distinctive

elements is “the effect that the woman is deprived of reproductive autonomy”. The fact that this case centralized the notion of reproductive autonomy is significant because it strengthens understanding that forced pregnancy is not simply a matter of sexual violence or physical harm. It also constitutes violence because of the loss of decision-making power over one’s reproductive capacity; this requires independent recognition.

Framing this crime in terms of a violation of autonomy conceptualizes acts of reproductive violence in a way that strengthens narratives around women’s agency and control over their bodies and reproductive lives as part of the discourse on war crimes and crimes against humanity. It also recognizes that these violations move beyond “health” to the realms of peace, security and democracy, allowing for the kind of structural analysis that sexual and reproductive justice demands.


oppression

4 Advancing Sexual and Reproductive Justice in Practice

Key Messages

- Many countries have taken important steps towards fulfilling the Commission's 2021 Call to Action but challenges remain.
- The high number of Nairobi commitments prioritizing sexual and gender-based violence in all regions may offer a powerful entry point for promoting broader sexual and reproductive justice approaches within and across regions and States.
- Private sector engagement with the Nairobi Summit commitments is critical to success.

Aligning actions and commitments

At the Nairobi Summit, governments, civil society, the private sector, parliamentarians, youth groups, academia, regional organizations, representatives of indigenous peoples, people with disabilities and faith-based organizations made over 1,300 commitments that align with the 12 core global commitments in the Nairobi Statement. The latter include:

Intensify efforts for the full, effective and accelerated implementation and funding of the ICPD Programme of Action, Key Actions for the Further Implementation of the Programme of Action of the ICPD, the outcomes of its reviews, and the 2030 Agenda for Sustainable Development

Zero unmet need for family planning information and services, and universal availability of quality, accessible, affordable and safe modern contraceptives

Zero preventable maternal deaths and maternal morbidities

Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality and timely services

Zero sexual and gender-based violence and harmful practices, and elimination of all forms of discrimination against all women and girls

Increasing domestic financing

Increasing international financing

Investing in the education, employment opportunities and health of adolescents and youth so as to fully harness the promises of the demographic dividend

Building peaceful, just and inclusive societies, where no one is left behind

Providing quality, timely and disaggregated data

Committing to the notion that nothing about young people's health and well-being can be discussed and decided upon without their meaningful involvement and participation

Upholding the right to sexual and reproductive health services in humanitarian and fragile contexts

An extensive, initial review considered 775 stakeholder commitments made by 111 governments,[128] out of the 145 that participated in the Summit.[129] Of these commitments, 56 per cent fell into the following areas: universal access to sexual and reproductive health and rights, safe abortion, comprehensive sexuality education, sexual and gender-based violence, and sexual and reproductive health and rights and gender equality in the political architecture. Other commitments addressed additional issues under the ICPD Programme of Action and within the five main themes of the Summit.

Africa had the highest number of commitments aligned with the themes defined in the analysis, with the greatest number focusing on gender equality and sexual and gender-based violence. Europe and Central Asia followed with sexual and gender-based violence again leading in the number of commitments. The Americas also put the largest focus on sexual and gender-based violence. Commitments by Arab States aligned primarily with sexual and gender-based violence and universal health coverage, as did those by countries in East Asia, South-East Asia and Oceania. South Asian countries made the smallest number of commitments aligned with the themes of the review of commitments, with equal numbers focusing on gender equality and sexual and gender-based violence.[130]

By region, the Americas made the greatest number of commitments to safe abortion rights; nine countries committed to these. Europe and Central Asia followed with two. Eritrea was the only African country that made a commitment to safe abortion care. It agreed to reduce preventable maternal deaths to zero through integrating access to safe abortion, to the full extent of the law, into universal health coverage strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights.

All regions made a broad range of data commitments. These varied in scope and focus, generally including the implementation of country-wide censuses, the need for data disaggregation and the inclusion of vulnerable groups, and the use of quality data to inform programme design and implementation. Some relate to the generation of reports on the implementation of the ICPD Programme of Action, with a focus on sexual and gender-based violence and gender equality. Most address the need for data collection analysis to inform programming. Data commitments also included strengthening national statistical systems and HIV prevalence surveys.

Numerous country-level commitments aligned with a sexual and reproductive justice framework by paying explicit attention to marginalized and vulnerable populations. Groups that appeared more consistently include people with disabilities, refugees, migrants (particularly migrant women) and older persons. Indigenous peoples, people of African descent and other ethnic minority groups, while having some commitments, received less attention.

The high number of Nairobi Summit commitments prioritizing sexual and gender-based violence in all regions suggests this may be a powerful entry point for promoting broader sexual and reproductive justice approaches within and across regions and States. As the Colombia, Nepal and

Uganda case studies have highlighted, emerging jurisprudence and good practices in addressing violence within a sexual and reproductive framework exist. These can be a source of shared learning and inspiration. Similarly, the widespread adoption of data commitments creates opportunities to ensure that data adequately capture the intersecting challenges faced by the most marginalized and vulnerable populations, and are used to inform laws, policies and programmes.

Countries are bringing their commitments into national plans and policies

Over the past two years, among developing countries tracked by UNFPA, at least 77 have created national action plans to implement their national Nairobi commitments, integrated commitments into national or sector policies and/or developed systems to monitor progress. They include: Albania, Angola, Argentina, Bangladesh, Benin, Bolivia, Burkina Faso, Cambodia, Cameroon, Central African Republic, Chad, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, Federated States of Micronesia, Fiji, Georgia, Ghana, Guinea, Guinea Bissau, Haiti, India, Iraq, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Mexico, Morocco, Myanmar, Nepal, Nicaragua, Nigeria, North Macedonia, Pakistan, Paraguay, Peru, Philippines, Rwanda, Samoa, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Syria, Thailand, Tonga, Tunisia, Turkey, Turkmenistan, Uganda, United Republic of Tanzania, Vanuatu, Viet Nam and Zimbabwe.

Momentum towards sexual and reproductive justice

The Commission, as it did in its 2021 report, reiterates that achieving the Nairobi commitments depends on advancing a unifying framework for sexual and reproductive justice. This report lays out the applicability of this framework in various contexts. Over the last year, the Commission has seen multiple countries heed its 2021 Call to Action and advance on the commitments, with many interventions cutting across multiple recommendations and commitments. The Commission appreciates this development as a critical step towards a sexual and reproductive justice framework and the accelerated momentum it can unleash.

The 2021 High-Level Commission Call to Action

1. **Make sexual and reproductive justice the goal.** Conduct all work on sexual and reproductive health and rights under a justice framework. This must consider human rights and fundamental freedoms as universal, indivisible, interdependent and interrelated.
   - Establish and use mechanisms for accountability.
   - Invest in people's movements to claim sexual and reproductive justice.
   - Strengthen and forge new alliances with parliamentarians.
2. **Put rights and development at the core.** Develop universal health coverage with comprehensive sexual and reproductive health and rights as essential services.
   - Use the COVID-19 recovery to jumpstart universal health coverage.
   - Scale up support for midwives as a proven investment.
   - Listen to health-care users to uphold their rights and improve the quality of care.
3. **Think differently.** Pursue recent innovations in health-care service delivery to accelerate sexual and reproductive justice and support people's agency and bodily autonomy.
   - Develop the potential of self-managed care.
   - Pursue digital innovations while tackling the digital divide.

4 **Reach further.** Prioritize groups facing the worst disparities in sexual and reproductive justice.

- Close gaps in humanitarian action and plan ahead.
- Reach youth on their terms.

5 **Show the money.** Increase domestic and international finance for sexual and reproductive health and rights at levels sufficient to achieve sexual and reproductive justice.

- Make expenditure visible and measurable.
- Introduce no-cost comprehensive services for sexual and reproductive health and rights.
- Explore new avenues for finance.
- Forge alliances with new partners.

6 **Tell a new story.** Create new narratives around sexual and reproductive justice that are accurate and powerful enough to counter ongoing opposition.

- Develop more robust systems to collect and use data.
- Inspire broad support and action.

A slew of new reproductive rights legislation has followed the Nairobi Summit, towards establishing a sexual and reproductive justice framework in line with **Global Commitment 1**, on intensifying ICPD implementation and **Call to Action 1**, on making sexual and reproductive justice the goal.

In Latin America, the "Green Wave" or "Marea Verde," a regional movement for expanding sexual and reproductive rights, has continued to accelerate positive change. The Wave began in Argentina in the early 2000s, when activists waved green handkerchiefs at protests to symbolize reproductive freedom.[131] The handkerchiefs were a nod to the white scarves used by Argentinian mothers who protested their children's disappearance under dictator Jorge Rafael Videla's regime in the 1970s. Their efforts spanning two decades paid off when Argentina legalized abortion up to 14 weeks in 2020.[132]

Mexico soon followed, declaring in September 2021 that criminalizing abortion is unconstitutional.[133] The latest country impacted by the Green Wave is Colombia. In February of 2022, the Constitutional Court responded to a 2020 lawsuit from activist groups by decriminalizing abortion up to 24 weeks of pregnancy and instructing Congress to write and implement new laws that expand access to sexual and reproductive health

care. This makes Colombia one of the most progressive nations in its region in terms of sexual and reproductive rights.[134] It follows global trends: 58 countries – including recent examples such as Benin, Ecuador, Kenya, New Zealand and the Republic of Korea – have liberalized their abortion laws since 1994. Only four countries have regressed on abortion rights.[135]

Some improvement is evident under **Global Commitment 2**, on meeting unmet need for family planning. Central and Southern Asia, Latin America and the Caribbean, Northern Africa and Western Asia all moved from orange to yellow in terms of progress in 2022, although still have far to go to reach the goal of zero unmet need (see Annex A for the results of the Global Commitments Monitoring Framework).

As part of its Nairobi commitment to ensure universal access to family planning and reproductive health services, Pakistan in 2020 conducted a first-ever landscape analysis of its family planning commodities supply chain to identify bottlenecks and solutions. The Government also passed the Anti-Rape (Investigation and Trial) Act in 2021 to expand legal redress and justice for survivors, effective prevention measures and multisectoral responses. A parliamentary forum brings together parliamentarians committed to addressing population dynamics, family planning and other issues. Recent catastrophic floods, however, threaten progress. The Commission deems it critical, as part of the humanitarian Inter-Agency Standing Committee's system-wide scale up, that UNFPA expand its capacity to deliver integrated sexual and reproductive health and gender-based violence services at health facilities, mobile clinics and gender-based violence one-stop centres.

With no positive movement registered in any region for **Global Commitment 3**, on zero preventable maternal deaths, improved access to family planning has yet to translate into improved maternal health outcomes. Skilled birth attendance remains low for too many countries, especially among the poorest, least educated and rural populations, as indicated in the country profiles, such as those of Haiti, Nepal and the United Republic of Tanzania (see Annex B). Countries that have increased the deployment of midwives or nurses at births, usually in facilities, have seen some success. For instance, Malawi's maternal mortality rate fell by more than 50 per cent as the percentage of births in a health facility increased by 83 per cent and the percentage of midwife/nurse-assisted births rose by 36 per cent.[136]

The Swedish Government commissioned the National Board of Health and Welfare to implement improved maternity care and women's health. The instruction has a focus on ensuring the continuum of care and creating national guidelines so that midwives can accompany the patient before, during and after childbirth in a coherent chain of care, according to the "caseload midwifery" model.[137]

In line with **Global Commitment 2** and **Call to Action 1**, the Vice President of the United States announced a drive to reduce maternal mortality and morbidity. The country has some of the highest rates in the developed world, with disproportionate levels among Black and indigenous women.[138] The Government recently launched an initiative detailing 50 actions, including those focused on structural forces driving maternal health disparities, such as environmental stressors and housing, food and/or economic insecurity.[139]

As a cross-cutting effort and direct contribution to **Call to Action 2**, on putting rights and development at the core, the Commission commends the WHO for releasing its handbook entitled "Critical considerations for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach." It offers guidance on the inclusion of comprehensive sexual and reproductive health services in health benefit packages, planning and implementation of integrated packages of sexual and reproductive health services, as well as accountability processes and measures for ensuring universal access to all essential sexual and reproductive health services. The Learning by Sharing Portal tool, developed through a longstanding partnership between the WHO and UNFPA, offers a repository of qualitative case studies on integrating sexual and reproductive health in wider universal health coverage-related reforms.[140]

The COVID-19 pandemic resulted in many different initiatives for sexual and reproductive health self-managed care, such as self-management of medical abortions. Towards **Call to Action 3**, on thinking differently, the Asia Pacific Alliance developed an advocacy toolkit of good self-care practices by civil society-led sexual and reproductive health initiatives, highlighting how self-care contributes to strong health systems.

Towards **Global Commitment 4**, on service access and information for adolescents and youth, and in line with **Call to Action 4**, on reaching further, the Commission notes some improvement in young people's access to comprehensive and age-responsive information and education, and adolescent-friendly, comprehensive, quality and timely services. In Central and Southern Asia, the indicator moved from red in 2021 to orange in 2022, although much more remains to be done in this region and others.

The Transforming Education Summit that took place in 2022 saw 130 countries commit to transforming education, which is critical to sexual and reproductive health outcomes. The country profiles underscore that those with the least education have the highest rates of adolescent births, child marriages and unmet need for family planning and the lowest rates of skilled birth attendance. Ensuring that adolescent girls, regardless of their background, can stay in school, is fundamental to the Nairobi commitments and the SDGs. This includes measures to support equity, inclusion and non-discrimination as well as gender-transformative curricula that integrate comprehensive sexuality education and address gender-based prejudices, norms and stereotypes.

In 2021, the United Republic of Tanzania announced that pregnant schoolgirls and adolescent mothers could continue their education, ending a discriminatory policy that barred them from school.[141] It is also revolutionizing how sexual and reproductive health education is taught both in and out of school through 3D animation, tackling the challenges and inequalities that continue to constrict young girls' rights and choices, including gender-based violence and harmful practices such as female genital mutilation, early, child and forced marriage, and adolescent pregnancy. Each animation uses an instantly recognizable female role model to offer information and inspiration to her audience.

In 2023, the fifty-sixth session of the Commission on Population and Development will discuss "population, education and sustainable development". The sixty-seventh session of the Commission on the Status of Women will consider "innovation and technological change, and education in the digital age for achieving gender equality and the empowerment of all women and girls". The Commission welcomes the two meetings as important opportunities to continue to put comprehensive sexuality education on the multilateral agenda and to make gains that reflect its centrality in achieving sustainable development, gender equality and advances in the rights and empowerment of all women and girls.

Certain regions and countries have made progress in advancing **Global Commitment 10**, on providing timely, quality and disaggregated data. Central and Southern Asia moved from red in 2021 to orange in 2022, as did Oceania. In Uzbekistan, UNFPA supported the Makhalla and Family Scientific-Research Institute to develop the concept of demographic resilience. This will help track and address emerging and accelerating trends, including ageing, urbanization and migration. Demographic resilience anticipates demographic shifts, understands their implications, and guides the design of evidence- and human rights-based policies. It marks a shift from narrow population-only approaches to integrated demographic and socioeconomic policies aimed at ensuring prosperity and well-being for all.

In 2021, as part of realizing **Global Commitment 12**, on upholding rights and fragile and humanitarian contexts, more than 100 health professionals and 10 mobile health teams deployed to strengthen maternal and sexual and reproductive health provision across 175 emergency-affected health facilities in Ethiopia. They provided critical services to over 1 million people in the most underserved areas. UNFPA also provides sexual and reproductive health services to affected populations in South Sudan, including in Protection of Civilians sites, and has a network of one-stop centres offering integrated services to survivors of gender-based violence.

In Bangladesh, in the Cox's Bazar refugee camps, Rohingya community activists have pointed out that the lack of privacy, alongside harmful gender norms, has left people, particularly women and girls, vulnerable to various forms of violence. A program called SASA! (Start, Awareness, Support and Action) has trained more than 2,300 activists, including both male and female community and religious leaders, within the camps and in surrounding host communities to challenge the norms underlying gender-based violence. Since December 2020, the activists have reached nearly 100,000 people with messages about gender equality and ending violence.

Civil society organizations continue to advocate for the implementation of the Minimum Initial Service Package (MISP) For Sexual and Reproductive Health in Crisis Situations. The agreed conclusions of the Commission on the Status of Women in 2022 called for "tak(ing) concrete measures to realize the right to the enjoyment of the highest attainable standards of physical and mental health for all women and girls, including in humanitarian settings."

While **Global Commitments 6 and 7** and **Call to Action 5** make the realization of sexual and reproductive justice contingent on finance, domestic and international, persistent underfunding[142] of services means that more than 4 billion people globally will lack access to at least one key sexual and reproductive health service during their lives. In many cases, these services remain funded mostly through out-of-pocket payments, although fully meeting all the needs of women in low- and middle-income countries for contraceptive, maternal, and newborn care through public resources would cost as little as $9 per capita annually.[143]

In low-income countries with the highest health burdens, external donor funding remains a significant source of funding for sexual and reproductive health services. Reproductive health services (maternal and perinatal health and family planning) receive 9 per cent of global donor funding for health.[144] To progress towards universal health coverage – and to ensure both overall sustainability and access to health services and financial protection – health services should be funded predominantly through domestic public funding that combines taxes and prepayment mechanisms. While public spending on health per capita has increased substantially in upper- and middle-income countries over the past decades, it has barely increased in low-income countries.

Enormous funding gaps continue to be among the key challenges to progress on sexual and reproductive health and universal health coverage in the SDG era. Required investments include improvements in the measurement and tracking of resource flows for sexual and reproductive health services, including out-of-pocket payments, disaggregated by gender and key equity indicators. An expanded evidence base should reveal the impact of health financing reforms on access to sexual and reproductive health services and on health outcomes.[145]

In Morocco, based on a social protection framework agreement, the Government plans to offer a national public health insurance plan for all citizens by the end of 2022 while also ensuring free sexual and reproductive health services at primary health-care facilities.[146] As part of the Social Security Financing Bill 2022 in France, Parliament supported the provision of free contraception to girls and young women aged 15–25 years (compared to 15–18 years previously). In Scotland, new legislation to fight period poverty makes free menstrual products available to anyone who needs them. The Government in Namibia eliminated a 15 per cent tax on period products.

Towards **Call to Action 6**, on telling a new story and inspiring broad-based support, the ACT Alliance Gender Justice Programme is working closely with its faith-based members and national and regional forums and platforms to harness the value-based power of faith actors to advance sexual and reproductive health and rights. In Argentina, the ACT Forum is confronting fundamentalist and hateful discourses that oppress, manipulate and deny the fundamental freedoms of women and girls in all their diversity. In Guatemala, the ACT Forum is inspiring broad support and action by tackling religious fundamentalism, chauvinism and resistance to women's rights and sexual and reproductive health and rights.

In Kenya, having played an instrumental role in mobilizing, sensitizing and consolidating youth voices in the build-up to the Nairobi Summit, the ICPD25 Youth Coalition reinvigorated its efforts in 2021. Youth-led and youth-serving organizations have been key champions for the national action plan to implement Kenya's commitments. Globally, a platform of youth advocates is engaging with young people to keep momentum going behind the Nairobi commitments as the world moves towards the ICPD30 anniversary and review process.

Calls to Action 5 and 6 recognize the critical role of private sector engagement in the Nairobi commitments and the broader quest for sexual and reproductive justice.[147] Accordingly, the Universal Access Project, an initiative of the United Nations Foundation, convenes philanthropists, advocates and companies to drive systemic, policy and programmatic changes that ensure women and other workers have access to the health services, products and information they need.[148] More such initiatives are needed, along with the development of robust accountability mechanisms, including to gauge the impact of industry-created environmental exposures on sexual and reproductive health outcomes and health overall. The Commission emphasizes that the private sector must adhere to human rights standards.

Accountability systems for the private sector should be built on shared metrics and standards and linked to existing systems, such as the SDGs. Using standardized metrics can create peer pressure and help advance systemic change. In addition, in line with Call to Action 6, the business case for sexual and reproductive health, rights and justice needs to be strengthened by engaging civil society and other stakeholders and including perspectives from employees as well as consumers. The private sector is also a key partner in ensuring broader outreach and reshaping gender norms, including through media.

Despite many points of progress on the global commitments and the Call to Action, the Commission remains concerned about backsliding on gender equality. Many women face greater poverty and fewer choices around sexual and reproductive health.[149] Eastern and South-Eastern Asia moved from yellow in 2021 to orange in 2022 in its score on **Global Commitment 1**, on accelerated implementation of ICPD commitments. It moved from green to orange on **Global Commitment 12**, on humanitarian responses. Europe and Northern America also pulled back on Global Commitment 12, from yellow to red, largely due to the war in Ukraine and challenges in meeting the sexual and reproductive health needs of those who have been displaced.

Stepping up reporting and accountability

Countries report on advances towards universal access to sexual and reproductive health care services and reproductive rights in line with the SDGs as part of the Voluntary National Reviews presented to the United Nations High-Level Political Forum.[150] Several countries have specifically integrated and reflected on the implementation of their Nairobi commitments as part of their reviews. The Commission commends countries for using this accountability

mechanism for this purpose. It wishes to recognize the 2021 reviews of Lao People's Democratic Republic, Madagascar, Sierra Leone, Tunisia and Zimbabwe, and the 2022 reviews of Botswana, Jordan and Mali for highlighting their Nairobi commitments and progress in implementation.

Sierra Leone reported in its 2021 Voluntary National Review that it committed to the overall goal of zero unmet need for family planning services by 2030 as well as the establishment of a family planning unit in the Ministry of Health to follow up on budget allocations. The Minister of Planning and Economic Development has sought to enhance transparency by providing frequent updates on the Nairobi commitments. In line with its commitment to achieve zero preventable maternal deaths by 2030, Sierra Leone reported plans to train and employ 1,000 midwives, 180 nurse anesthetists and 72 surgical assistants by 2025. From 2019 to 2020, it trained a total of 406 midwives, 24 surgical assistants and 50 nurse anesthetists. It intends to reduce maternal mortality by 50 per cent by 2028. Already, the rate has fallen by 38.5 per cent from 2013 to 2019.

In its 2022 Voluntary National Review, Jordan reported that it has prepared a draft national plan to implement the Nairobi commitments from 2021 to 2030 and to reach zero unmet need for family planning, zero maternal deaths and zero family violence by 2030.

Since the Nairobi Summit, the Human Rights Council's Universal Periodic Review has gained traction as a mechanism to hold Member States accountable for follow-up. Since last year's High-Level Commission report, the thirty-ninth session of the Universal Periodic Review examined Antigua and Barbuda, Eswatini, Ireland, Papua New Guinea, Saint Vincent and the Grenadines, Samoa, Suriname, Tajikistan, Thailand, Trinidad and Tobago and the United Republic of Tanzania. Of 2,176 recommendations made by the Council to these countries, at least 959 (44 per cent) related to global and national Nairobi commitments. Burkina Faso, Panama, Slovenia and Spain made recommendations explicitly mentioning the Nairobi Summit, while other countries drew language from Summit commitments.

The fortieth session considered reports by Haiti, Iceland, Moldova, South Sudan, Sudan, Syrian Arab Republic, Togo, Uganda and Zimbabwe. They received 2,249 recommendations, of which at least 781 (35 per cent) related to the Nairobi Summit. This strong alignment creates unique opportunities to integrate Nairobi Summit commitments in national implementation, monitoring and reporting processes related to the Universal Periodic Review, leading up to the next round for these sets of countries four years from now.

Parliamentarians in various countries, including Bangladesh, the Democratic Republic of the Congo, Denmark, Norway and Pakistan, have held dedicated sessions on national Nairobi commitment follow-up. To help reduce the adverse effects of the pandemic and accelerate progress on the commitments, UNFPA and its partners joined parliamentarians from Asia and Africa in June 2022 to agree to mobilize and educate communities on the relevance of the commitments; address demands for sexual and reproductive health services; hold leaders and service providers accountable for ensuring people-centred, quality sexual

and reproductive health services; and assess and propose appropriate laws to facilitate implementation of commitments.[151]

Parliamentarians from around the world highlighted the importance of health equity at the 144th Assembly of the Inter-Parliamentary Union, with a particular focus on promoting the health of women, children and adolescents. Some 110 national parliaments gathered in March 2022 in Nusa Dua, Indonesia, where a frank discussion took place at the thirty-third session of the IPU Forum of Women Parliamentarians[152] about the impact of COVID-19 on health, including on sexual and reproductive health and rights.

Parliamentarians shared actions taken to strengthen sexual and reproductive health services during the pandemic, including efforts to increase national health budgets, introduce gender-responsive legislation and hold government programmes accountable.[153] Significant parliamentary action has included investigations of escalating teenage pregnancy rates during the pandemic in the Seychelles, South Africa and Uganda, and addressing legal and administrative barriers to sexual and reproductive health. By revising legislation on civil registration and vital statistics, the Parliament of Rwanda contributed to ensuring individuals have a legal identity and thus access to vital rights and services.[154]

In October 2022, at the 145th IPU Assembly in Kigali, Rwanda, parliamentarians adopted the Kigali Declaration, which encourages parliaments to step up efforts to promote gender equality. It commits IPU members to end gender-based discrimination, violence and other harmful practices, and to ensure access to sexual and reproductive health, rights and justice for all women and girls.[155]

The Summit of Women Speakers of Parliament makes the link to justice

The fourteenth Summit of Women Speakers of Parliament, held in Tashkent, Uzbekistan in September 2022,[156] adopted a declaration with language on sexual and reproductive health, rights and justice as central to the realization of social justice and the achievement of global, regional and national sustainable development.

The declaration calls for prioritizing efforts to address vulnerabilities resulting from gaps in the sexual and reproductive health and rights of women and girls, especially during crisis response and recovery efforts. It underscores promoting and protecting universal access to sexual and reproductive health and rights as a prerequisite to advancing gender equality, social justice and sustainable development.

Mobilizing regional support through the Maputo Plan of Action and the Maputo Protocol on the Rights of Women in Africa

The Maputo Plan of Action 2016-2030 seeks to ensure universal access to sexual and reproductive health and rights across the African continent through 10 key strategies. These are geared towards operationalizing the commitments of the Continental Policy Framework on Sexual and Reproductive Health and Rights.[157] Significantly, one commitment relates to translating the ICPD and Beijing+20 commitments into national legislation and policies on sexual and reproductive health and rights.

Analysis of commitments by countries in the region showed that 41 per cent are linked to the UNFPA three zeros:[158] zero unmet need for family planning, preventable maternal mortality and gender-based violence. Overall, 49 per cent align with Nairobi Summit commitments related to demographic diversity, financing the ICPD, gender-based violence, sexual and reproductive health care in humanitarian and fragile contexts, and universal health coverage.

Nairobi Summit commitments by African governments largely align with the Maputo Plan of Action and its strategic interventions, with some important differences. The commitments represent strong political buy-in for ending sexual and gender-based violence and sexually transmitted infections including HIV, ensuring access to contraception, preventing maternal and child mortality, and ending child, early and forced marriages and female genital mutilation. There is significant commitment to providing youth-friendly programmes, including access to sexual and reproductive health care, and to data collection to inform programme design and implementation and, in some instances, to ensure the inclusion of vulnerable groups. Comprehensive sexuality education and universal health coverage, however, do not feature as significantly in the Nairobi commitments as they do in the Maputo Plan of Action recommendations and the East and Southern Africa Commitment on comprehensive sexuality education.

There appears to be a disconnect between the lack of commitment on abortion in the ICPD25 process and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol). The latter is the main legal instrument to protect the rights of women and girls in Africa. It explicitly mentions abortion rights, unlike most international treaties on women's rights.

General Comment No. 2 on Article 14 of the Maputo Protocol addresses various aspects of sexual and reproductive health, including access to safe abortion services, contraceptive services and sexuality education for young people. It urges African governments to ensure the removal of barriers to sexual and reproductive health services. General Comment No. 2 is historic in breaking the silence on some contentious sexual and reproductive health issues not often addressed within the African human rights system. Since the Maputo Protocol was passed, seven countries have reformed their laws to meet — and in one case, exceed — the African Union's legal criteria of allowing abortion when the woman's life or physical or mental health is threatened, and in cases of rape, incest and grave fetal anomaly.[159]

Viewing sexuality as strictly heteronormative has led to the criminalization of persons of non-heteronormative and diverse sexualities in some parts of Africa. This infringes on individual rights to equality and non-discrimination, privacy and inherent dignity. Other concerns relate to gaps in services and information for those in vulnerable situations or historically subjected to discrimination, such as adolescent girls, migrant women, women with disabilities, urban slum dwellers, people experiencing homelessness, refugees and persons of diverse sexual orientation and gender identity and communities. A further challenge is that only 13.2 per cent of Africa's commitments relate to financing sexual and reproductive health and rights or the ICPD agenda.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5 Conclusion

The Nairobi Summit illuminated how national mechanisms, donors and international development and humanitarian organizations must better address underlying intersecting injustices and emerging challenges driving poor sexual and reproductive health outcomes. The Summit highlighted the negative impacts of a widespread reluctance to address complex issues intermingling religion; socioeconomic status; disability; gender identity; social, cultural and family life; and limited national and international investment in sexual and reproductive justice.

Towards a more coherent agenda, the Nairobi commitments created a roadmap to shift towards comprehensive sexual and reproductive justice strategies that address current complexities. The Commission's 2021 report went further and provided a framework to speed up implementation of those commitments while identifying where more work is needed.

As this report demonstrates, the Commission's 2021 Call to Action remains relevant and vital today. We must do more to create sexual and reproductive justice by establishing better accountability mechanisms; increasing investment in people's movements and alliance-building with parliamentarians; expanding universal health coverage, including sexual and reproductive health; and increasing transparency in financing. As continuing humanitarian crises and growing challenges from transnational anti-democratic movements have taught us, we must think differently and explore digital innovations and self-managed care where possible.

The commitments envisage a deeper analysis and solutions to discrimination embedded in norms, law and practice. Further recommendations could include stipulating that any intervention to achieve the commitments show how it addresses economic obstacles and the specific needs of the range of affected communities addressed in this report.

Lastly, the Commission urges countries to reach further to prioritize those facing the worst disparities in sexual and reproductive justice, and to inspire action with new, powerful narratives that capture the complexity of people's lives and the intersecting forces that oppress them. Sexual and reproductive justice is a new concept that affords ample opportunity for success. It is an optimistic and robust set of approaches destined to transform our thinking and practice. We invite stakeholders to adopt this framework and transform our collective response.

The Commission is heartened by emerging State interventions premised on these concepts and is hopeful that more States and stakeholders will embrace a powerful vision of sexual and reproductive justice for all.

Annexes

ANNEX A

NAIROBI GLOBAL COMMITMENTS MONITORING FRAMEWORK

The 2019 Nairobi Summit showcased gains, gaps and shared commitment to action in completing the unfinished business of the ICPD Programme of Action. The Summit mobilized global momentum that resulted in over 1,300 commitments by diverse stakeholders, including governments. It also saw widespread endorsement of the Nairobi Statement, which outlines collective ambition to reach ICPD goals for everyone, everywhere. The Statement's 12 global, overarching commitments are key to ensuring full, effective and accelerated implementation of the ICPD agenda and to achieving the 2030 Agenda for Sustainable Development.

In the Commission's first report, "*No Exceptions, No Exclusions: Realizing sexual and reproductive health, rights and justice for all*", a Global Commitments Monitoring Framework (GCMF) was included to complement the narrative report. The GCMF uses a four-colour traffic light system to indicate progress globally and regionally on key global indicators under each of the 12 global commitments and as an overall score for every commitment.[I] The colours run from green as the most positive, to yellow, then orange and finally red as the lowest score. A grey colour means there is not sufficient data for that indicator for the respective region. The triangles indicate change and direction from 2021 to 2022. In the Commission's first report, a baseline for selected indicators and overall regional scores for each commitment were presented, against the benchmarks and level of ambition included in the Nairobi Statement commitments. In the current report the Commission has continued to reflect on the indicators and updated the overall regional scores for each commitment, based on the latest available data, as shown in this Annex. In addition, the Commission developed a select set of Country Profiles which are presented in Annex B. The country profiles are to be seen as examples that present deep dives on the available data, including disaggregated data, to further elucidate the concept of sexual and reproductive justice and with a desire of contributing to further dialogue on how to advance the Nairobi commitments on the ground ensuring that no one is left behind.

I Except commitments 6 and 7 which did not have relevant indicators or data sets at this stage.

1 NAIROBI GLOBAL COMMITMENT

Intensify our efforts for the **full, effective and accelerated implementation and funding of the ICPD Programme of Action**, Key Actions for the Further Implementation of the Programme of Action of the ICPD, the outcomes of its reviews, and Agenda 2030 for Sustainable Development.

COMMITMENT	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
2	▲	●	●	▲	▲	●	●
3	●	●	●	●	●	●	●
4	▲	●	●	●	●	●	●
5	●	●	●	●	●	●	●
8	●	●	●	●	●	●	●
9	●	●	●	●	●	●	●
10	▲	●	●	●	●	▲	●
11	●	●	●	●	●	●	●
12	●	▼	▼	●	●	●	●
OVERALL SCORE	◎	▼	◎	◎	◎	◎	◎

Zero unmet need for family planning information and services, and universal availability of quality, accessible, affordable and safe modern contraceptives.

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Adolescent birth rate							
Nr of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - contraceptive and family planning)							
Unmet need for modern methods, total (all women)							
OVERALL SCORE							

Zero preventable maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national UHC strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Universal Health Coverage Index (SDG 3.8.1)							
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - maternity care)							
Proportion of births attended by skilled health personnel (SDG 3.1.2)							
Maternal mortality ratio (SDG 3.1.1)							
World Abortion Laws							
OVERALL SCORE							

Access for all adolescents and youth, especially girls, to comprehensive and age-responsive **information, education and adolescent-friendly comprehensive, quality and timely services** to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood.

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Percentage of young women age 20–24 who gave birth by age 15							
Percentage of young women age 20–24 who gave birth by age 18							
Demand for family planning satisfied by modern methods (all women aged 15–24)							
Number of new HIV infections per 1,000 uninfected population (aged 15–24) (SDG 3.3.1)							
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - sexuality education)							
OVERALL SCORE							

Zero sexual and gender-based violence and harmful practices, including zero child, early and forced marriage, as well as zero female genital mutilation; **elimination of all forms of discrimination against all women and girls**, to realize all individuals' full socioeconomic potential.

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Violence against women from an intimate partner (SDG 5.2.1)							
Proportion of women aged 20–24 years who were married or in a union before age 15 (SDG 5.3.1 - under age 15)							
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - violence against women)							
Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment (SDG 5.c.1)							
Consensual same sex sexual acts between adults legal							
OVERALL SCORE							

8 NAIROBI GLOBAL COMMITMENT

Investing in the education, employment opportunities, health, including family planning and sexual and reproductive health services, of adolescents and youth, especially girls, so as to fully **harness the promises of the demographic dividend.**

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Secondary school net attendance ratio							
Proportion of youth (aged 15–24 years) not in education, employment or training (SDG 8.6.1)							
Proportion of women aged 20-24 years who were married or in a union before age 18 (SDG 5.3.1 - under age 18)							
OVERALL SCORE							

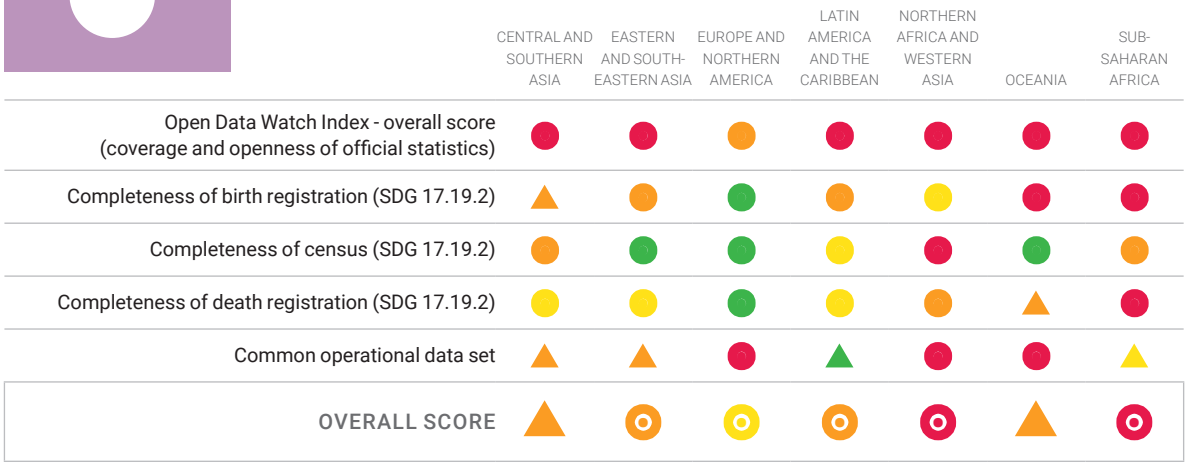
9 NAIROBI GLOBAL COMMITMENT

Building **peaceful, just and inclusive societies**, where no one is left behind, where all, irrespective of race, colour, religion, sex, age, disability, language, ethnic origin, sexual orientation, and gender identity or expression, feel valued, and are able to shape their own destiny and contribute to the prosperity of their societies.

	CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Representation in public institutions (ratio of female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)							
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)							
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1. - employment and economic benefits)							
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - overarching legal frameworks and public life)							
Existence of independent national human rights institutions in compliance with the Paris Principles (SDG 16.A.1 - A status)							
Protection against hate crimes (ILGA)							
Protection against incitement (ILGA)							
OVERALL SCORE							

10 NAIROBI GLOBAL COMMITMENT

Providing **quality, timely and disaggregated data**, that ensures privacy of citizens and is also inclusive of younger adolescents, investing in digital health innovations, including in big data systems, and improvement of data systems to inform policies aimed at achieving sustainable development.

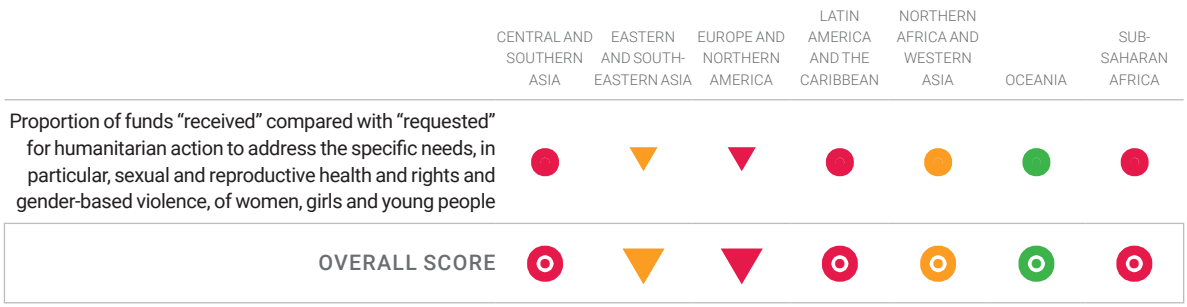


11 NAIROBI GLOBAL COMMITMENT

Committing to the notion that nothing about **young people's** health and well-being can be discussed and decided upon without their **meaningful involvement and participation** ("nothing about us, without us").

12 NAIROBI GLOBAL COMMITMENT

Ensuring that the **basic humanitarian needs and rights** of affected populations, especially that of girls and women, are addressed as critical components of responses to humanitarian and environmental crises, as well as fragile and post-crisis reconstruction contexts, **through the provision of access to comprehensive sexual and reproductive health information, education and services**, including access to safe abortion services to the full extent of the law, and post-abortion care, to significantly reduce maternal mortality and morbidity, sexual and gender-based violence and unplanned pregnancies under these conditions.



REPUBLIC OF ALBANIA

ANNEX B

COUNTRY PROFILES

TOTAL POPULATION [I] **2,836,790**

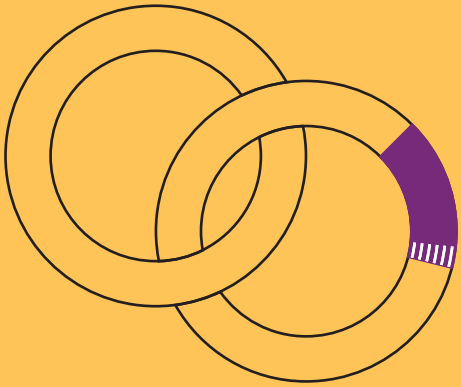
POPULATION 24 YEARS OR YOUNGER [I]

29.38%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **657,490**

POPULATION 15-24 YEARS (male + female) [I] **377,170**

WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **11.8%**

BEFORE AGE 15 **1.4%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **15 / 100,000**

TOTAL FERTILITY RATE [I] (births per woman) **1.38**

ADOLESCENT BIRTH RATE [I] (births per 1000 girls) **14.03**

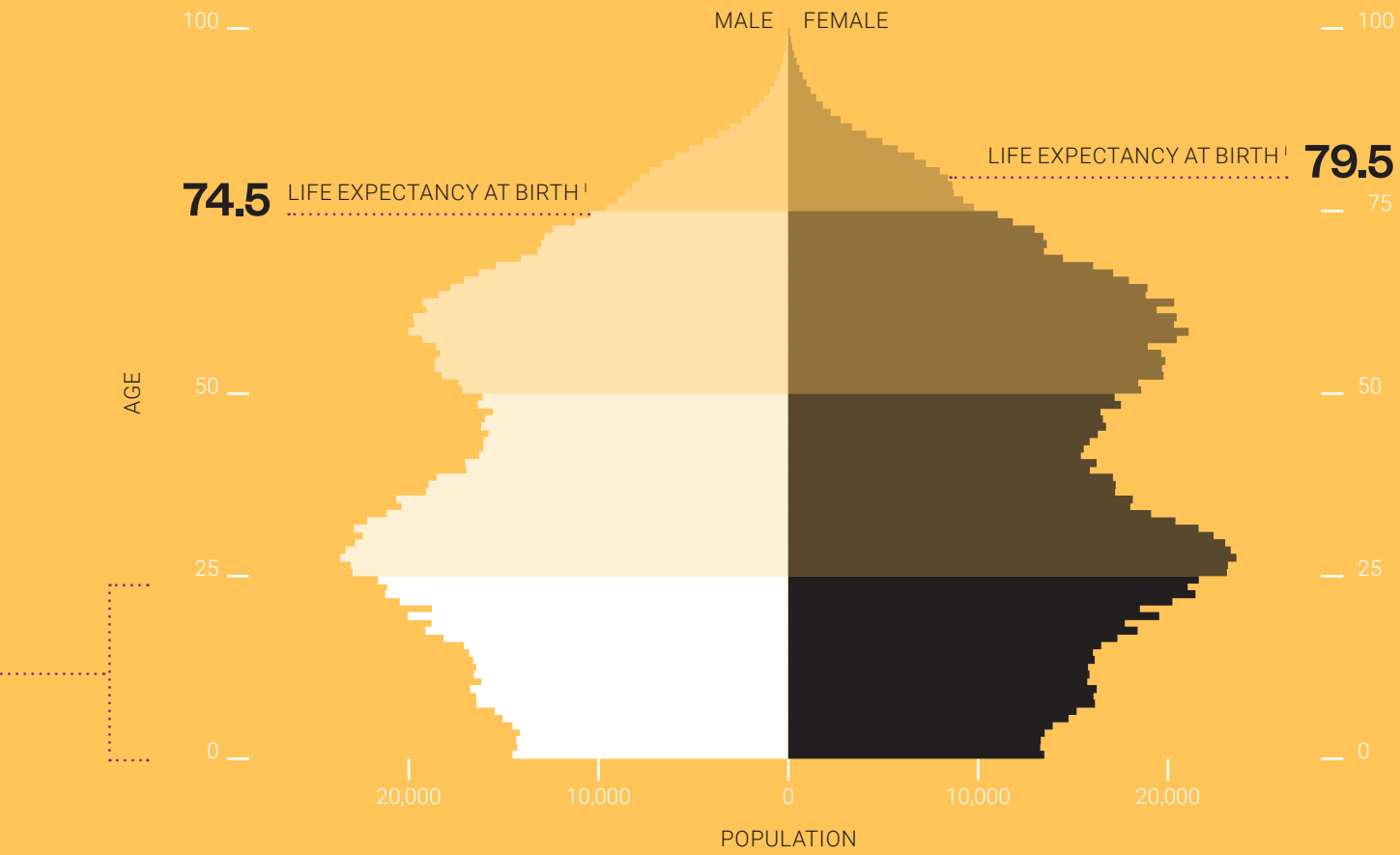
I. World Population Prospects 2022 II. SDG

11.9% UNMET NEED FOR FAMILY PLANNING (all women) [III]

10.5% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

99.8% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

As part of its ICPD25 commitments, the Republic of Albania has committed to **ending** unmet need for family planning and ending preventable maternal deaths, as well as an **increase in financing** for reproductive, maternal and adolescent health.



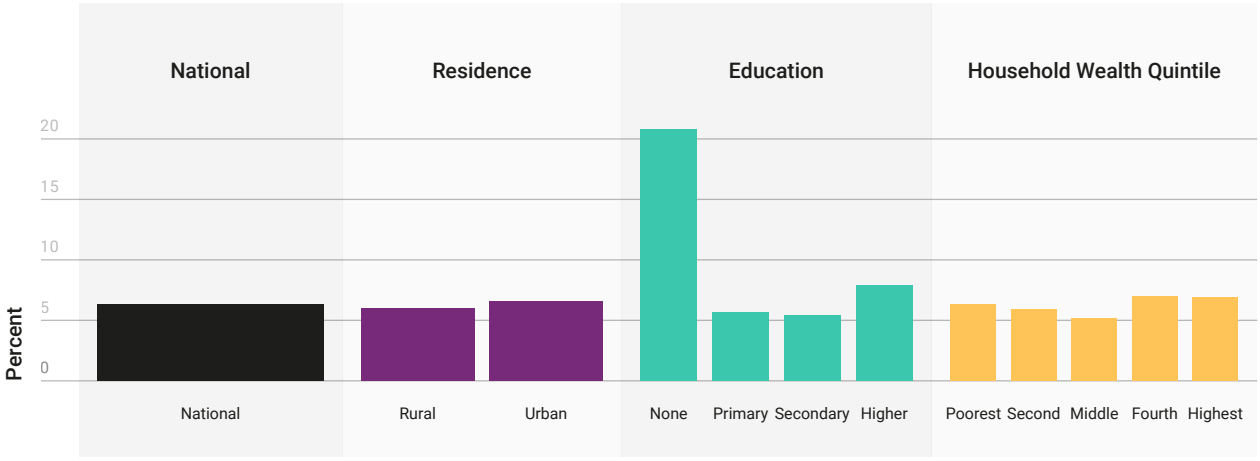
I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

Albania's total fertility rate (TFR) – the number of children that would be born to a woman if she were to live to the end of her childbearing years is 1.38. In Albania, traditional methods account for the majority of contraceptive use. Unmet need for family planning is relatively the same in urban and rural areas, but is highest among women with no education and women from the poorest households. Demand for family planning satisfied by modern methods is highest among women with no education, with traditional method use being more common among women with higher education.

Unmet Need for Family Planning, All Women

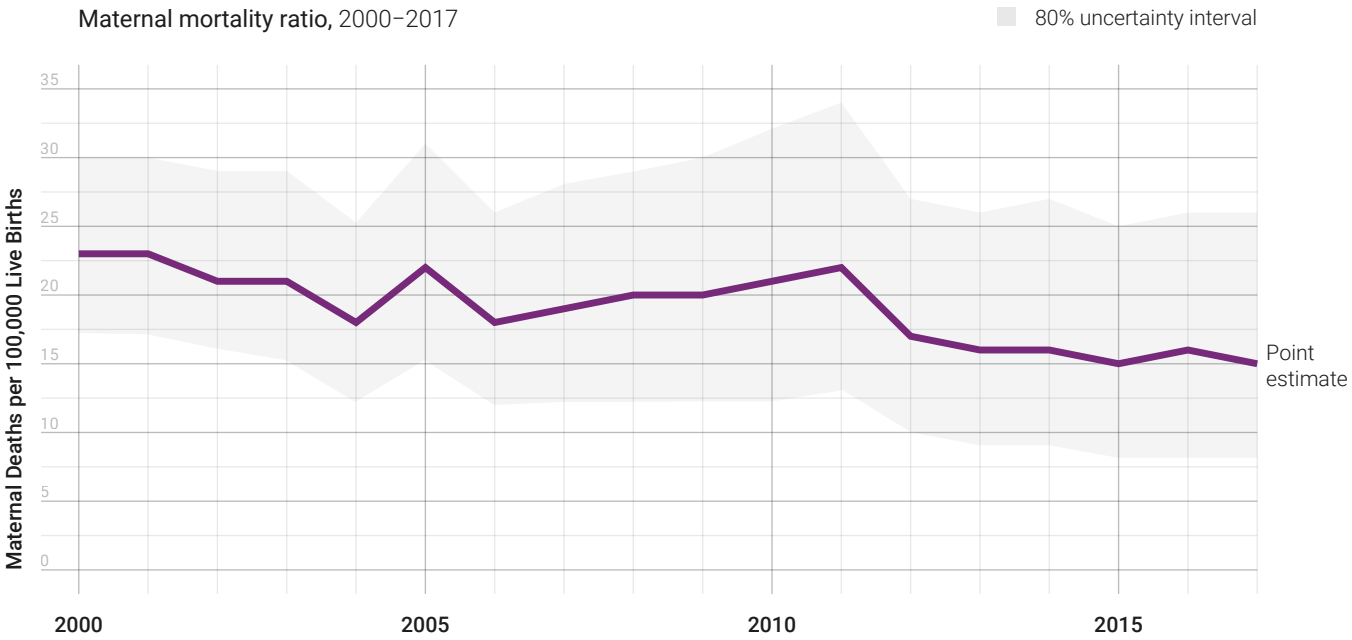
Source: Demographic and Health Survey, 2017

Demand for Family Planning Satisfied with Modern Methods, All Women



Source: Demographic and Health Survey, 2017

Albania's maternal mortality ratio declined from 2000 to 2017, the year in which it was estimated to be 15 deaths per 100,000 live births. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Abortion is permitted in Albania.



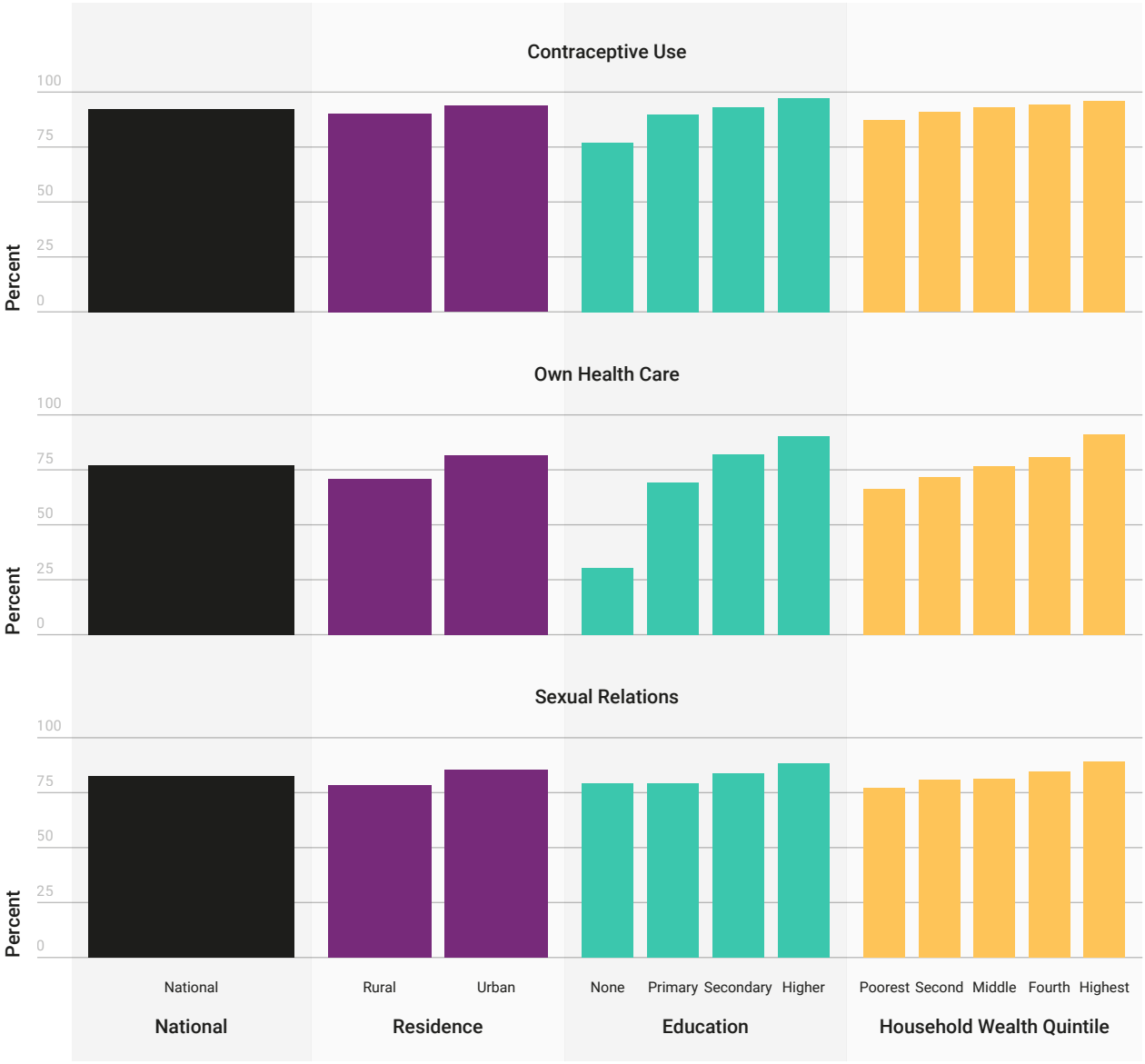
Source: World Health Organization, 2019

In Albania, 93% of married of in-union women aged 15 to 49 make their own decisions regarding sexual and reproductive health and rights. 84% of married or in-union women have autonomy in deciding to use contraception, and 84% can say no to sex. The percentages are slightly lower among women with no education and women in the poorest households. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. Albania has achieved 86% of enabling laws and regulations that guarantee full and equal access to women and men to maternity care, and 100% to contraceptive and family planning services, and sexuality education.

Extent to which Albania has 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

Source: United Nations Population Fund, 2022

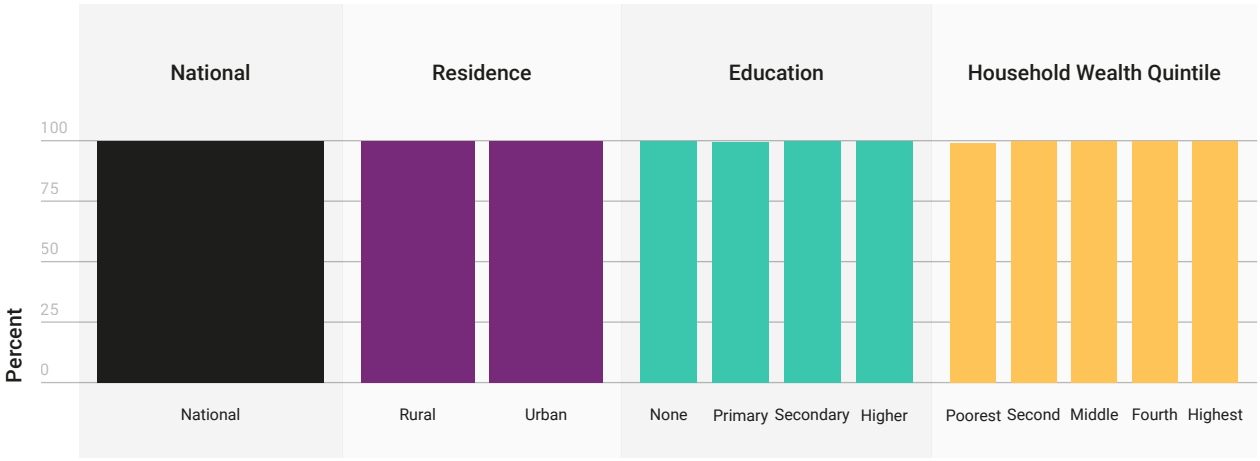
Proportion of married women who make their own informed decisions regarding reproductive health care, contraceptive use, and sexual relations



Source: Demographics and Health Survey, 2017

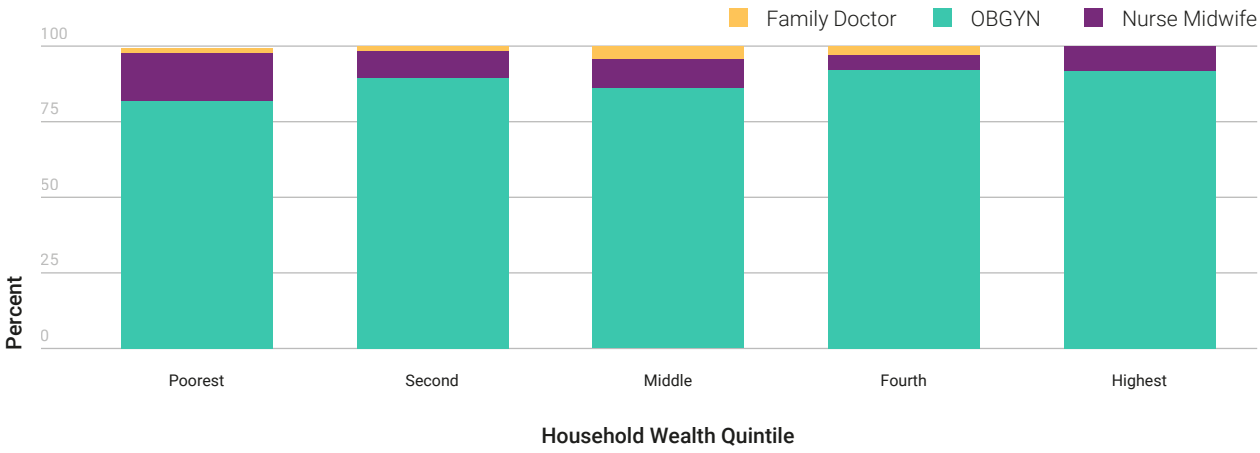
In Albania, nearly all deliveries among married women 15-49 years who had a live birth in the last two years are assisted by a skilled attendant. The percentage of deliveries assisted by a skilled attendant is the same among women in urban rural areas, as well as among education level and household wealth. In Albania, the majority of births are attended by Ob/gyns, with only a slightly larger percent of births attended by Nurse Midwives among women living in the poorest households.

Births with Skilled Attendant



Source: Demographics and Health Survey, 2017

Skilled Birth Providers by Wealth Quintile

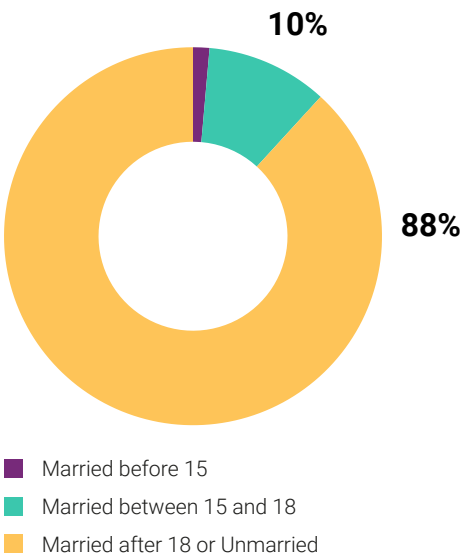


Source: Demographic and Health Survey, 2017

At the Nairobi Summit, Albania has committed to scaling up and implementing comprehensive sexuality education nationally by 2022.

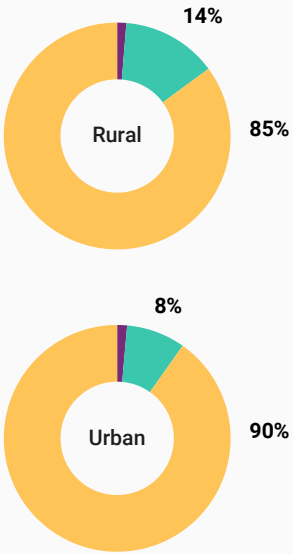
In Albania 11.8% of women aged 20-24 years were married before age 18, with 1.4% of women were married before age 15 – one of the highest in the region. Marriage before age 18 is highest among women with only primary education, and those in the poorest and middle-income households.

Age of Marriage Distribution, Women 20–24

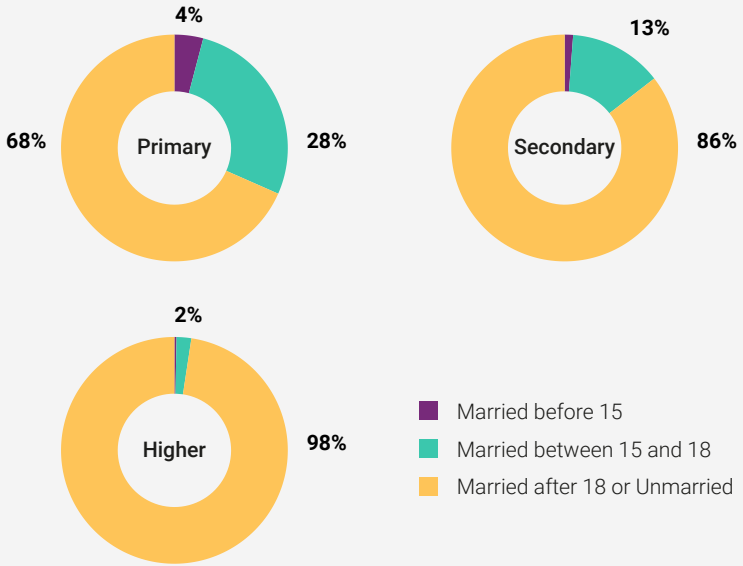


Source: Demographic and Health Survey, 2017

Age of Marriage Distribution by Residence, Women 20–24

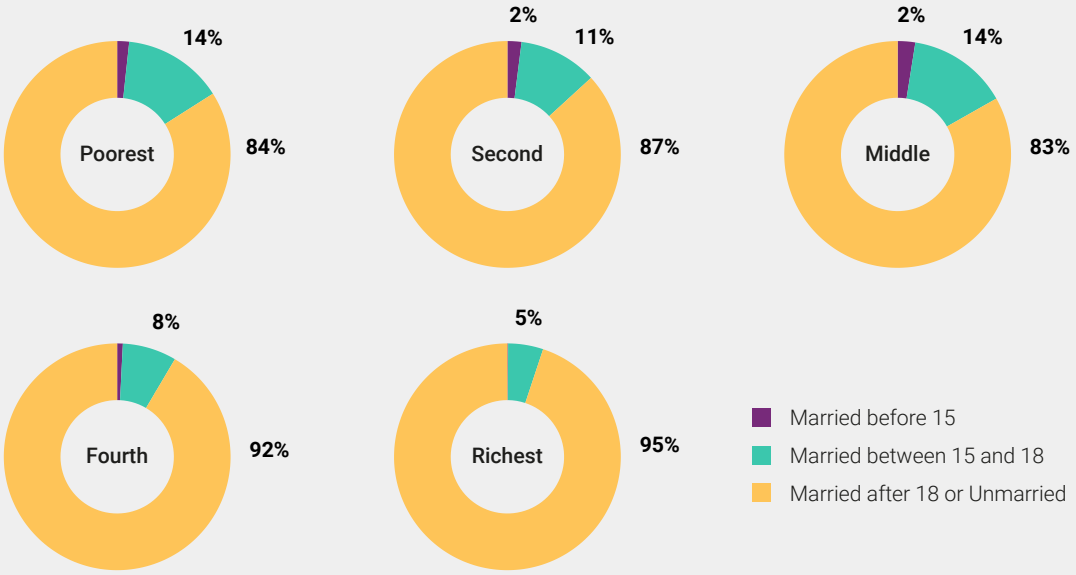


Age of Marriage Distribution by Level of Education, Women 20–24



Source: Demographic and Health Survey, 2017

Age of Marriage Distribution by Household Wealth Quintile, Women 20–24

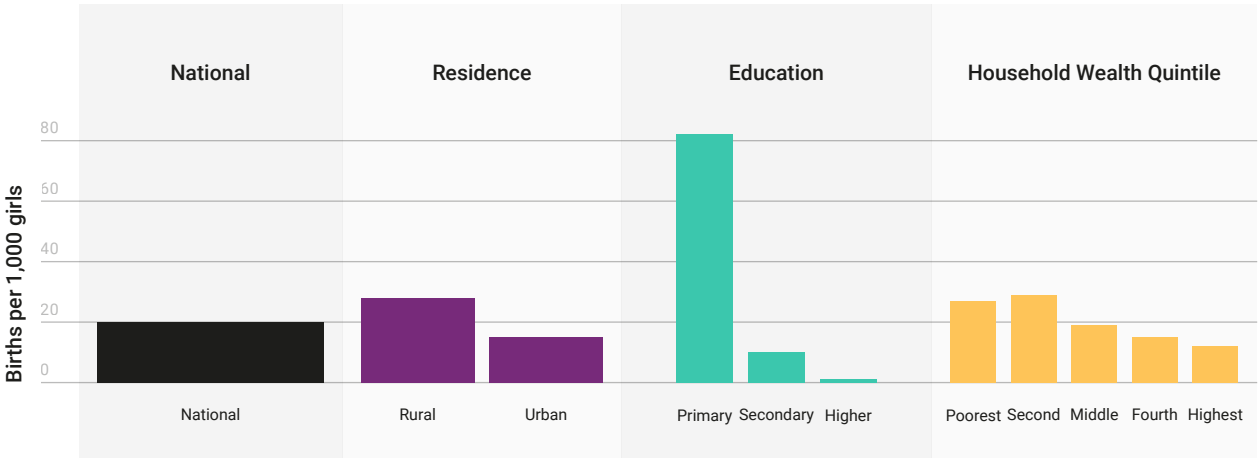


Source: Demographic and Health Survey, 2017

Since the Nairobi Summit, forums on sustainable development, sexual and reproductive health and prevention of gender-based violence were utilized to advance advocacy for the ICPD agenda and the Nairobi commitments and strengthen the cooperation of stakeholders.

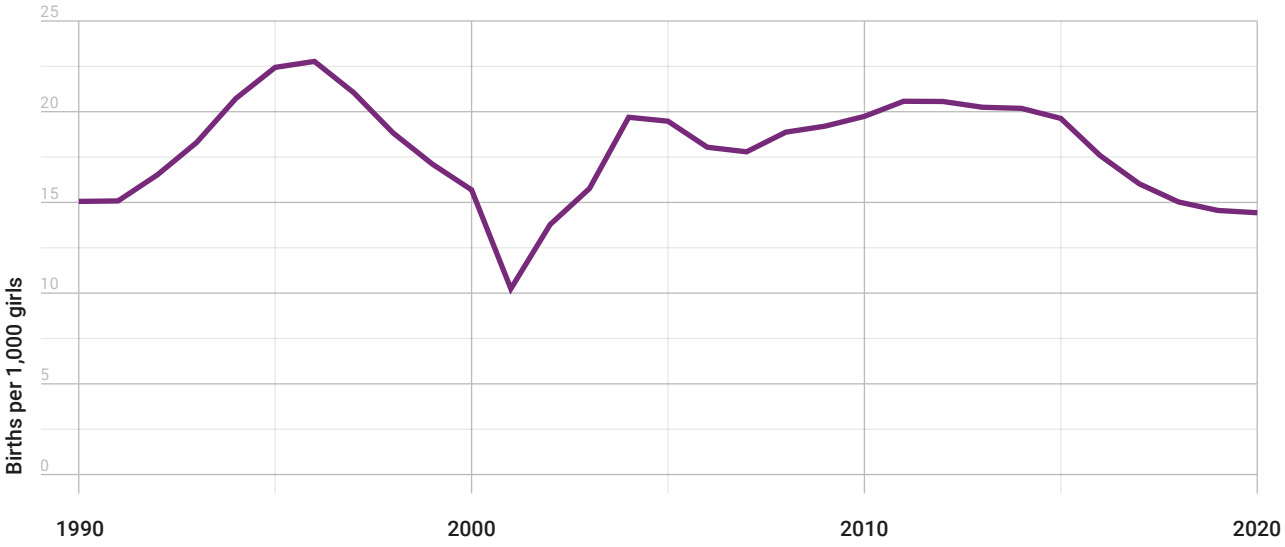
Albania's adolescent birth rate in 2020 remains approximately the same as it was in 1990. It is highest among girls with only primary education, and higher in rural areas than urban areas of the country. The adolescent birth rate among girls in the poorest households is two times higher than the rate in the wealthiest households.

Adolescent birth rate



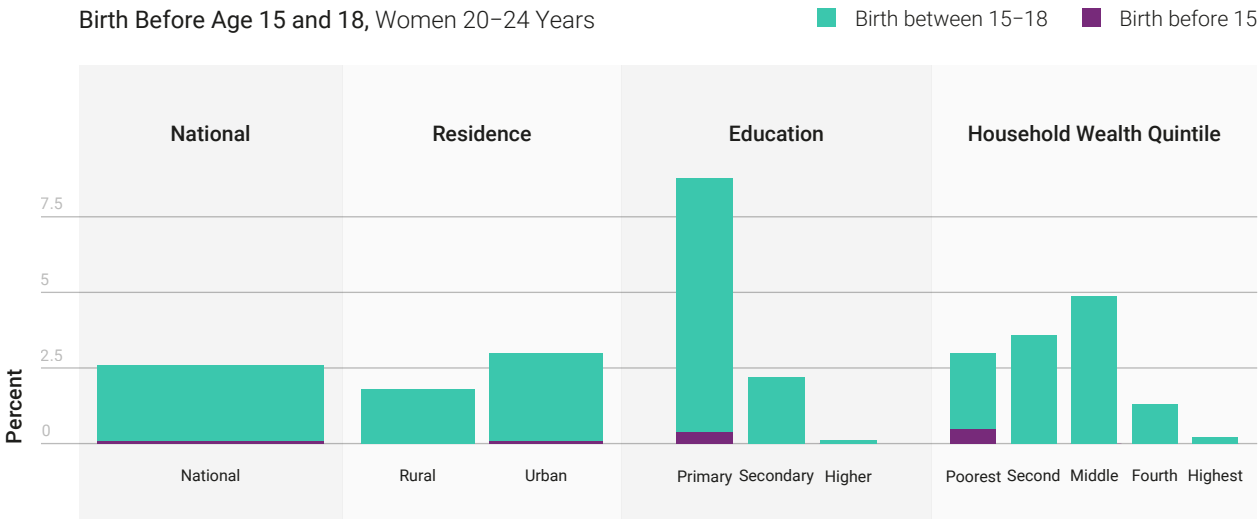
Source: Demographic and Health Survey, 2017

Adolescent birth rate, 1990–2020



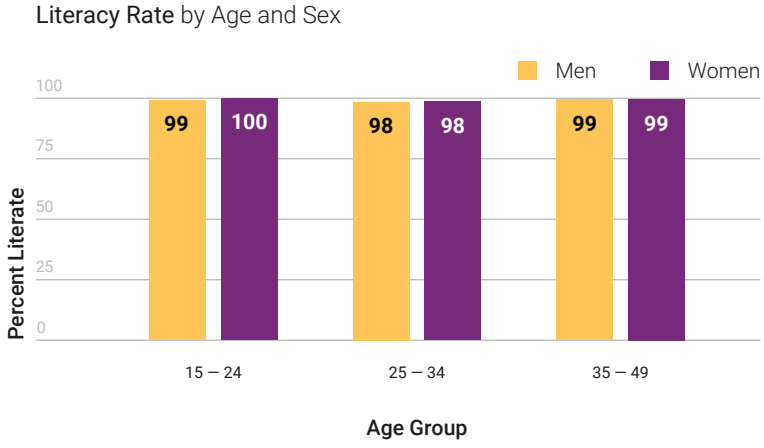
Source: World Population Prospects, 2022

2.6% of women aged 20-24 years in Albania gave birth before age 18. Most births occur among women who have only primary education, and those women in middle income households.



Source: Demographic and Health Survey, 2017

Albania's literacy rate is extremely high among all age groups and sex. Secondary education completes the provision of basic education that began at the primary level and aims at laying the foundations for lifelong learning and human development, by offering more subject- or skill-oriented instruction using more specialized teachers. In 2018, the latest year for which data is available, Albania's secondary school net attendance ratio[IV] was 87.

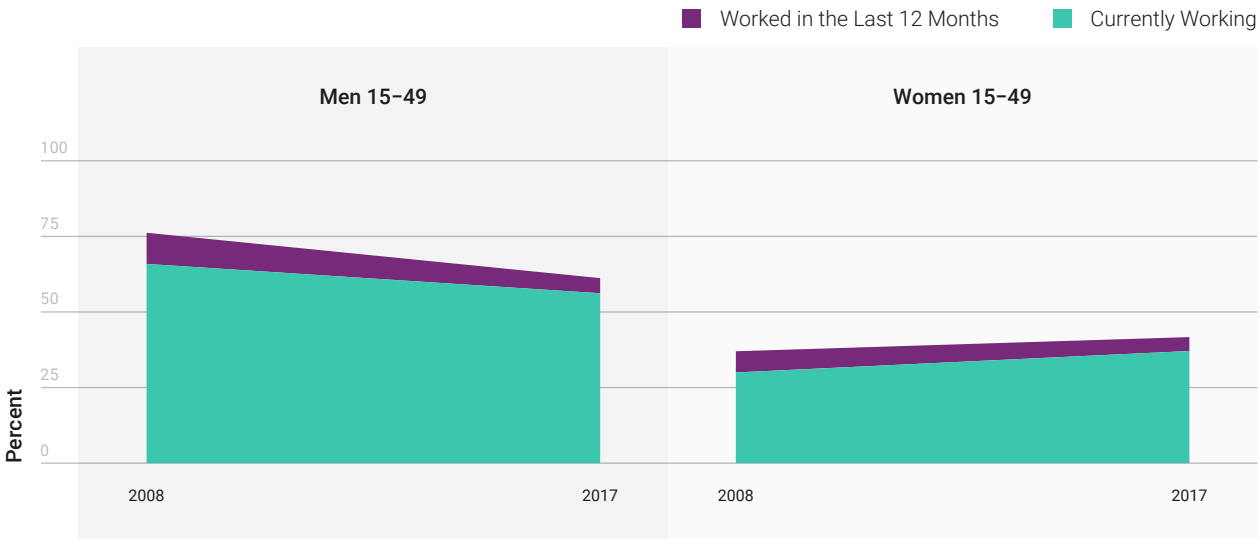


Source: Demographic and Health Survey, 2017

IV Ratio of children of official school age who are enrolled in school to the population of the corresponding official school age.

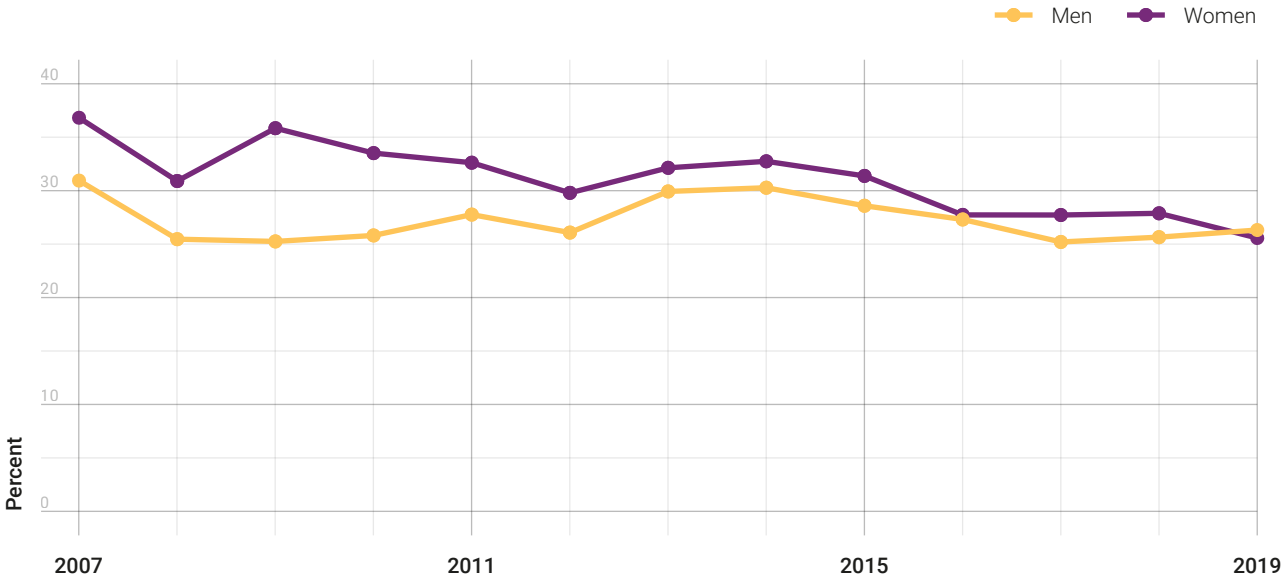
Employment trends for men declined in Albania from 2001 to 2016, while they increased for women during this period, during this time the proportion of men who worked in the last 12 months decreased, while the proportion for women remained the same. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Albania, the percentage of youth not in education, employment or training has been decreasing among women, and in 2019 it is relatively the same for men and women.

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 2008—2017

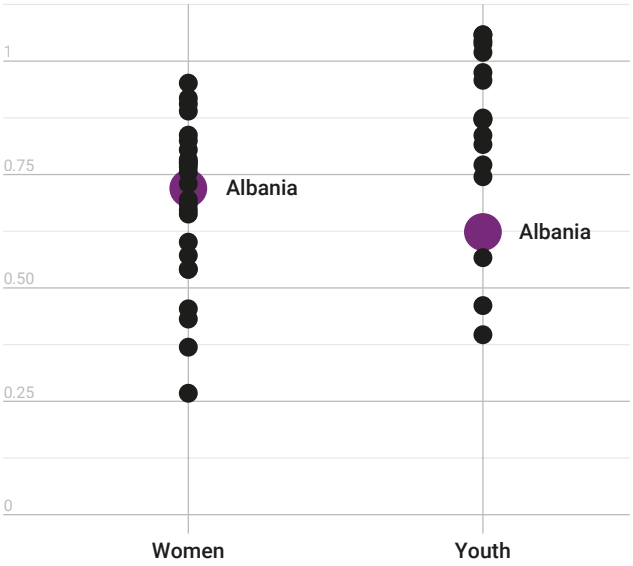
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Labour Force Survey, 2007–2019

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in Albania is near the median compared with those in the region, while the ratio of the proportion of young Members of Parliament is the fourth lowest in the region (SDG 16.17.1).

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, European and North American Countries



Source: Inter–Parliamentary Union, 2022

With a rapidly ageing population and continual out-migration, Albania is facing an imminent challenge to ensure access to affordable and quality care services for all elderly in need. Between 2020 and 2050, the population aged 65 or above will increase from 420,000 to 623,000, and its share in the total population will increase from 15% to 26%[V]. As part of its ICPD25 commitments, Albania committed to implement the National Action Plan for Elderly 2020-2025, by allocating respective budget and monitoring its implementation step by step and making the necessary legal provisions by 2023. Since the Nairobi Summit, the National Action Plan on Ageing 2020-2024 was drafted and adopted.

To advance ICPD25 commitments, in April 2020, Albania's Ministry of Health and Social Protection created a protocol that ensured women's shelters in the country would function undisrupted among the COVID-19 pandemic. This protocol designated the shelters for domestic violence protection as essential services.

Further to the ICPD25 commitments and in regards the major gaps and challenges for achievement of SDG 3, "ensuring access to sexual and reproductive health services, in line with EU human and reproductive rights policies" is noted as a priority in the Government of Albania - United Nations Sustainable Development Cooperation Framework 2022-2026.

V International Labour Organization, https://www.ilo.org/budapest/whats-new/WCMS_847680/lang--en/index.htm

DOMINICAN REPUBLIC

TOTAL POPULATION [I] **11,281,880**

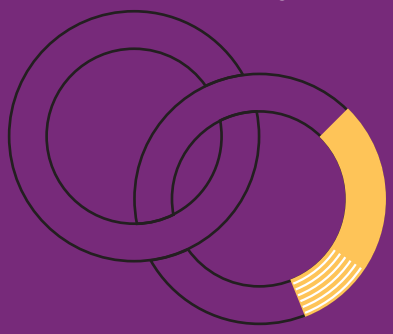
POPULATION 24 YEARS OR YOUNGER [I]

44.03%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **2,911,760**

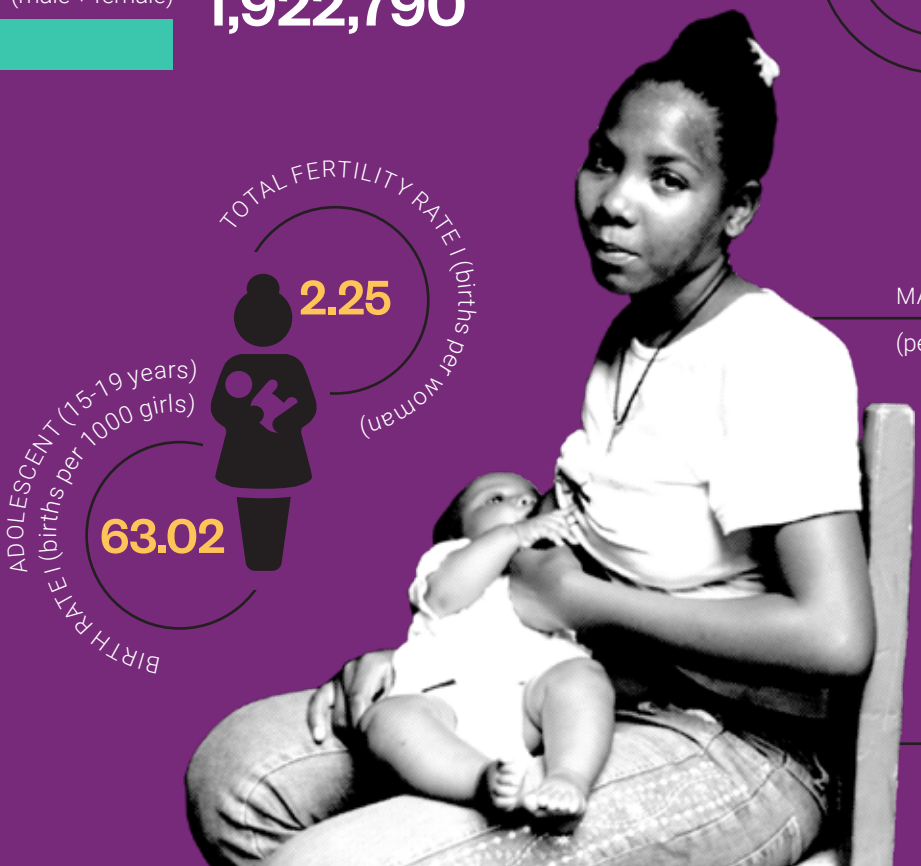
POPULATION 15-24 YEARS (male + female) [I] **1,922,790**

WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **31.5%**

BEFORE AGE 15 **9.4%**



MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **95** / **100,000**

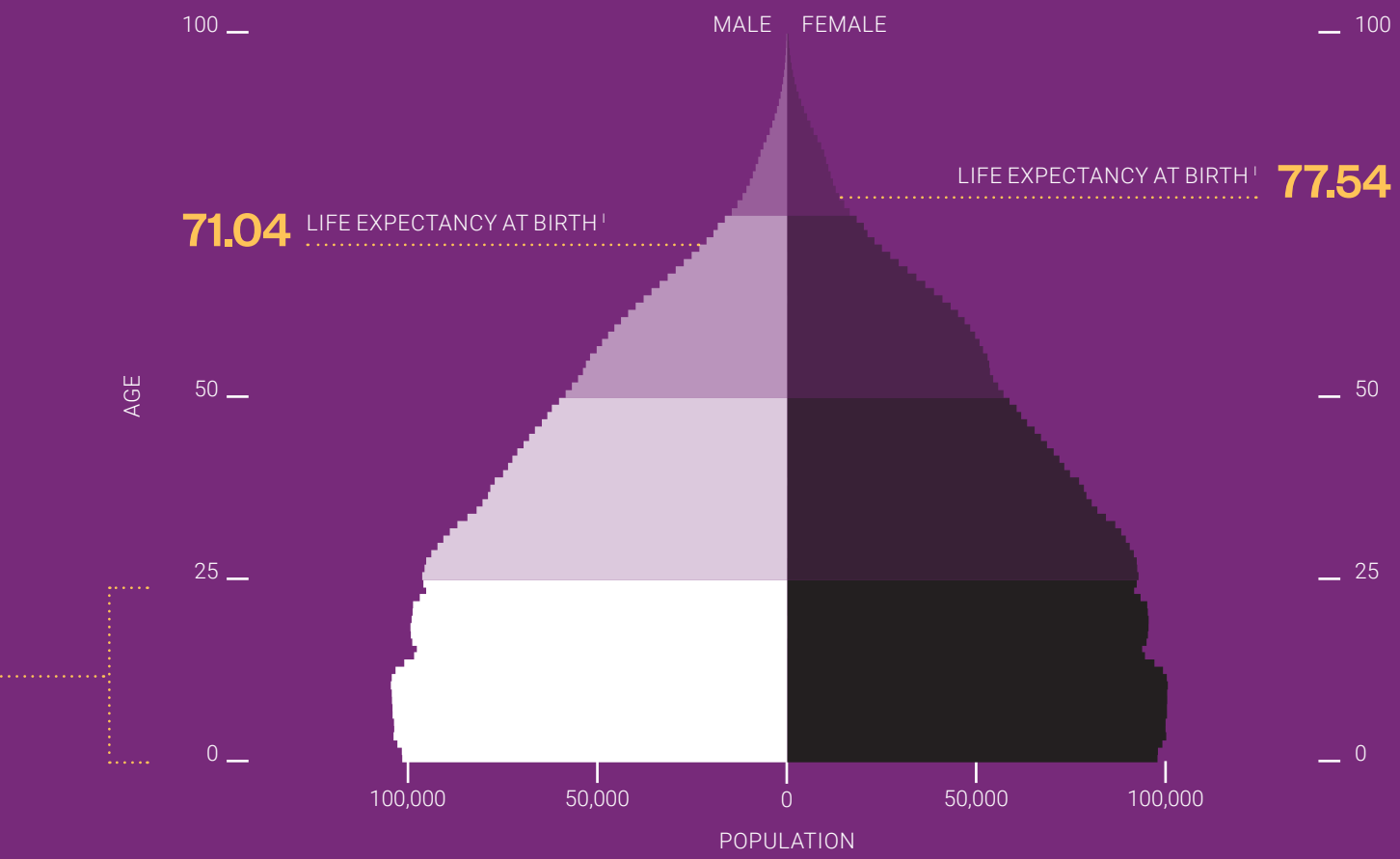
I. World Population Prospects 2022 II. SDG

9.7% UNMET NEED FOR FAMILY PLANNING (all women) [III]

81.9% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

99.2% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

At the Nairobi Summit, the Dominican Republic committed to promote the **recognition and effective realization** of sexual rights and reproductive rights as human rights. This includes strengthening the response to maternal mortality, unsafe abortions, teenage pregnancies, STIs and HIV.



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In the Dominican Republic, unmet need for family planning is slightly higher in urban than rural areas. It is highest among women with no or pre-primary education, and women living in the poorest households. Demand for family planning satisfied by modern methods is highest among women in rural areas, and those with primary or more education, and fairly similar by household wealth.

Demand for Family Planning Satisfied with Modern Methods, All Women

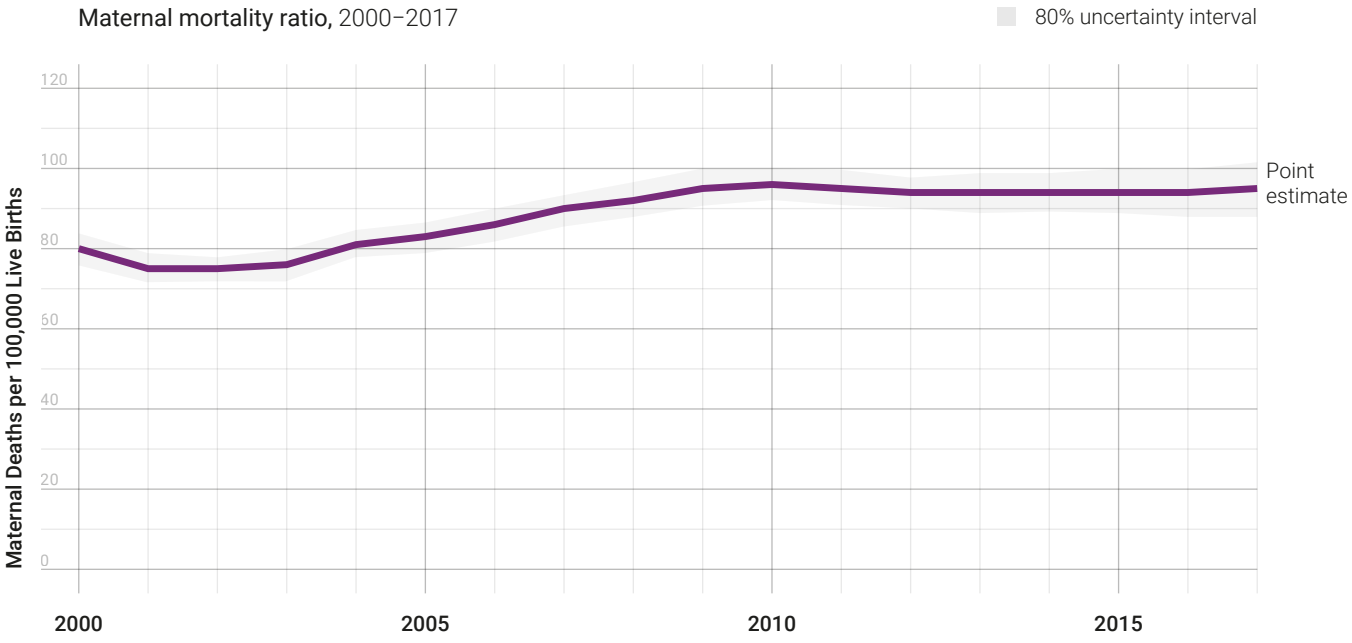
Source: Multiple Indicator Cluster Survey, 2019

Unmet Need for Family Planning, All Women

Source: Multiple Indicator Cluster Survey, 2019

The maternal mortality ratio in the Dominican Republic remained largely the same from 2000 to 2017, the latest year for which data is available, the year in which it was estimated to be 95 deaths per 100,000 live births, one of the lowest in the region. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Abortion is not permitted in Dominican Republic.

Maternal mortality ratio, 2000–2017



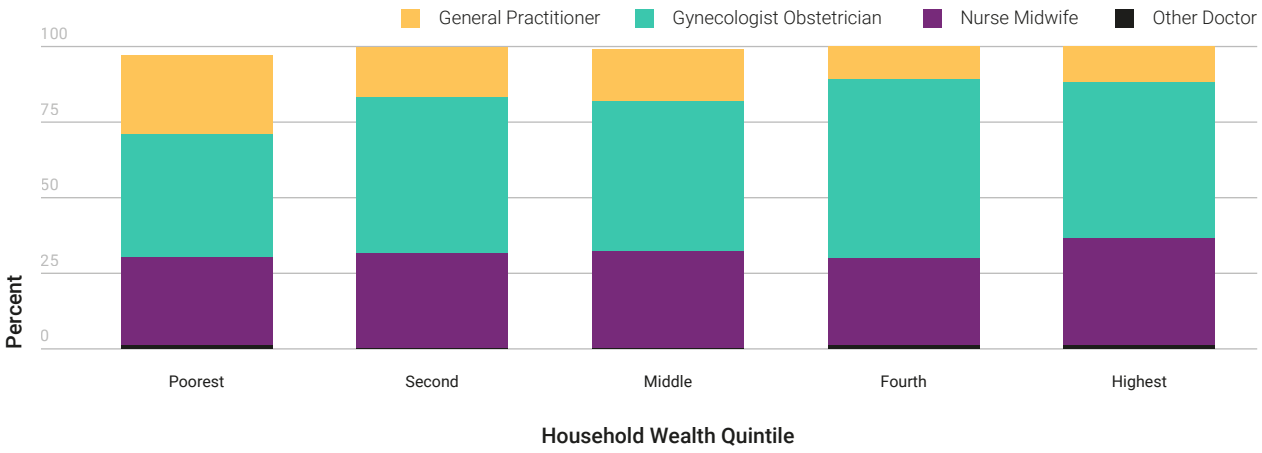
Source: World Health Organization, 2019

The Dominican Republic has one of the highest percentages in the region of deliveries assisted by a skilled attendant among married women 15-49 years who had a live birth in the last two years. The percentage of deliveries assisted by a skilled attendant is relatively the by geographic area, level of education and household wealth. Approximately 30% of births are attended by nurse midwifes in the Dominican Republic, and this percentage remains fairly consistent by regardless of household wealth. As household wealth increases, the portion of births attended by gynecologists and obstetricians increases over that of births attended by general practitioners.

Births with Skilled Attendant

Source: Multiple Indicator Cluster Survey, 2019

Skilled Birth Providers by Wealth Quintile

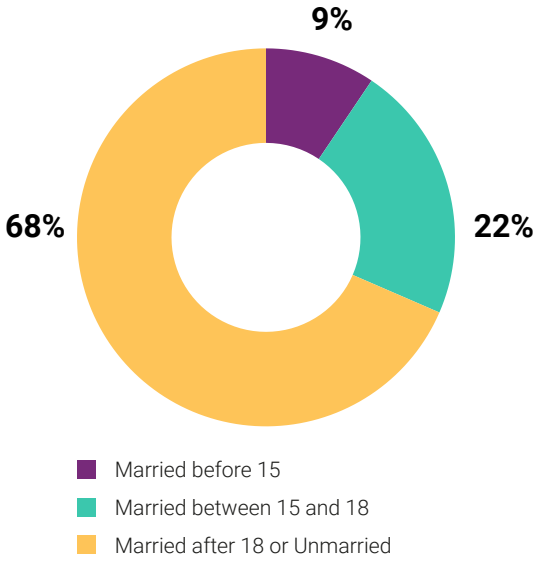


Source: Multiple Indicator Cluster Survey, 2019

Since the Nairobi Summit, young people have been mobilized to review and share their reflections on the progress of the implementation of the ICPD Programme of Action and the Montevideo Consensus. The three zeros have been advocated through the preparation of the National Plan for the Prevention of Teenage Pregnancy, the plan for reducing violence against women and girls, and the law for the prevention, care, punishment and eradication of violence against women.

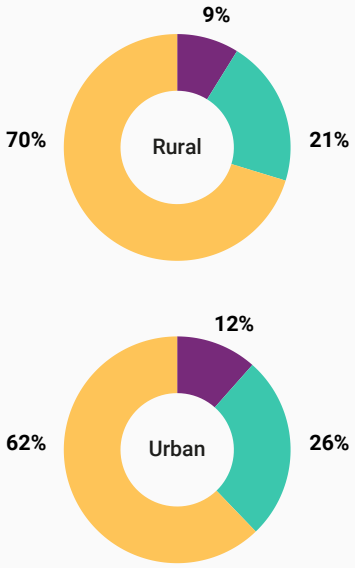
In the Dominican Republic 31% of women aged 20-24 years were married before age 18, with 9% of women married before age 15, which is one of the highest in the region. Child marriage is highest among women with primary education, and those in the poorest households.

Age of Marriage Distribution, Women 20–24

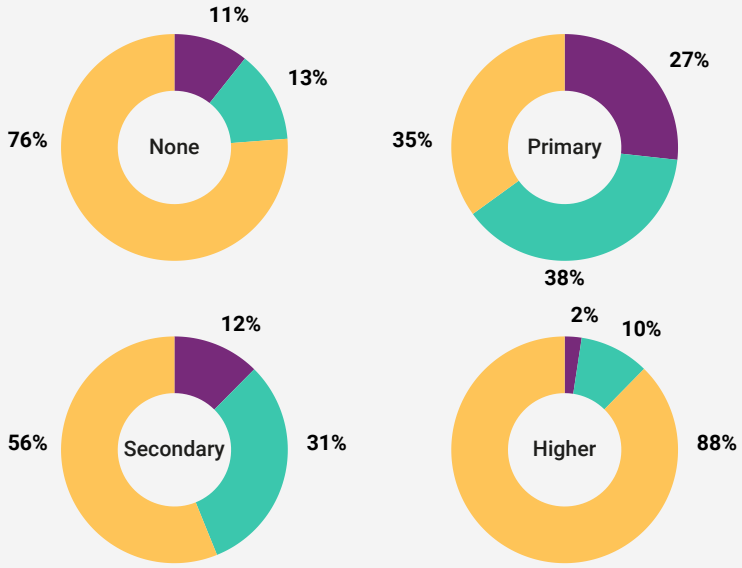


Source: Multiple Indicator Cluster Survey, 2019

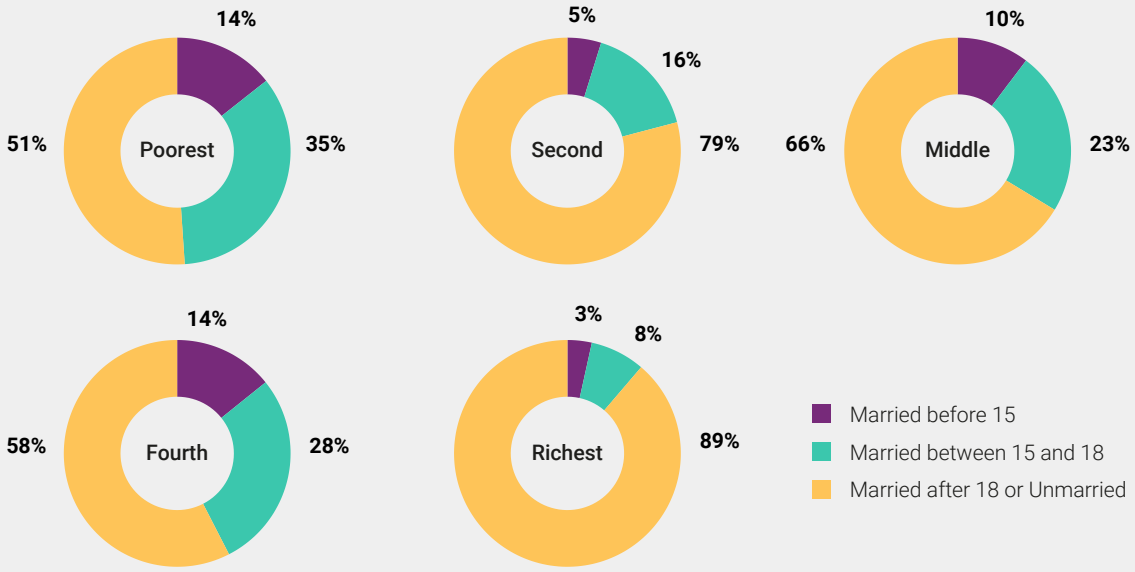
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



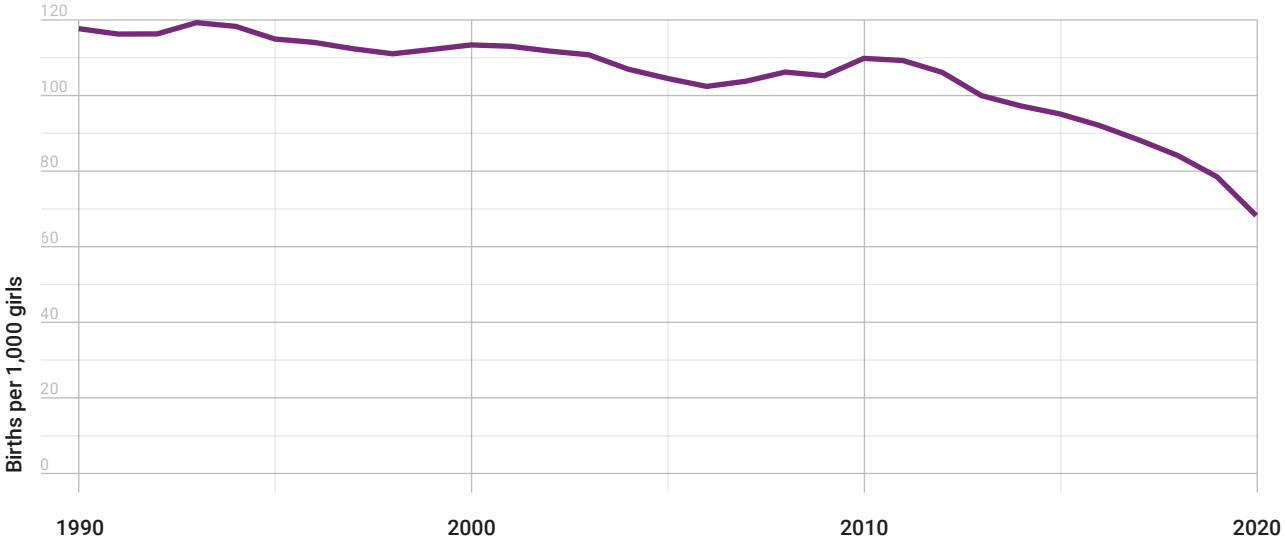
Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



Source: Multiple Indicator Cluster Survey, 2019

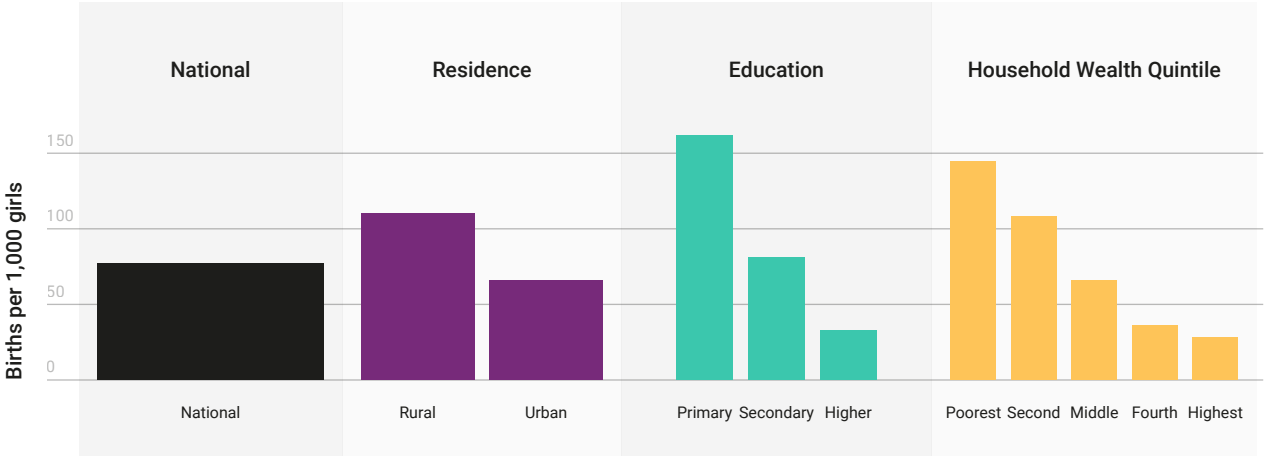
The Dominican Republic's adolescent birth rate decreased from 1990 to 2020. The adolescent birth rate is 1.7 times higher in rural areas than in urban areas, and is five times higher among girls with primary education than those with higher education, and among girls in the poorest households compared with those in the wealthiest households.

Adolescent birth rate, 1990–2020



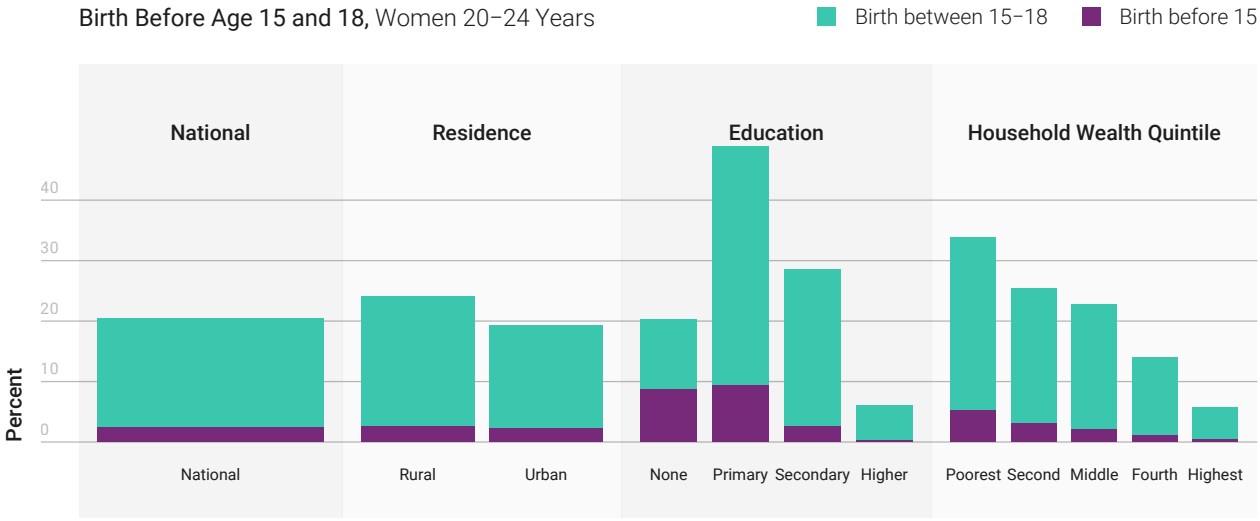
Source: World Population Prospects, 2022

Adolescent birth rate



Source: Multiple Indicator Cluster Survey, 2019

Birth Before Age 15 and 18, Women 20–24 Years



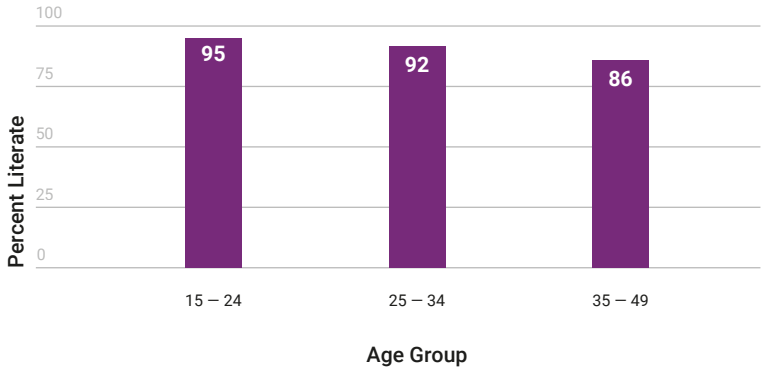
Source: Multiple Indicator Cluster Survey, 2019

23.7% of women aged 20-24 years in the Dominican Republic gave birth before age 18, and 3.1% gave birth before age 15 – both of which are one of the highest in the region. Most births occur among women who have only primary education, and those women in the poorest households. Births before age 18 among women with primary education was eight times higher than for women with higher education; they were also nearly six times higher among women living in the poorest households compared to those living in the wealthiest households.

Significant challenges prevail in terms of gender inequality and the empowerment of women, with gender-based violence indicators at worrying levels and cases having increased 122% between 2015 and 2019[IV]. According to the Economic Commission for Latin America and the Caribbean (ECLAC), the country is one of the countries in the region with the highest incidence of femicides.

The female literacy rate in the Dominican Republic is highest among those 15-24 years old.

Female Literacy Rate by Age

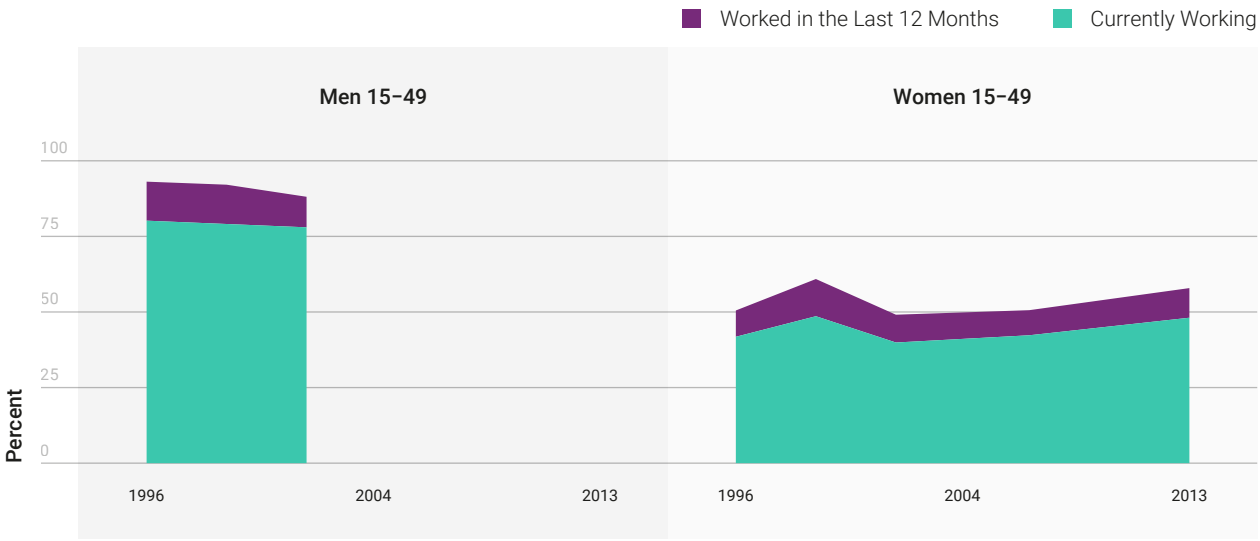


Source: Demographic and Health Surveys, 1996-2013

IV UN Dominican Republic

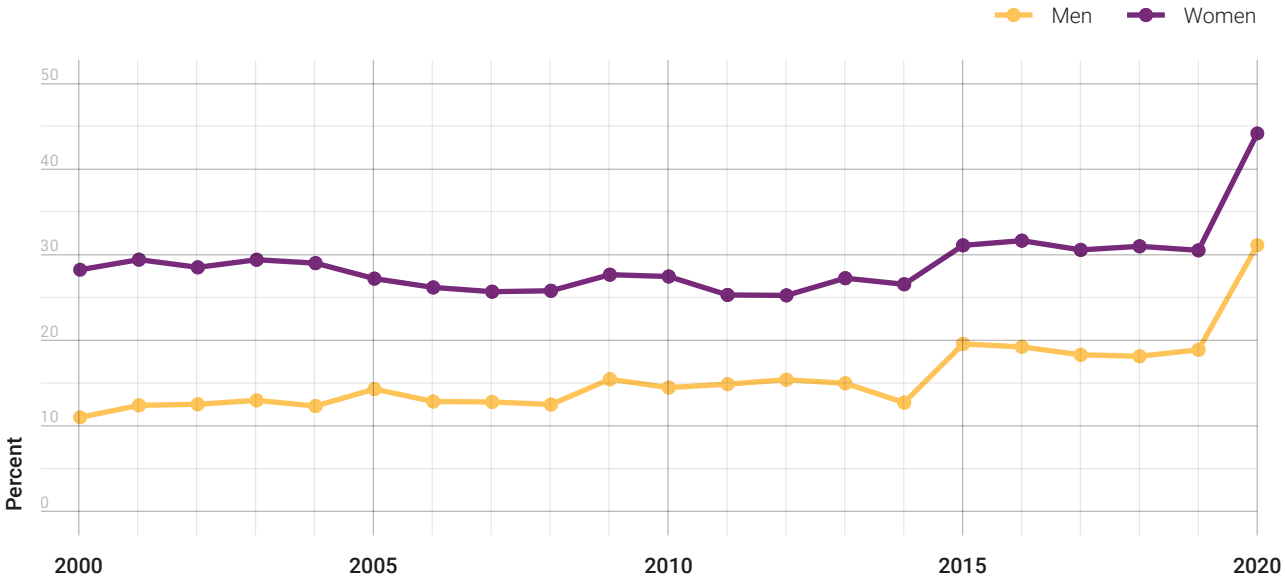
Employment trends among women remained relatively the same from 2001 to 2016, however they are approximately half of the employment rates of men. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Dominican Republic, the percentage of youth not in education, employment or training has been increasing among men and women, with the percentage among women being higher than for men.

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 2000—2016

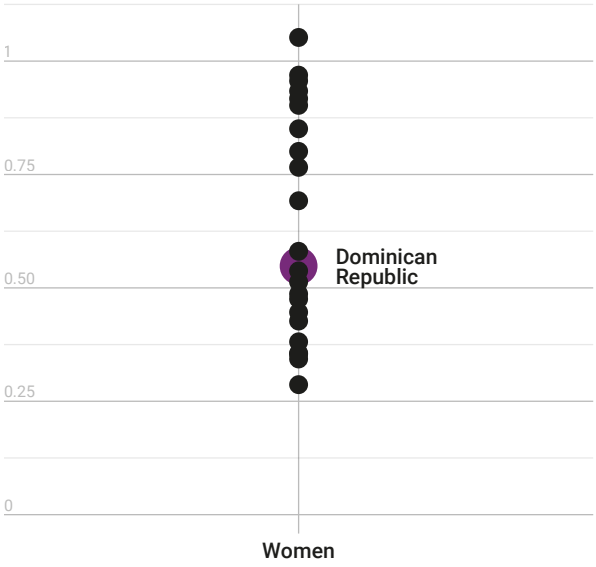
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: National Labour Force Survey, 2000–2014 and Continuous National Labour Force Survey, 2015–2020

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in the Dominican Republic is near the median compared with those in the region, and there is no information about the ratio of the proportion of young Members of Parliament (SDG 16.17.1).

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, Latin American and Caribbean Countries



Source: Inter–Parliamentary Union, 2022

The Dominican Republic explicitly committed to incorporate the mainstreaming of the equality approach in the National Health System in the performance of the essential functions, including financing, regulation and provision of individual and collective health services as part of its ICPD25 commitments. To support advancing on this commitment a national study on ethnic and racial self-perception, vis-à-vis actions developed by the Dominican government in favor of Afro-descendant populations and a mapping of organizations, movements and practices related to Afro-descendency in the country have been taken forward.

REPUBLIC OF HAITI

TOTAL POPULATION [I] **11,653,950**

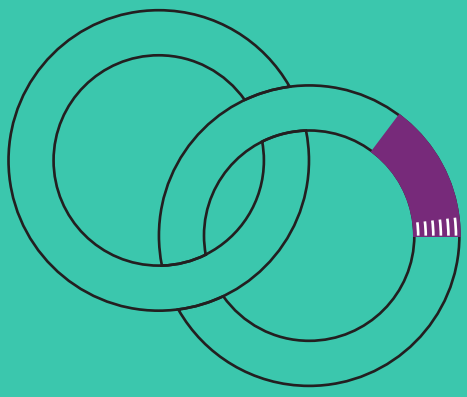
POPULATION 24 YEARS OR YOUNGER [I]

51.16%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **3,141,200**

POPULATION 15-24 YEARS (male + female) [I] **2,240,100**

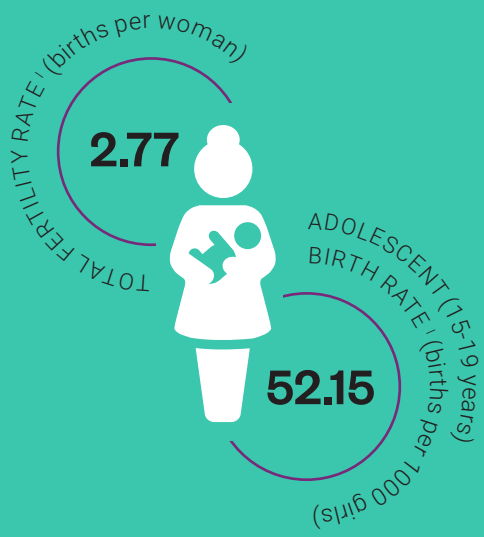
WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **14.9%**

BEFORE AGE 15 **2.1%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **480**



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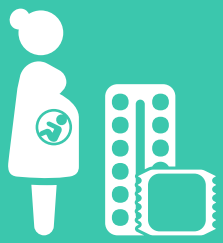
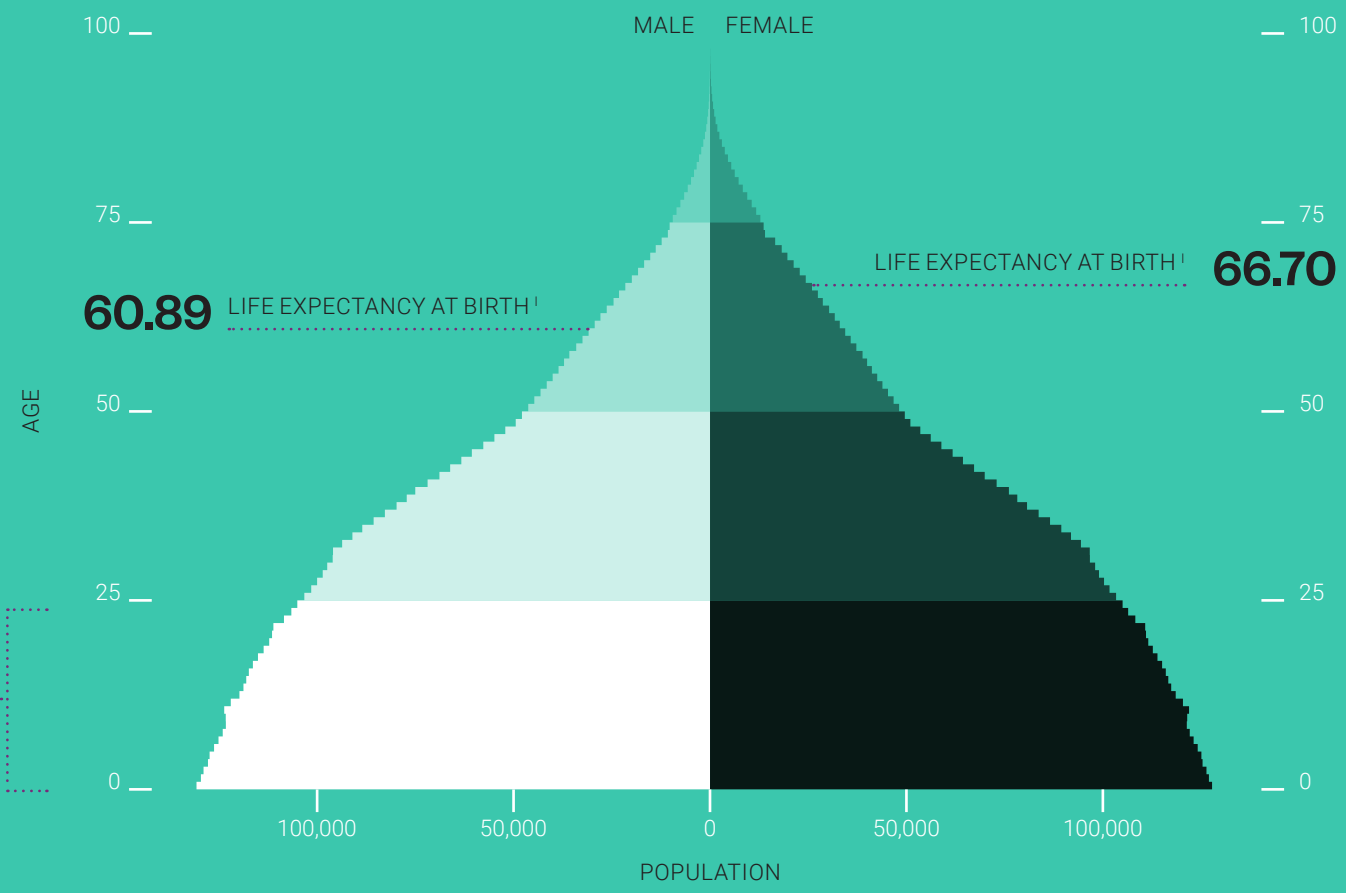


23.1% UNMET NEED FOR FAMILY PLANNING (all women) [III]

50.2% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

41.6% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

The UN estimates that at least **1.5 million** people in the Republic of Haiti have been directly impacted by recent unrest, with gender-based violence, and in particular rape, being used systematically. The economic crisis has caused food prices to soar, while fuel is often available only on the black market. Speaking to the United Nations Security Council on 26 September 2022, UN Special Representative Helen La Lime warned that "an economic crisis, a gang crisis and a political crisis have converged into a humanitarian catastrophe". Vulnerable populations, including pregnant women and girls, are the most impacted by restricted access to health services that are the result of this crisis. In this context, it will undoubtedly prove many times harder to find common pathways and achieve Haiti's ICPD25 commitments.



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At the Nairobi Summit, Haiti committed to broaden access to a choice of modern contraceptive methods and prioritizing comprehensive sexuality education

Haiti's total fertility rate (TFR) - the number of children that would be born to a woman if she were to live to the end of her childbearing years is 2.77. TFR and unmet need for family planning is highest among rural women, women with no and primary education, and those in the poorest and second poorest households. 31.8% of married and in-union women were using a modern contraceptive method in 2016/2017, the most recent year for which data is available. Modern contraceptive use and demand satisfied with modern methods is higher for Haitian women in urban areas, among women with secondary or higher education, and in middle to the highest income households.

Unmet Need for Family Planning, All Women

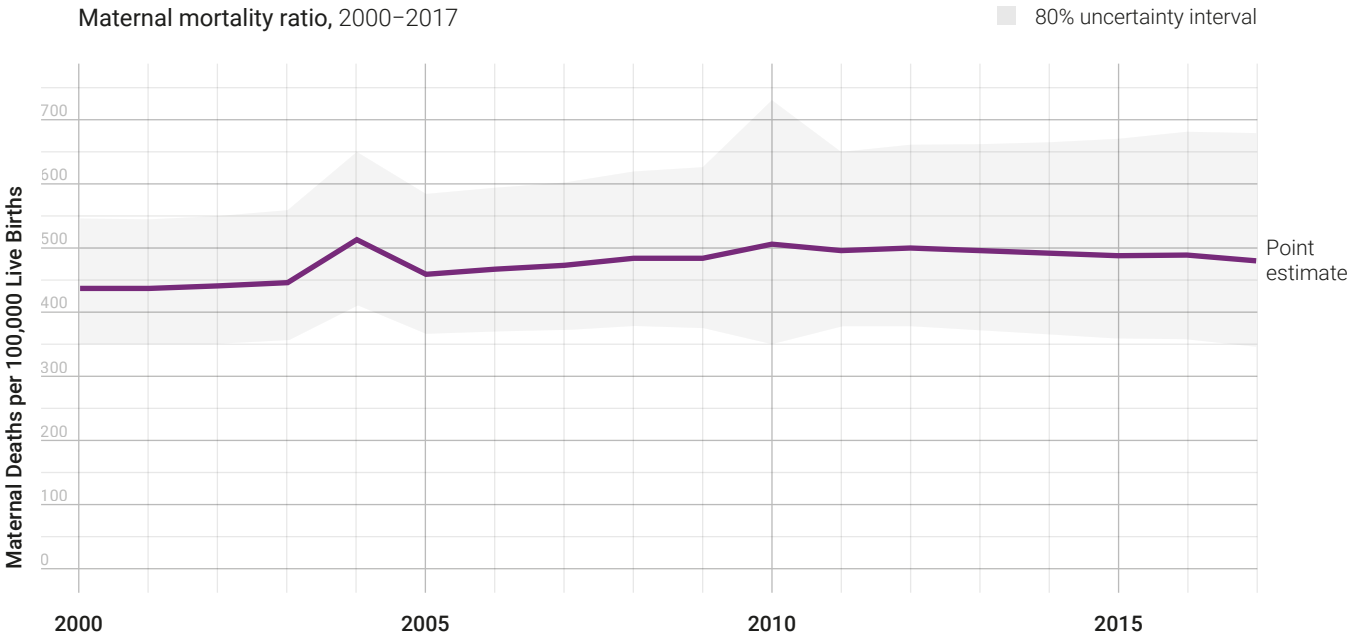
Source: Demographic and Health Survey, 2016

Demand for Family Planning Satisfied with Modern Methods, All Women

Source: Demographic and Health Survey, 2016

At the Nairobi Summit, Haiti committed to prioritize targeted funding to increase and facilitate access to quality emergency obstetric care to reduce maternal mortality

Haiti's maternal mortality ratio remained relatively static from 2000 to 2017 and was estimated to be 480 maternal deaths per 100,000 live births in 2017, the latest year for which most recent data is available, the highest among countries in the region. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Abortion is not permitted in Haiti. Now with intensified fighting in the capital and many essential services and health facilities still damaged or destroyed in the south of the country following last year's earthquake, humanitarian needs are soaring: Over 4.9 million people are currently in need of assistance, including some 1.3 million women of reproductive age.



Source: World Health Organization, 2019

In the current context, access to the few health centres and hospitals that are still functioning has become treacherous if not impossible. Not being able to receive critical sexual and reproductive health care is endangering the lives of women and girls in need, particularly survivors of sexual violence and an estimated 85,000 currently pregnant women – around 30,000 of whom are due to give birth in the throes of the crisis over the next three months. [IV]

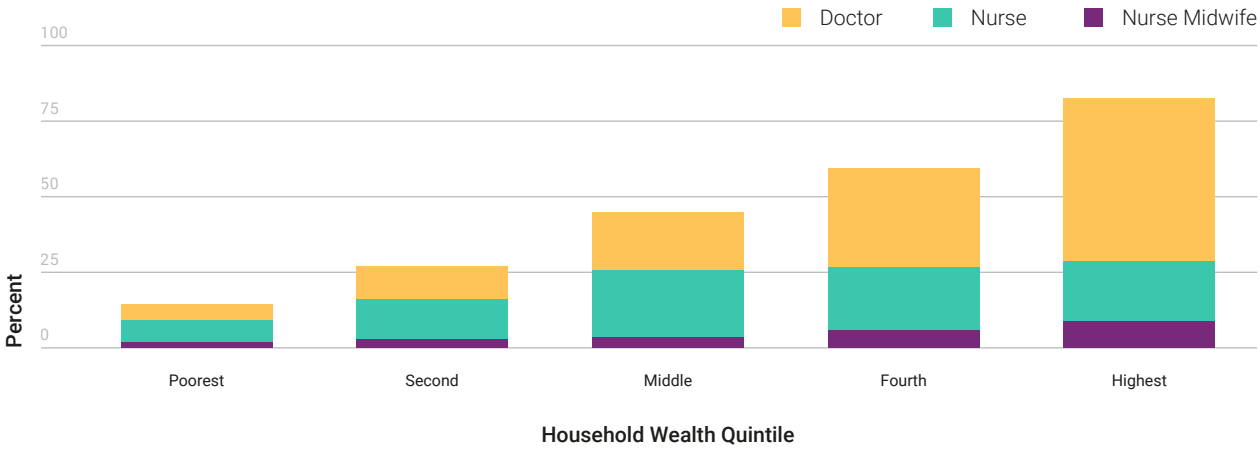
IV https://www.unfpa.org/news/amid-gruelling-violence-and-economic-collapse-women-and-girls-haiti-need-urgent-support

In 2017, the latest year for which data is available, the proportion of births in Haiti attended by skilled health personnel was 41.6%. Among married women 15-49 years who had a live birth in the last two years, deliveries assisted by a skilled attendant were twice as high in urban areas compared with rural areas. The percent of births with a skilled attendant is six times higher among women with the highest education compared with women with no education, and almost six times higher among women in the wealthiest households compared with those in the poorest households. As household wealth increases, so does the portion of births attended by doctors, nurses and midwives. Among women in the poorest households, most births were attended by nurses, while the majority of women in the wealthiest households had their deliveries attended by doctors.

Births with Skilled Attendant

Source: Demographics and Health Survey, 2016

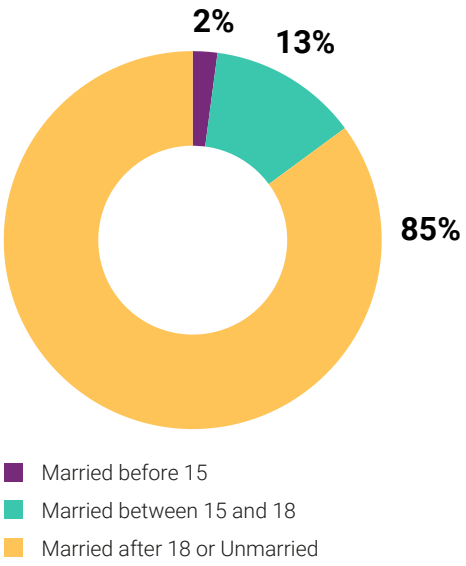
Skilled Birth Providers by Wealth Quintile



Source: Demographic and Health Survey, 2016

In Haiti, 15% of women aged 20-24 years were married before age 18, with 2% of women were married before age 15. There has been a decline in the adolescent birth rate from 75.88 in 1990 to 52.15 in 2022; Haiti's adolescent birth rate falls halfway between that of countries in the region with the highest and lowest rates.

Age of Marriage Distribution, Women 20–24

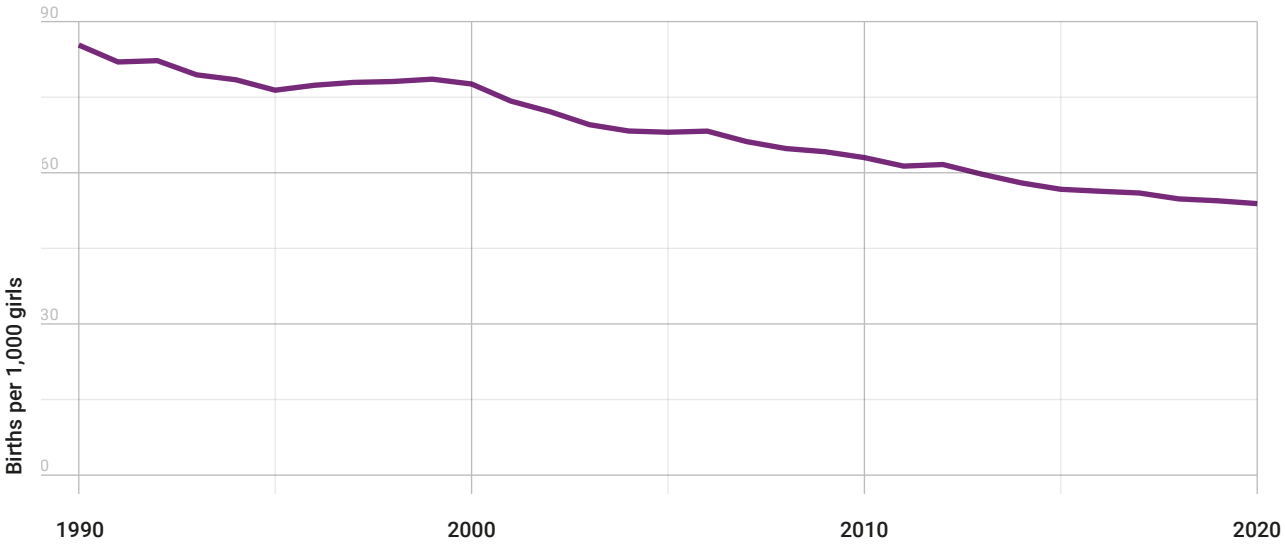


Source: Demographic and Health Survey, 2016

Haiti's ICPD25 commitments include:

- Investing in the economic empowerment of women and girls, encourage women's leadership, and to taking all other measures required to reduce gender inequalities and discrimination
- Adopting and enforcing the law against gender-based violence
- Involving youth in all decisions affecting them
- Ensuring young people's access to decent work in the public, private and informal sectors

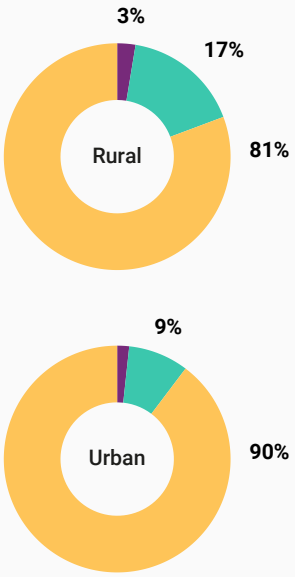
Adolescent birth rate, 1990–2020



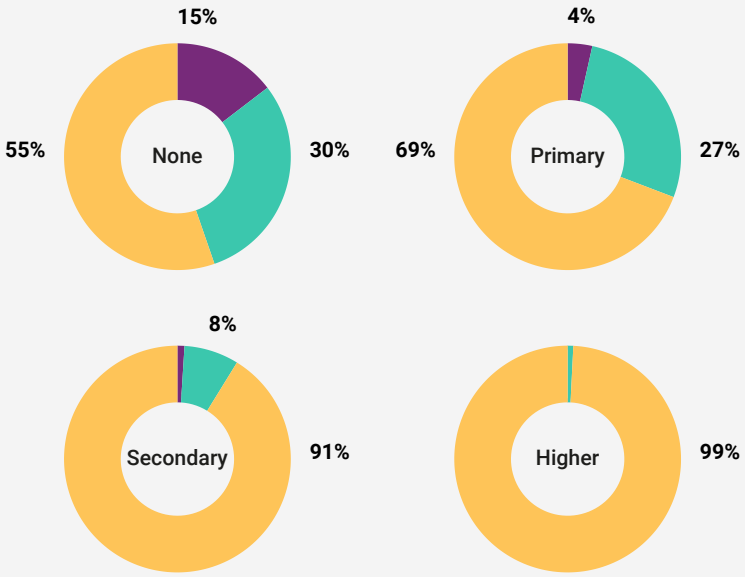
Source: World Population Prospects, 2022

Most women 20-24 years who were married before 18 years are from rural areas. Approximately 45% of women married before age 18 have no education, while 31% have primary education. Marriage before age 18 is also highest among women living in the poorest households. Marriage before 15 is seven times higher among girls living in the poorest households compared to those living in the richest households; marriage before 18 is four times higher among girls living in the poorest households compared to those living in the richest households.

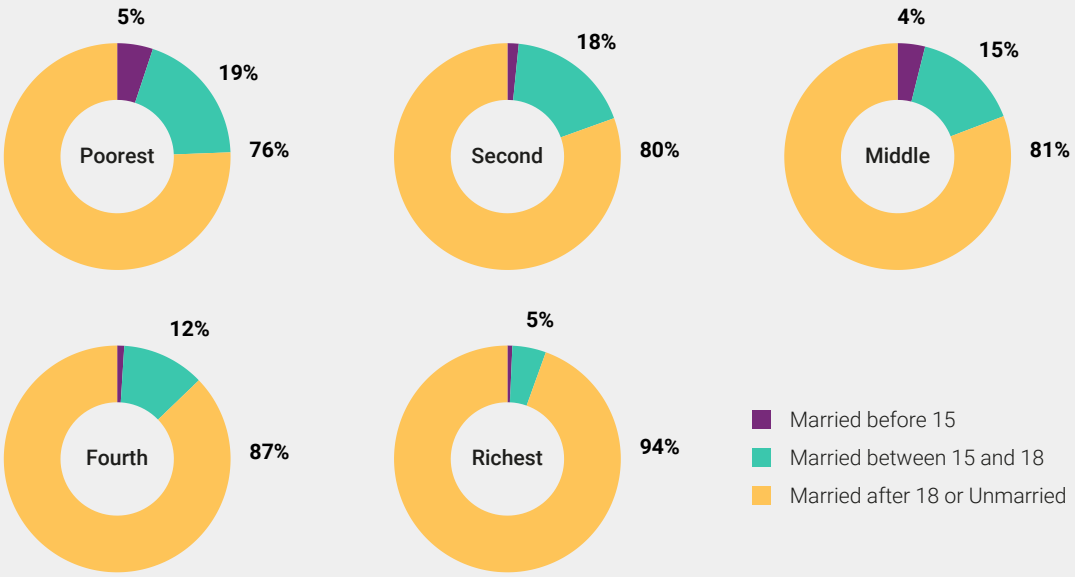
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



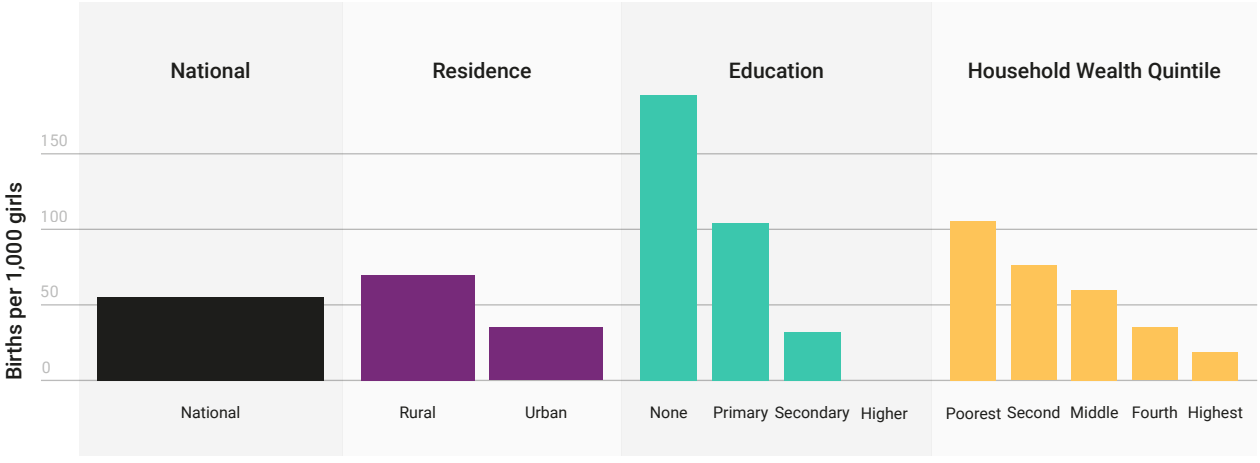
Source: Demographic and Health Survey, 2016

Since the Nairobi Summit, the results framework tool to be used for the follow-up on the implementation of the Montevideo Consensus and Haiti's 10 Nairobi commitments received national validation. A Commitment Pact on Political Participation was signed by influential youth groups. A youth policy and strategic plan to strengthen the partnership framework between actors for the benefit of young people have been developed. Young people have been advocating for increased investment in adolescent girls at risk of early marriage, HIV, adolescent pregnancy, GBV, and reproductive rights. A national multisectoral committee has taken shape, with involvement of civil society organizations as well as other state entities

Haiti was reviewed at the 40th session of the UPR in January 2022. It received 221 recommendations, of which at least 63 (29% of all recommendations) were related the Nairobi Summit on ICPD25.

Haiti's adolescent birth rate in rural areas is double the rate in urban areas; it is seven times higher among girls with no education compared to those with secondary education and higher. The adolescent birth rate is highest for women in the poorest households; it is nearly six times higher among girls with no education compared with those with secondary and higher education, and 5.5 times higher among girls in the poorest households compared with those in the richest households.

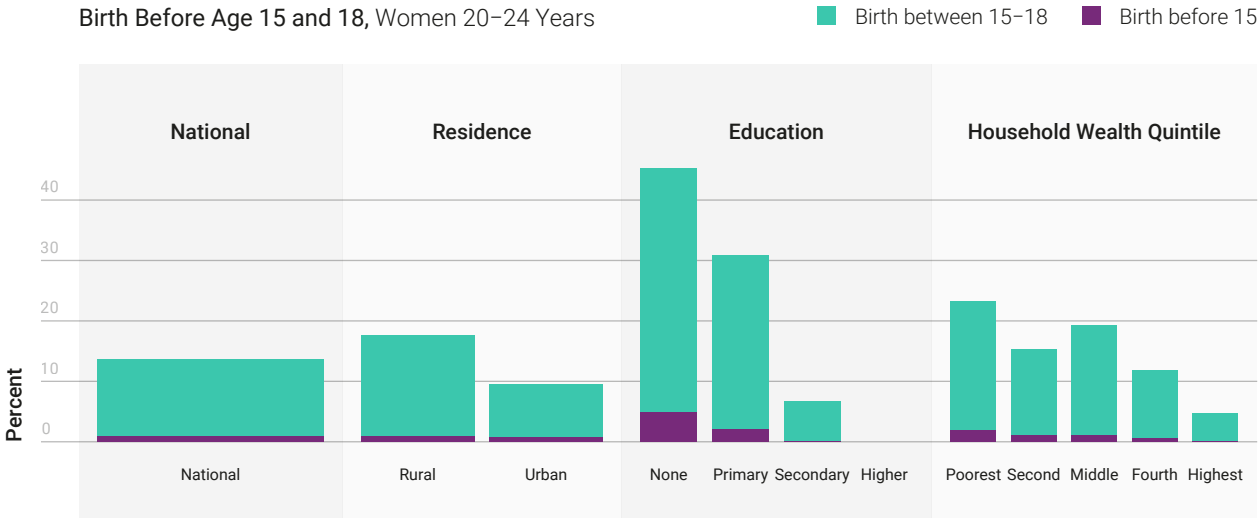
Adolescent birth rate



Source: Demographic and Health Survey, 2016

The proportion of girls who give birth before age 18 is higher for girls in rural areas than urban areas. The majority of births before aged 18 occurred among girls with no education, followed by those with primary education. Births among married girls 15-19 years are also higher among girls from the poorest and second poorest households. Births before age 18 are nearly 5 times higher among girls in the poorest households

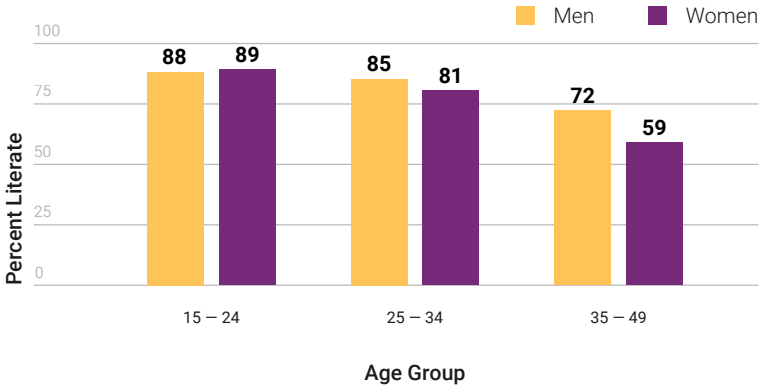
Birth Before Age 15 and 18, Women 20–24 Years



Source: Demographic and Health Survey, 2016

Among those 15 to 24 years, Haiti's literacy rate is higher for women than for men. However, among those 25 to 24 years and those 25 to 49 years, the literacy rate is higher among men than women.

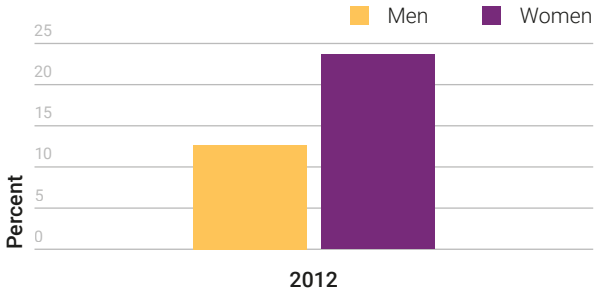
Literacy Rate by Age and Sex



Source: Demographic and Health Survey, 2016

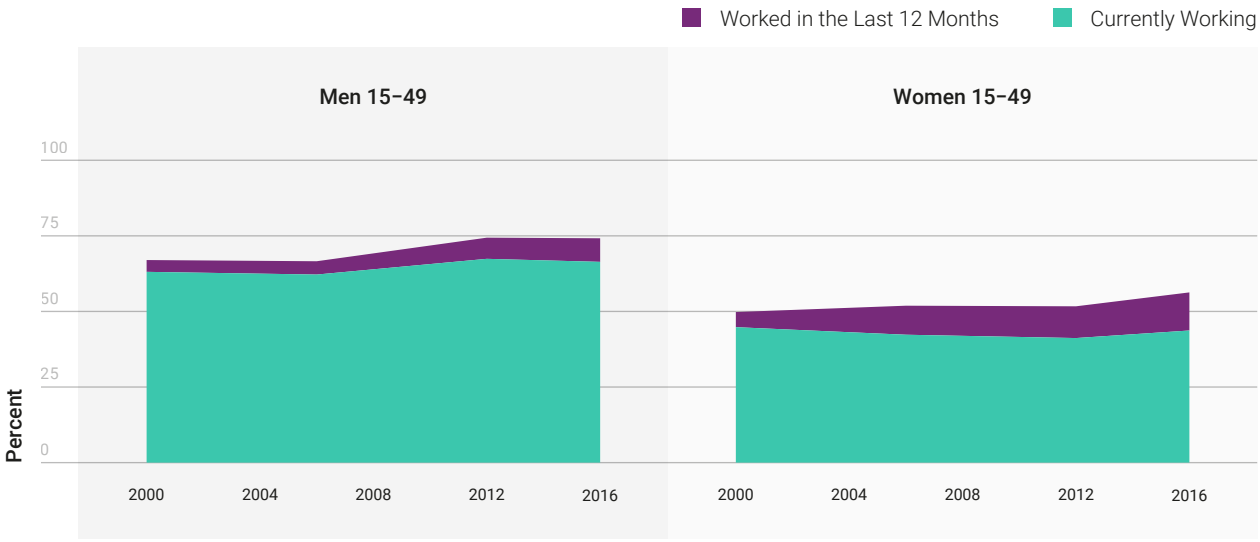
Employment trends for both men and women have remained relatively the same in Haiti from 2001 to 2016. The proportion of women who worked in the last 12 months has increased more than the proportion for men. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Haiti, the percent of youth not in education, employment or training is nearly twice as much among women than men.

Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Households Living Conditions Survey after the Earthquake, 2012

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 2000—2016

Without stability, security and justice, economic progress is however severely hampered. This is unfortunately becoming increasingly clear with the continued slow-down of the Haitian economy whose effects are most felt by the most vulnerable and marginalized individuals and communities.

UNFPA estimates that close to 30,000 pregnant women are at risk of being unable to access essential healthcare, and almost 10,000 could experience life-threatening – if not fatal – obstetric complications without skilled medical assistance. Survivors of sexual violence could be left without medical and psychosocial support. Despite the extremely challenging security situation and fuel shortages, UNFPA and others are collaborating with hospitals, health authorities and partners to install solar power supplies at facilities across Haiti, which have improved cold-chain storage and enabled maternity services to continue to the extent possible.

HASHEMITE KINGDOM OF JORDAN

TOTAL POPULATION [I] **11,315,550**

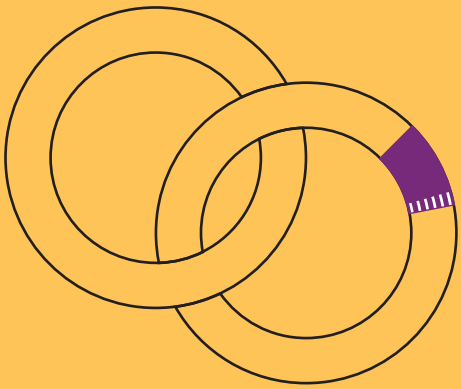
POPULATION 24 YEARS OR YOUNGER [I]

50.22%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **2,888,550**

POPULATION 15-24 YEARS (male + female) [I] **2,084,520**

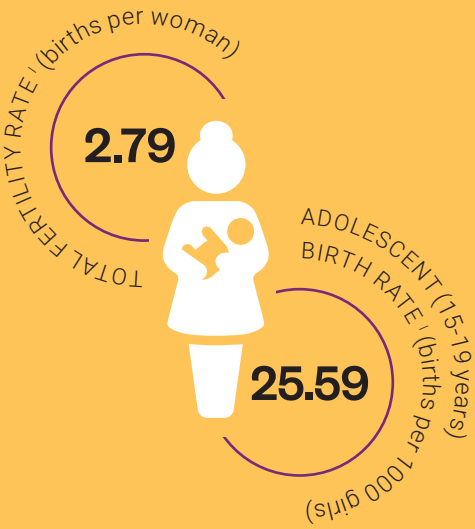
WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **9.7%**

BEFORE AGE 15 **1.5%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **46 / 100,000**



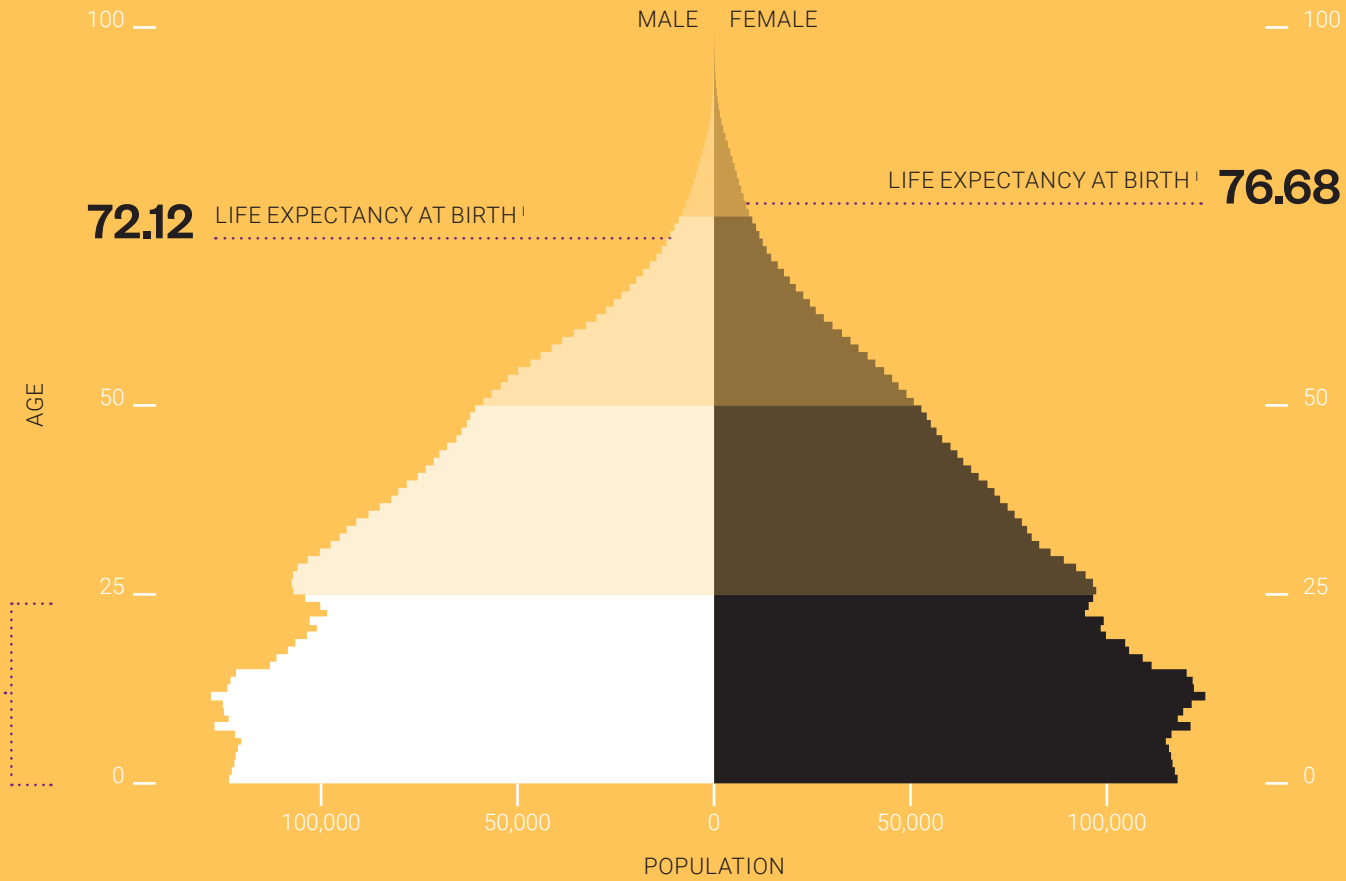
I. World Population Prospects 2022 II. SDG

8% UNMET NEED FOR FAMILY PLANNING (all women) [III]

57% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

99.7% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

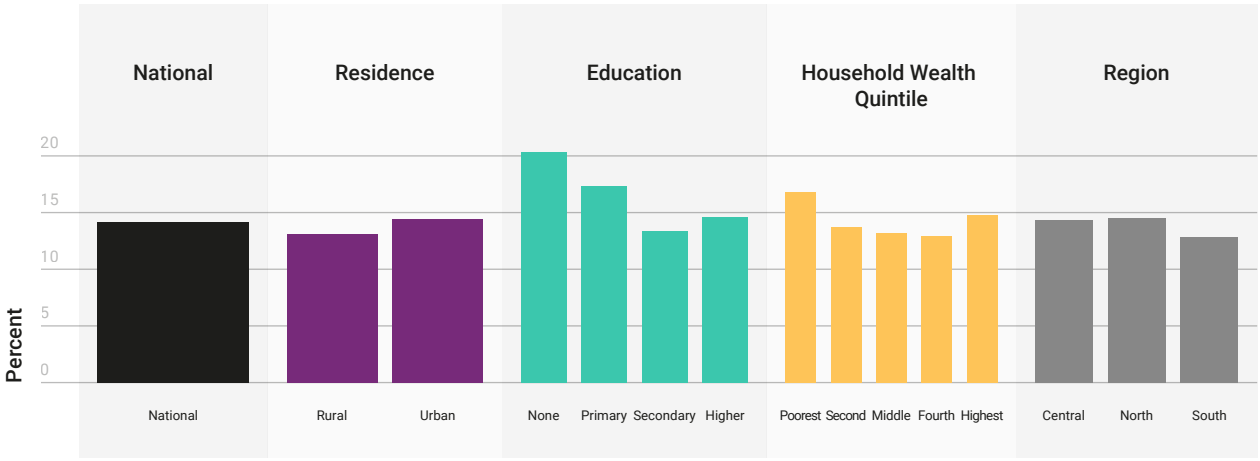
The Hashemite Kingdom of Jordan has committed to intensify efforts for the full, effective and accelerated implementation and funding of the ICPD Programme of Action, Key Actions for the Further Implementation of the Programme of Action of the ICPD and Agenda 2030 for Sustainable Development. Jordan has also affirmed commitment to the ICPD's Programme of Action, and the Sustainable Development Goals. The country made a broad range of commitments during the Nairobi Summit on ICPD25, including the provision of quality information, counseling and family planning services based on a human rights approach, especially in **remote areas and for vulnerable groups.** Jordan has also affirmed its commitment to reducing maternal morbidity and mortality.



I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

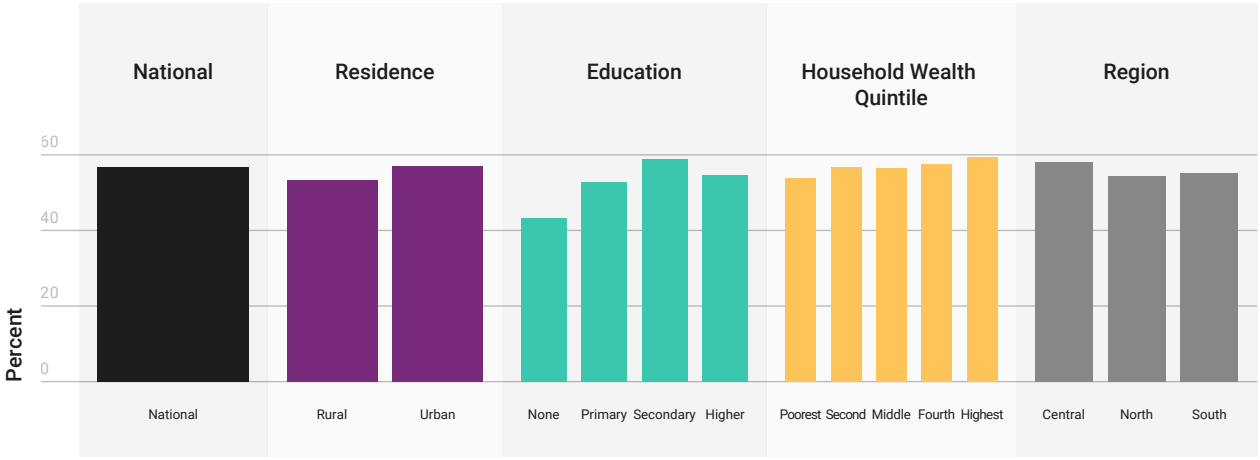
In 2017, the most recent year for which data is available, 14.2% of currently married or in union women had an unmet need for family planning. This was highest among women with no education and women living in the poorest households. In 2017, 56.7% of currently married or in union women had their demand for family satisfied by modern methods. This was higher among women with secondary education and above, and among women living in wealthy households.

Unmet Need for Family Planning, Married Women



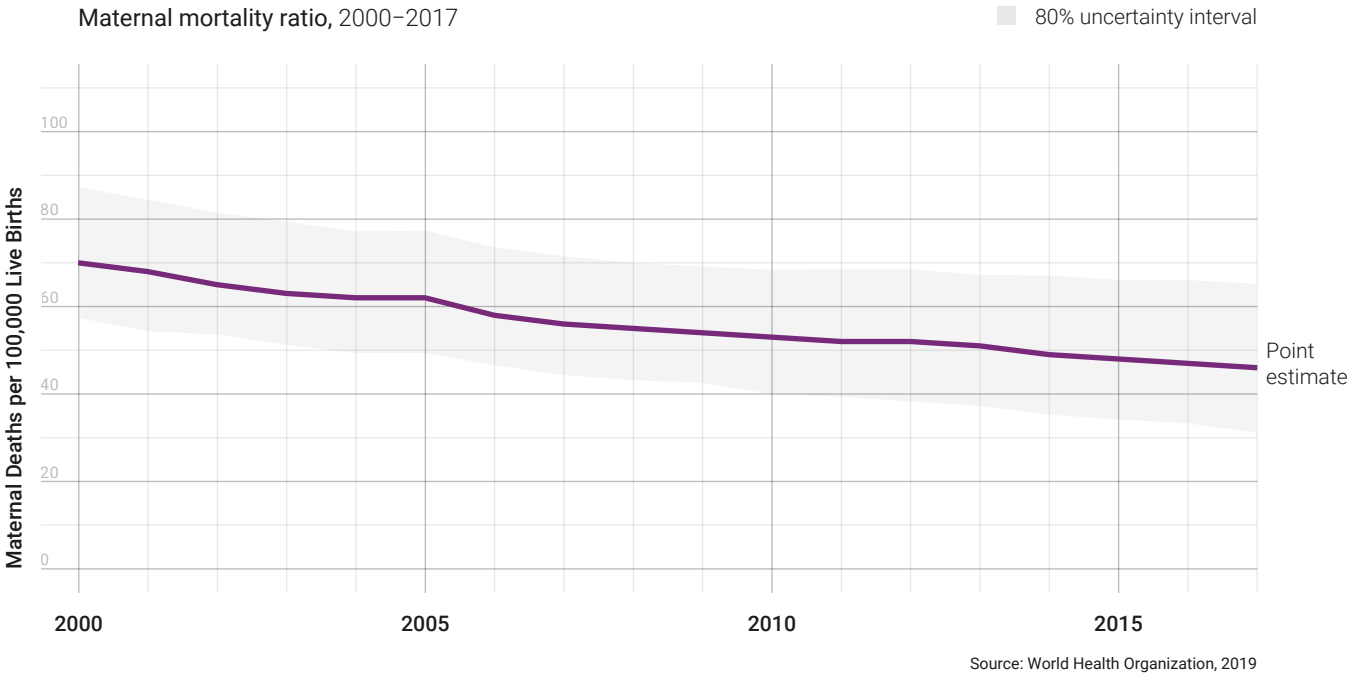
Source: Demographic and Health Survey, 2017

Demand for Family Planning Satisfied with Modern Methods, Married Women



Source: Demographic and Health Survey, 2017

Jordan's maternal mortality ratio decreased from 2000 to 2017 and was estimated to be 46 maternal deaths per 100,000 live births in 2017, the latest year for which most recent data is available, a low rate for the region where the highest maternal mortality ratio is 295 maternal deaths per 100,000 live births. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Abortion is only permitted in Jordan under certain circumstances including to preserve the mother's health.

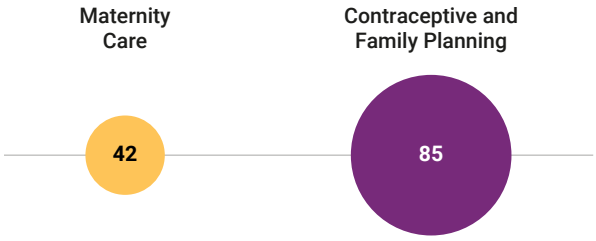


Source: World Health Organization, 2019

Since the Nairobi Summit, stakeholders have explored opportunities to advance Jordan's commitments. A monitoring and evaluation system to track ICPD and SDGs was taken place. In its 2022 Voluntary National Review of the implementation of sustainable development, Jordan reflected that a draft national plan was prepared to implement the commitments of the Nairobi Summit 2021-2030 and to reach targets of zero unmet need for family planning, zero (preventable) maternal deaths and zero family violence by 2030.

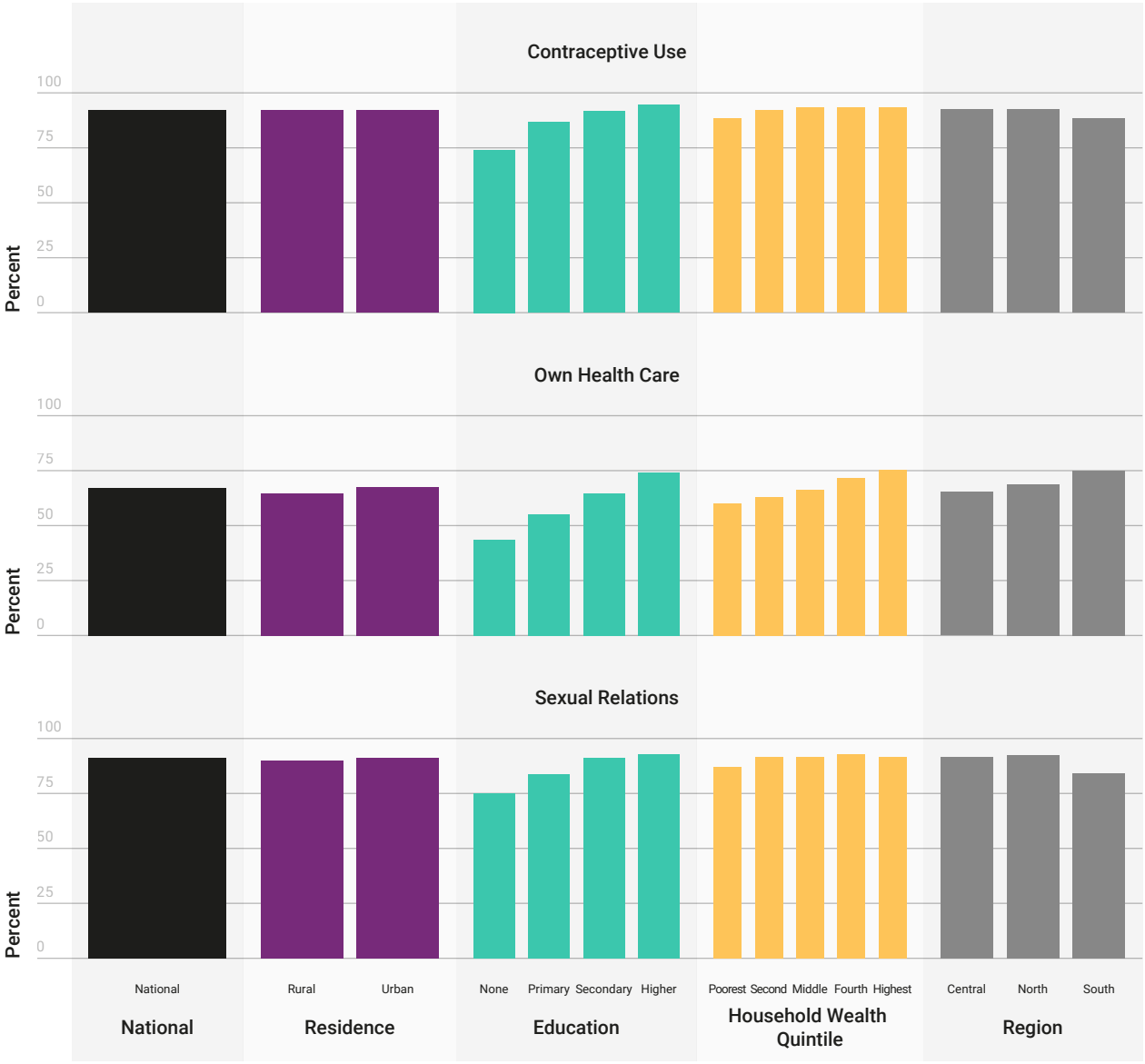
In Jordan, 91.2% of married women aged 15 to 49 make their own decisions regarding sexual relations, 92.3% about contraceptive use, 67.3% about health care, and 58.2% about all three decisions. The percentages are higher among women with secondary and higher education. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. On average, Jordan has achieved 42% of enabling laws and regulations that guarantee full and equal access to women and men to maternity care, and 85% to contraceptive and family planning services.

Extent to which Jordan has 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



Source: United Nations Population Fund, 2022

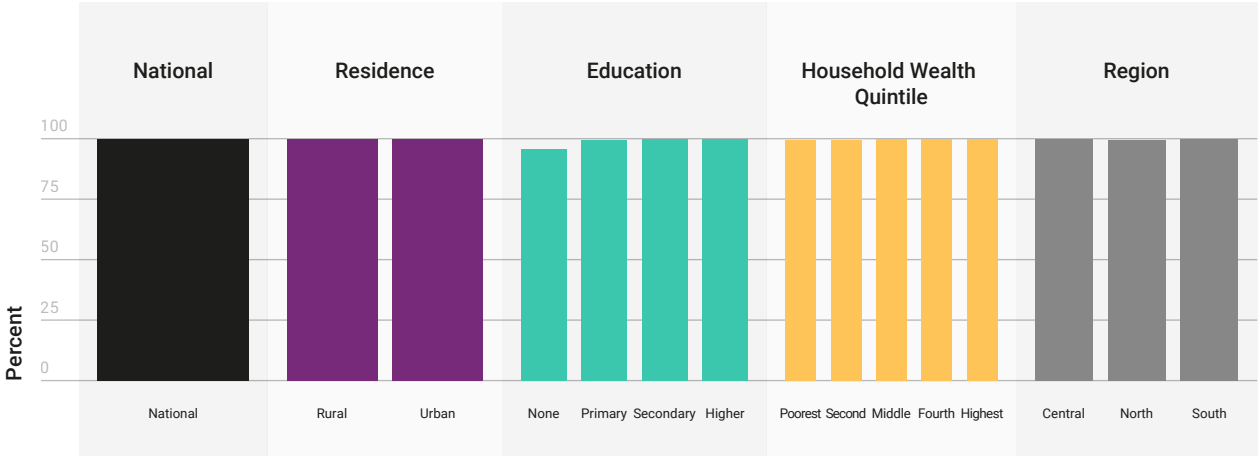
Proportion of married women who make their own informed decisions regarding reproductive health care, contraceptive use, and sexual relations



Source: Demographic and Health Survey, 2017

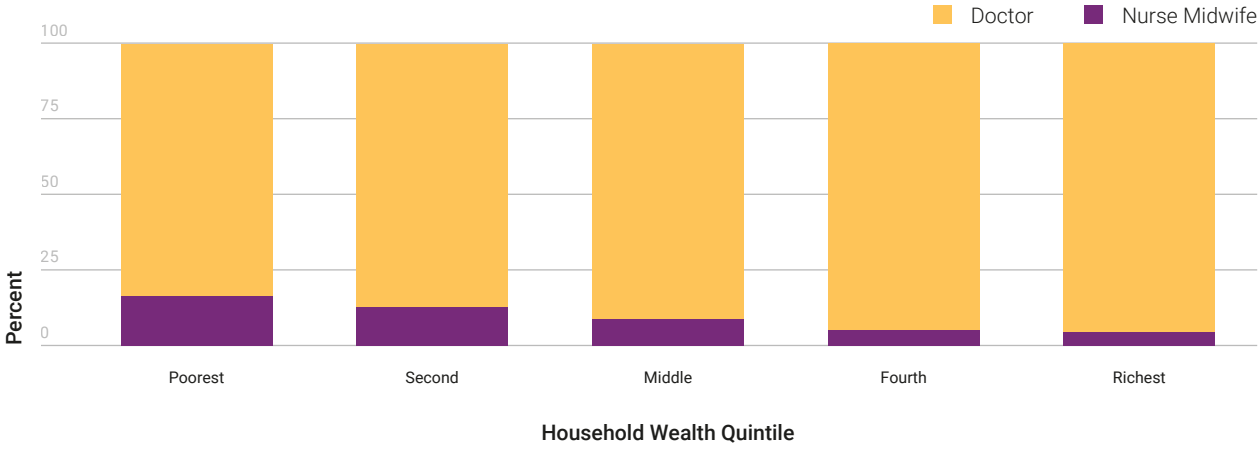
In 2017, the percentage of births in Jordan that were attended by skilled health personnel was 99.7% - the highest in the region, with very little variation between geography, residence, and wealth, and the percentage being only slightly lower among women with no education. As household wealth increases, so does the proportion of births attended by doctors; however overall doctors are the main attendants at births in Jordan.

Births with Skilled Attendant



Source: Demographic and Health Survey, 2017

Skilled Birth Providers by Wealth Quintile



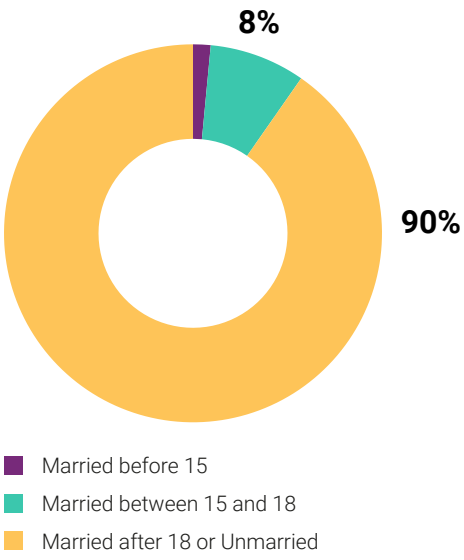
Source: Demographic and Health Survey, 2017

Jordan has made important achievements in the field of reproductive health, especially in reducing the maternal mortality rate, by providing advanced health care for mothers in hospitals. In its Voluntary National Review report in 2022 Jordan reported that a national plan for the period 2021-2030 was prepared to implement the commitments of the Nairobi Summit and to reach zero indicators of the unmet need for family planning, zero maternal deaths and zero family violence by 2030. Further in 2022, Jordan launched the National Reproductive and Sexual Health Strategy for the years (2020-2030).

At the Nairobi Summit, Jordan has affirmed its commitment to ensuring that adolescents and young people have comprehensive and age-appropriate information, to help them make sound decisions related to their sexual and reproductive health

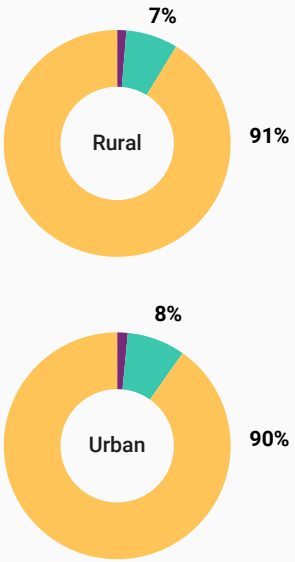
In Jordan, 9.8% of women aged 20-24 years were married before age 18, with 1.5% of women were married before age 15 – one of the lowest in the region. There is little variation in the percentage of marriage before 15 and 18 by residence. Marriage before age 18 is greater among those with primary and no education, and in the poorest and second poorest households.

Age of Marriage Distribution, Women 20–24

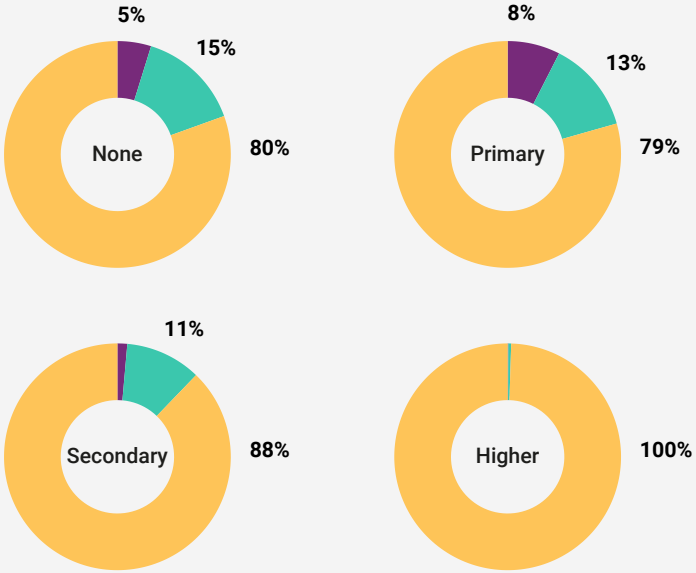


Source: Demographic and Health Survey, 2017

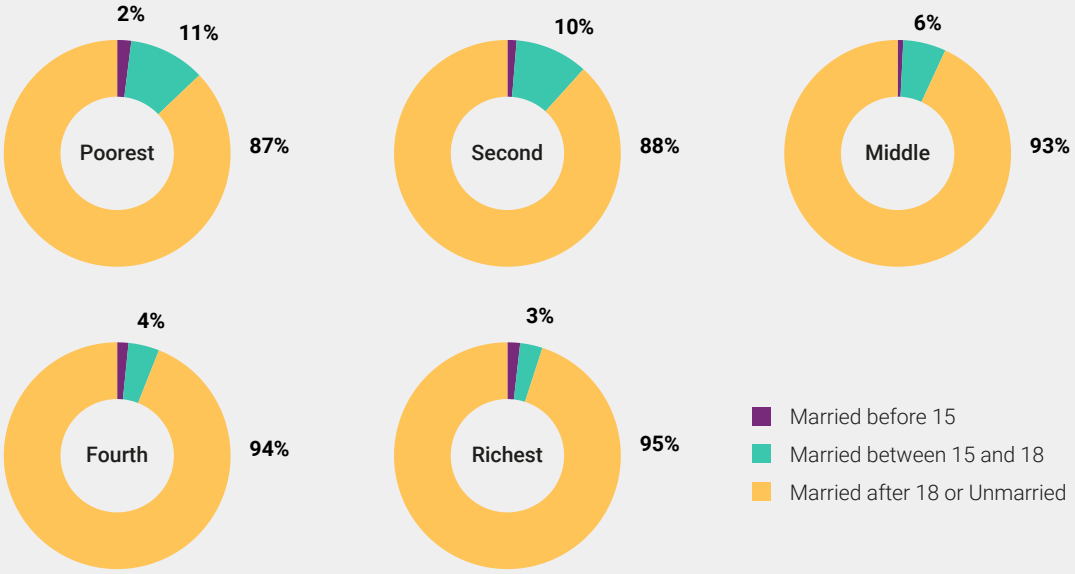
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



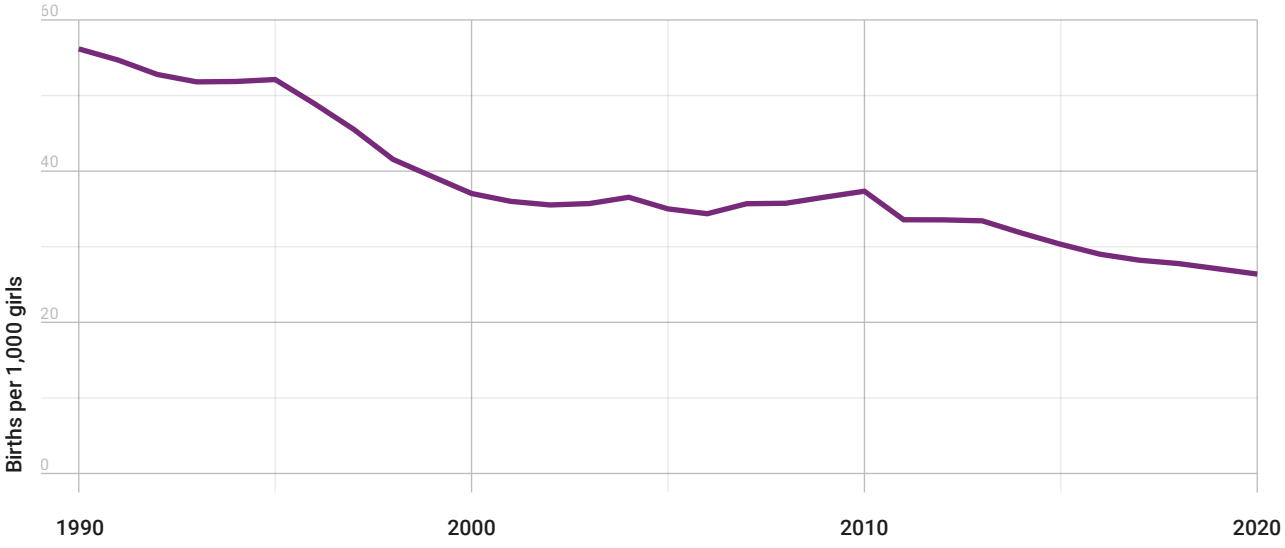
Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



Source: Demographic and Health Survey, 2017

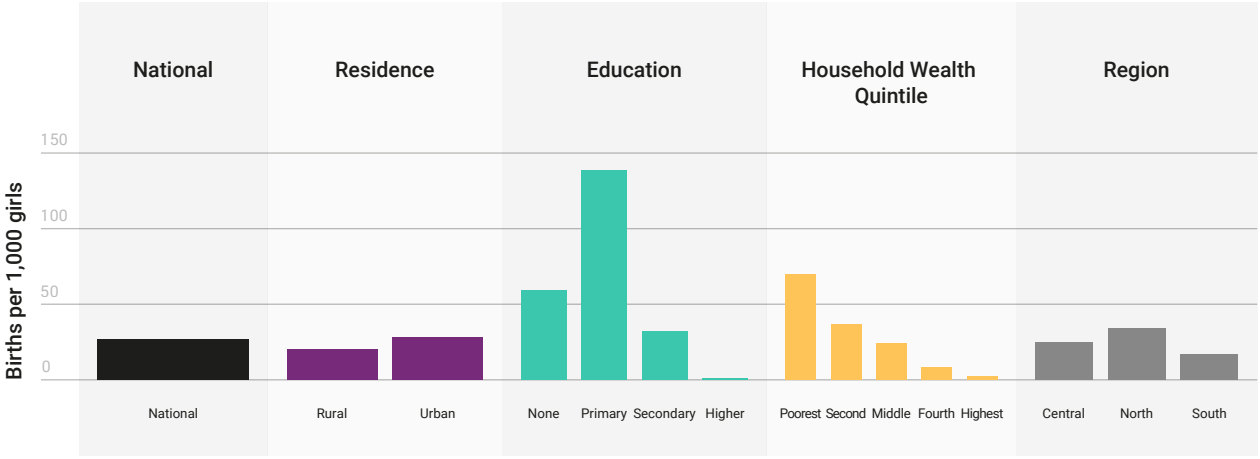
Jordan's adolescent birth rate has been steadily decreasing from 1990 to 2020, and is estimated to be 24 births per 1,000 girls in 2022. The adolescent birth rate is higher in urban areas than rural areas, highest among those with primary education, and in the poorest households.

Adolescent birth rate, 1990–2020



Source: World Population Prospects, 2022

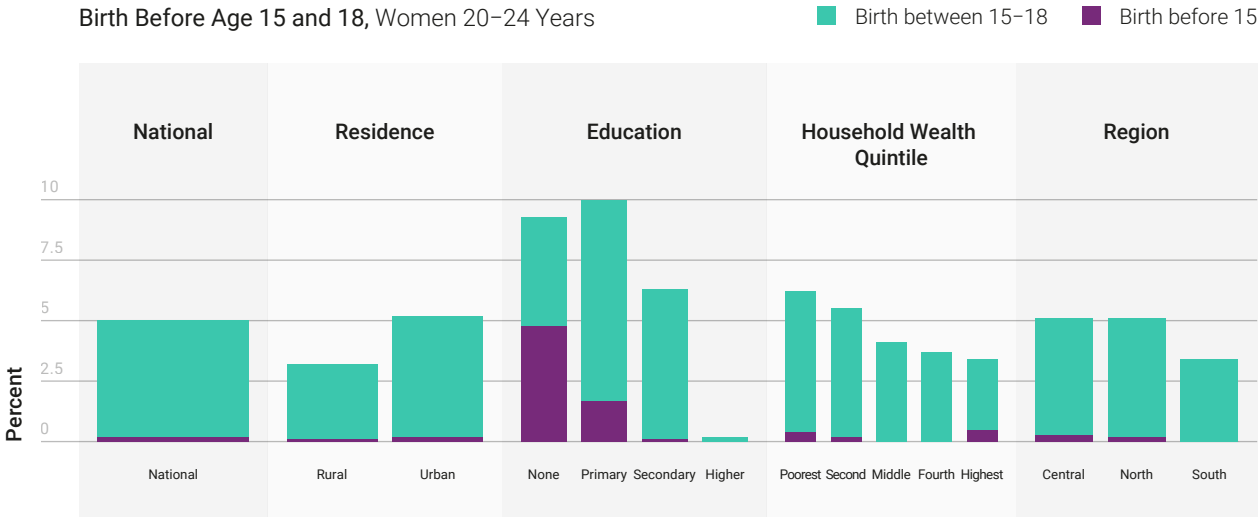
Adolescent birth rate



Source: Demographic and Health Survey, 2017

Among those girls who give birth before age 18, the percentage is higher in urban areas than in rural areas, and is highest among those with no and primary education, and among those in the poorest households. Among women with no education, the proportion of births before age 15 and before age 18 is approximately the same. As education and wealth increases, the proportion of births before 15 years decreases.

Birth Before Age 15 and 18, Women 20–24 Years

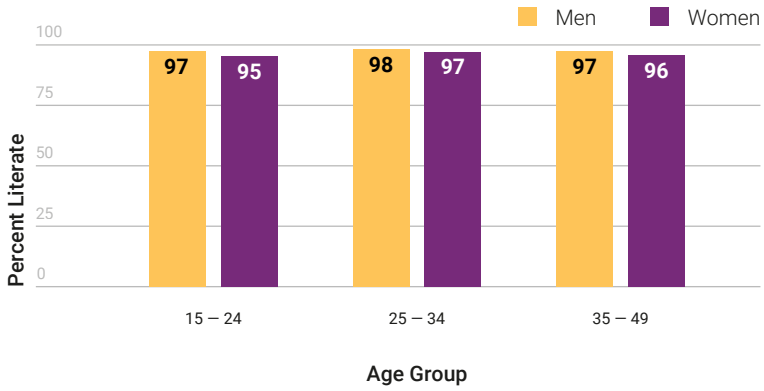


Source: Demographic and Health Survey, 2017

At the Nairobi Summit, Jordan committed to the continued participation of young people in the development of national strategies and plans, and to help youth participate in decision-making.

Jordan's literacy rate is greater than 95% among men and women, but slightly higher for men than for women.

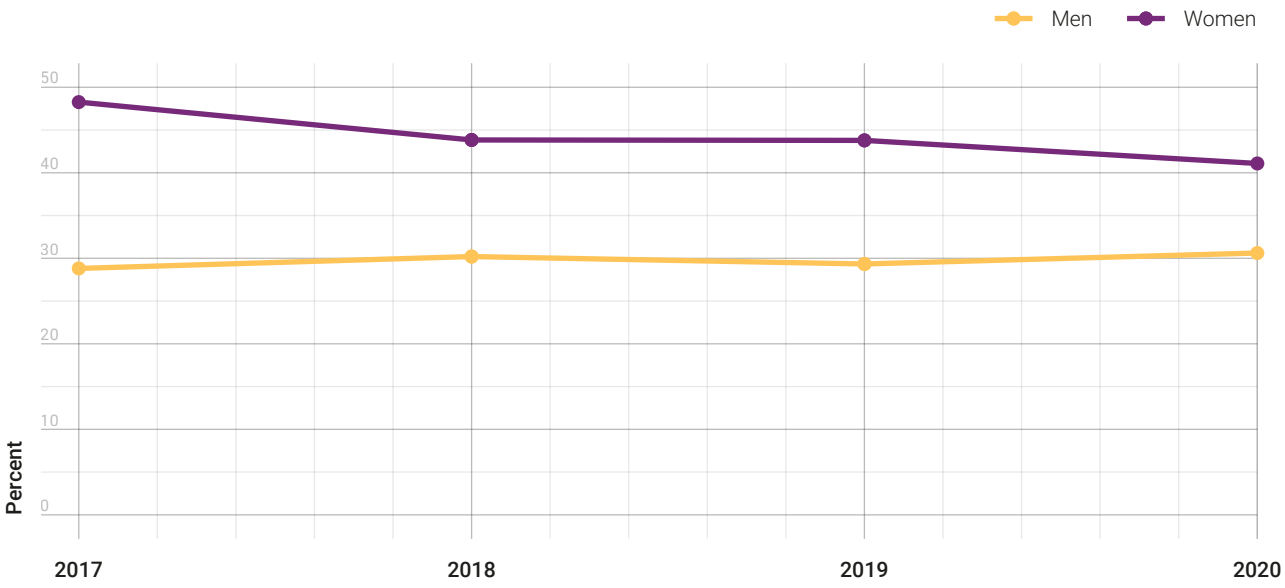
Literacy Rate by Age and Sex



Source: Demographic and Health Survey, 2017

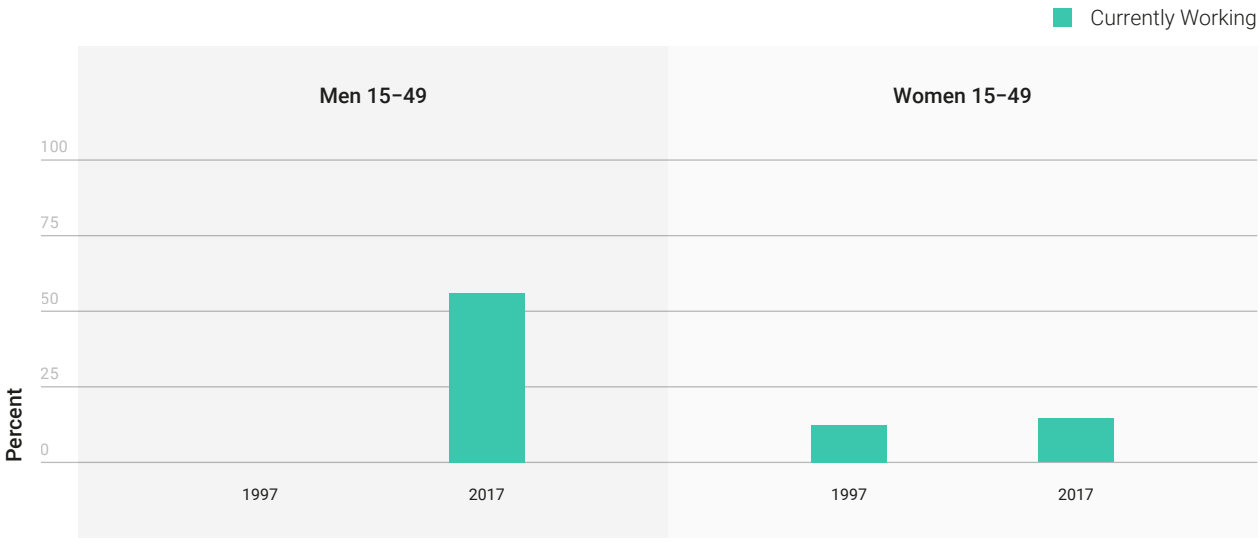
In 2017, nearly four times as many men (56.1%) were currently working, compared with women (14.5%), with the percentage of women currently working increasing only slightly between 1997 and 2017. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Jordan, the percent of youth not in education, employment or training is greater among women than men; the percentage is decreased from 2017 to 2020 among young women, but increased slightly for young men during this period.

Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



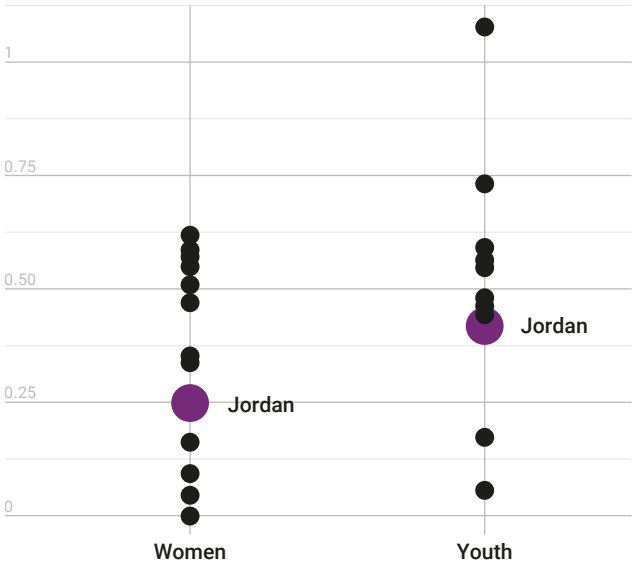
Source: LFS – Employment and Unemployment Survey, 2017–2020

Employment Trends (Currently Working), by Sex



Source: Demographic and Health Survey, 1998—2017

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, North African and West Asian Countries



Source: Inter–Parliamentary Union, 2022

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of women Members of Parliament in Jordan is lower than the median for the region, while that for youth Members of Parliament is the third lowest in the region (SDG 16.17.1).

Jordan is hosting the second-highest share of refugees per capita in the world. More than 760,000 refugees are registered with UNHCR, predominantly from Syria, with large groups from Iraq, Yemen, Sudan, and Somalia. Some 83% live in urban areas outside of refugee camps.[IV] 2022 marks the 10 years since Jordan's Za'atari camp opened its doors to displaced Syrians. Over 20,000 births have been recorded in Za'atari, equating to around 40 babies being born every week.[V] UNFPA Jordan has been active from the onset of the Syrian crisis to respond to the needs of the Syrians both in the communities and the established camps, as well as other affected populations, with a goal of minimizing maternal and neonatal morbidity and mortality, and reducing the risks and consequences of gender-based violence.[V] As part of its ICPD25 commitments, Jordan is committed to implement the Response Plan for the Syria Crisis for the years 2020-2022, which focuses on the provisioning of health services to refugees and improving services in rural health centers that host refugees in cooperation with international donors. Additionally, Jordan has been committed to implementing the minimal initial service package.

IV. UNHCR V. UNFPA

NEPAL

TOTAL POPULATION [I] **30,723,210**

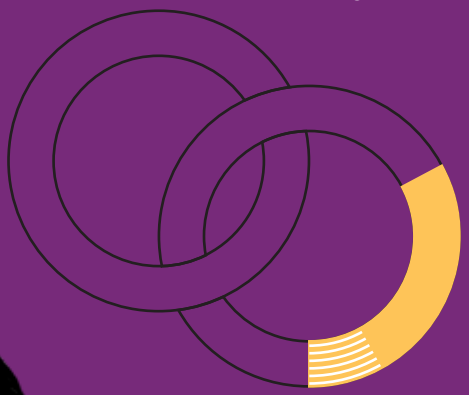
POPULATION 24 YEARS OR YOUNGER [I]

49.56%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **8,993,000**

POPULATION 15-24 YEARS (male + female) [I] **6,407,050**

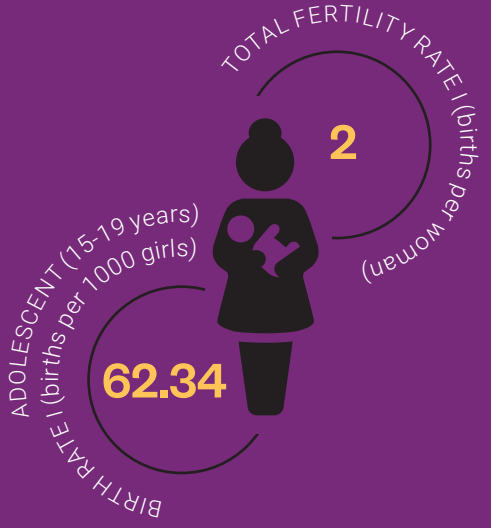
WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **32.8%**

BEFORE AGE 15 **7.9%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **186** / **100,000**



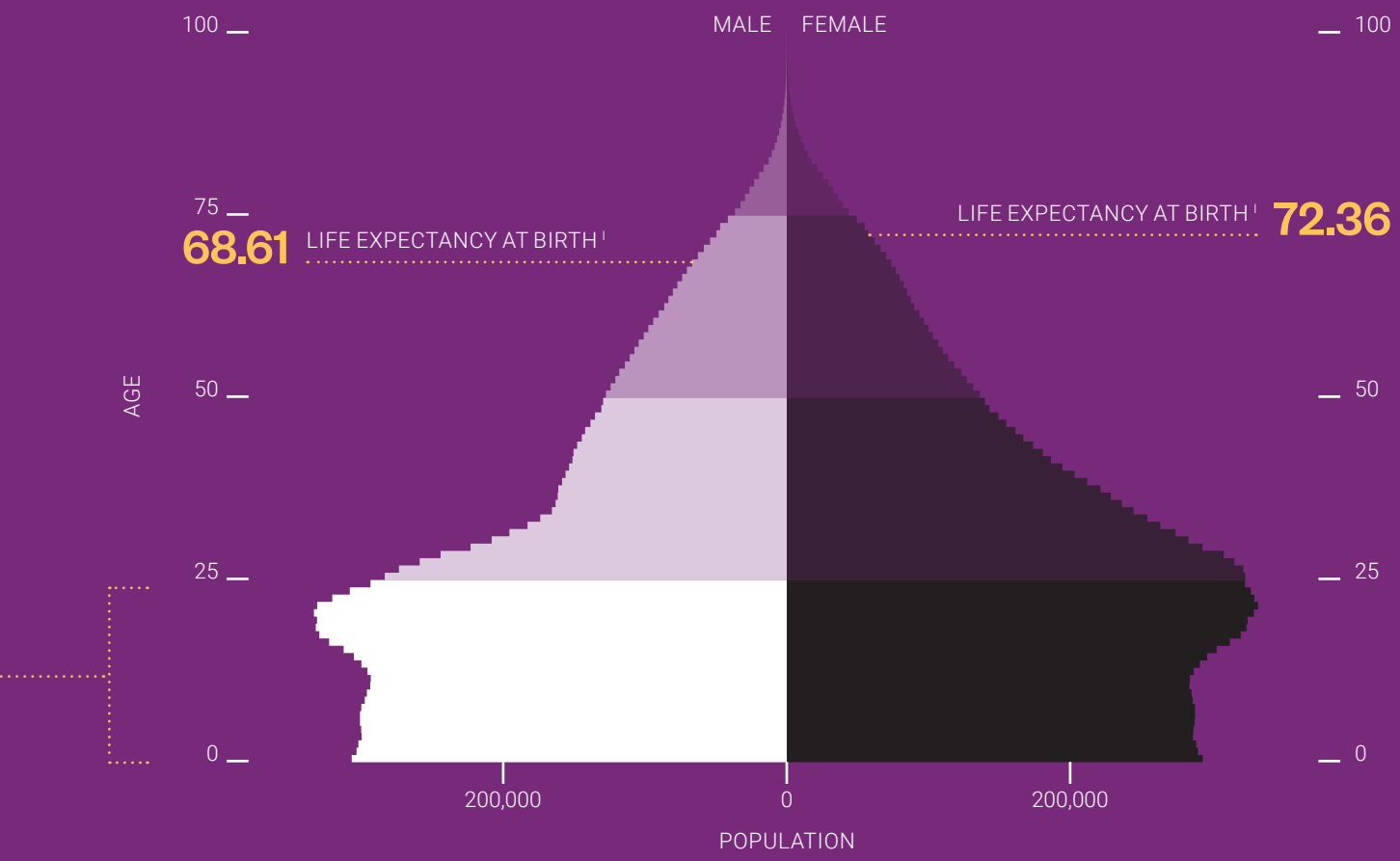
I. World Population Prospects 2022 II. SDG

16.2% UNMET NEED FOR FAMILY PLANNING (all women) [III]

63.5% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

77.2% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

As part of its ICPD25 commitments, Nepal has committed ensuring that marginalized groups, in particularly **adolescents and youth**, are able to exercise their reproductive rights through universal access to quality family planning services including modern contraception, and the country continues to make progress in fulfilling unmet need and expanding access to modern family planning.

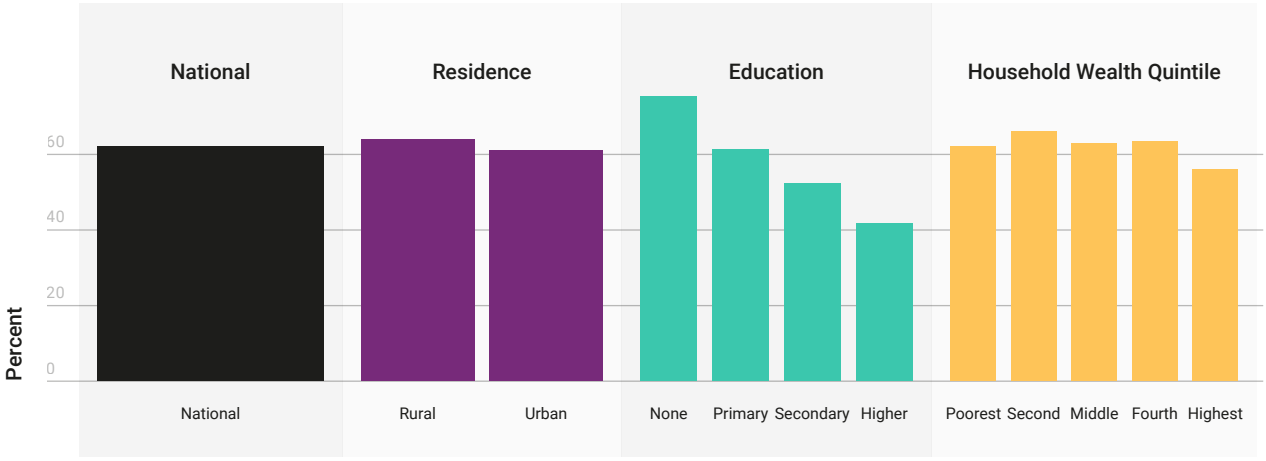


I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

Nepal's total fertility rate (TFR) – the number of children that would be born to a woman if she were to live to the end of her childbearing years –is 2.0; it is highest in Karnali Province (TFR = 2.7) and lowest in Bagmati Province (TFR = 1.6). TFR is highest among women with no education (TFR = 3.2); it is also highest among those women in the poorest households (TFR = 2.9).

Based on the latest available data, 44.2% of married and in-union women were using a modern contraceptive method. The percentage of demand for family planning satisfied by modern methods was nearly 62% nationally, while unmet need was approximately 25%; both do not vary greatly by household wealth. Nepalese women with no education (who primarily include women 35 years and older, who are also more likely to be users of contraceptives for limiting births) have the lowest unmet need for family planning and highest demand for family planning satisfied.

Demand for Family Planning Satisfied with Modern Methods, Married Women



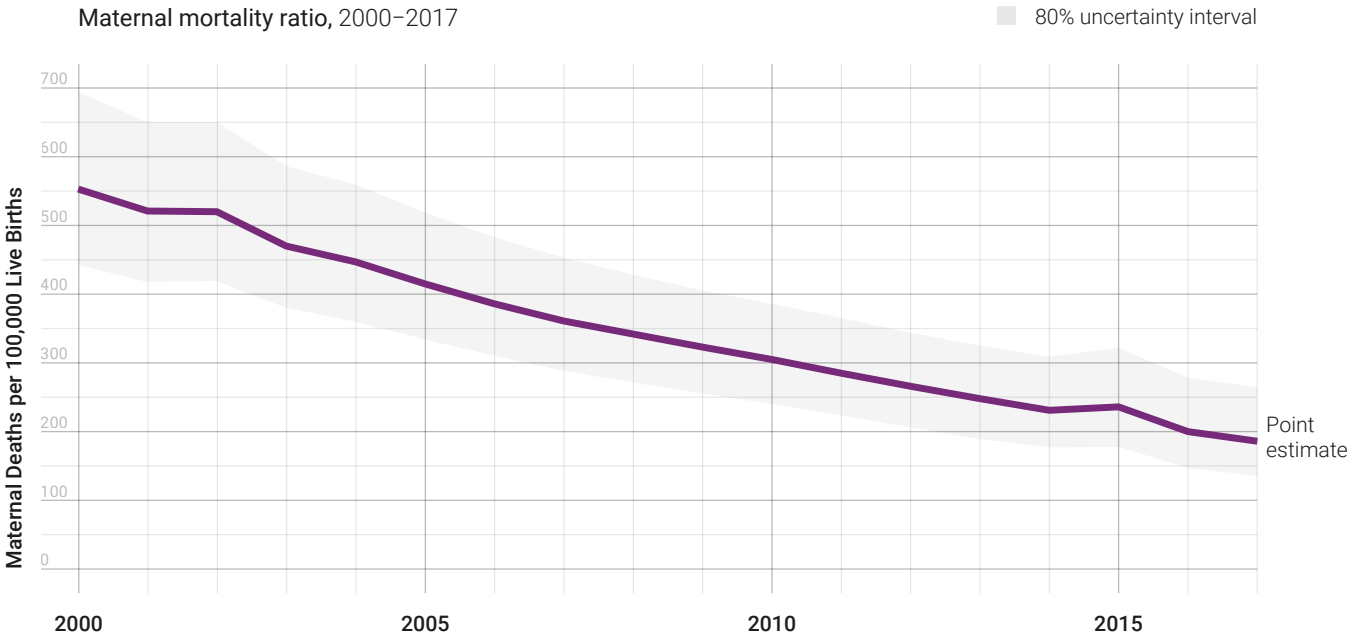
Source: Multiple Indicator Cluster Survey, 2019

Unmet Need for Family Planning, Married Women

Source: Multiple Indicator Cluster Survey, 2019

Nepal is committed to ending preventable maternal deaths and reducing maternal morbidity through integrating comprehensive sexual and reproductive health services as part of the universal health coverage basic health package, ensuring births are attended by skilled birth attendants, and ensuring the provision of legal abortion and post-abortion care services are safe, accessible, affordable and or good quality.

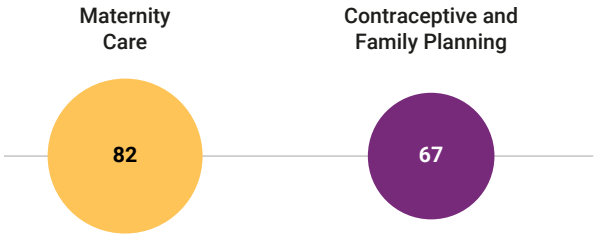
Nepal's maternal mortality ratio declined from 2000 to 2017, the year in which it was estimated to be 186 maternal deaths per 100,000 live births. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Nepal is one of 18 countries that have overturned complete bans on abortion, reforming their laws to permit abortion under various circumstances, and is one of 15 countries who have reformed their laws to allow abortion on certain grounds and to ensure Nepalese women's right to decide on their fertility choices.



Source: World Health Organization, 2019

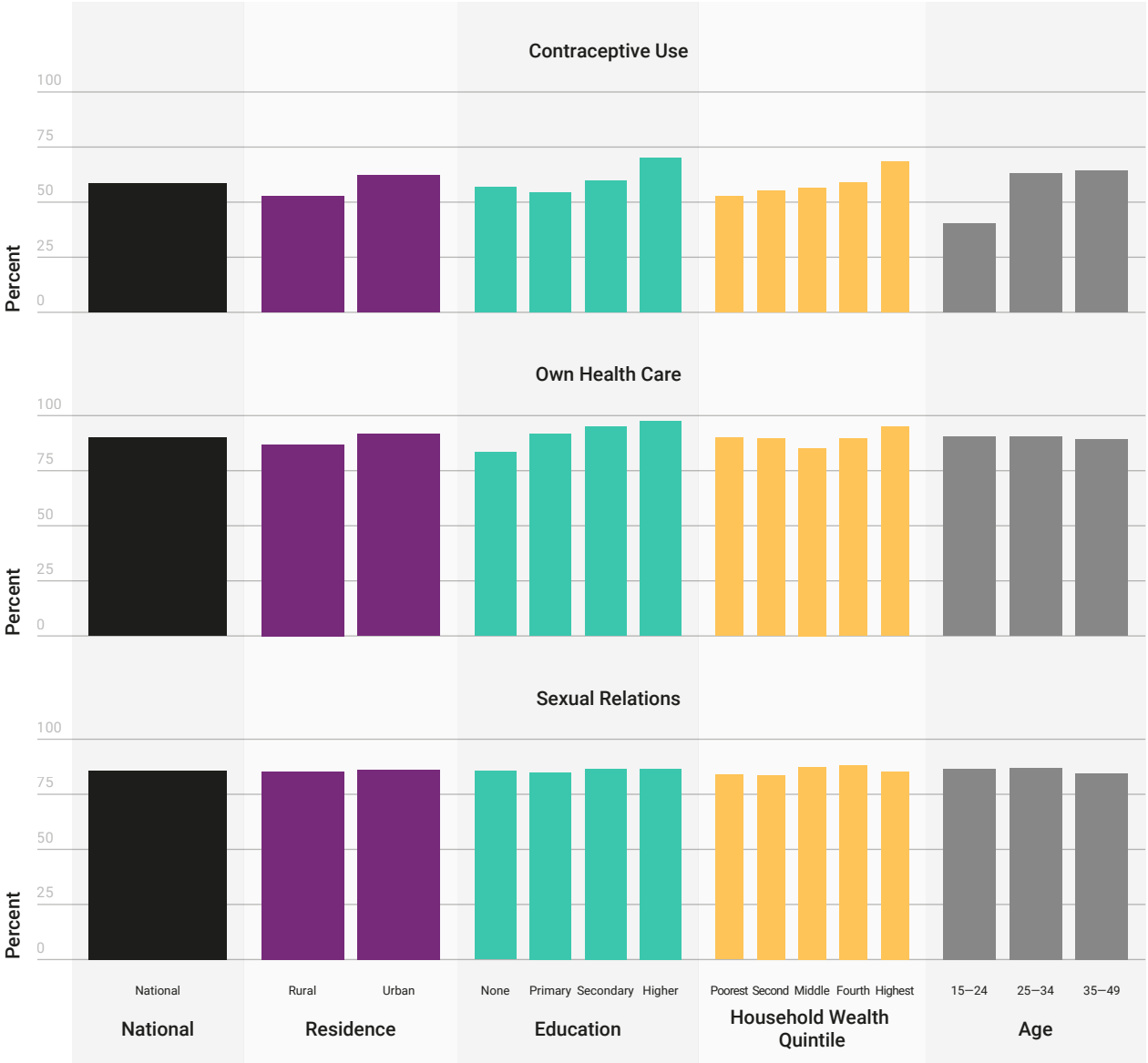
In Nepal, 59% of married or in-union women make decisions on their health care; 85% have the autonomy in deciding to use contraception, and 91% can say no to sex. Overall, 48% of married or in-union women aged 15-49 years in Nepal make their own decisions regarding sexual and reproductive health and rights, including deciding on their own health care, deciding on the use of contraception, and can say not to sex. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. On average, Nepal has achieved 48% of enabling laws and regulations for full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education.

Extent to which Nepal has 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



Source: United Nations Population Fund, 2022

Proportion of married women who make their own informed decisions regarding reproductive health care, contraceptive use, and sexual relations



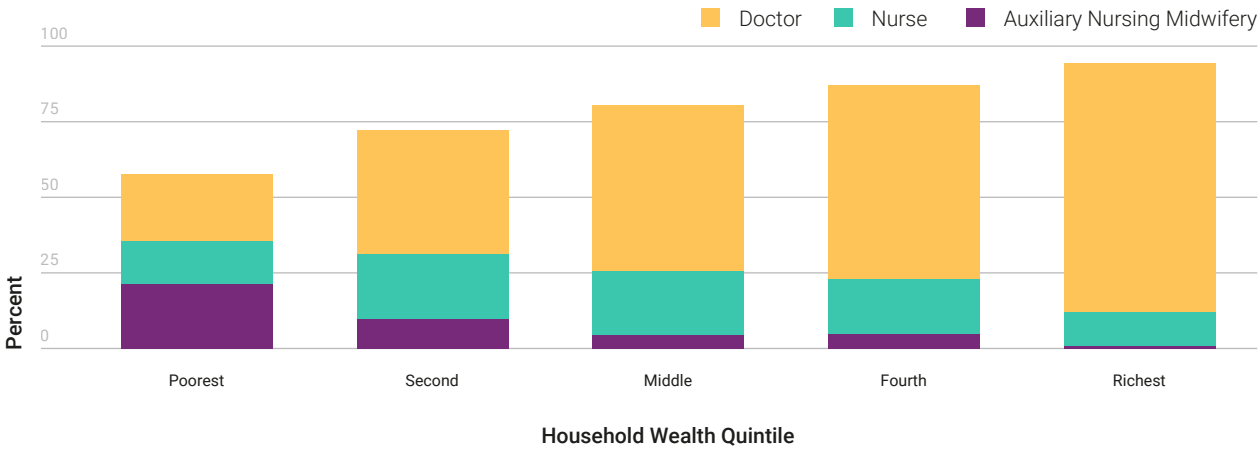
Source: Demographics and Health Survey, 2016

In 2019, the proportion of births in Nepal that were attended by skilled health personnel was greater than 75%. Among married women 15-49 years who had a live birth in the last two years, deliveries assisted by a skilled attendant were higher among women in urban areas, and was lowest among women with no education and among women living in the poorest households. As education and household wealth increases, so does the portion of births attended by skilled health personnel. Among women living in the poorest households, approximately the same percentage of births were attended by auxiliary nursing midwives and by doctors. As household wealth increases, so does the portion of births attended by doctors.

Births with Skilled Attendant

Source: Multiple Indicator Cluster Survey, 2019

Skilled Birth Providers by Wealth Quintile



Source: Multiple Indicator Cluster Survey, 2019

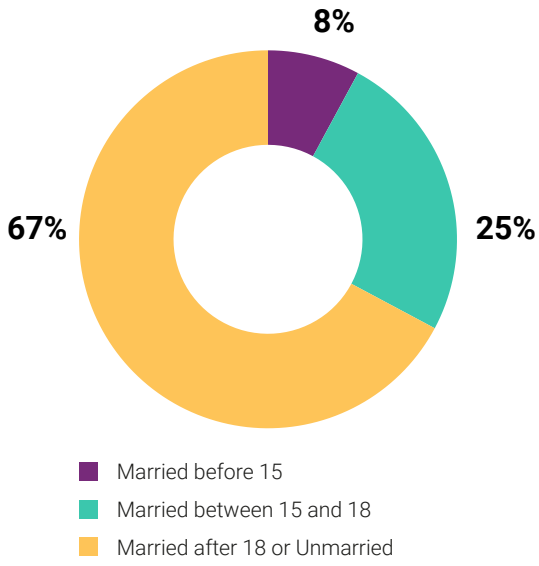
Since the Nairobi Summit, high-level national and provincial policy dialogues have taken place, with participation of national and local government, development partners, implementing partners, NGOs, and other stakeholders to discuss inequities in sexual and reproductive health and rights. Youth-led advocacy is also active. National and sub-national youth networks and platforms were mobilized to follow up on youth commitments. An ICPD25 youth coalition alliance with youth-led CSOs was formalized.

At the Nairobi Summit on ICPD25, Nepal also committed to:

- ensuring that marginalized groups, in particularly adolescents and youth, are able to exercise their reproductive rights through universal access to quality family planning services including modern contraception, and the country continues to make progress in fulfilling unmet need and expanding access to modern family planning;
- harnessing the demographic dividend through investing in adolescents' and youth's education, employment opportunities and health care; and
- attaining gender equality, eliminating all forms of violence against women and girls, ending child and early and forced marriage.

In Nepal, 33% of women aged 20-24 years were married before age 18; 8% of women were married before age 15 and 25% were married between ages 15 and age 18. The percentage of girls married before age 15 is nearly 1.5 times higher among those living in rural areas compared with those living in urban areas. The percentage of girls married before age 15 is six times higher among those living in the poorest households compared to those living in the wealthiest households, and two times higher for girls married between 15 and 18 years living in the poorest households compared to those living in the wealthiest households.

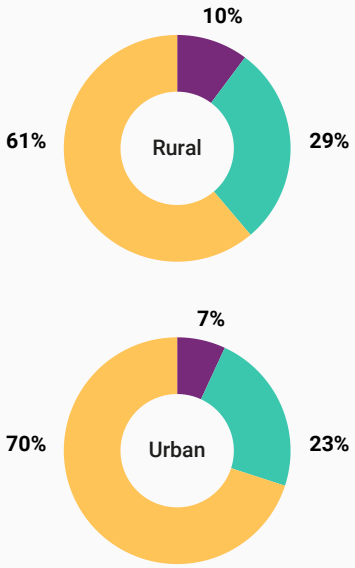
Age of Marriage Distribution, Women 20–24



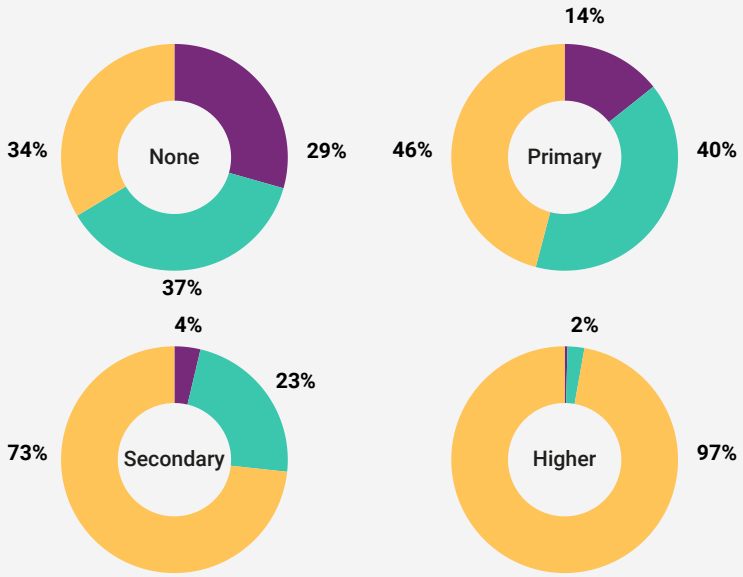
Source: Multiple Indicator Cluster Survey, 2019

Nepal was reviewed at the 37th session of the Universal Periodical Review of the UN Human Rights Council in January 2021. It received 233 recommendations, of which at least 89 (38% of all recommendations) were related to the Nairobi Summit, and more explicitly referenced Nepal's ICPD25 commitments.

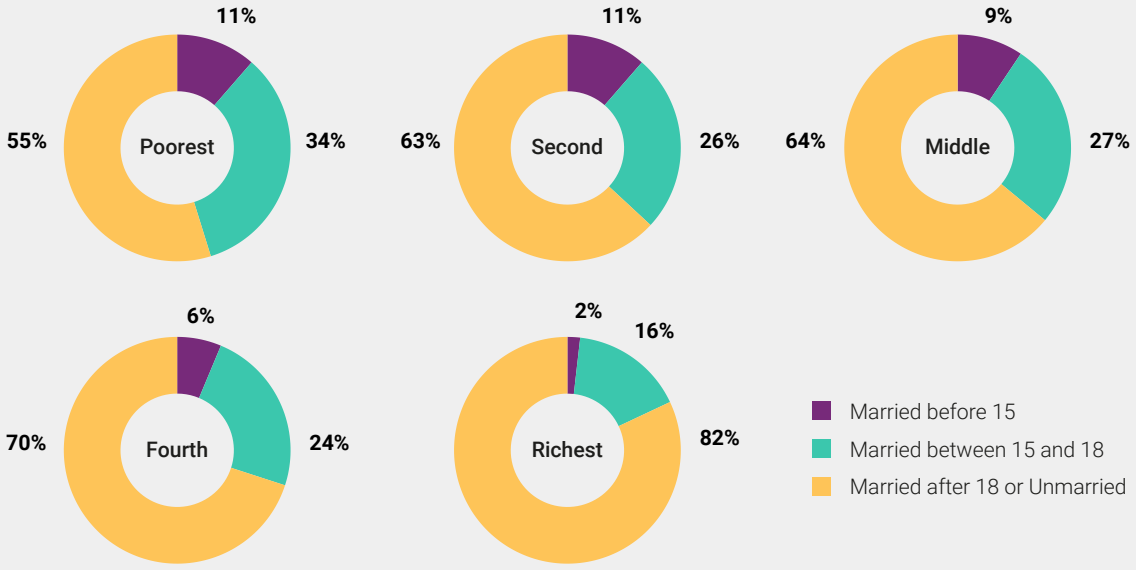
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



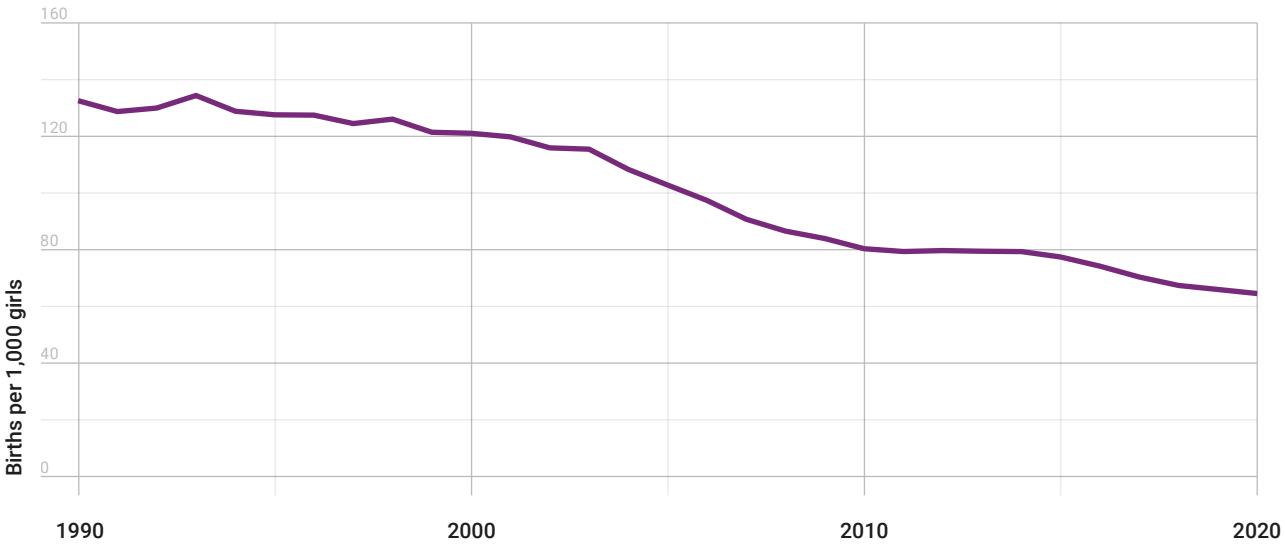
Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



Source: Multiple Indicator Cluster Survey, 2019

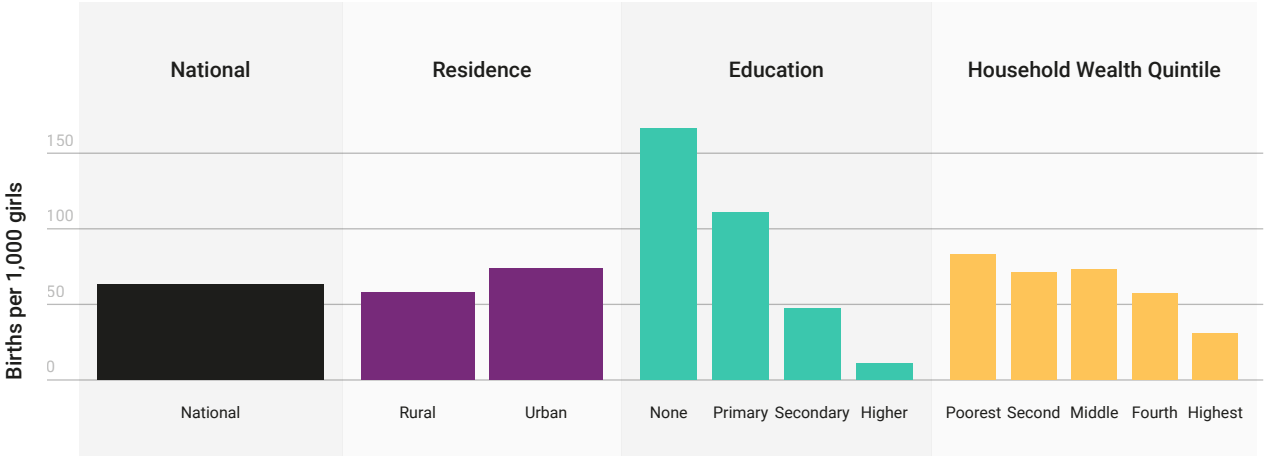
Nepal has made progress in meeting the sexual and reproductive health needs of adolescents, as seen in the decline in the adolescent birth rate, however it still remains one of the highest among countries in the region. The adolescent birth rate is higher among those living in rural areas, and is 15 times higher among girls with no education compared to those with higher education, and nearly three times higher among those living in the poorest households compared to those in the wealthiest households.

Adolescent birth rate, 1990–2020



Source: World Population Prospects, 2022

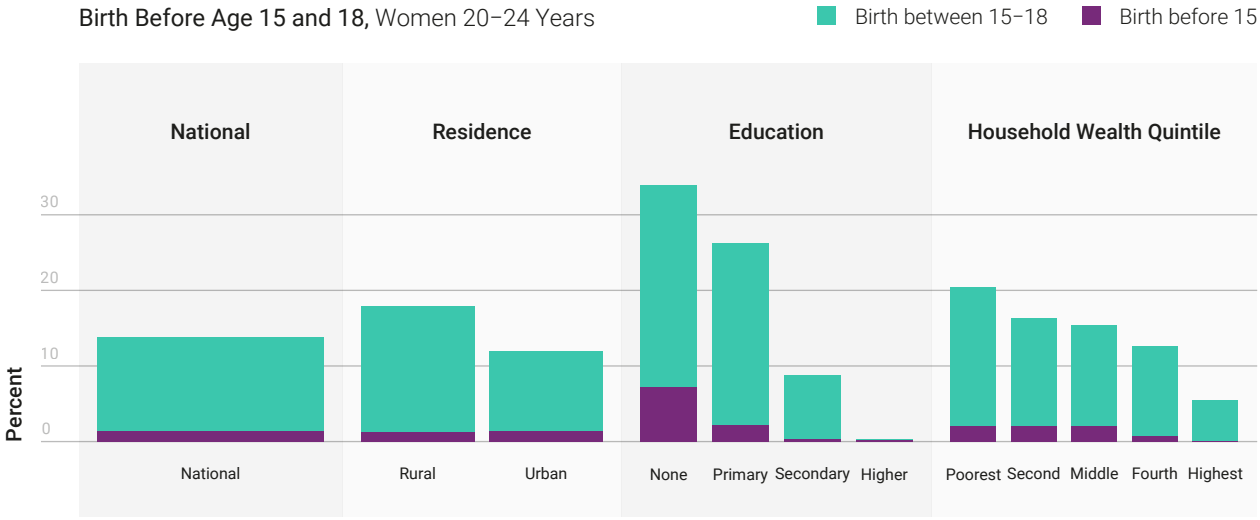
Adolescent birth rate



Source: Multiple Indicator Cluster Survey, 2019

A greater percentage of married girls who give birth before age 18 live in rural areas of the country. Women from the poorest households are three times more likely to have a live birth before the age of 18 (20%) than women from the wealthiest households (6%). 9% of women with higher education attainment level had a live birth before 18 years of age, compared with 34% of women 20-24 years with no education.

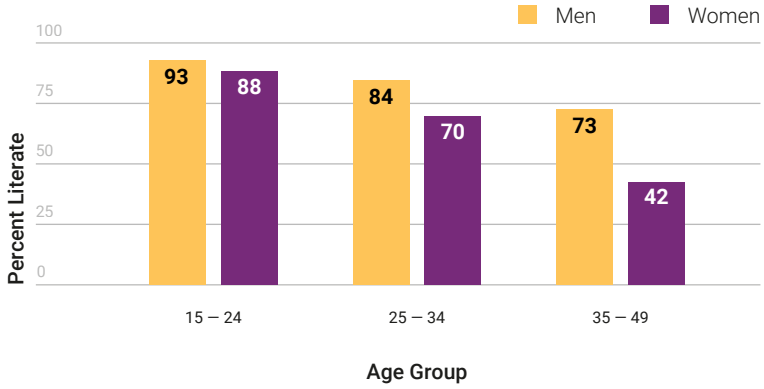
Birth Before Age 15 and 18, Women 20–24 Years



Source: Multiple Indicator Cluster Survey, 2019

Harnessing the promises of the demographic dividend requires that young people are educated in order to enter the workforce. Nepal's literacy rate is higher among men than women regardless of age group. Secondary education completes the provision of basic education that began at the primary level, and aims at laying the foundations for lifelong learning and human development by offering more subject- or skill-oriented instruction using more specialized teachers. Nepal's secondary school net attendance ratio[IV] is 62, almost halfway between those countries with the lowest and highest rates in the region.

Literacy Rate by Age and Sex

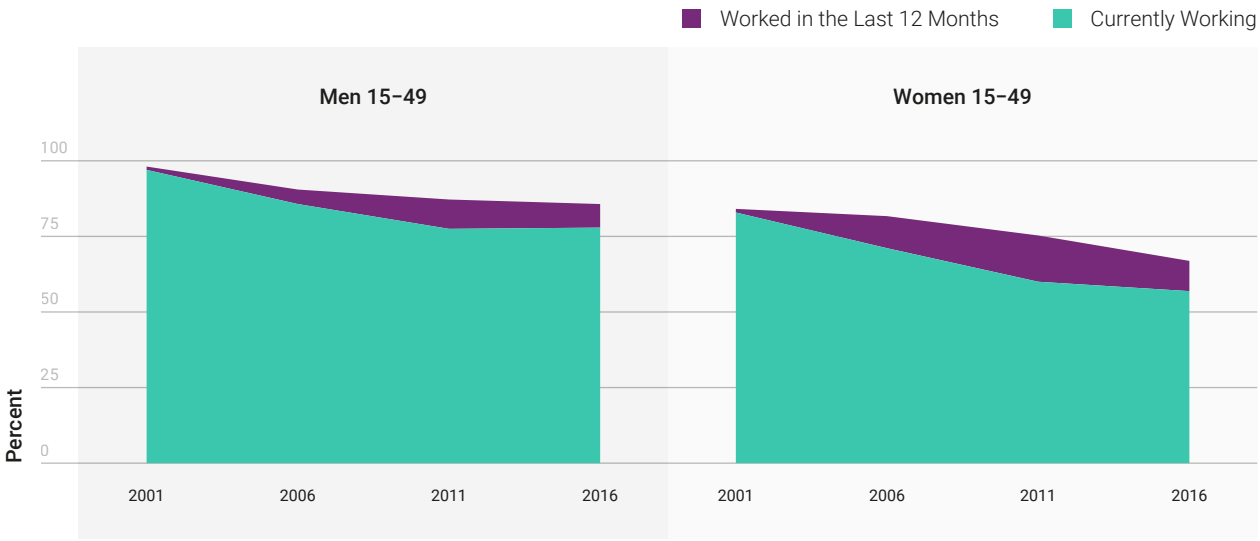


Source: Multiple Indicator Cluster Survey, 2019

IV Ratio of children of official school age who are enrolled in school to the population of the corresponding official school age.

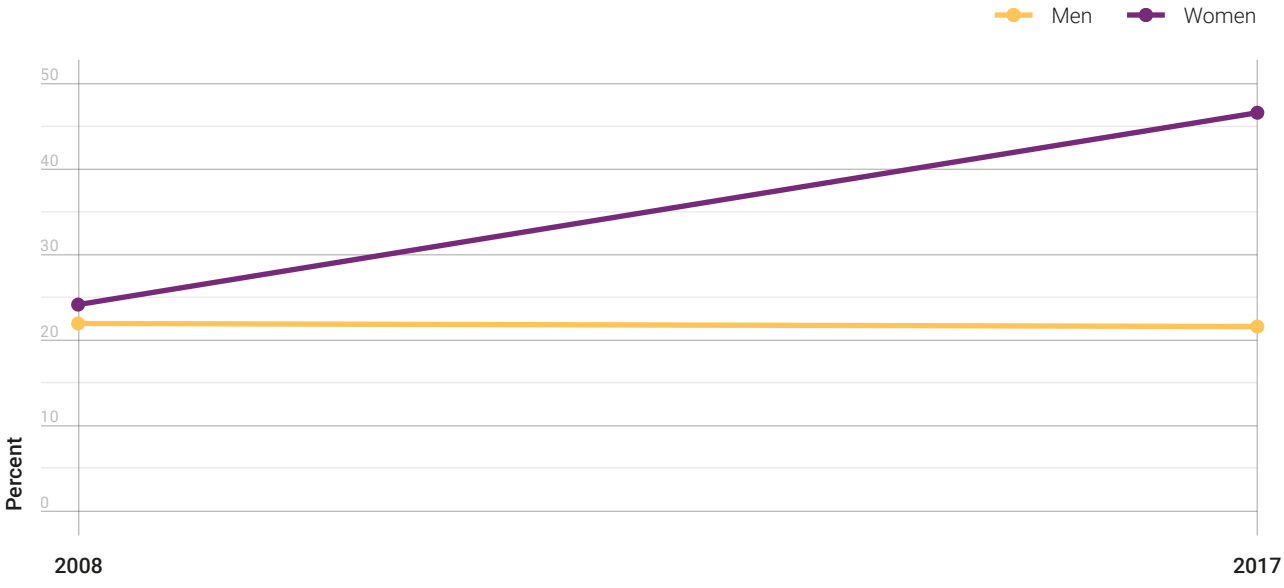
Harnessing the promises of the demographic dividend requires that young people have opportunities for employment. Employment trends for both men and women have been declining in Nepal from 2001 to 2016, with fewer women than men "currently" working. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Nepal, the percentage of youth not in education, employment or training has been increasing in women compared with men, where it is 2.5 times higher as of 2017.

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 2000—2016

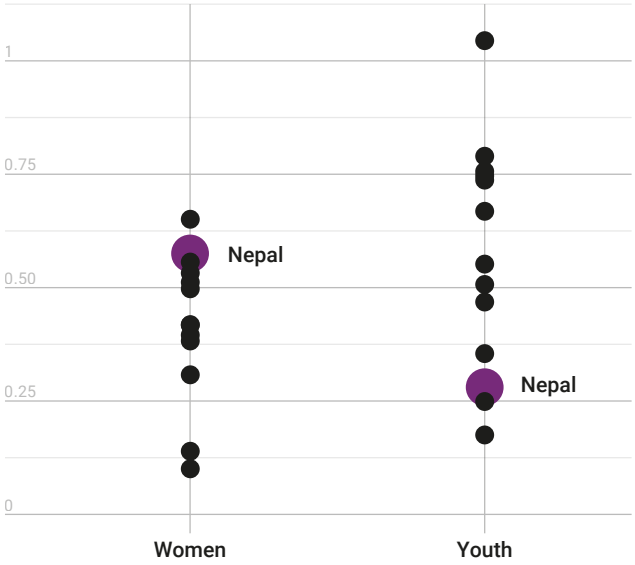
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Nepal Labour Force Survey, 2008–2017

Nepal has some of South Asia's most progressive laws on the rights of persons of different sexual orientation and gender identity, with landmark reforms passed in 2007 prohibiting gender or sexual orientation discrimination. In 2013, Nepal issued a third gender category for citizenship documents, and in 2021 determined to include the third gender in the next population census.

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, Central and South Asian Countries



Source: Inter–Parliamentary Union, 2022

In Nepal, among ever married women who experienced intimate partner violence in the last 12 months, 8% experienced emotional violence, 10% physical violence, and 4% sexual violence.

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in Nepal is one of the highest in the region, while the ratio of the proportion of young Members of Parliament is one of the lowest in the region (SDG 16.17.1).

With the shortfall of financing, Nepal's hard-earned development gains are at risk at a time it is preparing to graduate from the least developed countries (LDC status) by 2026[V]. Nepal is moreover highly susceptible to natural hazards such as earthquakes and floods. For example, the Province of Sudurpaschim recently witnessed heavy flooding and landslides triggered by incessant rainfall, resulting in the loss of lives and displacement of people. The impact of climate change on livelihoods and health is significant, especially on women and girls. During disasters and emergencies, women and girls are more at risk of experiencing gender-based violence (GBV), exploitation and abuse[VI].

V Nepal's national statement on the General Debate at the 77th Session of the UN General Assembly
VI UNFPA

REPUBLIC OF THE PHILIPPINES

TOTAL POPULATION [I] **116,451,700**

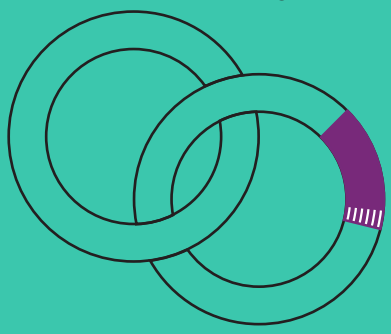
POPULATION 24 YEARS OR YOUNGER [I]

48.51%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **29,862,490**

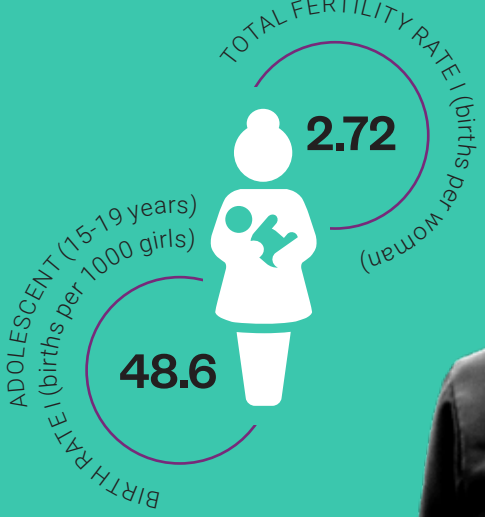
POPULATION 15-24 YEARS (male + female) [I] **21,359,950**

WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **16.5%**

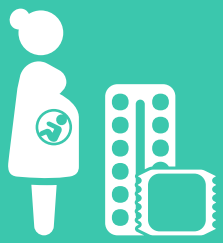
BEFORE AGE 15 **2.2%**



MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **121** / **100,000**

I. World Population Prospects 2022

II. SDG

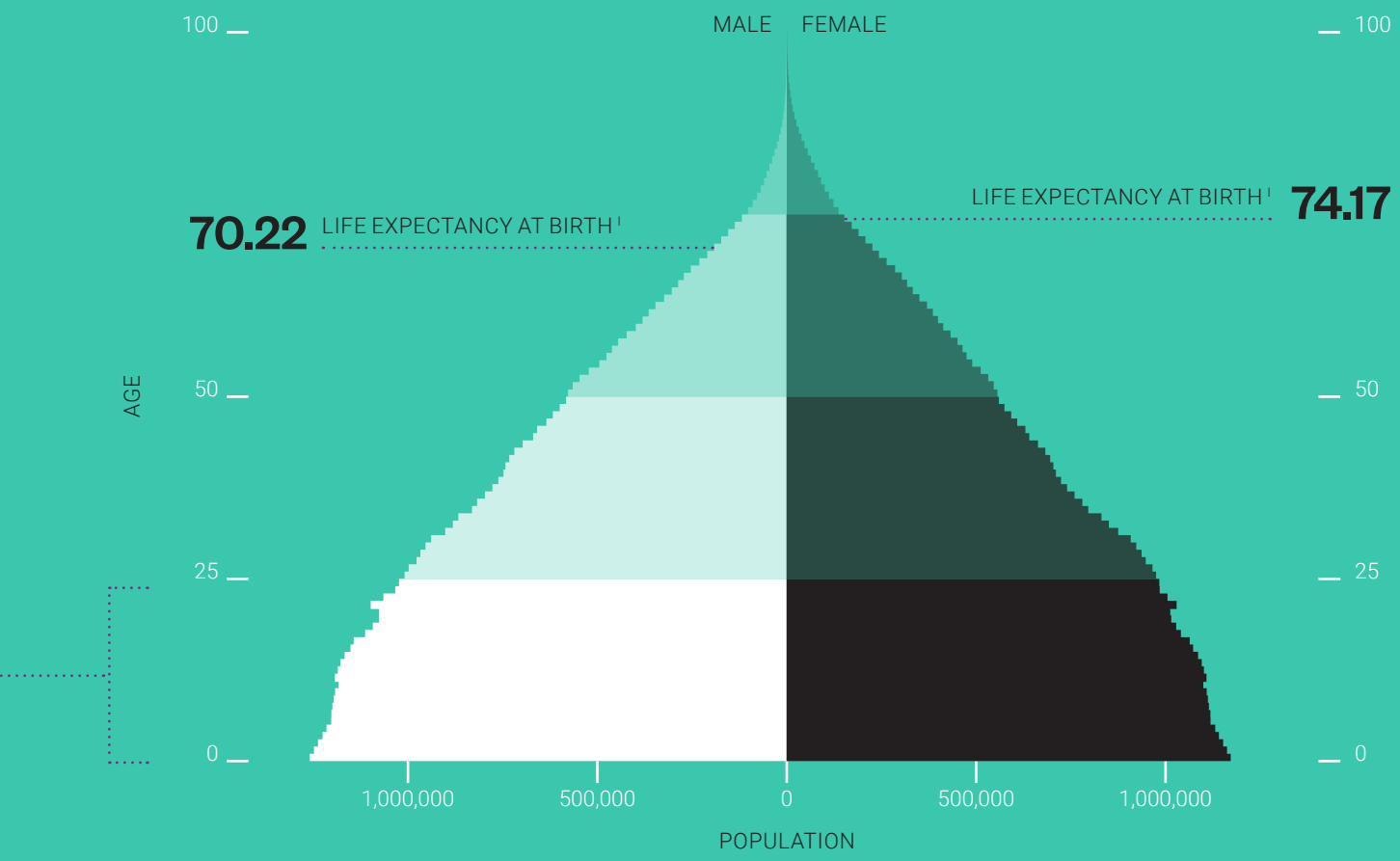


9.9% UNMET NEED FOR FAMILY PLANNING (all women) [III]

58.6% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

84.4% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

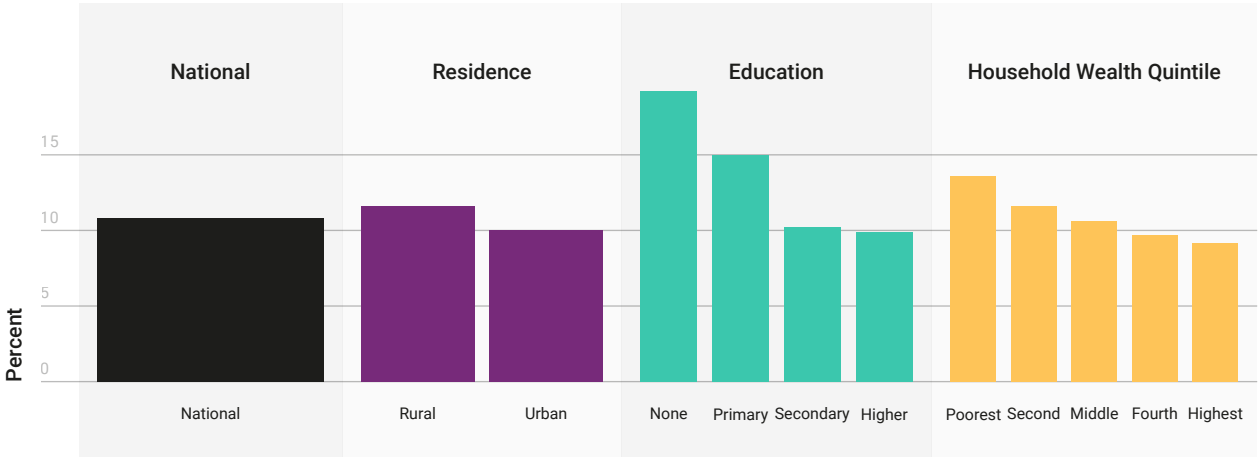
As part of its ICPD25 commitments, the Republic of the Philippines has committed to actualizing and sustaining the Promise of ICPD and the 2030 Agenda for Sustainable Development; and to **fully implement** responsible reproductive health care and universal health care laws to reduce unmet need for modern family planning and adolescent pregnancy.



I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

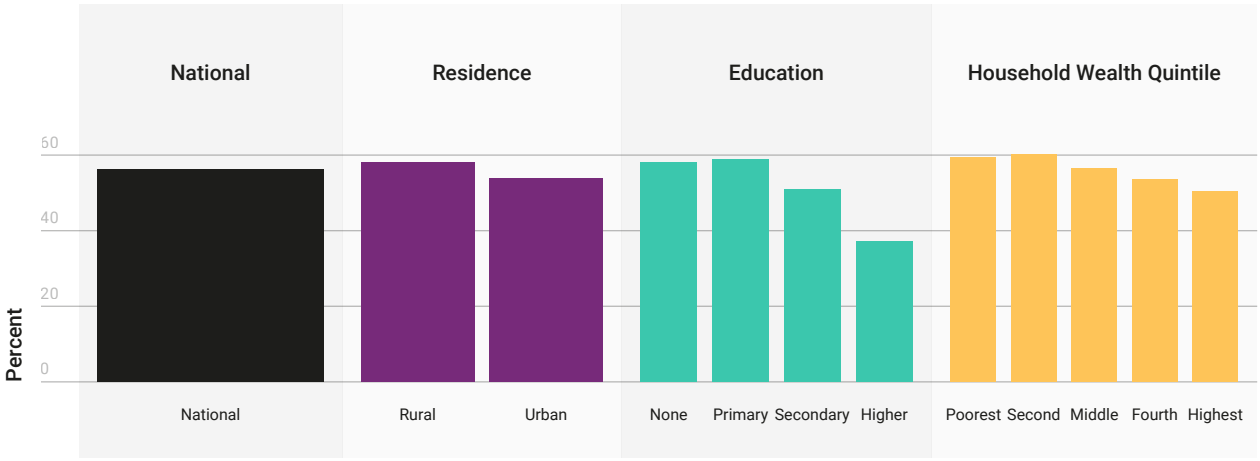
The Philippines is one of eight countries where more than half of the projected increase in the global population up to 2050 will be concentrated [IV]. In 2022, Philippine's total fertility rate (TFR) – the number of children that would be born to a woman if she were to live to the end of her childbearing years – is 2.72. Unmet need for family planning is higher among rural women than urban women, and is almost 1.5 times higher among women with no education compared with women with higher education. It is also highest among women in the poorest households, and decreases with household income. Based on the latest available data, 40.4% of married and in-union women were using a modern contraceptive method, and the percent of demand for family planning satisfied by modern methods was 56.9%, with demand being slightly higher in rural areas than in urban areas, among women with no education or primary education, and among women in poorer households.

Unmet Need for Family Planning, All Women



Source: Demographic and Health Survey, 2017

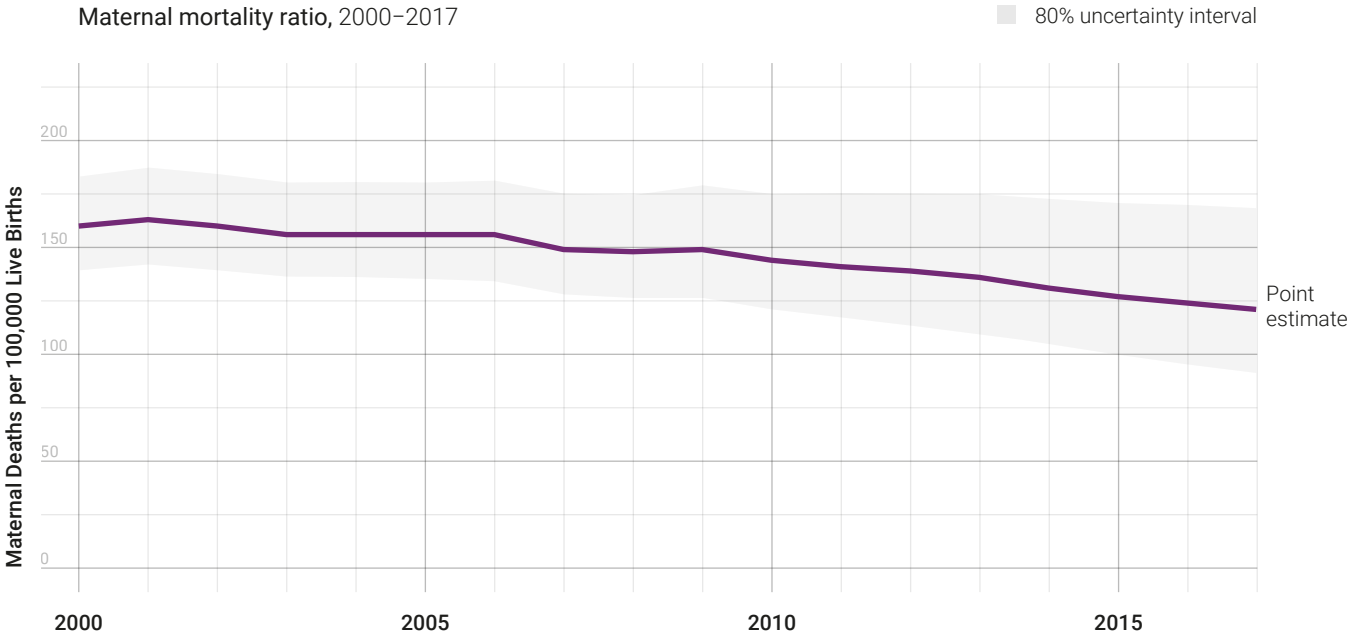
Demand for Family Planning Satisfied with Modern Methods, All Women



Source: Demographic and Health Survey, 2017

IV World Population Prospects 2022

The maternal mortality ratio in the Philippines decreased from 2000 to 2017 and was estimated to be 121 maternal deaths per 100,00 live births in 2017, the year for which the most recent data is available. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". Abortion is not permitted in the Philippines.



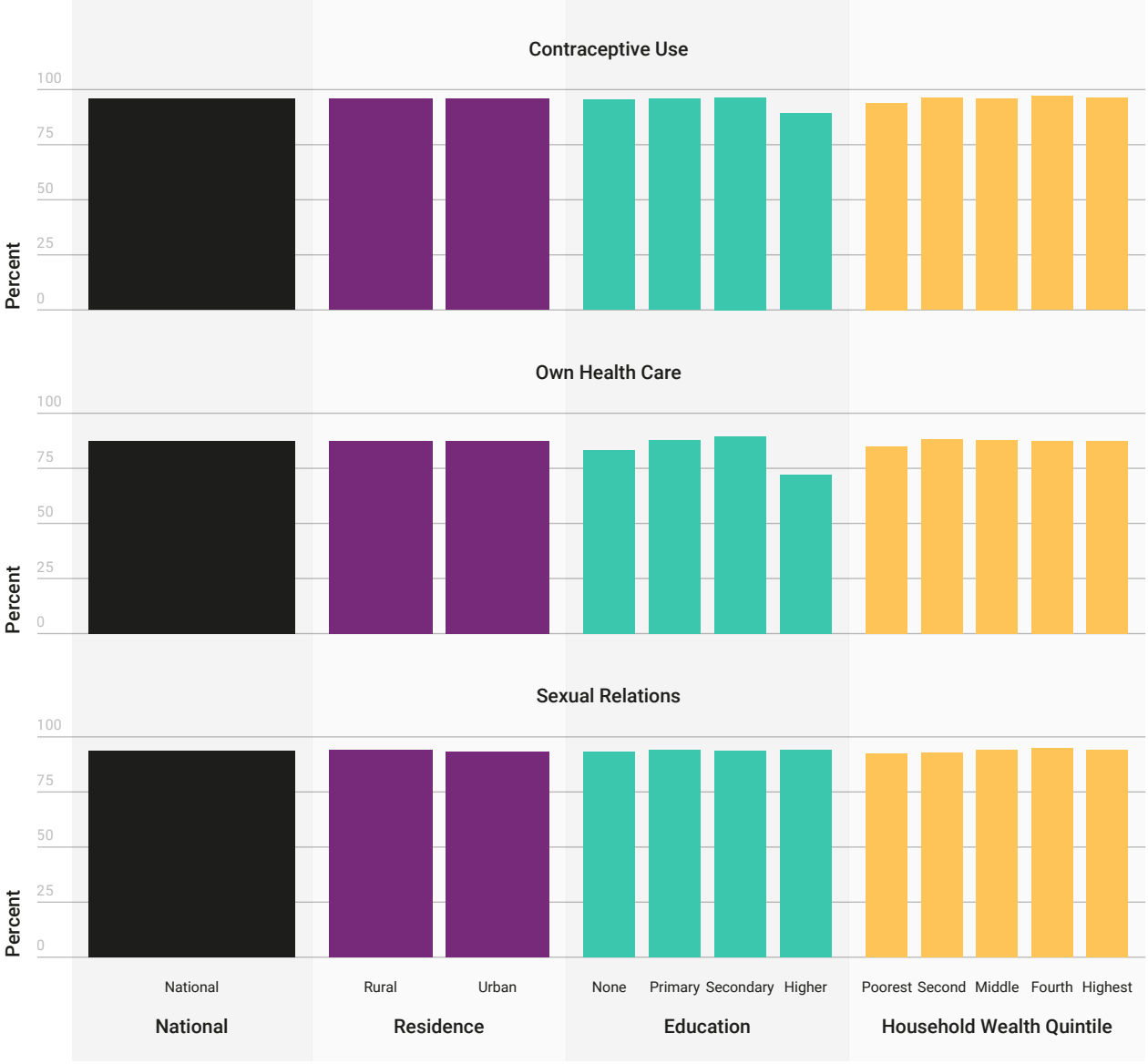
Source: World Health Organization, 2019

In the Philippines, 97% of married or in-union women make decisions on their health care; 94% have the autonomy in deciding to use contraception; 88% can say no to sex. This is higher among women who have more than primary education than among women with no education. Overall, 81% of married or in-union women aged 15 to 49 in Philippines make their own decisions regarding sexual and reproductive health and rights, including deciding on their own health care, deciding on the use of contraception, and can say no to sex. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. On average, the Philippines has achieved 71% of enabling laws and regulations that guarantee full and equal access to women and men to maternity care, and 60% to contraceptive and family planning services, and 100% to sexuality education.

Extent to which Philippines has 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

Source: United Nations Population Fund, 2022

Proportion of married women who make their own informed decisions regarding reproductive health care, contraceptive use, and sexual relations



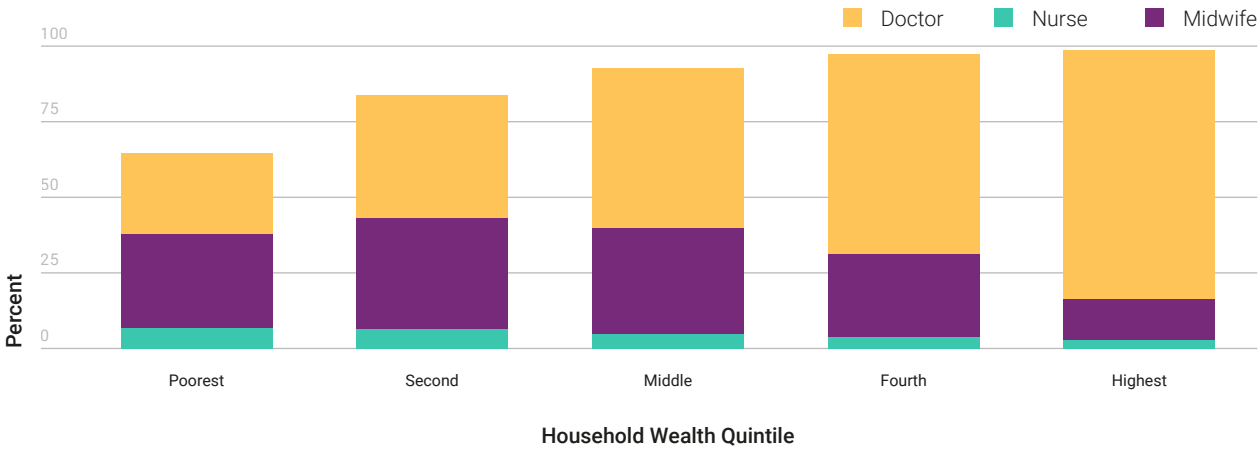
Source: Demographic and Health Survey, 2017

In 2017, the most recent year for which data is available, the proportion of births in the Philippines that were attended by skilled health personnel was 84.4%. Among married women 15-49 years who had a live birth in the last two years, deliveries assisted by a skilled attendant were higher among women in urban areas, among women with secondary and higher education, and among women in households the middle and higher incomes. As household wealth increases, so does the portion of births attended by doctors compared with midwives and nurses. Women in the poorest households had their deliveries attended mostly by midwives followed by doctors and nurses, while in the richest households, births were mostly attended by doctors.

Births with Skilled Attendant

Source: Demographic and Health Survey, 2017

Skilled Birth Providers by Wealth Quintile

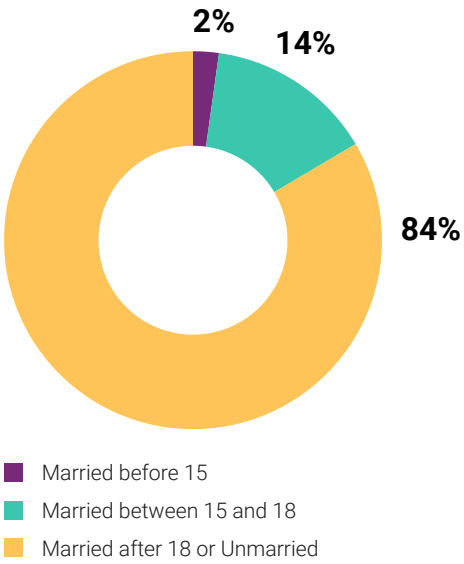


Source: Demographic and Health Survey, 2017

At the Nairobi Summit, the Philippines has committed to accelerating efforts to reach and optimize the demographic dividend

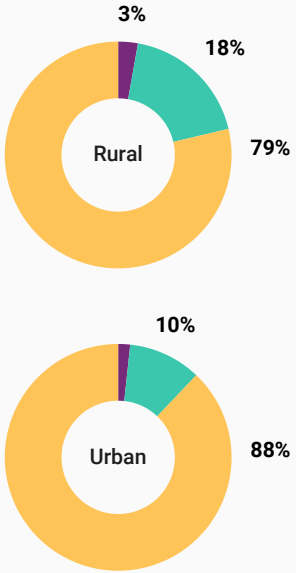
In the Philippines, 16% of women aged 20-24 were married before age 18, with 2% of women were married before age 15. The percentage of girls married before age 15 is almost four times higher among girls with no education compared with those with secondary education and higher, and almost ten times higher among girls in the poorest households compared with those in the wealthiest households. Births among those women before age 18 are 11 times higher among women in the poorest households compared with those in the wealthiest households.

Age of Marriage Distribution, Women 20–24

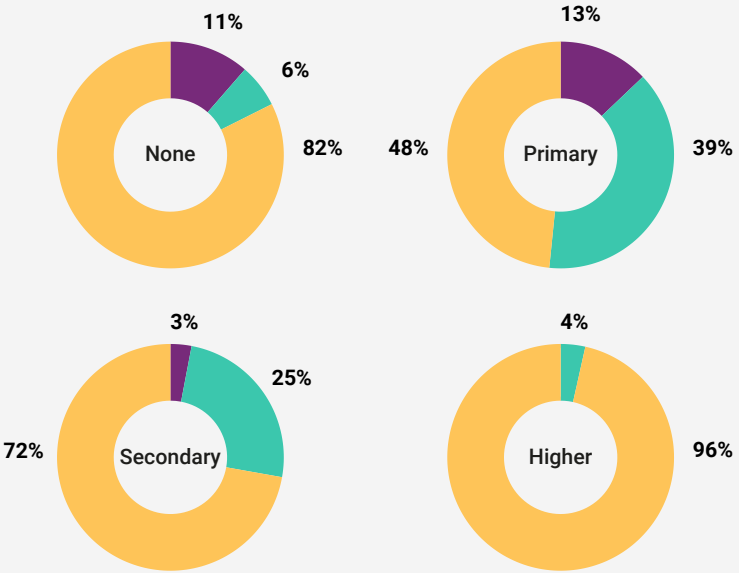


Source: Demographic and Health Survey, 2017

Age of Marriage Distribution by Residence, Women 20–24

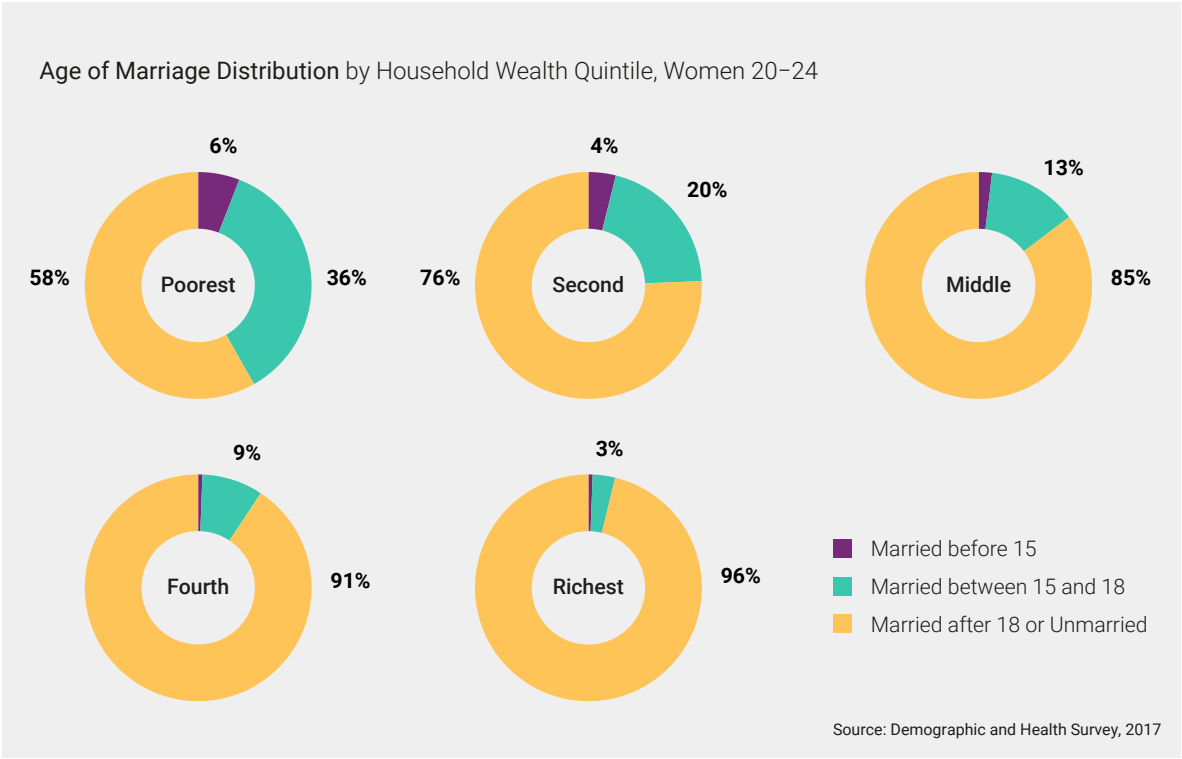


Age of Marriage Distribution by Level of Education, Women 20–24



Married before 15 Married between 15 and 18 Married after 18 or Unmarried

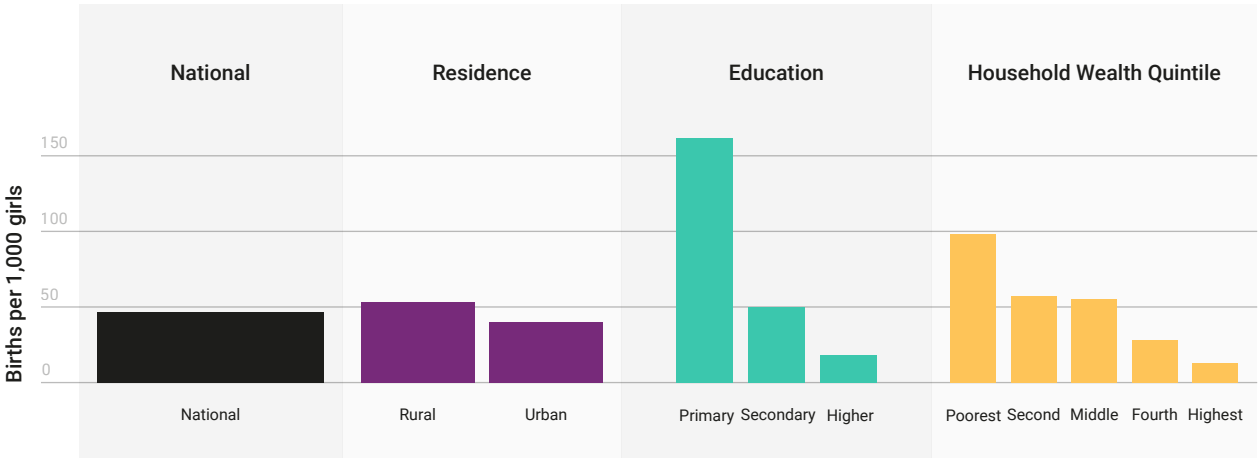
Source: Demographic and Health Survey, 2017



The Philippines have been following up to the ICPD25 commitments made. A post-Nairobi Summit consultation meeting was organized by the Philippines Commission on Population and Development (POPCOM) in 2020 and a report on the implementation of the Nairobi Summit Action Plan was drafted and adopted by the Government in 2021. The country has advocated for initiatives related to Nairobi commitments, such as demographic dividend-related policies and the reduction of adolescent pregnancies, including budget-related advocacy in Congress.

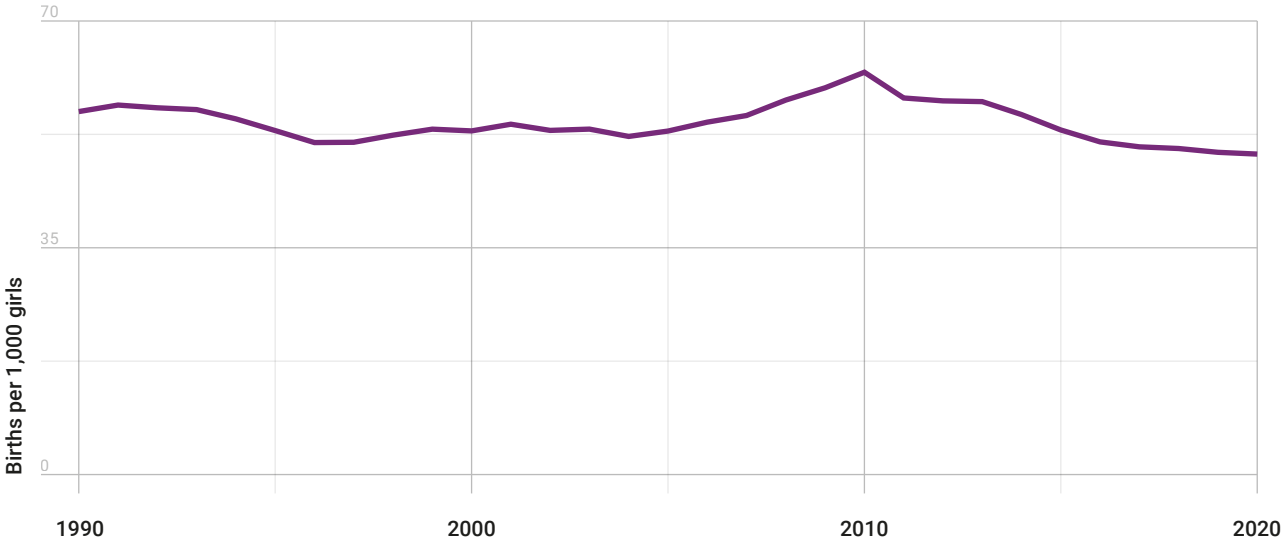
The adolescent birth rate for the Philippines has decreased slightly from 1990 to 2020; it is nine times higher among adolescents with only primary education compared with those with higher education, and 7.5 times higher among teenagers who live in the poorest households compared to those in the wealthiest households.

Adolescent birth rate



Source: Demographic and Health Survey, 2017

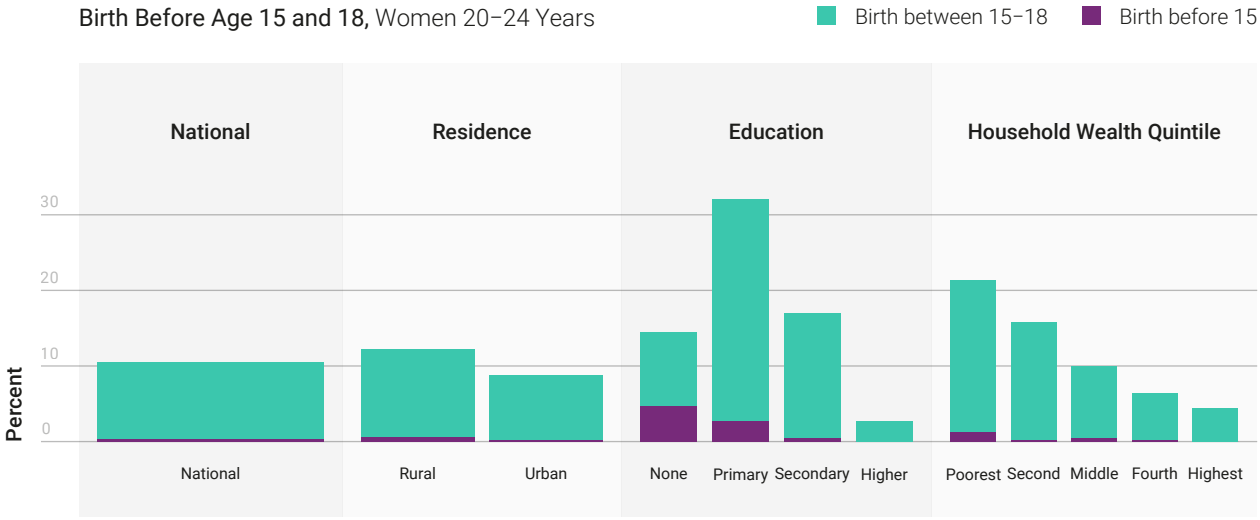
Adolescent birth rate, 1990–2020



Source: World Population Prospects, 2022

Among girls 20-24 years, births before age 18 are higher among girls who live in rural areas, those with primary education, and those girls from the poorest households. The percent of women from the poorest households who have a birth before age 18 is nearly four times higher than those from the wealthiest households.

Birth Before Age 15 and 18, Women 20–24 Years

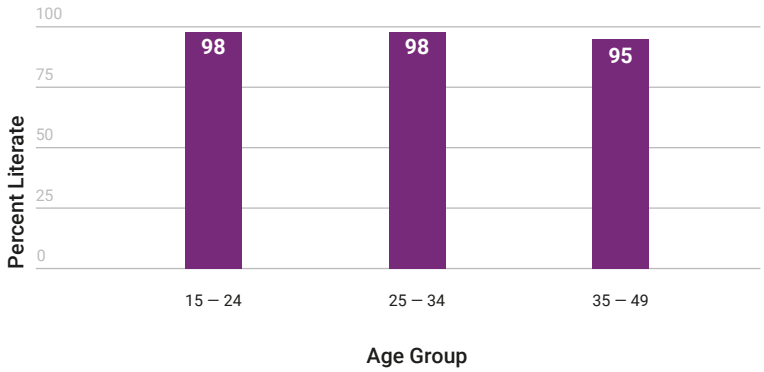


Source: Demographic and Health Survey, 2017

Amid the exacerbation of child rights issues due to the COVID-19 pandemic, compounded by the onslaught caused by Typhoon Odette (Rai), a major recent milestone has been the passage of the "Prohibition of Child Marriage Law at the start of 2022." The phenomenon of child marriage has been seen to have been practiced in indigenous and Muslim communities in the country. Globally, the Philippines ranks 12th in the absolute number of child marriages. While these communities have been trying to address this issue through community-based programmes, passing a legislation strengthens the legal framework and protection of adolescent girls in line with Global Commitment 5.

The female literacy rate in the Philippines is generally high in all age groups.

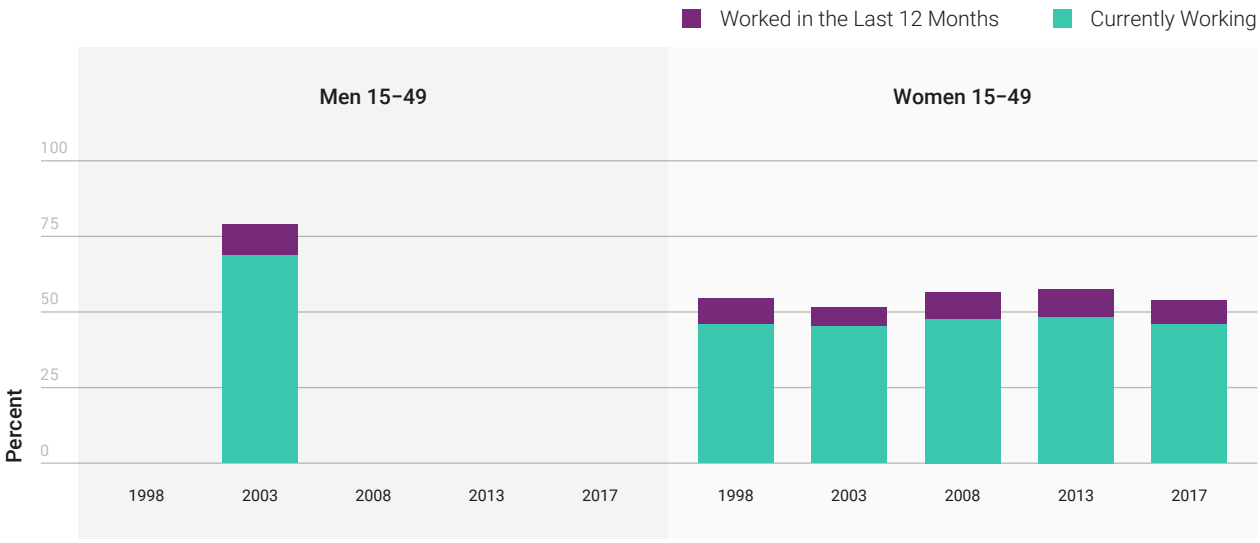
Female Literacy Rate by Age



Source: Demographic and Health Survey, 2008

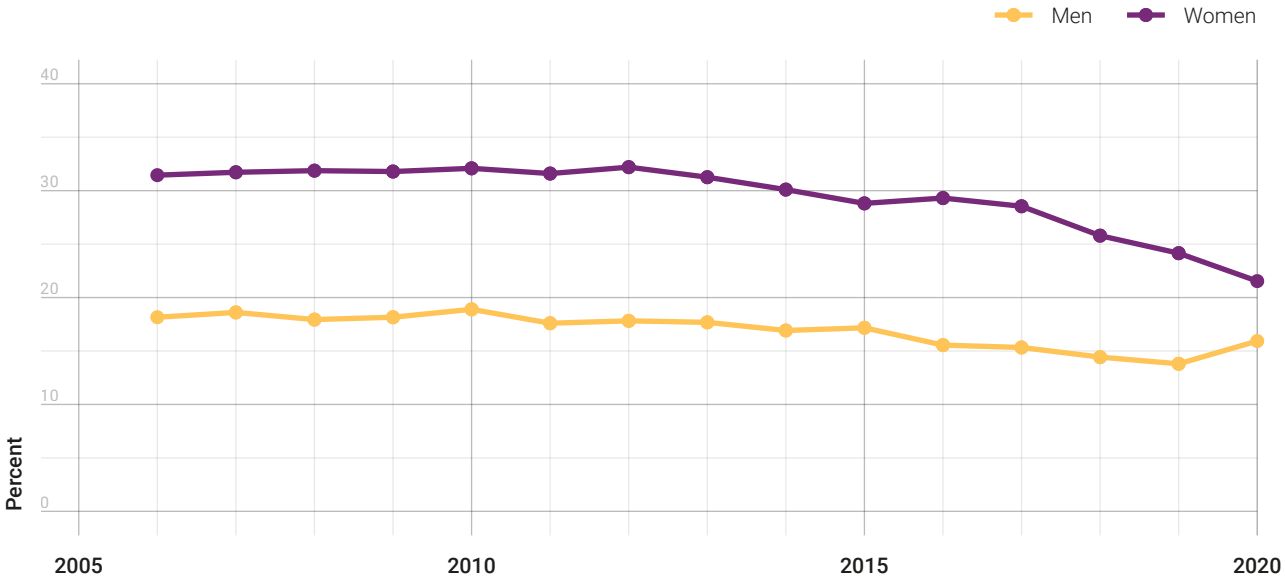
Employment trends (i.e., those currently working and who have worked in the last 12 months) for women have remained relatively the same in the Philippines from 2001 to 2016. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In the Philippines, the percent of female youth not in education, employment or training has been decreasing, while that for males has remained approximately the same.

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 1998—2017

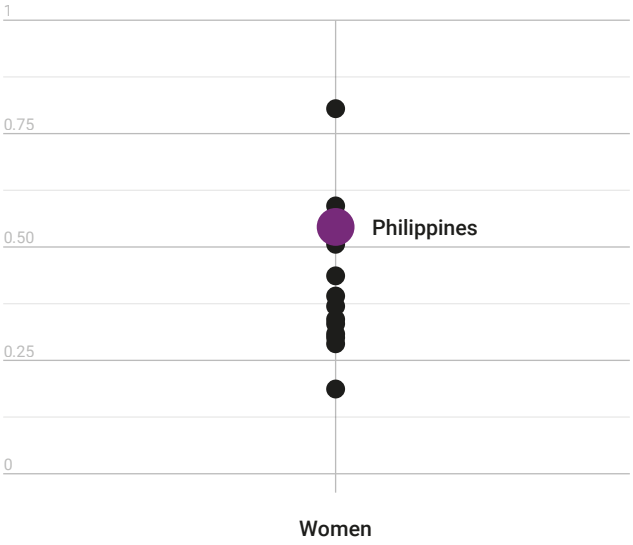
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Labour Force Survey, 2006–2020

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in the Philippines is the third highest in the region (SDG 16.17.1).

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, East and Southeast Asian Countries



Source: Inter–Parliamentary Union, 2022

REPUBLIC OF SIERRA LEONE

TOTAL POPULATION [I] **8,697,890**

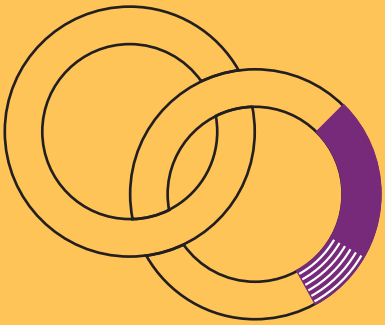
POPULATION 24 YEARS OR YOUNGER [I]

59.37%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **2,172,890**

POPULATION 15-24 YEARS (male + female) [I] **1,792,160**

WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **29.6%**

BEFORE AGE 15 **8.6%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **1,120** / **100,000**

TOTAL FERTILITY RATE [I] (births per woman) **3.88**

ADOLESCENT BIRTH RATE [I] (births per 1000 girls) (15-19 years) **99.17**

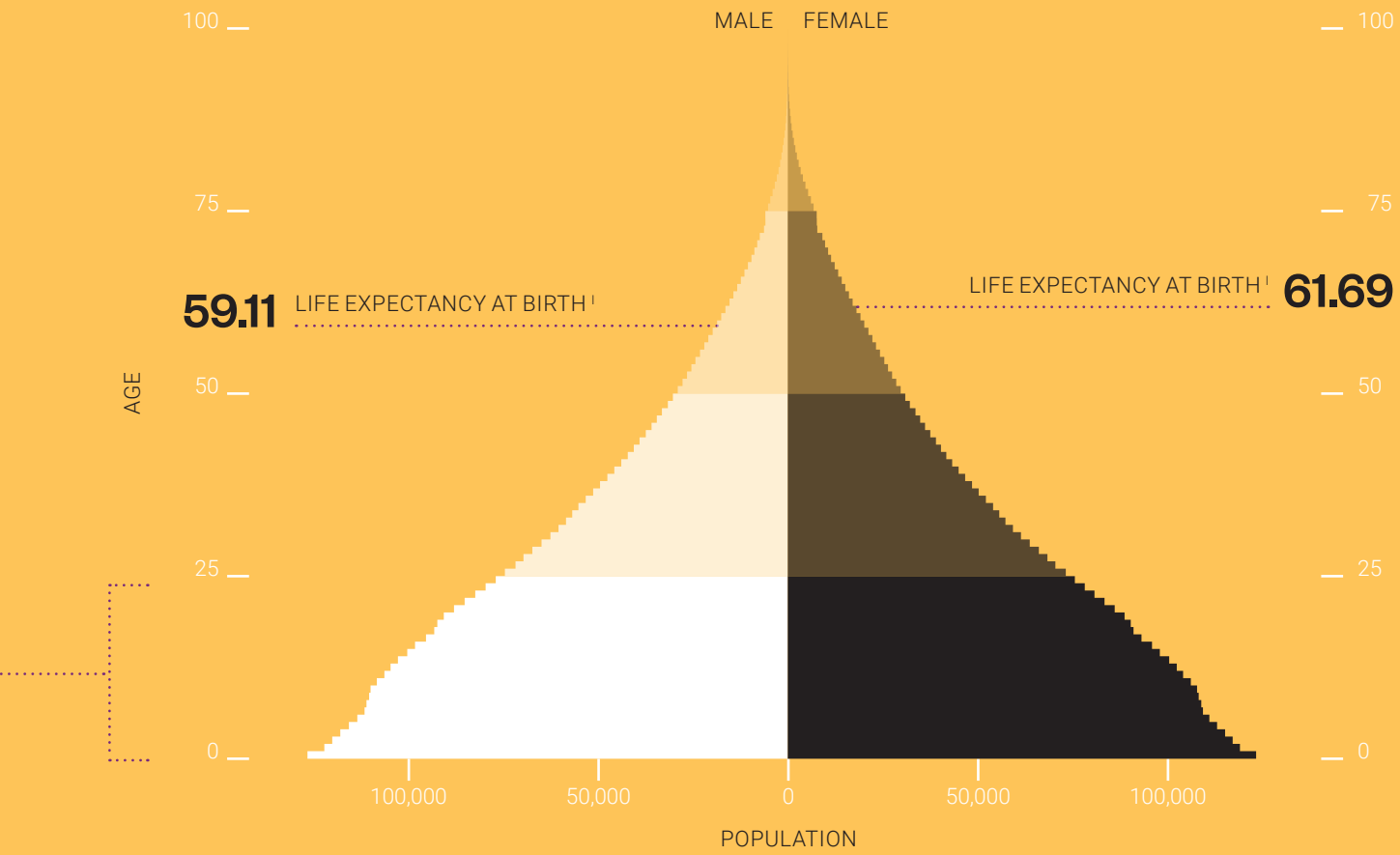
I. World Population Prospects 2022 II. SDG

19.8% UNMET NEED FOR FAMILY PLANNING (all women) [III]

56.8% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

86.9% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

At the Nairobi Summit the Government of the Republic of Sierra Leone committed to the **overall goal** of the ICPD Programme of Action, in line with the National commitments in the Sierra Leone Medium Term National Development Plan (2018 – 2023), the national population policy (2018), and the 2017 Family Planning 2020 commitments.



I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

The Government of Sierra Leone has committed to the overall goal of zero unmet need for family planning services by 2030. As part of this commitment, Sierra Leone is working to raise the contraceptive prevalence rate from 22.5% in 2017 to 50% by 2028.

In 2022, Sierra Leone's total fertility rate (TFR) – the number of children that would be born to a woman if she were to live to the end of her childbearing years – is estimated to be 3.88. Unmet need for family planning is slightly higher in rural areas than in urban areas, and is highest among women with no education and primary education. Demand for family planning satisfied by modern methods is higher among women living in urban areas, among women with secondary and higher education, and among women living in wealthier households.

Unmet Need for Family Planning, All Women

Source: Demographic and Health Survey, 2019

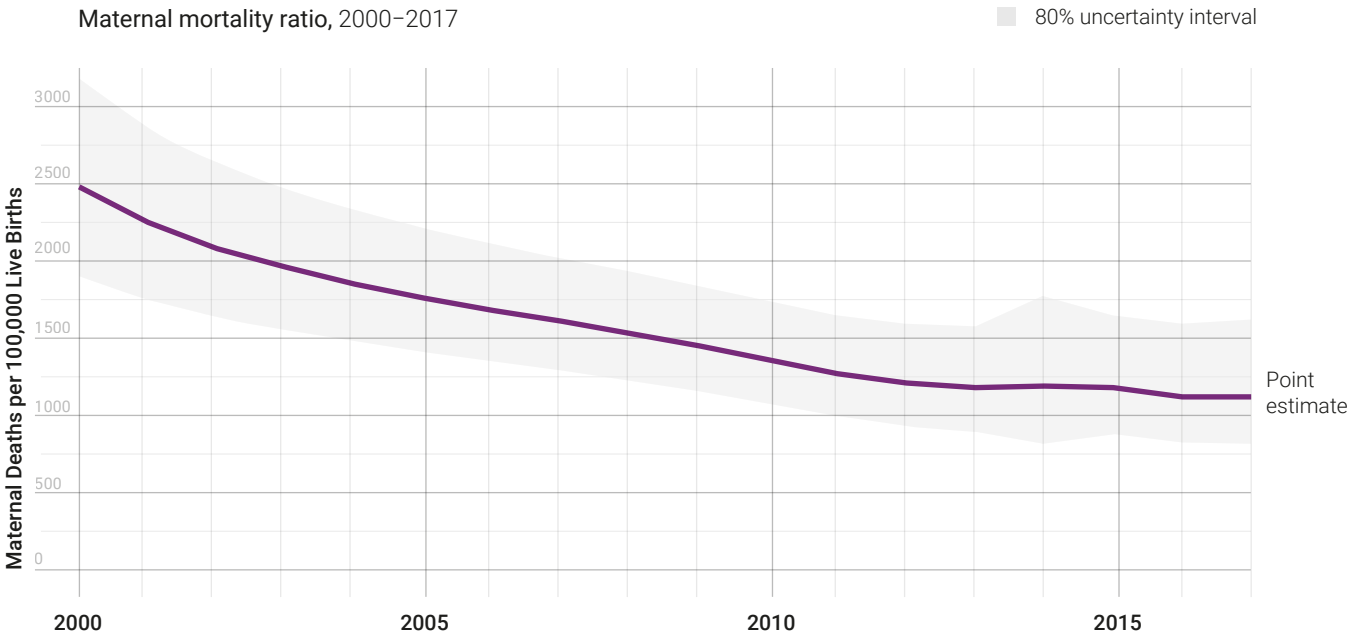
Demand for Family Planning Satisfied with Modern Methods, All Women

Source: Demographic and Health Survey, 2019

The Government of Sierra Leon has committed to the overall goal of zero preventable maternal deaths by 2030.

Sierra Leone's maternal mortality ratio declined from 2000 to 2017 and recent survey estimates from the Demographic and Health Survey, 2019 indicate that the rate is 717 deaths per 100,000 live births. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights". While abortion has been prohibited altogether in Sierra Leone, in 2022 Sierra Leone's President and Cabinet backed a bill to decriminalize abortion and overturn a pre-independence, colonial-era law dating back to 1861. The bill is due to be debated and signed into law before the end of 2022. The Government of Sierra Leone has committed itself to train and employ 1,000 midwives, 180 nurse anaesthetists, 72 surgical assistants by 2025, with progress underway, as reported by Sierra Leone in its Voluntary National Review of the SDG implementation to the United Nations High Level Political Forum in 2021.

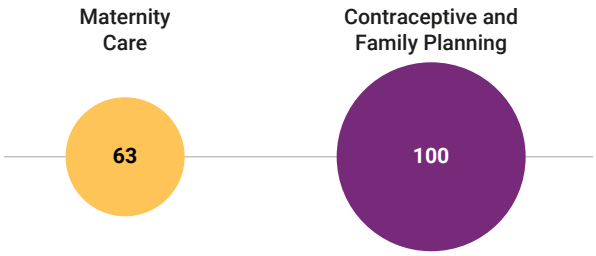
Maternal mortality ratio, 2000–2017



Source: World Health Organization, 2019

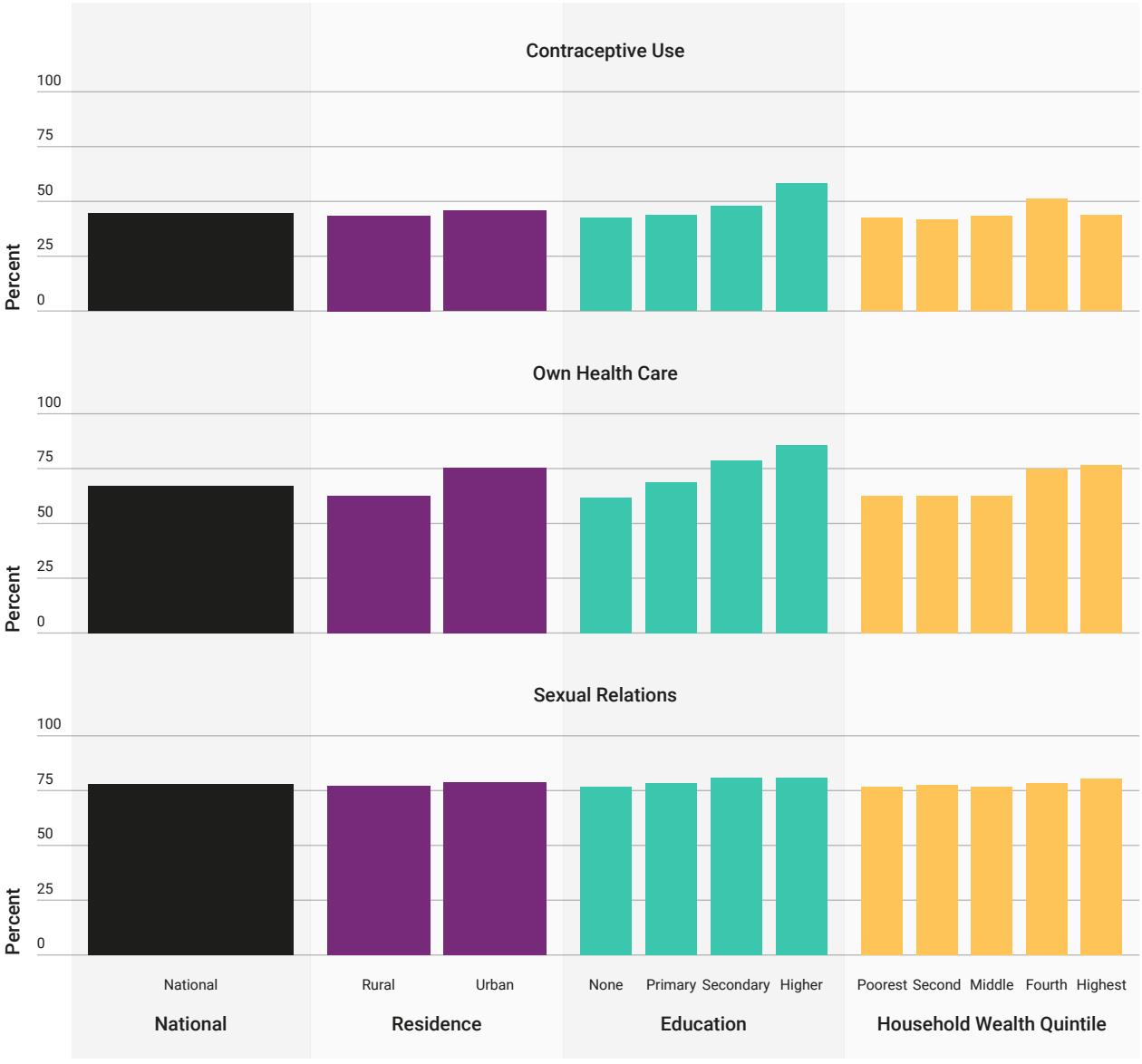
In Sierra Leone, 78% of married or in-union women aged 15 to 49 make their own decisions regarding sexual relations, 44.2% about contraceptive use, and 67.5% about their own health care. The percentages related to sexual relations are fairly consistent geographical region, education level and household wealth, while the percentages about contraceptive use and own health care increase with education level and with household wealth. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. Sierra Leone has achieved 63% of enabling laws and regulations that guarantee full and equal access to women and men to maternity care, and 100% to contraceptive and family planning services.

Extent to which Sierra Leone has 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



Source: United Nations Population Fund, 2022

Proportion of married women who make their own informed decisions regarding reproductive health care, contraceptive use, and sexual relations



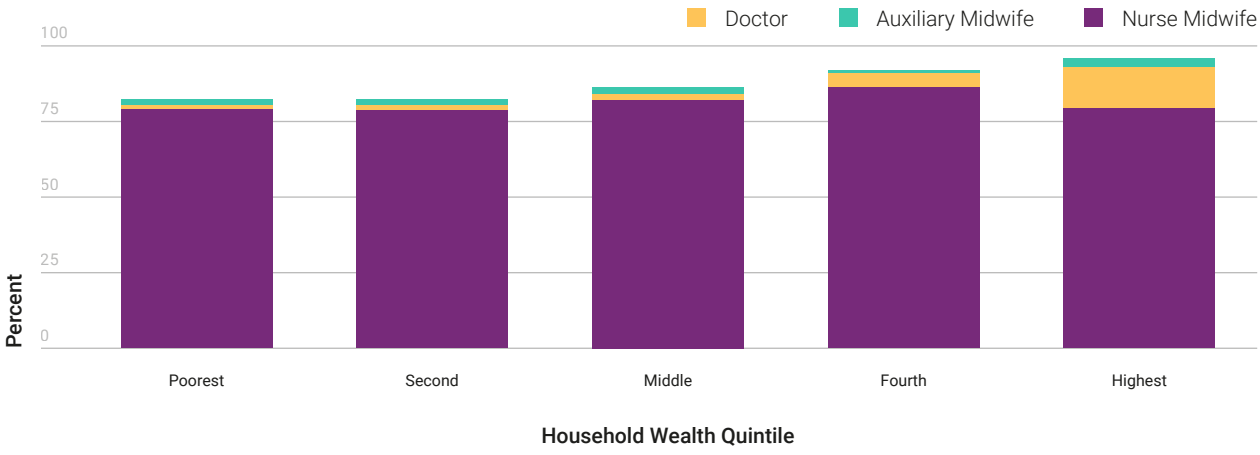
Source: Demographic and Health Survey, 2019

86.9% of deliveries among married women 15-49 years who had a live birth in the last two years in Sierra Leone were assisted by a skilled attendant. This percentage is one of the highest in the region. The percentage of deliveries assisted by a skilled attendant was higher among women who live in urban areas, and increased with a woman's education level and with household income. Most births in Sierra Leone are attended by nurse midwifes; in the wealthiest households, approximately 14% of births are attended by doctors (compared with 80% attended by nurse midwives).

Births with Skilled Attendant

Source: Demographic and Health Survey, 2017

Skilled Birth Providers by Wealth Quintile

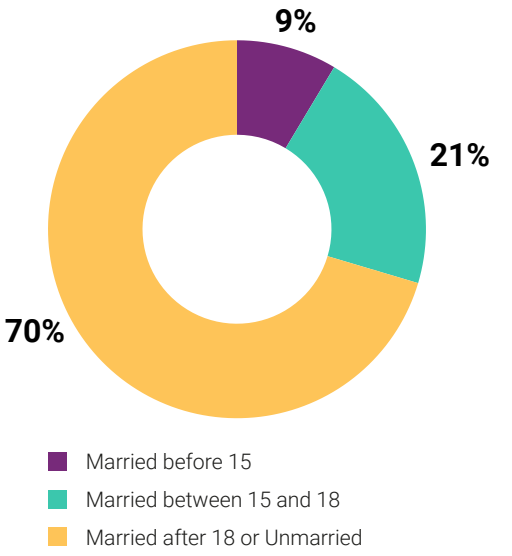


Source: Demographic and Health Survey, 2019

The Government of Sierra Leone has committed to enact the Prohibition of Child Marriage Bill in Sierra Leone which criminalizes child marriage for all types of marriages. Some initial milestones have included a wide-spread child marriage campaign in communities, the engagement with traditional and religious leaders, and review of the Child Rights Act 2007.

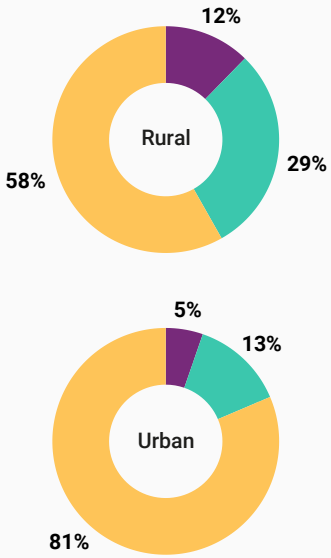
In Sierra Leone 29.6% of women aged 20-24 years were married before age 18, with almost 9% of women married before age 15. Marriage before age 18 is two times higher among women living in rural areas compared to women living in urban areas. It is higher among women with no education and only primary education, and is four times higher among those living in the poorest households compared to those living in the wealthiest households.

Age of Marriage Distribution, Women 20–24

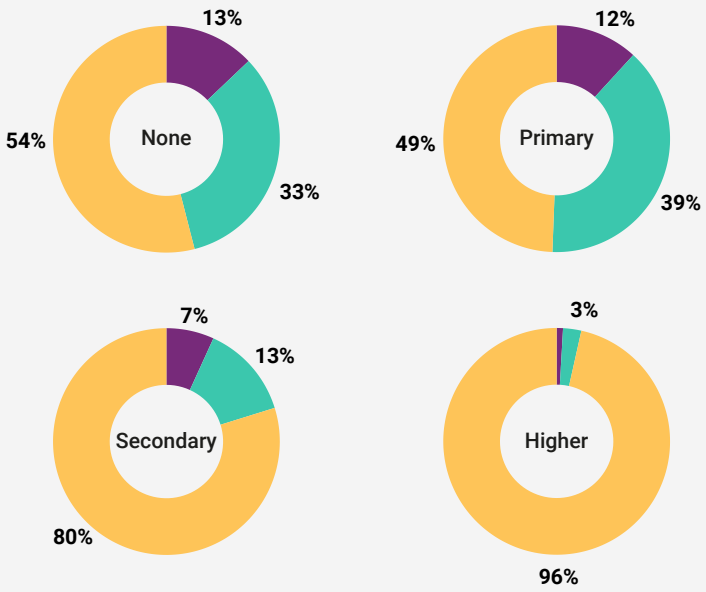


Source: Demographic and Health Survey, 2019

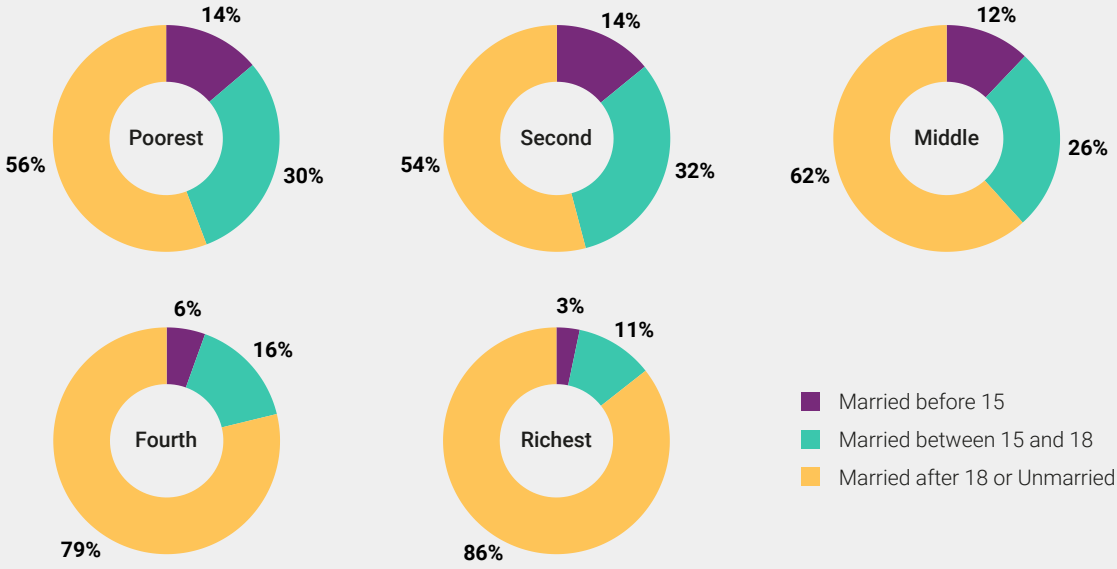
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



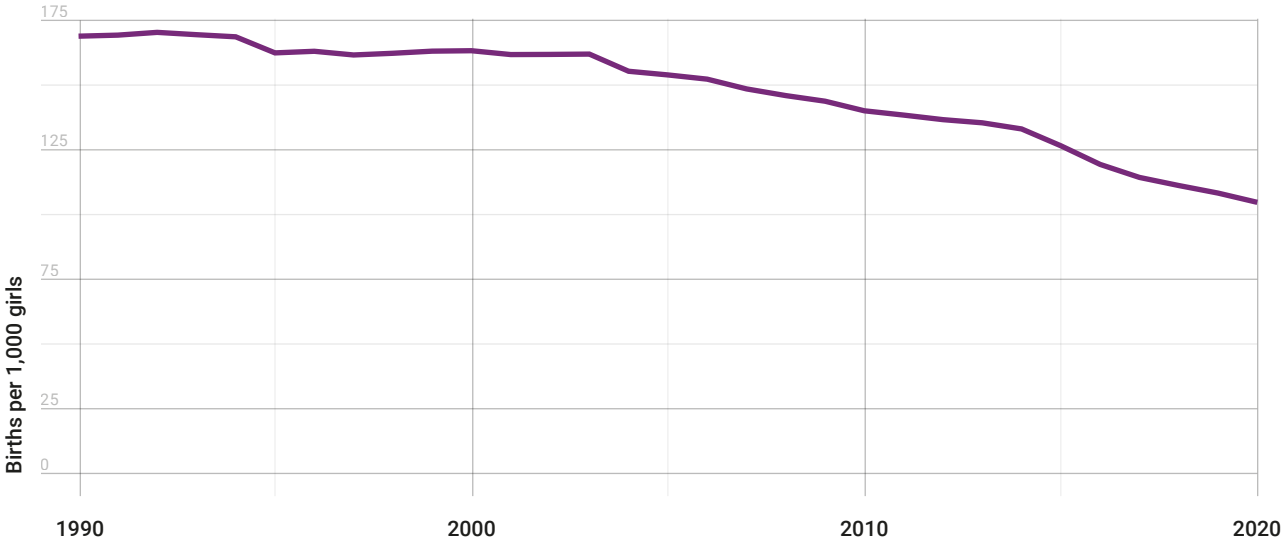
Source: Demographic and Health Survey, 2019

Sierra Leone's adolescent birth rate has been decreasing from 1990 to 2020 and is currently slightly over 100 births per 1,000 girls. The adolescent birth rate is two times higher among women living in rural areas of the country compared with those living in urban areas, two times higher among those with no education compared with those with secondary education, and three times higher among those living in the poorest households compared to those living in the wealthiest households.

Adolescent birth rate

Source: Demographic and Health Survey, 2019

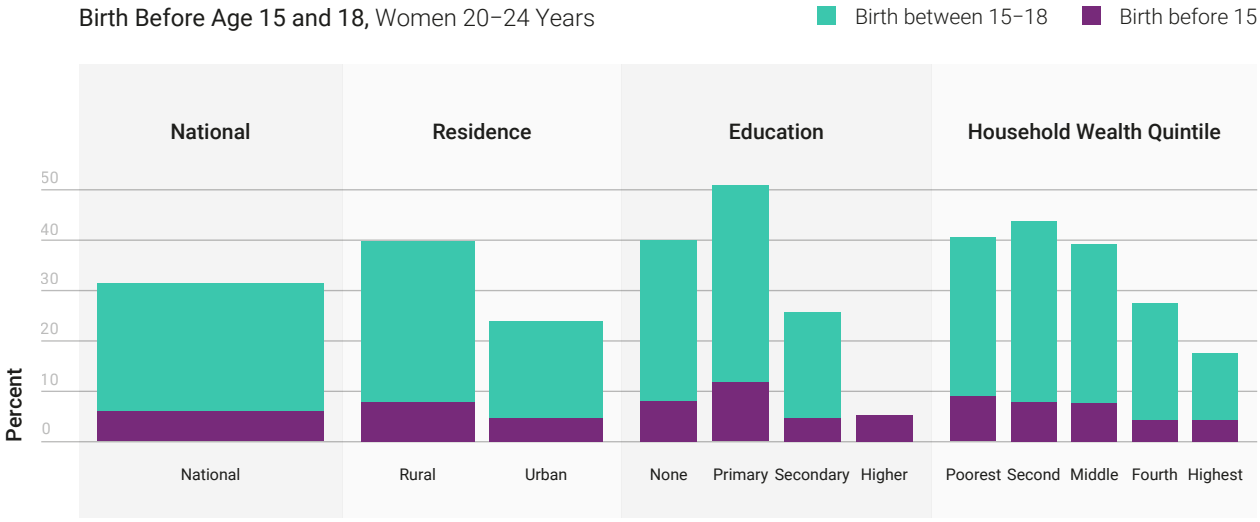
Adolescent birth rate, 1990–2020



Source: World Population Prospects, 2022

31.3% of women aged 20-24 years in Sierra Leone gave birth before age 18, including 6.1% before age 15. Most births occur among women in residing in rural areas and those with primary education, as well as those living in the poorest and second poorest households. The percentage of births before age 15 and age 18 is 1.6 times higher in rural areas than in urban areas, and two times higher among women living in the second most poor households compared with those in the wealthiest households.

Birth Before Age 15 and 18, Women 20–24 Years

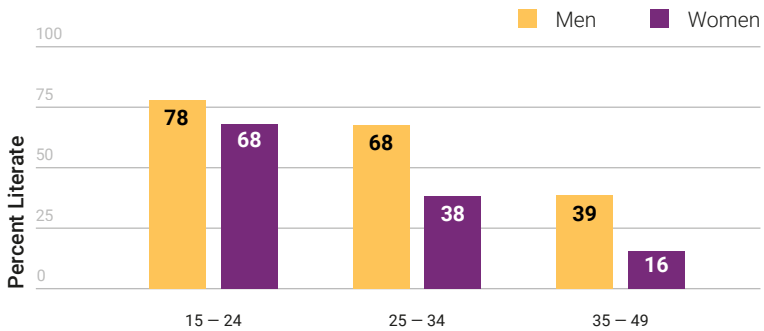


Source: Demographic and Health Survey, 2017

More than 90% of women over 30 in Sierra Leone have undergone female genital cutting, compared to 61% of those ages 15-19[IV]. Sierra Leone is one of a few countries in Sub-Saharan Africa that have not banned female genital mutilation.

The literacy rate in Sierra Leone among men is higher than that for women. Both rates decrease by age group from 15-24 years old to 35-49 years old. Secondary education completes the provision of basic education that began at the primary level, and aims at laying the foundations for lifelong learning and human development, by offering more subject- or skill-oriented instruction using more specialized teachers. In 2018, Sierra Leone's secondary school net attendance ratio[V] is 41.8. The 2020 decision by the Government of Sierra Leone end a 10-year ban against pregnant girls and teenage mothers attending school is an important step to improve education for girls in the country, in line with their human rights and in support of advancing gender equality and the Nairobi commitments.

Literacy Rate by Age and Sex



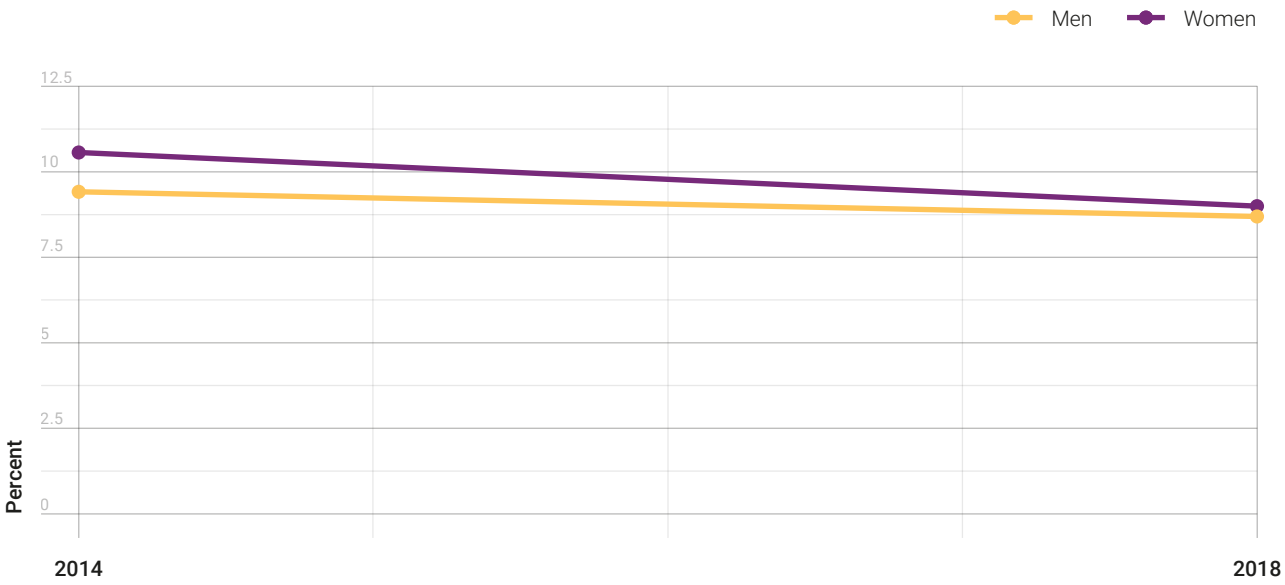
Source: Demographic and Health Survey, 2019

IV Demographic and Health Survey, 2019

V Ratio of children of official school age who are enrolled in school to the population of the corresponding official school age

Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Sierra Leone, the percentage of youth not in education, employment or training has been decreasing among women and men, and in 2019 it is relatively the same for sexes.

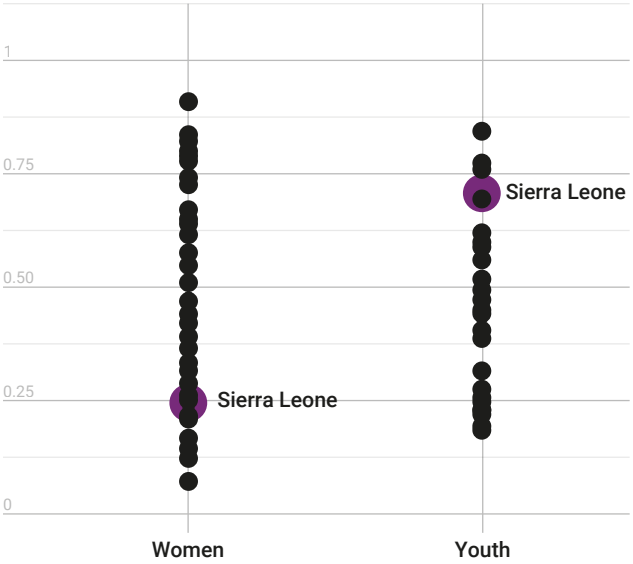
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Labour Force Survey, 2014 and Integrated Household Survey, 2018

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in Sierra Leone is one of the lowest compared with those in the region, while the ratio of the proportion of young Members of Parliament is among the highest in the region (SDG 16.17.1).

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, Sub-Saharan African Countries



Source: Inter–Parliamentary Union, 2022

Since the Nairobi Summit, Sierra Leone launched its National Strategy for Response to Sexual and Gender-Based Violence. A National Demographic Dividend Observatory tracker is also being set up.

In its 2021 Voluntary National Review, Sierra Leone explicitly reported progress made on its national ICPD25 commitments to zero unmet need of family planning, zero preventable maternal deaths, and zero gender-based violence and harmful practices.

Prior to that, Sierra Leone was reviewed at the 38th session of the Universal Periodic Review at the UN's Human Rights Council in May 2021. It received 274 recommendations, of which at least 136 (nearly half of all recommendations) were related to the Nairobi Summit on ICPD25.

UNITED REPUBLIC OF TANZANIA

TOTAL POPULATION [I] **66,455,900**

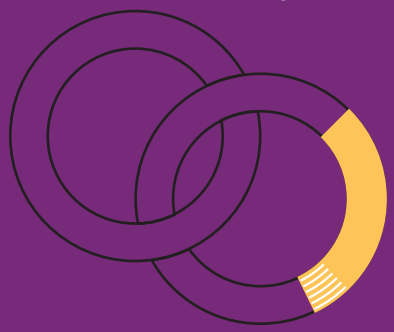
POPULATION 24 YEARS OR YOUNGER [I]

63.35%

WOMEN OF REPRODUCTIVE AGE (15-49 years) [I] **16,110,640**

POPULATION 15-24 YEARS (male + female) [I] **13,363,090**

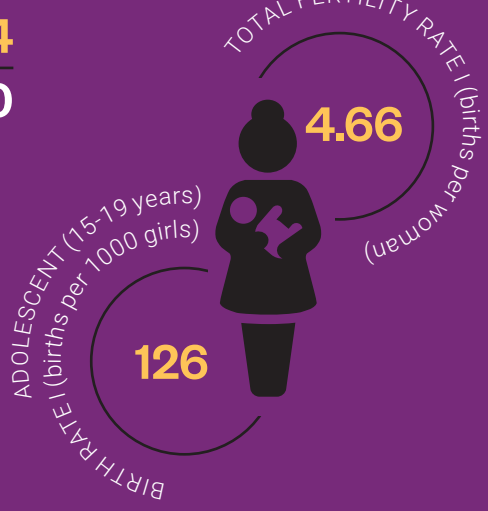
WOMEN (20-24 years) WHO WERE FIRST MARRIED OR IN UNION [II]



BEFORE AGE 18 **30.5%**

BEFORE AGE 15 **5.2%**

MATERNAL MORTALITY RATIO (per 100,000 live births) [II] **524** / **100,000**



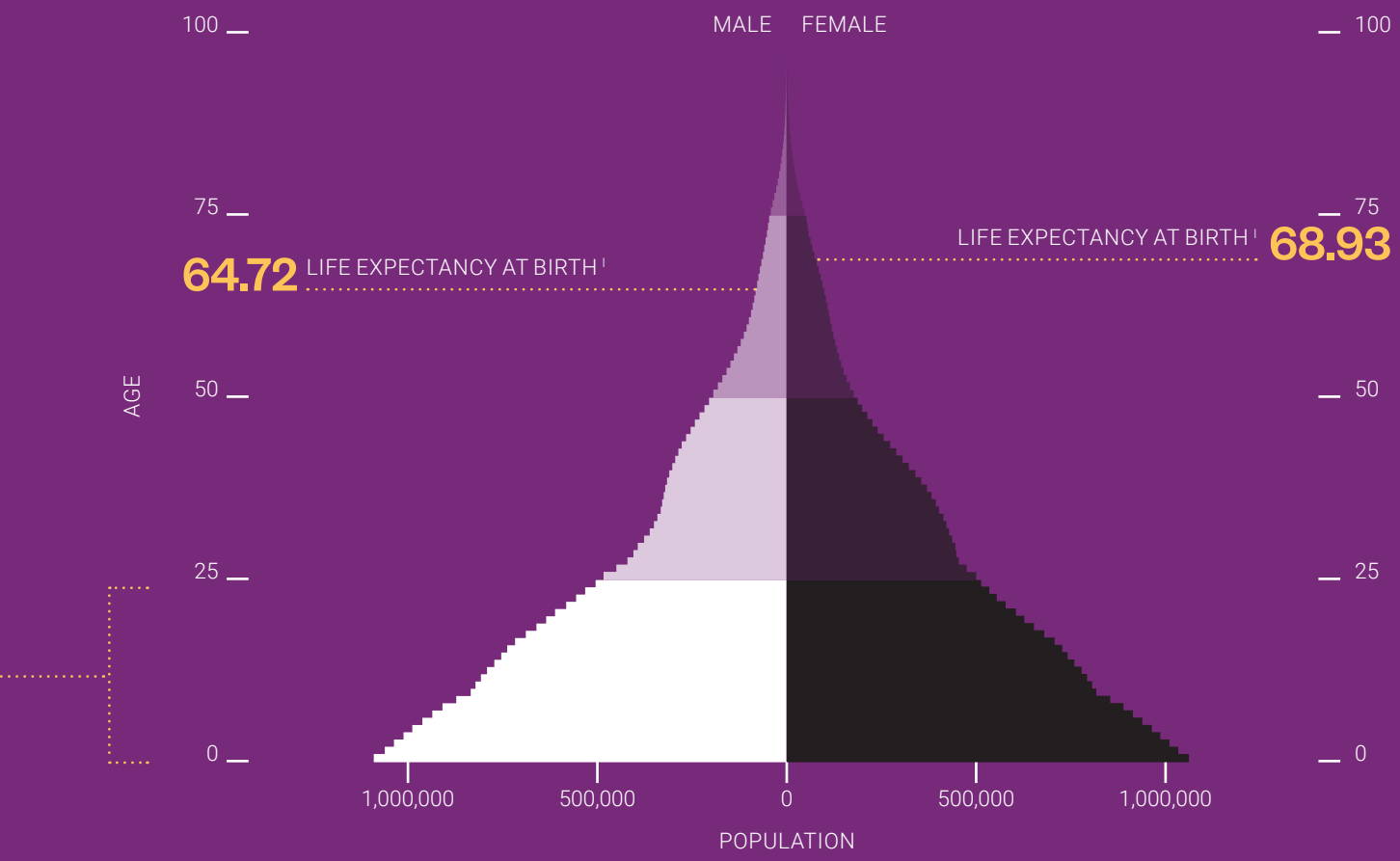
I. World Population Prospects 2022 II. SDG

15.2% UNMET NEED FOR FAMILY PLANNING (all women) [III]

62% DEMAND FOR FAMILY PLANNING SATISFIED WITH MODERN METHODS (all women) [III]

63.5% DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL [II]

As part of the commitments made at the Nairobi Summit on ICPD25, the United Republic of Tanzania has committed to accelerating the implementation and funding of the ICPD Programme of Action, in line with the Tanzania Development Vision 2025. Tanzania has committed to enhancing efforts towards achieving the goal of zero unmet needs for family planning services to **enhance child and maternal survival.**



I. World Population Prospects 2022 II. SDG III. World Contraceptive Use 2022

The United Republic of Tanzania is one of eight countries where more than half of the projected increase in the global population up to 2050 will be concentrated [IV]. In 2022, Tanzania's total fertility rate (TFR) – the number of children that would be born to a woman if she were to live to the end of her childbearing years, is estimated to be 4.66 [V]. TFR and unmet need for family planning is highest among rural women, women with no or only primary education, and those in the poorest and second poorest households. 32% of married and in-union women were using a modern contraceptive method according to the 2015/2016 Tanzania Demographic and Health Survey, with demand satisfied by a modern family planning method being 52.9%. Both current modern method use and demand satisfied by modern methods is higher among Tanzanian women in urban areas, and those women in the middle- and highest- income households. Tanzania is committed to increasing the modern contraceptive prevalence for all women to 42% by 2025. As part of this effort, it has been working to identify gaps in existing policies and guidelines to determine areas for review and harmonization, to develop knowledge and skills of service providers in postpartum and postabortion family planning, and to build capacity of health care providers with regards to proper self-care for short-term contraceptive methods, documentation, and report [VI].

Unmet Need for Family Planning, All Women

Source: Demographic and Health Survey, 2015

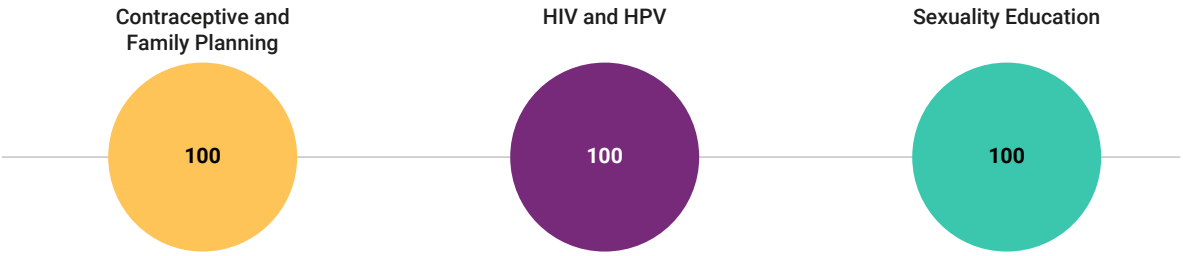
Demand for Family Planning Satisfied with Modern Methods, All Women

Source: Demographic and Health Survey, 2015

IV World Population Prospect 2022
V Ibid
VI https://fp2030.org/tanzania

SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women and men's full and equal access to health and rights. Tanzania has achieved 100% of enabling laws and regulations that guarantee full and equal access to women and men to HIV and HPV, to sexuality education, and to contraceptive and family planning services. While it is commendable that certain legal frameworks are in place, enforcement and implementation lag behind.

Extent to which Tanzania has 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



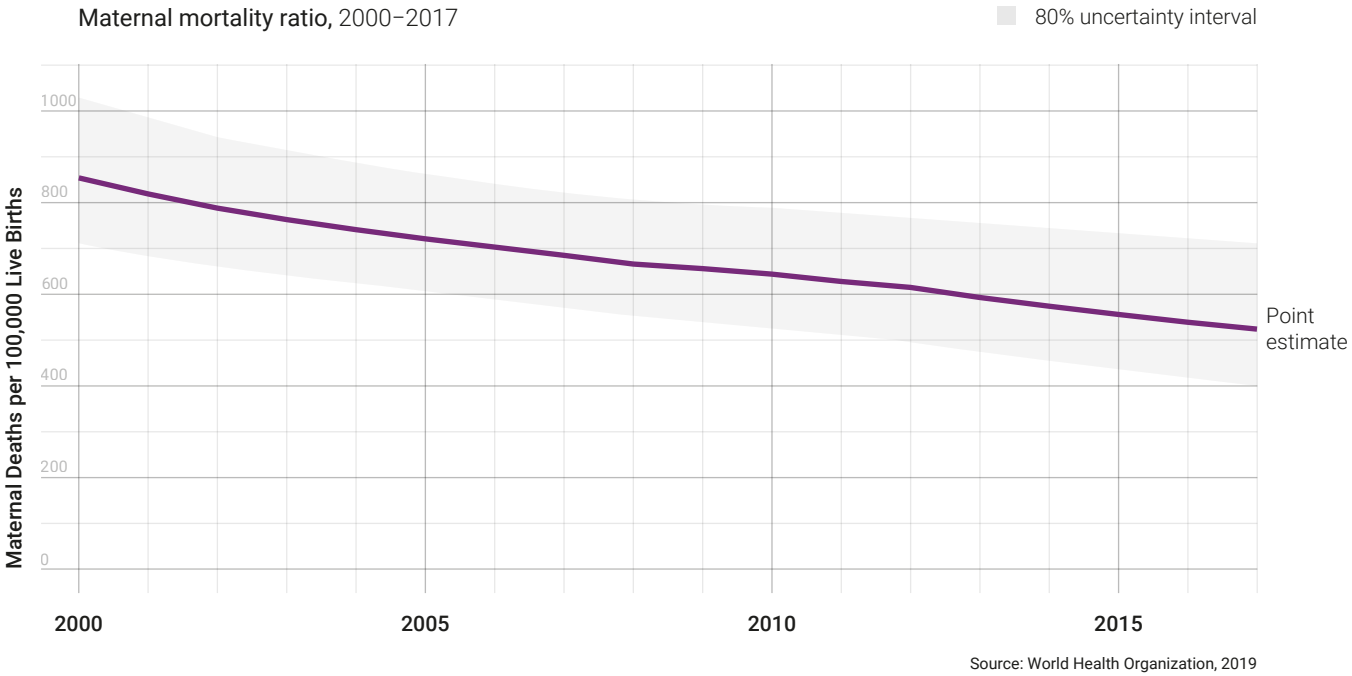
Source: United Nations Population Fund, 2022

Since the Nairobi Summit, Tanzania's commitments were reflected in some of the country's development and strategic documents, including the Health Sector Strategic Plan V and the National Family Planning Costed Implementation Plan. A tool to track ICPD commitments was developed at the regional level and customized at the country level.

Tanzania was reviewed at the 39th session of the UPR in November 2021. It received 252 recommendations, of which at least 113 (45% of all recommendations) were related to the Nairobi Summit on ICPD25.

At the Nairobi Summit, Tanzania committed to enhancing efforts towards achieving the goal of zero preventable maternal deaths, and maternal morbidities. This includes a commitment to increase the national budget allocation for health to meet the Abuja declaration target of 15% and the commitment to roll out a competency-based curriculum for midwives by 2030 to enhance the provision of quality care. In addition, Tanzania is committed to accelerate the integration of HIV and other reproductive health services to reduce the burden of HIV, including reducing mother-to child-transmission to <5 percent by 2030.

Tanzania's maternal mortality ratio (MMR) declined from 2000 to 2017, when it was estimated to be 524 maternal deaths per 100,000 live births; this rate falls halfway between that of countries in the region with the highest and lowest MMRs. Recognizing the impact of unsafe abortion on maternal deaths, Nairobi Summit Commitment 3 highlights the integration of "a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and the provision of post-abortion care into national UHC strategies, policies and programmes, and the need to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights. Abortion is prohibited in Tanzania, with the only exclusion being to save the life of the mother.



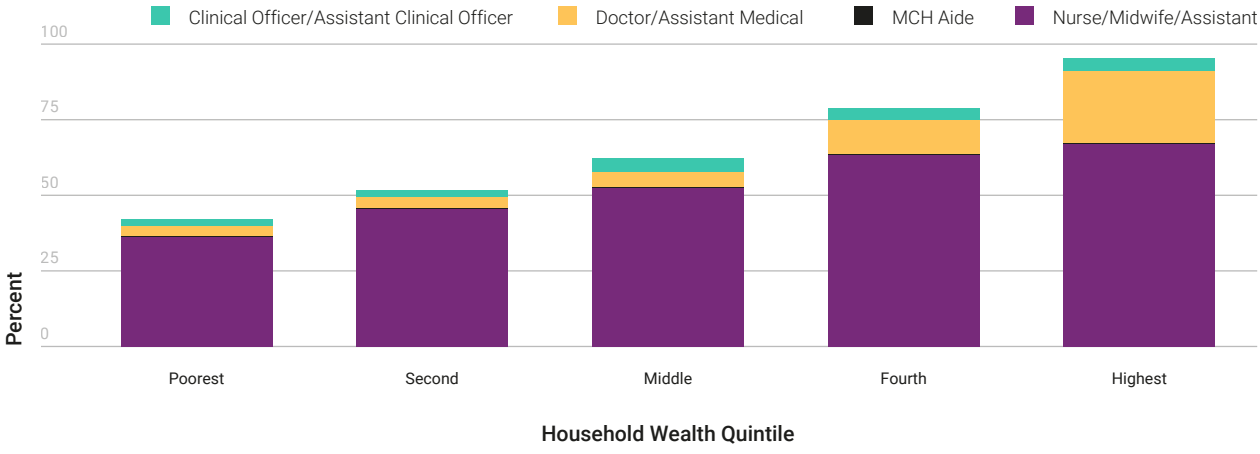
Source: World Health Organization, 2019

In 2016, 63.5% of births in Tanzania were attended by skilled health personnel and 62.6% of births were delivered at a health facility. Among married women 15-49 years who had a live birth in the last two years, deliveries assisted by a skilled attendant were highest among women in urban areas, among women with secondary and higher education, and among women in wealthier households. This is also the case for births delivered at a health facility. Most births are attended by nurse midwives/assistant nurses, and this proportion increases as household wealth increases. The proportion of births attended by doctors and assistant medical officers also increases with household wealth.

Births with Skilled Attendant

Source: Demographic and Health Survey, 2015

Skilled Birth Providers by Wealth Quintile



Source: Demographic and Health Survey, 2015

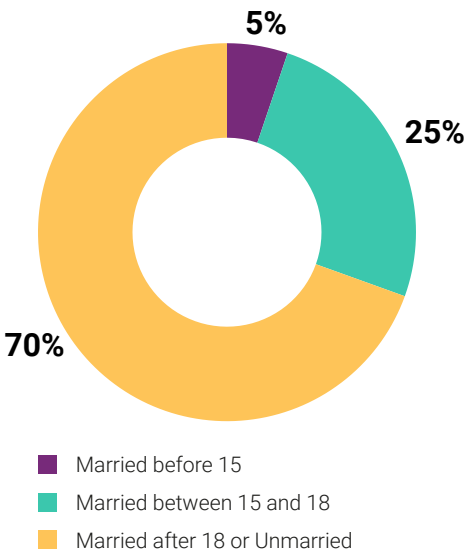
As part of the commitments made at the Nairobi Summit on ICPD25, Tanzania has committed towards ending sexual and gender-based violence of all forms, including zero child marriage, female genital mutilation, in order to realize all individuals' potential as agents of change in their societies.

In Tanzania, 40% of all women aged 15-49 years have experienced physical violence, while 17% have experienced sexual violence. 44% of women aged 15-49 years have experienced either physical or sexual violence by an intimate partner; the prevalence of spousal violence is highest in rural areas (52% compared to 45% in urban areas), and almost 30% of girls experience sexual violence before the age of 18 [VII].

The prevalence of female genital mutilation (FGM) in Tanzania among women aged 15 to 49 years has decreased over the past decade from 18% in 1996 to 10% in 2016, but again there are significant regional variations [VIII]. In Tanzania, FGM generally takes place when girls are infants, or past the age of 13 years. FGM is highest in the centre and north of the country, and almost all cases of FGM in Tanzania are carried out by traditional practitioners [IX].

Tanzania has one of the highest child marriage rates in the region and in the world. Based on the latest available data, 30% of women aged 20-24 years were married before age 18, with 5% of women married before age 15.

Age of Marriage Distribution, Women 20–24

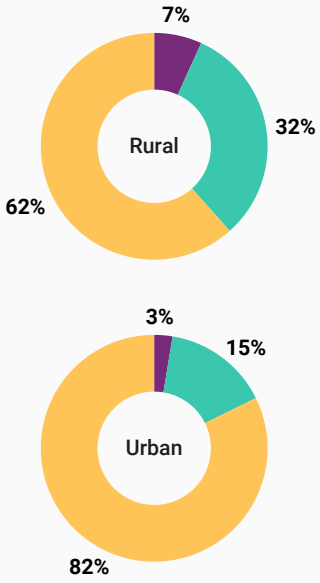


Source: Demographic and Health Survey, 2015

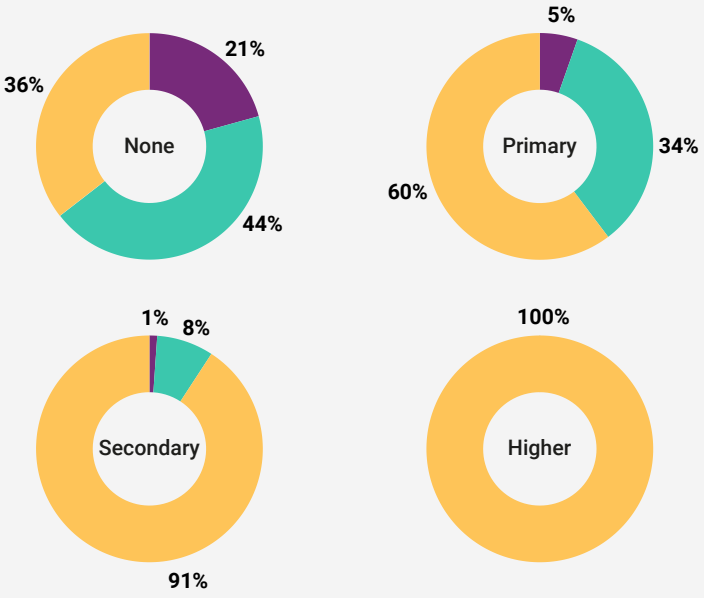
VII World Bank, Tanzania Gender-Based Violence Assessment
VIII https://www.28toomany.org/country/tanzania/
IX Ibid

Most women 20-24 years who were married before 18 years are those from rural areas (39%) compared with urban areas (18%). Approximately 65% of women married before age 18 have no education, while 39% have primary education. Marriage before age 18 is also highest among women living in the poorest (49%) and second poorest (47%) households.

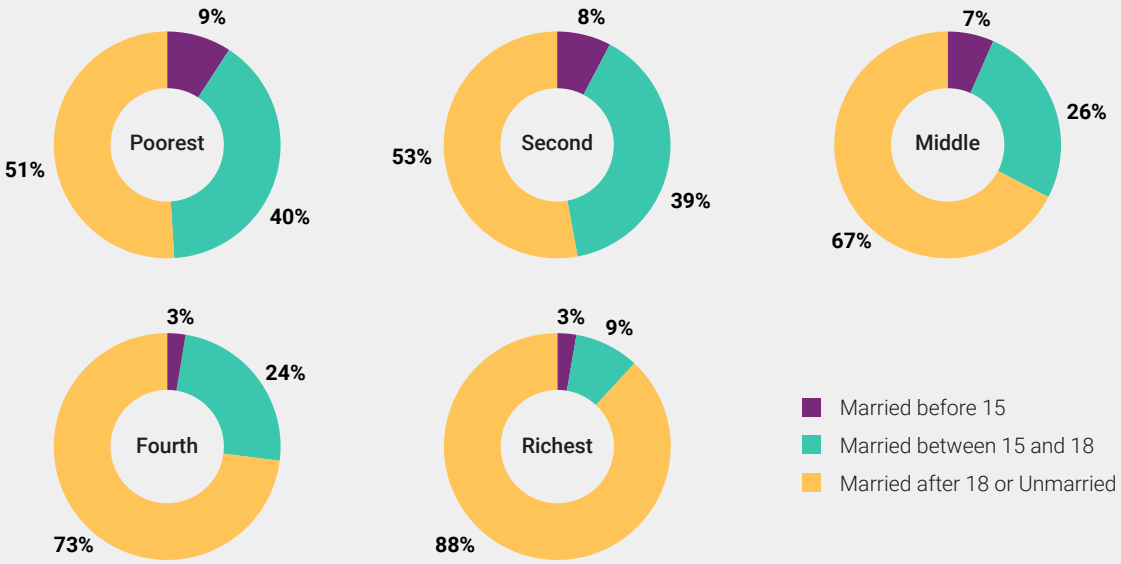
Age of Marriage Distribution by Residence, Women 20–24



Age of Marriage Distribution by Level of Education, Women 20–24



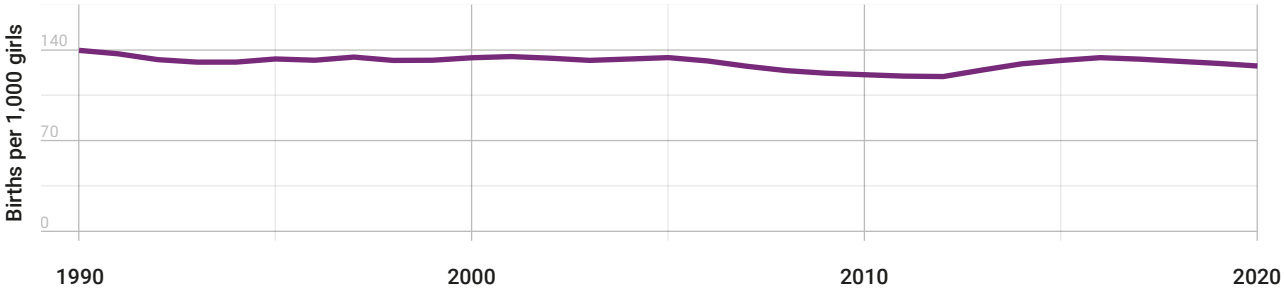
Age of Marriage Distribution by Household Wealth Quintile, Women 20–24



Source: Demographic and Health Survey, 2015

Tanzania's adolescent birth rate has remained relatively the same from 1990 to 2020, and is estimated to be 123 per 1,000 women girls 15-19 years old in 2022; it is one of the highest in the region. Compared with the national rate, Tanzania's adolescent birth rate is higher in rural areas (1.5 times higher than in urban areas), among girls with no education (nearly four times higher than girls with secondary or higher education), and among those living in the poorest households (three times higher than those in the richest households). Births among girls 15-19 years is higher among girls who live in rural areas, those with no education and primary education, and those girls from the poorest households.

Adolescent birth rate, 1990–2020

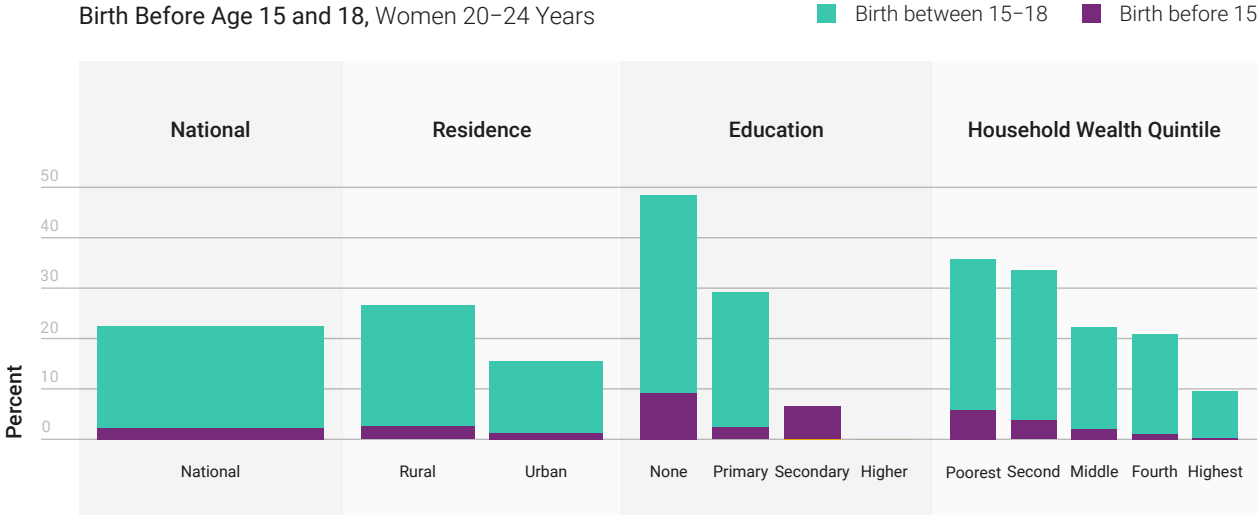


Source: World Population Prospects, 2022

Adolescent birth rate

Source: Demographic and Health Survey, 2015

Birth Before Age 15 and 18, Women 20–24 Years



Source: Demographic and Health Survey, 2015

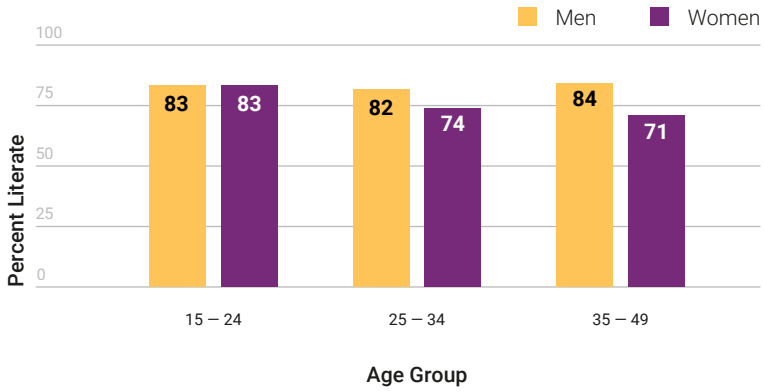
Tanzania's ICPD25 Commitments include:

- Increase the proportion of youths in the decision-making bodies by 2030
- Increase access to comprehensive age-appropriate sexual and reproductive services to adolescent and young people in and out of schools and health facilities
- Empower and invest in adolescents and youth in education, employment opportunities and health including family planning and sexual and reproductive health and services

Adolescent girls and young women account for 80% of the 28,000 new HIV infections in Tanzania annually; prevalence rates for young women aged 20 to 24 are nearly double that of young males.[X]

Tanzania's literacy rate is the same between males and females among those 15 to 24 years of age, while women aged 25 to 34 and 35 to 49 years of age have lower literacy rates than their male counterparts. Secondary education completes the provision of basic education that began at the primary level and aims at laying the foundations for lifelong learning and human development by offering more subject- or skill-oriented instruction using more specialized teachers. Tanzania's secondary school net attendance ratio[XI] is 27; 27 for females and 26 for males. A 2020 report by the National Bureau of Statistics indicated that the proportion of primary school children aged 7 to 13 years attending school was more than 90%, but only one in three adolescents (boys and girls) complete secondary school. According to a 2018 World Bank study on girls in secondary education in Tanzania, high child marriage rates contribute to the high percentage of teenage pregnancy and by extension to just under three in four girls failing to complete their secondary education. In November 2021, the Tanzanian government announced to lift the ban on teenage mothers continuing their education, allowing them two years to return to school after giving birth.

Literacy Rate by Age and Sex



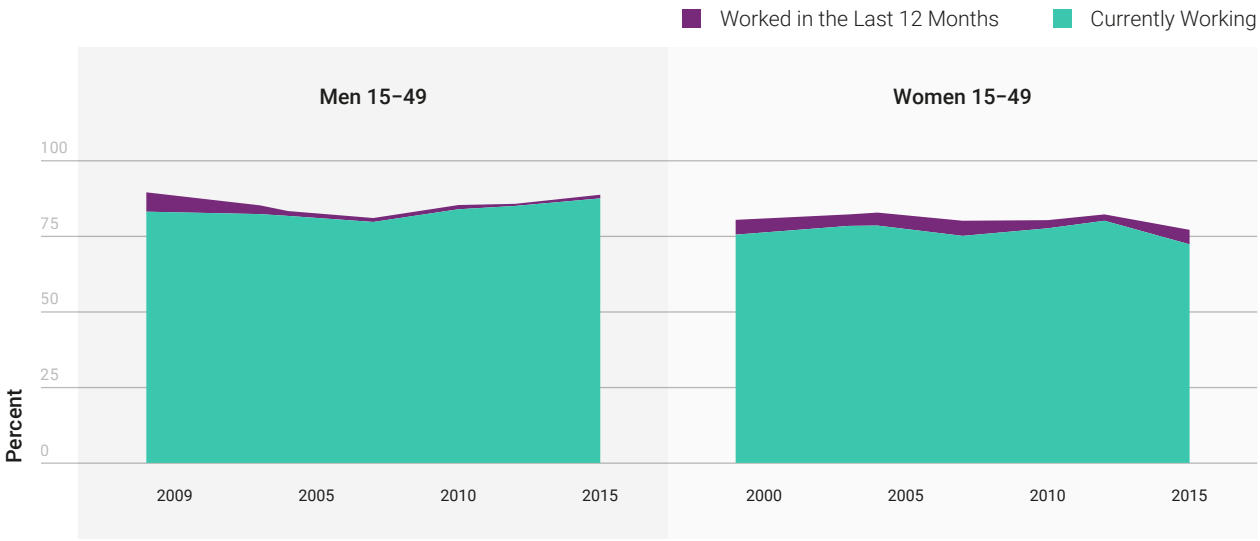
Source: Demographic and Health Survey, 2015

X Tanzania HIV Impact Survey 2016-2017

XI Ratio of children of official school age who are enrolled in school to the population of the corresponding official school age

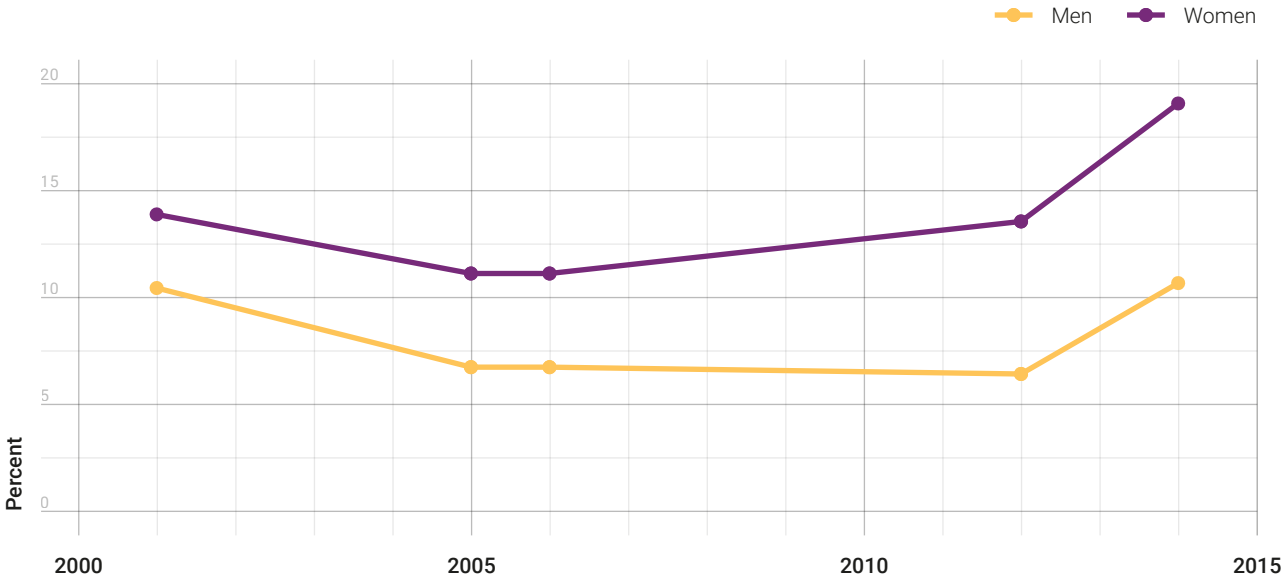
Employment trends for men and women remained largely the same from 2001 to 2016. The proportion of men "currently" working has increased during this period, while the share of women "currently" working has declined slightly. Young people who are not in education, employment or training (i.e., the NEET population) quantifies the proportion of young people who find themselves outside of the educational system and without work. In Tanzania, the percentage of youth not in education, employment or training has remained relatively the same among men from 2008 to 2017, but has been increasing among women.

Employment Trends (Currently Working and Worked in the Last 12 Months), by Sex



Source: Demographic and Health Survey, 1999-2015

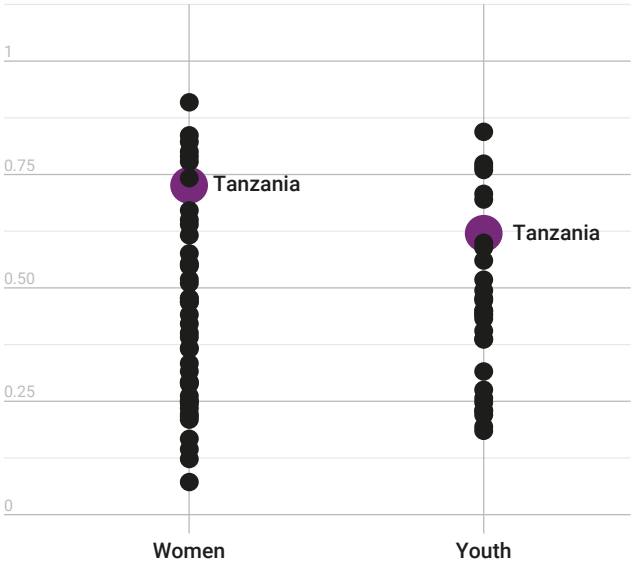
Percent of Youth (15–24) Not in Education, Employment, or Training, by Sex



Source: Labour Force Survey, 2001, 2005, 2006, 2014; National Household Budget Survey, 2012

SDG Goal 16 seeks to promote peaceful and inclusive societies for sustainable development, to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. One component of this is ensuring responsive, inclusive, participatory and representative decision-making at all levels. The ratio of the proportion of female Members of Parliament in Tanzania is one of the highest in the region, while the ratio of the proportion of young Members of Parliament is slightly higher than the median in the region (SDG 16.17.1).

Ratio of proportion of population in parliament to proportion in national population, Lower Chamber or Unicameral, Sub-Saharan African Countries



Source: Inter–Parliamentary Union, 2022

In 2022, Tanzania completed the data collection for its most recent population and housing census, adapting new and advanced technologies and achieving a coverage of 99.99%. It is expected that the population of the country will be at 61.3 to 64 million based on projections made before census. The main contributing factor for the country's population growth is fertility; and teenage pregnancy contributing highly to the large number of young people and children in proportion to the entire country's population. The impact of population growth upon poverty rates is compounded by variations in fertility rates across income groups and levels of education. As the world is about to reach a population of 8 billion, Tanzania will be amongst the eight countries where half of the projected increase in the global population up to 2050 will be concentrated[XII]. Despite its explicit ICPD25 commitment to harnessing the demographic dividend, unless additional measures are introduced to significantly reduce fertility rates, such as the rapid acceleration of current trends in the uptake of modern contraceptives, alongside efforts to tackle the underlying drivers of high birth rates, especially among the least educated, rural poor, Tanzania will not see a demographic dividend until after 2060.

XII World Population Prospect 2022

ANNEX C

METHODOLOGICAL NOTE

This methodological note documents the development of the Global Commitments Monitoring Framework to track and report on the 12 overarching global commitments in the Nairobi Statement. It also presents further information on selected indicators.

The framework was developed at the request of and fully endorsed by the High-Level Commission. Avenir Health lead the process in collaboration with the ICPD25 Follow-up Secretariat, the Commission and technical experts at UNFPA and its partners. The work built off on the initial draft framework that was prepared by a UNFPA Task Team during 2020. The GCMF was launched in 2021 and included in the report of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up; it has been updated in 2022.

Within the framework, an index for each global commitment allows a regional comparison of a single measure that combines many facets. These include indicators selected to measure what a particular commitment is meant to capture, the scale used to compare indicators, cut-off thresholds for each traffic light colour, and the weight assigned to each indicator to capture its relative importance in realizing the global commitment. Global commitments 6 and 7 were not included given challenges around indicator and data quality, representation and accuracy. Annex A presents the baseline indicators and overall regional scores for each commitment in 2021, as well as scores for the 2022 update.

Indicator selection

For each global commitment[I], indicators were selected based on several criteria, namely that they:

- Are available for and representative of as many countries as possible,
- Are from publicly available datasets, and
- Measured something that is expected to change over time in order to track progress.

Two principles guided the construction of the framework. First, a decision was made to avoid repeating indicators across different commitments. This was to prevent overlap in the representation of indicators, especially in the computation of global commitment 1 as a composite of all other commitments. Second, while many different indicators can be used to track each global commitment, a limited number was included to prevent the framework from becoming overly complex and difficult to comprehend, and so that indicators would carry an appropriate weight in measuring the commitment.

A special note is necessary on the inclusion of SDG 5.6.1 (the proportion of women who make their own informed decisions regarding reproductive health care, contraceptive use and sexual relations). Subsections of this indicator were originally proposed as indicators under global commitments 2, 3 and 5. Due to a lack of data for many countries and regions, however, this indicator has not been included. Since the indicator is key to issues under the Commission's purview, it may be reconsidered for future inclusion as more countries report on it.

Data for selected indicators are the most recent available. The number of countries covered by data for each indicator and the proportion of the population represented were captured using United Nations World Population Prospects data. Indicators are detailed below.

I Except for commitments 1, 6, and 7.

Missing data

For several indicators, data were missing for multiple countries. In these situations, we used regional averages for countries with available data. To determine representation of the indicator in the region, we also calculated the proportion of the population represented by the data for each indicator and region.

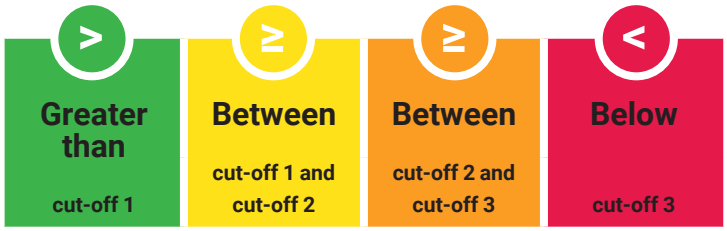
Scaling indicators

To combine multiple indicators in an index, all indicators need to be scaled to range from 0 to 1. In some cases, where lower measures of an indicator signified a positive outcome, the minimum was a larger number than the maximum, so once scaled the indicator would have the worst possible score as 0 and the best as 1. Once we selected the maximum and minimum values, we rescaled the indicators and cut-offs using the following equation:

$$\text{Scaled Indicator} = \frac{\text{Indicator} - \text{ScaleMin}}{\text{ScaleMax} - \text{ScaleMin}}$$

Traffic light cut-off thresholds

To assign traffic light colours by region, three cut-off values were determined for each indicator and applied as shown to the right.



The 2022 GCMF uses circles and triangles, as well as colors to represent the traffic light score for each indicator. Circles indicate that there was not enough difference recorded compared to 2021 to cause the traffic light to change colour. Triangles indicate that there has been a significant enough change in scores to determine a new traffic light colour. Triangles pointing up designate progress, while pointing down show regress.

Indicator weights

Countries were weighted by relevant population when creating regional averages for individual indicators. While all indicators selected for each global commitment capture an element of a given commitment, some indicators better represent the commitment as a whole. Each indicator was therefore assigned a weight reflecting its relative importance in capturing the concept of the commitment. For example, for commitment 3, the maternal mortality ratio indicator was given a weight of 50 per cent with respect to other indicators. To create traffic light thresholds for the commitments, each indicator's cut-offs were scaled, weighted and combined to form the commitment's cut-offs. The threshold cut-offs for each commitment and for the indicators in each commitment are presented in Tables 20 and 21.

Regional classification

The results for each indicator of each commitment are presented by geographic regions based on the country groupings defined by the UN Statistics Division in presenting the SDG indicators. Table 22 shows the number of countries represented in each region.

Country Profiles

In 2022, several country profiles were developed to further conceptualize the concept of sexual and reproductive justice, and to complement the 2022 GCMF and report being developed following the launch of the first report "*No Exceptions, No Exclusions: Realizing sexual and reproductive health, rights and justice for all*". As part of this exercise, several criteria were used to identify countries to profile. As a first step, an exercise was done to determine the level at which each indicator included in the GCMF could be disaggregated. Members of the Commission's Working Group on the Global Commitments Monitoring Framework used this analysis to rank the importance of each indicator included in the GCMF to represent the concept of sexual and reproductive justice. Following this exercise, a short-list of two to three countries per region were selected to be profiled based on additional criteria including:

- Countries with a recent (i.e., after 2015) Demographic and Health Survey (DHS) or Multiple Indicator Cluster Survey (MICS) survey, including those countries where new survey rounds are being conducted in 2022
- Countries that have made commitments to meet the Nairobi Commitments
- Countries that have a Strategic Information System (SIS) report, and/or that have conducted a Voluntary National Review (VNR), and/or that have gone through a Universal Periodic Review (UPR) and received recommendations on implementing commitments, and/or with an available United Nations Sustainable Development Cooperation Framework (UNSDCF), and/or are recipients of ICPD25 Follow-up seed grants supported with the funding of the Government of Denmark.

In developing country profiles, key national commitments made by the country (and possibly other national stakeholders) at the Nairobi Summit and thereafter were identified and highlighted. In addition, making use of the most recent data available for that particular country (e.g., data from a DHS, a MICS, etc.), each profile examines country-level data with a lens to identify differences in indicators by geographic location, by (sub-national) region, and by other elements such as age, household wealth, education, etc. Furthermore, in the selection of countries to be featured with country profiles, an effort was made to ensure cross-regional balance. The profiles are to be taken as a set of samples that offer the opportunity to dive deeper on what discrepancies in sexual and reproductive health outcomes exist at country levels, while focusing on issues of intersectionality, and as such to give direction to how the sexual and reproductive justice framework is to be applied. The country profiles as such can help in driving action on the ground, and there is an intention by the Commission to develop additional country profiles for select countries, beyond the scope of those featured in the current report.

Global Commitments Monitoring Framework summary

Table 1 shows the results from the framework with index values and the corresponding traffic light colours reported for each commitment.

Table 1. Commitment index value and color by region, 2022

	1	2	3	4	5	8	9	10	11	12
Central and Southern Asia	0.629	0.763	0.795	0.738	0.641	0.589	0.304	0.665	0.552	0.457
Eastern and South-eastern Asia	0.744	0.850	0.854	0.878	0.839	0.750	0.400	0.721	0.575	0.671
Europe and Northern America	0.821	0.832	0.947	0.877	0.930	0.897	0.723	0.809	0.672	0.585
Latin America and the Caribbean	0.690	0.744	0.828	0.794	0.845	0.708	0.608	0.741	0.621	0.150
Northern Africa and Western Asia	0.662	0.738	0.811	0.689	0.686	0.639	0.396	0.599	0.539	0.740
Oceania	no data	0.795	0.857	no data	0.848	0.857	0.498	0.621	0.698	1.000
Sub-Saharan Africa	0.527	0.551	0.559	0.637	0.599	0.498	0.433	0.480	0.536	0.389

Commitment details

The section below presents a detailed look at each commitment, including indicators selected to measure the commitment, data sources, relative weights of each indicator and threshold cut-offs.

Global commitment 1

Intensify our efforts for the full, effective and accelerated implementation and funding of the ICPD Programme of Action, Key Actions for the Further Implementation of the Programme of Action of the ICPD, the outcomes of its reviews, and Agenda 2030 for Sustainable Development.

Commitment 1 is a composite index constructed using a weighted mean of commitments 2-5 and 8-12. Commitments 2, 3 and 5 were given 1.5 times the weight of the indicators for the other commitments due to their centrality in achieving commitment 1.

Global commitment 2

Zero unmet need for family planning information and services, and universal availability of quality, accessible, affordable and safe modern contraceptives.

Tables 2 and 3 present the indicators, weights and cut-off thresholds for commitment 2. Indicators with an asterisk use a reverse scale for the cut-off thresholds.

Table 2. Global Commitment 2 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Adolescent birth rate (SDG 3.7.2)	Adolescent birth rate per 1,000 women aged 15-19 years.	World Population Prospects 2022
Sexual and reproductive health care laws and regulations: Number of countries with 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 5.6.2 Section 2: Contraceptive and Family Planning)	Extent to which countries have 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 (Section 2, contraceptive and family planning).	SDG Global Database
Unmet need for modern methods, total (all women)	Percentage of all women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with an unmet need are those who want to stop or delay childbearing but are not using any modern method of contraception.	World Contraceptive Use 2022

Table 3. Global Commitment 2 indicator weights, scales and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Adolescent birth rate (SDG 3.7.2)*	Women aged 15-19 years	0.4	25	37.5	50
Sexual and reproductive health care laws and regulations: Extent to which countries have 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 5.6.2 Section 2: Contraceptive and Family Planning)	Men and women aged 15 and over	0.2	90	75	60
Unmet need for modern methods, total (all women)*	Women aged 15-49 years	0.4	0	15	30

Global Commitment 3

Zero preventable maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national UHC strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights

Tables 4 and 5 present the indicators, weights and cut-off thresholds for commitment 3. Indicators with an asterisk use a reverse scale for the cut-off thresholds.

Table 4. Global Commitment 3 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Universal Health Coverage Index (SDG 3.8.1)	Coverage of essential health services (defined as the 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). The indicator is an index reported on a unitless scale of 0 (worst) to 100 (best), which is computed as the geometric mean of 14 tracer indicators of health service coverage.	SDG Global Database
Sexual and reproductive health care laws and regulations: Number of countries with 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 5.6.2 Section 1, maternity care)	Extent to which countries have 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 (Section 1, maternity care)	SDG Global Database
Proportion of births attended by skilled health personnel (SDG 3.1.2)	Proportion of births attended by skilled health personnel (generally doctors, nurses or midwives but can refer to other health professionals providing childbirth care)	SDG Global Database
Maternal mortality ratio (SDG 3.1.1)	Number of maternal deaths during a given time period per 100,000 live births during the same time period. It depicts the risk of maternal death relative to the number of live births and essentially captures the risk of death in a single pregnancy or of a single live birth	SDG Global Database
World Abortion Laws	The Center for Reproductive Rights tracks the legal status of abortion in countries across the globe. Countries are classified by several categories (e.g., prohibited altogether, to save the woman's life, to preserve health, etc.). For the GCMF each category is assigned a numeric level (i.e., "Prohibited altogether" = 0; "To save the woman's life" = 0.25; "To preserve health" = 0.5; "subnational variation to save women's life and on request existing in different jurisdictions" = 0.625; "Broad social or economic grounds" = 0.75; "On request (gestational limits vary)" = 1)	Center for Reproductive Rights

Table 5. Global Commitment 3 indicator weights, scales and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Universal Health Coverage Index (SDG 3.8.1)	Women aged 15-49 years	0.125	80	75	60
Sexual and reproductive health care laws and regulations: Number of countries with 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 5.6.2 Section 1: maternity care)	Women aged 15-49 years	0.125	90	75	60
Proportion of births attended by skilled health personnel (SDG 3.1.2)	Births	0.125	98	94	90
Maternal mortality ratio (SDG 3.1.1)*	Women aged 15-49 years	0.5	70	105	140
World Abortion Laws	Women aged 15-49 years	0.125	0.75	0.50	0.25

Global Commitment 4

Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality and timely services to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood

Tables 6 and 7 present the indicators, weights and cut-off thresholds for commitment 4. Indicators with an asterisk use a reverse scale for the cut-off thresholds.

Table 6. Global Commitment 4 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Young women aged 20–24 giving birth by age 15	Percentage of young women aged 20-24 who gave birth by age 15.	Demographic and Health Survey, Multiple Indicator Cluster Survey
Young women aged 20–24 giving birth by age 18	Percentage of young women age 20-24 who gave birth by age 18	Demographic and Health Survey, Multiple Indicator Cluster Survey
Demand for family planning satisfied by modern methods of contraception, all women aged 15–24 years	The number of women aged 15–24 years using modern methods of family planning divided by the number of currently married women with demand for family planning (either with unmet need or currently using any family planning).	Demographic and Health Survey, Multiple Indicator Cluster Survey
Number of new HIV infections per 1,000 uninfected population aged 15–24 years (SDG 3.3.1)	Number of new cases of HIV per year per uninfected adolescents per 1,000 people aged 15-24 years	UNAIDS 2022 Report

INDICATOR	DEFINITION	SOURCE
Sexual and reproductive health care laws and regulations: Number of countries with 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 5.6.2 Section 3: sexuality education)	Extent to which countries have 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 (Section 3, sexuality education).	SDG Global Database

Table 7. Global Commitment 4: Indicator weights, scales, & threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Young women aged 20-24 giving birth by age 15*	Women aged 20-24 years	0.125	0	2.5	5
Young women aged 20-24 giving birth by age 18*	Women aged 20-24 years	0.125	0	2.5	5
Demand for family planning satisfied by modern methods (all women 15-24)	Women aged 15-24 years	0.25	90	75	60
Number of new HIV infections per 1,000 uninfected population aged 15–24 years (SDG 3.3.1)*	Men and women aged 15-24 years	0.25	0.2	0.6	1
Sexual and reproductive health-care laws and regulations: Number of countries with 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 5.6.2, Section 3, sexuality education)	Men and women aged 15 years and older	0.25	90	75	60

Global Commitment 5

Zero sexual and gender-based violence and harmful practices, including zero child, early and forced marriage, as well as zero female genital mutilation[II]; elimination of all forms of discrimination against all women and girls, to realize all individuals' full socio-economic potential

Tables 8 and 9 present the indicators, weights and cut-off thresholds for commitment 5. Indicators with an asterisk use a reverse scale for the cut-off thresholds.2

II The issue of female genital mutilation proved challenging. The practice of female genital mutilation only occurs in a specific number of countries, and as such it was not possible to find a meaningful indicator that was globally comparable. In addition, for those countries in which female genital mutilation is practiced, data on its incidence or prevalence is reported in different ways, and it was determined that these indicators are likely not to change considerably on an annual or bi-annual timeframe because of how they are captured. As such, no indicators related to female genital mutilation are included in the current matrix.

Table 8. Global Commitment 5 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Violence against women from an intimate partner (SDG 5.2.1)	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical sexual or psychological violence by a current or former intimate partner in the previous 12 months	SDG Global Database
Women married before age 15 (SDG 5.3.1)	Proportion of women aged 20-24 years who were married or in a union before age 15	SDG Global Database
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 2, violence against women)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (Area 2, violence against women)	SDG Global Database
Systems to track gender equality (SDG 5.c.1)	Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment	SDG Global Database
Consensual same sex sexual acts between adults legal	The *State-Sponsored Homophobia: Global Legislation Overview Update 2020* report states that consensual same sex sexual acts between adults are considered legal if they are not criminalized. For the framework: Countries where same-sex sexual acts are legal = 1; countries where they are not legal or de facto criminalized = 0.	International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)

Table 9. Global Commitment 5 indicator weights, scales, and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Violence against women from an intimate partner (SDG 5.2.1)*	Women aged 15-49 years	0.3	0	15	30
Women married before age 15 (SDG 5.3.1)*	Women aged 20-24 years	0.175	0	10	20
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 2, violence against women)	Entire population	0.175	90	75	60
Systems to track gender equality (SDG 5.c.1)	Entire population	0.175	0.9	0.75	0.6
Consensual Same Sex Sexual Acts between Adults Legal	Entire population	0.175	1	0.9	0.8

Global Commitment 6

Using national budget processes, including gender budgeting and auditing, increasing domestic financing and exploring new, participatory and innovative financing instruments and structures to ensure full, effective and accelerated implementation of the ICPD Programme of Action

Potential indicators to track this commitment were discussed. But the commitment could not be considered in this current framework because data are not systematically tracked and are therefore not globally comparable.

Global Commitment 7

Increasing international financing for the full, effective and accelerated implementation of the ICPD Programme of Action, to complement and catalyze domestic financing, in particular of sexual and reproductive health programmes, and other supportive measures and interventions that promote gender equality and girls' and women's empowerment

Potential indicators to track this commitment were discussed. But the commitment could not be considered in this current framework because data are not systematically tracked and are therefore not globally comparable.

Global Commitment 8

Investing in the education, employment opportunities, health, including family planning and sexual and reproductive health services, of adolescents and youth, esp girls, so as to fully harness the promises of the demographic dividend

Tables 10 and 11 present the indicators, weights and cut-off thresholds for commitment 8. Indicators with an asterisk use a reverse scale for the cut-off thresholds.

Table 10. Global Commitment 8 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Total net enrolment rate, secondary school	Total number of students of secondary school age who are enrolled in secondary education, expressed as a percentage of the corresponding population in that age group	World Bank
Young people not in education, employment or training (SDG 8.6.1)	This indicator presents the share of young people who are not in employment, education or training (NEET) as a percentage of the total number of young people in the corresponding age group, by gender	SDG Global Database
Women married before age 18 (SDG 5.3.1)	Proportion of women aged 20-24 years who were married or in a union before age 18	SDG Global Database

Table 11. Global Commitment 8 indicator weights, scales, and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Total net enrolment rate, secondary school	Men and women 12-17 years	0.33	90	80	70
Young people not in education, employment or training (SDG 8.6.1)*	Men and women 15-24 years	0.33	10	12.5	15
Women married before age 18 (SDG 5.3.1)*	Women aged 20-24 years	0.33	0	10	20

Global Commitment 9

Building peaceful, just and inclusive societies, where no one is left behind, where all, irrespective of race, colour, religion, sex, age, disability, language, ethnic origin, sexual orientation and gender identity or expression, feel valued and are able to shape their own destiny and contribute to the prosperity of their societies

Tables 12 and 13 present the indicators, weights and cut-off thresholds for commitment 9.

Table 12. Global Commitment 9 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Representation in public institutions (ratio for female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Proportions of positions in national and local institutions, including (a) the legislature, (b) the public services, and (c) the judiciary, compared to national distributions (Ratio of the proportion of women in parliament in the proportion of women in the national population with the age of eligibility as a lower bound boundary)	SDG Global Database
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Proportions of positions in national and local institutions, including (a) the legislature, (b) the public services, and (c) the judiciary, compared to national distributions (Ratio of the proportion of young members in parliament in the proportion of the national population with the age of eligibility as a lower bound boundary)	SDG Global Database
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 3, employment and economic benefits)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (Area 3: employment and economic benefits)	SDG Global Database
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 1, overarching legal frameworks and public life)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (Area 1: overarching legal frameworks and public life)	SDG Global Database
National human rights institutions – A: Status (SDG 16.A.1)	Existence of independent national human rights institutions in compliance with the Paris Principles (A: Status)	SDG Global Database

INDICATOR	DEFINITION	SOURCE
Protection against hate crimes	The *State-Sponsored Homophobia: Global Legislation Overview Update 2020* report states that hate crime protection is composed of "different legal vehicles to address the violence motivated by a victim's sexual orientation". For the framework, countries are defined as: 1 = "yes protection exists", 0 = "no protection exists" or 0.25 (for a limited number of countries) = "protection is not available nationwide or does not meet the threshold for the category".	International Lesbian, Gay, Bisexual, Trans and Intersex Association
Protection against Incitement	The *State-Sponsored Homophobia: Global Legislation Overview Update 2020* report states that protection against incitement entails laws that "recognize the paramount importance of securing the safety and protection of marginalized communities". For the framework, countries are defined as: 1 = "yes protection exists", 0 = "no protection exists" or 0.25 (for a limited number of countries) = "protection is not available nationwide or does not meet the threshold for the category".	International Lesbian, Gay, Bisexual, Trans and Intersex Association

Table 13. Global Commitment 9 indicator weights, scales, and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Representation in public institutions (ratio for female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Women aged 18 years and older	0.125	0.9	0.75	0.6
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Men and women aged 18-44 years	0.125	0.9	0.75	0.6
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 3, employment and economic benefits)	Entire population	0.125	90	75	60
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 1, overarching legal frameworks and public life)	Entire population	0.125	90	75	60
National human rights institutions – A: Status (SDG 16.A.1)	Entire population	0.25	0.9	0.75	0.6
Protection against Hate Crimes	Entire population	0.125	0.9	0.75	0.6
Protection against Incitement	Entire population	0.125	0.9	0.75	0.6

Global Commitment 10

Providing quality, timely and disaggregated data, that ensures privacy of citizens and is also inclusive of younger adolescents, investing in digital health innovations, including in big data systems, and improvement of data systems to inform policies aimed at achieving sustainable development

Tables 14 and 15 present the indicators, weights and cut-off thresholds for commitment 10.

Table 14. Global Commitment 10 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Open Data Watch Inventory – overall score	The inventory assesses the coverage and openness of official statistics to monitor the progress of open data relevant to the economic, social and environmental development of a country. The overall score is an indicator of how complete and open a national statistical office's data offerings are. It comprises a coverage subscore (how complete the country's data offerings are) and an openness subscore (how well the data meet standards recommended by the Open Definition and Open Data Charter).	Open Data Watch ODIN
Completeness of birth registration (SDG 17.19.2)	Proportion of countries that have achieved 100% birth registration	State of the World's Children - UNICEF
Completeness of census (SDG 17.19.2)	Proportion of countries that have conducted at least one population and housing census in the last 10 years	SDG Global Database
Completeness of death registration (SDG 17.19.2)	Proportion of countries that have achieved 80% death registration	The United Nations Statistics Division's Population and Vital Statistics Report and the United Nations Population Division's World Population Prospects.
Common Operational Dataset – population statistics	Common Operational Datasets (CODs) are authoritative reference datasets needed to support operations and decision-making for all actors in a humanitarian response. "Up-to-date" COD-PS are those whose reference year is within three years of the current year.	OCHA Common Operational Datasets

Table 15. Global Commitment 10 indicator weights, scales, and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Open Data Watch Inventory – overall score	Entire population	0.2	90	75	60
Completeness of birth registration (SDG 17.19.2)	Births	0.2	0.9	0.75	0.6
Completeness of census (SDG 17.19.2)	Entire population	0.2	0.9	0.75	0.6
Completeness of death registration (SDG 17.19.2)	Deaths	0.2	0.9	0.75	0.6
Common Operational Dataset – population statistics	Entire population	0.2	0.9	0.75	0.6

Global Commitment 11

Committing to the notion that nothing about young people's health and well-being can be discussed and decided upon without their meaningful involvement and participation ("nothing about us, without us")

The Youth Empowerment Index being developed by UNFPA was used to track global commitment 11. The index was constructed using six domains, each with three subdomains (resource, agency and achievement) with several indicators. The domains of "gender and autonomy" and "sexual and reproductive health empowerment" were not included due to an overlap with indicators used for other commitments. Tables 16 and 17 present the domains, weights and cut-off thresholds for commitment 11.

Table 16. Global Commitment 11 domains and definitions

INDICATOR	DEFINITION	SOURCE
Economic empowerment	This domain encompasses the sub-domains of resource, agency and achievement and relate to the "My Life" component of the UNFPA global strategy for adolescents and youth	Youth Empowerment Index
Education	This domain encompasses the sub-domains of resource, agency and achievement and relate to the "My Life" component of the UNFPA global strategy for adolescents and youth	Youth Empowerment Index
Youth policy and political participation	This domain encompasses the sub-domains of resource, agency and achievement and relate to the "My World" component of the UNFPA global strategy for adolescents and youth	Youth Empowerment Index
Safety and security	This domain encompasses the sub-domains of resource, agency and achievement and relate to the "My World" component of the UNFPA global strategy for adolescents and youth	Youth Empowerment Index

Table 17. Global Commitment 11 indicator weights, scales and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Economic empowerment	Men and women 15-24 years	0.25	0.7	0.6	0.5
Education	Men and women 15-24 years	0.25	0.7	0.6	0.5
Youth policy and political participation	Men and women 15-24 years	0.25	0.7	0.6	0.5
Safety and security	Men and women 15-24 years	0.25	0.7	0.6	0.5

Global Commitment 12

Ensuring that the basic humanitarian needs and rights of affected populations, especially girls and women, are addressed as critical components of responses to humanitarian and environmental crises, as well as fragile and post-crisis reconstruction contexts, through the provision of access to comprehensive sexual and reproductive health information, education and services, including access to safe abortion services to the full extent of the law, and post-abortion care, to significantly reduce maternal mortality and morbidity, sexual and gender-based violence and unplanned pregnancies under these conditions

One indicator was identified to track Global Commitment 12; Tables 18 and 19 present its definition, weight and cut-off thresholds. The indicator reflects only countries within the regional categories that needed humanitarian support in 2020.

Table 18. Global Commitment 12 indicator and definition

INDICATOR	DEFINITION	SOURCE
Humanitarian "ask" versus "give"	Funding coverage for each country; proportion of funds "received" compared with "requested" for humanitarian action to address the specific needs – in particular, sexual and reproductive health and rights, and the prevention of and response to gender-based violence – of women, girls and young people	UNFPA

Table 19. Global Commitment 12 indicator weights, scales and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT 1	CUT 2	CUT 3
Humanitarian "ask" versus "give"	Entire population	1	0.9	0.75	0.6

Table 20 presents scaled cut-off thresholds for each global commitment. The scaled thresholds were used to generate the traffic light colours for each indicator.

Table 20. Scaled cut-off thresholds by global commitment

	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Commitment 1	0.900	0.753	0.607
Commitment 2	0.930	0.725	0.520
Commitment 3	0.898	0.816	0.733
Commitment 4	0.945	0.839	0.733
Commitment 5	0.965	0.724	0.483

	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Commitment 8	0.911	0.822	0.733
Commitment 9	0.900	0.750	0.600
Commitment 10	0.900	0.750	0.600
Commitment 11	0.700	0.600	0.500
Commitment 12	0.900	0.750	0.600

Table 21. Scaled threshold cut-offs for indicators included in the commitments

	SCALED CUT-OFF 1	SCALED CUT-OFF 2	SCALED CUT-OFF 3
Commitment 2			
Adolescent birth rate	0.875	0.8125	0.75
Sexual and reproductive health care laws and regulations (SDG 5.6.2 - contraceptive and family planning)	0.9	0.75	0.6
Unmet need for mordern contraception, all women	1	0.625	0.25
Commitment 3			
Universal Health Coverage Index	0.8	0.7	0.6
Sexual and reproductive health-care laws and regulations (SDG 5.6.2, Section 1, maternity care)	0.9	0.75	0.6
Skilled birth attendance (SDG 3.1.2)	0.98	0.94	0.9
Maternal mortality rate (SDG 3.1.1)	0.93913	0.908696	0.878261
World Abortion Laws	0.75	0.5	0.25
Commitment 4			
Women aged 20–24 who gave birth before age 15	1	0.875	0.75
Women aged 20–24 who gave birth before age 18	1	0.958333	0.916667
Family planning demand satisfied by modern contraception, aged 15–24	0.9	0.75	0.6
New HIV infections (SDG 3.3.1)	0.98	0.94	0.9
Sexual and reproductive health care laws and regulations (5.6.2, Section 3, sexuality education)	0.9	0.75	0.6
Commitment 5			
Intimate partner violence (SDG 5.2.1)	1	0.625	0.25
Women aged 20–24 years who married before age 15 (SDG 5.3.1)	1	0.666667	0.333333
Legal framework (SDG 5.1.1, Area 2, violence against women)	0.9	0.75	0.6
Countries tracking gender equality (SDG 5.c.1)	0.9	0.75	0.6
Same sex sexual acts legal	1	0.9	0.8

	SCALED CUT-OFF 1	SCALED CUT-OFF 2	SCALED CUT-OFF 3
Commitment 8			
Secondary-school net attendance ratio	0.9	0.8	0.7
Youth not in education, employment or training	0.833333	0.791667	0.75
Women aged 20–24 years who married before age 18 (SDG 5.3.1)	1	0.875	0.75
Commitment 9			
Female Members of Parliament (SDG 16.7.1)	0.9	0.75	0.6
Young Members of Parliament (SDG 16.7.1)	0.9	0.75	0.6
Employment and economic benefits (SDG 5.1.1, Area 3, employment and economic benefits)	0.9	0.75	0.6
Overarching legal frameworks and public life (SDG 5.1.1 Area 1, overarching legal frameworks and public life)	0.9	0.75	0.6
Independent human rights institutions (SDG 16.A.1, A: status)	0.9	0.75	0.6
Protection against hate crimes	0.9	0.75	0.6
Protection against incitement	0.9	0.75	0.6
Commitment 10			
Open Data Watch Index	0.9	0.75	0.6
Birth registration (SDG 17.19.2)	0.9	0.75	0.6
Census (SDG 17.19.2)	0.9	0.75	0.6
Death registration (SDG 17.19.2)	0.9	0.75	0.6
Common operational data set	0.9	0.75	0.6
Commitment 11			
Economic empowerment	0.7	0.6	0.5
Education	0.7	0.6	0.5
Youth policy and political participation	0.7	0.6	0.5
Safety and security	0.7	0.6	0.5
Commitment 12			
Humanitarian “ask” vs “give”	0.9	0.75	0.6

Global Commitments Monitoring Framework results

Table 22 presents the numbers of countries included in each region. Results by commitment are shown in the tables below.Each table displays, for each indicator, the index values, traffic light colours, number of countries and percentage of the population represented by available data.

Table 22. Regional groupings used in the framework

REGION	NUMBER OF COUNTRIES INCLUDED IN THE REGION
Central and Southern Asia	13
Eastern and South-Eastern Asia	14
Europe and Northern America	26
Latin America and the Caribbean	26
Northern Africa and Western Asia	17
Oceania	10
Sub-Saharan Africa	48

Table 23. Global Commitment 1 results by region, 2022

REGION	COMPOSITE INDEX VALUE
Central and Southern Asia	0.629
Eastern and South-eastern Asia	0.744
Europe and Northern America	0.821
Latin America and the Caribbean	0.690
Northern Africa and Western Asia	0.662
Oceania	no data
Sub-Saharan Africa	0.527

Table 24. Global Commitment 2 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Adolescent birth rate	Index value	0.862	0.899	0.944	0.739	0.803	0.938	0.503
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Nr of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - contraceptive and family planning)	Index value	0.783	0.886	0.872	0.786	0.890	0.610	0.711
	# countries	12	11	18	21	12	3	41
	% population	92.31%	78.57%	69.23%	80.77%	70.59%	30.00%	85.42%
Unmet need for modern methods, total (all women)	Index value	0.654	0.783	0.699	0.728	0.597	0.745	0.518
	# countries	13	14	24	26	17	9	47
	% population	100.0%	100.0%	99.9%	100.0%	100.0%	99.6%	100.0%

Table 25. Global Commitment 3 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Universal Health Coverage Index (SDG 3.8.1)	Index value	0.582	0.761	0.829	0.740	0.660	0.843	0.448
	# countries	13	14	26	25	16	9	48
	% population	100.0%	100.0%	100.0%	99.99%	98.94%	99.95%	100.0%
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - maternity care)	Index value	0.768	0.688	0.895	0.710	0.727	0.575	0.713
	# countries	11	10	15	17	9	2	30
	% population	84.62%	71.43%	57.69%	65.38%	52.94%	20.00%	62.50%
Proportion of births attended by skilled health personnel (SDG 3.1.2)	Index value	0.824	0.950	0.987	0.958	0.873	0.975	0.630
	# countries	13	14	22	26	16	10	48
	% population	100%	100%	87%	100%	98.35%	100%	100%
Maternal mortality ratio (SDG 3.1.1)	Index value	0.868	0.947	0.990	0.941	0.933	0.990	0.552
	# countries	13	14	26	25	17	9	48
	% population	100%	100%	100%	99.99%	100%	99.95%	100%
World Abortion Laws	Index value	0.712	0.607	0.923	0.413	0.500	0.500	0.464
	# countries	13	14	26	26	17	9	48
	% population	100%	100%	100%	100%	100%	90%	100%

Table 26. Global Commitment 4 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Percentage of young women age 20–24 who gave birth by age 15	Index value	0.939	0.982	0.999	0.904	0.965	no data	0.762
	# countries	12	7	3	13	8		40
	% population	99.96%	35.24%	4.60%	81.90%	61.21%	0.00%	97.10%
Percentage of young women age 20–24 who gave birth by age 18	Index value	0.823	0.879	0.946	0.706	0.874	no data	0.550
	# countries	12	7	3	13	8		40
	% population	99.96%	35.24%	4.60%	81.90%	61.21%		97.10%
Demand for family planning satisfied by modern methods (all women aged 15–24)	Index value	0.526	0.715	0.662	0.671	0.497	no data	0.464
	# countries	8	5	3	10	5		39
	% population	74.1%	27.7%	4.7%	57.0%	33.1%		96.8%

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Number of new HIV infections per 1,000 uninfected population (aged 15–24) (SDG 3.3.1)	Index value	0.993	0.968	0.992	0.974	0.996	0.998	0.872
	# countries	10	10	16	22	11	3	47
	% population	29.97%	37.25%	29.36%	67.20%	67.87%	92.95%	99.99%
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - sexuality education)	Index value	0.553	0.897	0.882	0.725	0.344	0.833	0.555
	# countries	12	9	17	20	10	3	41
	% population	92.31%	64.29%	65.38%	76.92%	58.82%	30.00%	85.42%

Note: This indicator uses the latest HIV incidence estimates from UNAIDS (2022). However for 10 countries (Egypt, Liberia, Mozambique, Nepal, Pakistan, Armenia, Trinidad and Tobago, Somalia, Syrian Arab Republic, and Venezuela) since there are no updated HIV incidence rates in the 2022 report, the 2019 HIV incidences have been used for these countries.

Table 27. Global Commitment 5 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Violence against women from an intimate partner (SDG 5.2.1)	Index value	0.538	0.805	0.871	0.794	0.674	0.879	0.495
	# countries	11	12	25	23	11	10	39
	% population	97.97%	97.16%	91.37%	99.88%	68.63%	100.00%	94.32%
Proportion of women aged 20–24 years who were married or in a union before age 15 (SDG 5.3.1 - under age 15)	Index value	0.770	0.934	0.991	0.844	0.870	0.921	0.641
	# countries	13	10	7	21	15	6	45
	% population	100%	37.24%	7.79%	93.26%	97.91%	9.26%	99.69%
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non- discrimination on the basis of sex (SDG 5.1.1 - violence against women)	Index value	0.833	0.736	0.830	0.852	0.595	0.917	0.656
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%
Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment (SDG 5.c.1)	Index value	0.750	0.889	1.000	0.923	0.889	1.000	0.821
	# countries	8	9	15	13	9	5	28
	% population	61.5%	64.3%	57.7%	50.0%	52.9%	50.0%	58.3%
Consensual same sex sexual acts between adults legal	Index value	0.385	0.857	1.000	0.846	0.412	0.500	0.458
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%

Table 28. Global Commitment 8 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Secondary school net attendance ratio	Index value	0.596	0.744	0.930	0.800	0.681	0.918	0.338
	# countries	11	8	25	24	13	6	35
	% population	99.69%	32.76%	99.78%	97.48%	78.28%	95.17%	58.52%
Proportion of youth (aged 15–24 years) not in education, employment or training (SDG 8.6.1)	Index value	0.517	0.702	0.801	0.610	0.470	0.816	0.597
	# countries	10	11	26	21	13	10	41
	% population	98.26%	41.26%	100.00%	98.57%	84.61%	100.00%	94.93%
Proportion of women aged 20–24 years who were married or in a union before age 18 (SDG 5.3.1 - under age 18)	Index value	0.653	0.805	0.961	0.713	0.766	0.836	0.557
	# countries	13	10	11	21	15	6	45
	% population	100.00%	37.24%	17.47%	93.26%	97.91%	9.26%	99.69%

Table 29. Global Commitment 9 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Representation in public institutions (ratio of female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Index value	0.344	0.463	0.625	0.579	0.391	0.645	0.480
	# countries	13	14	26	24	14	9	47
	% population	100.0%	100.0%	100.0%	98.4%	87.2%	100.0%	99.7%
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Index value	0.374	0.309	0.696	0.745	0.474	0.562	0.498
	# countries	13	11	25	18	12	6	32
	% population	100.00%	93.25%	95.44%	94.22%	67.49%	98.04%	80.56%
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1. - employment and economic benefits)	Index value	0.417	0.683	0.905	0.778	0.600	0.900	0.663
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - overarching legal frameworks and public life)	Index value	0.683	0.606	0.814	0.726	0.570	0.700	0.655
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%
Existence of independent national human rights institutions in compliance with the Paris Principles (SDG 16.A.1 - A status)	Index value	0.308	0.500	0.731	0.615	0.529	0.400	0.521
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Protection against Hate Crimes (ILGA)	Index value	0.000	0.143	0.548	0.462	0.059	0.225	0.083
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Protection against Incitement (ILGA)	Index value	0.000	0.000	0.731	0.346	0.015	0.150	0.047
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%

Note: Global Commitment 10 has been rerun for 2021 due to an error identified specifically with the "Common operational dataset" indicator. The Common Operational Dataset is maintained by the United Nations Office for the Coordination of Humanitarian Affairs for 160 countries, and during the course of generating the GCMF for 2022 it was discovered that the 2021 data did not use these 160 countries as the denominator for this indicator. This has been fixed in the 2022 GCMF, and results for Global Commitment 10 have been rerun for 2021 to allow for comparability.

Table 30. Global Commitment 10: results by region, 2021 rerun

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Open Data Watch Index - overall score (coverage and openness of official statistics)	Index value	0.439	0.538	0.691	0.457	0.510	0.461	0.395
	# countries	13	13	26	23	16	7	45
	% population	100%	92.9%	100%	88.5%	94.1%	70.0%	93.8%
Completeness of birth registration (SDG 17.19.2)	Index value	0.556	0.625	1.000	0.600	0.813	0.571	0.222
	# countries	9	8	26	25	16	7	27
	% population	69.23%	57.14%	100.00%	96.15%	94.12%	70.00%	56.25%

Completeness of census (SDG 17.19.2)	Index value	0.692	1.000	0.923	0.885	0.588	1.000	0.688
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Completeness of death registration (SDG 17.19.2)	Index value	0.889	0.750	1.000	0.760	0.625	0.571	0.273
	# countries	9	8	26	25	16	7	23
	% population	69.2%	57.1%	100%	96.2%	94.1%	70.0%	47.9%
Common operational data set	Index value	0.273	0.538	0.167	0.731	0.267	0.167	0.625
	# countries	11	13	6	26	15	6	48
	% population	84.62%	92.86%	23.08%	100%	88%	60%	100%
Commitment score		0.570	0.690	0.756	0.686	0.560	0.554	0.440

Table 31. Global Commitment 10 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Open Data Watch Index - overall score (coverage and openness of official statistics)	Index value	0.439	0.538	0.691	0.457	0.510	0.461	0.395
	# countries	13	13	26	23	16	7	45
	% population	100%	92.9%	100%	88.5%	94.1%	70.0%	93.8%
Completeness of birth registration (SDG 17.19.2)	Index value	0.667	0.625	1.000	0.640	0.875	0.429	0.222
	# countries	9	8	26	25	16	7	27
	% population	69.23%	57.14%	100.00%	96.15%	94.12%	70.00%	56.25%
Completeness of census (SDG 17.19.2)	Index value	0.692	1.000	0.923	0.885	0.588	1.000	0.688
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Completeness of death registration (SDG 17.19.2)	Index value	0.889	0.750	1.000	0.800	0.688	0.714	0.261
	# countries	9	8	26	25	16	7	23
	% population	69.2%	57.1%	100%	96.2%	94.1%	70.0%	47.9%
Common operational data set	Index value	0.636	0.692	0.429	0.923	0.333	0.500	0.833
	# countries	11	13	7	26	15	6	48
	% population	84.62%	92.86%	26.92%	100%	88%	60%	100%

Table 32. Global Commitment 11 results by region

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Economic empowerment	Index value	0.622	0.666	0.706	0.640	0.568	0.708	0.629
Education	Index value	0.500	0.671	0.804	0.772	0.670	0.784	0.470
Youth policy and political participation	Index value	0.460	0.274	0.443	0.525	0.349	0.485	0.476
Safety and security	Index value	0.626	0.688	0.735	0.548	0.569	0.815	0.568

Table 33. Global Commitment 12 results by region, 2022

		CENTRAL AND SOUTHERN ASIA	EASTERN AND SOUTH-EASTERN ASIA	EUROPE AND NORTHERN AMERICA	LATIN AMERICA AND THE CARIBBEAN	NORTHERN AFRICA AND WESTERN ASIA	OCEANIA	SUB-SAHARAN AFRICA
Proportion of funds "received" compared with "requested" for humanitarian action to address the specific needs, in particular, sexual and reproductive health and rights and gender-based violence, of women, girls and young people	Index value	0.457	0.671	0.585	0.150	0.740	1.000	0.389
	# countries	6	7	1	7	9	1	30
	% population	46.2%	50.0%	3.9%	26.9%	52.9%	10.0%	62.5%

ANNEX D

HIGH-LEVEL COMMISSION MEMBERS

Co-Chairs

- H.E. Jakaya Mrisho Kikwete, Former President, United Republic of Tanzania
- H.E. Michaëlle Jean, Former Governor General and Commander in chief of Canada; former Secretary General of the International Organization of la Francophonie

Members

- H.R.H. Crown Princess Mary, Crown Princess of Denmark, Countess of Monpezat
- Hatim Aznague, Founder and President of The Sustainable Development's Youth, Morocco
- Alvaro Bermejo, Director General, International Planned Parenthood Federation (IPPF)
- Rudelmar Bueno de Faria, General Secretary (CEO), Action by Churches Together (ACT) Alliance
- Franka Cadée, President, International Confederation of Midwives (ICM)
- Alexandra Chichikova, Miss Wheelchair World 2017 and health advocate
- Martin Chungong, Secretary General, Inter-Parliamentary Union
- Myrna Cunningham, First Vice-President of the Fund for the Development of Indigenous Peoples of Latin America and the Caribbean (FILAC)
- Jaha Dukureh, CEO, Safe Hands for Girls
- Mary-Ann Etiebet, Lead & Executive Director, Merck for Mothers
- Senait Fisseha, Director, International Programs, Susan Thomas Buffett Foundation and Chief Adviser to the WHO Director-General
- Lorence Kabasele Birungi, President of AfriYAN for Eastern and Southern Africa
- Martin Karadzhov, Board member and Chair of the Youth Steering Committee of ILGA World (The International Lesbian, Gay, Bisexual, Trans and Intersex Association)
- Hon. Angélica Lozano Correa, Lawyer, civic activist and Senator of Colombia
- Sangeet Kayastha, Coordinator, Y-PEER Asia Pacific Center
- Hans Linde, President, Swedish Association for Sexuality Education (RFSU)
- Latanya Mapp Frett, President and CEO, Global Fund for Women
- Lucy Mulenkei, Executive Director, Indigenous Information Network
- Friday Okonofua, Professor of Obstetrics and Gynaecology, University of Benin, Nigeria
- Sara Pantuliano, Chief Executive, Overseas Development Institute (ODI)
- Bandana Rana, Vice-Chair, United Nations CEDAW Committee
- Jan-Willem Scheijgrond, Vice President – Global Government & Public Affairs, Royal Philips
- Gamal Serour, Professor of Obstetrics and Gynecology and Director of the International Islamic Center for Population Studies and Research, Al-Azhar University
- Keizo Takemi, Member, House of Councillors in the Japanese parliament and WHO Goodwill Ambassador
- Nahid Toubia, Director of the Institute for Reproductive Health & Rights in Sudan
- Jayathma Wickramanayake, United Nations Secretary-General's Envoy on Youth
- H.E. Lindiwe Zulu, Minister of Social Development, South Africa and Chairperson, Partners in Population and Development

ANNEX E

HIGH-LEVEL COMMISSION SECRETARIAT AND SUPPORT TEAMS

Secretariat

- Saskia Schellekens, Global Coordinator, ICPD25 Follow-up & Lead HLC Secretariat
- De-Jane Gibbons, Coordination Specialist, ICPD25 Follow-up
- Gabriela Ullauri, Communications and Outreach Consultant, ICPD25 Follow-up
- Lisha Du, Technical Consultant, ICPD25 Follow-up
- Ivy Jagganarine, Administrative and Finance Consultant, ICPD25 Follow-up

Sherpas and Support Teams

- Co-Chair H.E. Dr. Jakaya Mrisho Kikwete: Lucas Mayenga and Medard Ngaiza, Private Secretaries
- Co-Chair H.E. The Right Honorable Michaëlle Jean: Alice Mutezintare, Office Manager

ENDNOTES

1 Taylor, 2002.
2 OCHA, 2022.
3 OCHA, 2019.
4 OCHA, 2021.
5 Guttmacher Institute, 2022.
6 Human Rights Committee, General Comment No. 36, supra note 11, para. 8 outlines that States must provide access to abortion in cases where "carrying a pregnancy to term would cause the pregnant [person] substantial pain or suffering."
7 CDC, 2021
8 High-Level Commission on the Nairobi Summit on ICPD25 Follow-up, 2022.
9 Job, 2021.
10 Guttmacher Institute, 2021.
11 PRB, 2021.
12 Alizada, Boese, Lundstedt, et al., 2022; Bayerlein, Boese, Gates, et al., 2021.
13 WFP, 2022
14 UNHCR, 2022.
15 Ross, 2017.
16 Morison and Mavuso, 2022; Rebouche, 2017.
17 Ross and Solinger, 2017; Meeting of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-Up, 9 June 2022.
18 Ibid; Ross, 2017.
19 WHO, 2015.
20 Gilliam, Neustadt and Gordon, 2009; Macleod, Beynon-Jones and Toerien, 2017.
21 Ross, 2006.
22 Nedelsky, 2012.
23 Kim, Young and Lee, 2019.
24 Gago, 2022.
25 Raj, Day, Boyce, et al., 2017.
26 Vedam, Stoll, Taiwo, et al., 2019.
27 Manning and Schaaf, 2018.
28 Tulloch, 2015.
29 Human Rights Funders Network, 2022.
30 UNFPA East and Southern Africa Regional Office, 2022a.
31 OHCHR, 2022a.
32 Meeting of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-Up, 9 June.
33 Liddell and Kington, 2021; Human Rights Council, 2022.
34 Finlay and Lee, 2018.
35 World Bank, 2022; Sobngwi-Tambekou, Tsague-Agnoux, Fezeu, et al., 2022; Stoner, Rucinski, Edwards, et al., 2019.
36 Gammage, Joshi and Rodgers, 2020.
37 UN Women, 2022; IPU, n.d.(b).
38 African Commission on Human and Peoples' Rights, 2014.
39 African Commission on Human and Peoples' Rights, 2003.
40 African Commission on Human and Peoples' Rights, 2014, para. 44.
41 Bartholet, 2014.
42 Aboderin, 2014; Banke-Thomas, Olorunsaiye and Yaya, 2020.
43 WHO, 2022a
44 Aboderin, 2014.
45 WHO, 2022a.
46 United Nations Committee on the Rights of the Child, 2016.
47 UNFPA, 2020a.
48 PRB, n.d.; Patton, Sawyer, Santelli, et al., 2016.
49 OHCHR, n.d..
50 Inter-American Commission on Human Rights, 2017, para 39. See also: Comisión Interamericana de Derechos Humanos, 2017.
51 Committee on the Elimination of Discrimination against Women, 2016, para. 14.
52 PAHO, 2022.
53 Knight, Bunch, Tuffnell, et al., 2021.
54 WHO, UNICEF, UNFPA, et al., n.d..
55 Sub-Saharan Africa alone accounted for roughly two thirds (196,000) of maternal deaths, while Southern Asia accounted for nearly one fifth (58,000).
56 Human Rights Council, 2015.
57 Australian Institute of Health and Welfare, 2021.
58 Sharma, Kolahdooz, Launier, et al., 2016.
59 Views of the Committee on the Elimination of Discrimination against Women under Article 7, Paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women.
60 The Committee relied on Recommendation No. 28 (2010) in this regard.
61 Ibid.
62 Nariño and Santos, 2021.
63 Center for Reproductive Rights, 2007.
64 Its Política Nacional de Saúde Integral da População Negra (National Policy for Health and Healthcare for the Black Population) promotes policies that formally categorize race. See Nariño and Santos, 2021.
65 Center for Reproductive Rights, 2014.
66 OHCHR, UN Women, UNAIDS, et al., 2014.
67 Ibid, pp. 2-3.
68 BBC, 2021.
69 OHCHR, 2022c.
70 Chapin, 2020. See also OHCHR, UN Women, UNAIDS, et al., 2014.
71 Kluchin, 2011.
72 Southern Africa Litigation Centre, 2014a; Smith, "2014; Agiresaasi, 2016.
73 Government of the Republic of Namibia v LM and Others (SA 49 of 2012) [2014] NASC 19.
74 Southern Africa Litigation Centre, 2014b.
75 Commission for Gender Equality, 2020.
76 Ebrahim, 2020.
77 Kanmony, 2021.
78 Sexual Rights Initiative, National Council of Women Leaders, Dalit Human Rights Defenders Network, et al., 2022.
79 Patel, Das and Dasc, 2018.
80 International Dalit Solidarity Network, 2021.
81 Swabhiman Society and Equality Now, 2020.
82 Center for Reproductive Rights, 2021d.
83 See Human Rights Council, 2021b.
84 National Indigenous Disabled Women Association Nepal, 2021.
85 Visible Impact, 2019.
86 Mofokeng, 2021.
87 Kwete, Tang, Chen, et al., 2022.
88 UNFPA has done a considerable amount in this area that can be developed towards a justice perspective. See UNFPA's work on indigenous Issues at https://www.unfpa.org/sites/default/files/pub-pdf/Indigenous_Issues.pdf.
89 A foundation for intercultural health has also been set out in the United Nations Declaration on the Rights of Indigenous People, Article 24.
90 National Assembly Legislative and Oversight Committee, 2008, Article 32.
91 Mofokeng, 2021; Ross and Solinger, 2017.
92 Dodor, Grabowski and Leasure, 2021.
93 Mofokeng, 2021.
94 Human Rights Council, 2021a, paras. 69-72.

95 Human Rights Watch, 2008; Dickson, Loft, Robinson, et al., 2022.

96 Akinwotu, 2022.

97 Fòs Feminista, 2022.

98 Ngwena, 2010.

99 UNFPA, 2021b.

100 Marking the twenty-fifth anniversary of the 1995 Fourth World Conference on Women in Beijing.

101 IANWGE, 2019.

102 Nove, Friberg, de Bernis, et al., 2020.

103 These include the Fourth World Conference on Women in Beijing (1995), the 23rd Special Session of the UN General Assembly (2000), the Millennium Summit (2000), the Commission on the Status of Women (2006), the Addis Ababa Action Agenda (2015), the Sustainable Development Goals (2015) and United Nations country programme documents. Still, women continue to bear the burden of poverty and discrimination. Currently, over 95 per cent of United Nations Member States – 185 countries – are parties to the Convention on the Elimination of All Forms of Discrimination against Women (1979). In its General Recommendations, the Committee on the Elimination of Discrimination against Women urges political parties to provide financial resources to overcome obstacles to women's full participation and representation.

104 General Secretariat, 2007.

105 Moro-Coco and Raaber, 2013; Clark, Sprenger, Veneklasen, et al., 2006; Lu, Schneider, Gubbins, et al., 2010.

106 Hall, Samari, Garbers, et al., 2020.

107 Heidari, Onyango and Chynoweth, 2019.

108 UNFPA, 2015.

109 See the statement of the UNFPA Executive Director at the 2022 meeting of the Executive Board: https://www.unfpa.org/press/statement-executive-director-second-regular-session-executive-board-2022.

110 UNFPA, 2021a; Homer, Turkmani, Wilson, et al., 2022.

111 Heidari, Onyango and Chynoweth, 2019.

112 Abubakar, Aldridge, Devakumar, et al., 2018.

113 Li, Richter and Lu, 2019; Patel, Das and Dasc, 2018.

114 Prosecutor v. Dragoljub Kunarac, Radomir Kovac, and Zoran Vukovic. para 342, 583; Prosecutor v. Radoslav Brdanin. para 1011.

115 Prosecutor v. Jean-Paul Akayesu. para 428, 437; Human Rights Watch, 1996.

116 United Nations, 2022a, pp 20-21.

117 OHCHR, 2022b.

118 Bennetts, 2022.

119 More than 90 per cent of approximately 4.7 million Ukrainian refugees are women and children.

120 United Nations, 2022b.

121 To address the gaps people face in accessing sexual and reproductive health services in humanitarian crises, including in war situations, the Inter-Agency Working Group for Reproductive Health in Crisis developed the Minimum Initial Service Package for sexual and reproductive health in crisis situations. The package makes provisions for safe and clean access to newborn care and emergency obstetric care at the community, referral hospital and primary health facility levels, as well as a 24/7 referral system to enable transportation and communication between communities and health facilities. It includes access to family planning and emergency contraception, prevention of and response to sexual violence, and provision of clinical management of rape. The package prioritizes safe abortion care ("to the full extent of the law") and post-abortion care in health-care facilities. It addresses morbidity and mortality due to HIV and other sexually transmitted infections by promoting the use of standard safety precautions, the availability of contraception, the provision of antiretroviral therapy for people enrolled in such programmes prior to the onset of an emergency, and the availability of syndromic treatment for sexually transmitted infections. The International Federation for Human Rights has also pointed out that for certain groups of refugees, including Romani women, African women, and women of African descent, the risk of sexual and reproductive health and rights violations is exacerbated by racism and other forms of discrimination. See: https://www.fidh.org/en/region/europe-central-asia/ukraine/call-to-action-sexual-and-reproductive-health-rights

122 WHO, 2022c; Physicians for Human Rights, 2022.

123 OHCHR, 2022d.

124 Kismödi and Pitchforth, 2022.

125 People in Need, 2022; OHCHR, 2022d.

126 Women's Link Worldwide, 2019a.

127 Women's Link Worldwide, 2019b.

128 IPPF, 2020.

129 UNFPA, 2020b.

130 Ibid.

131 Carino, 2021.

132 Hernandez, 2022.

133 Center for Reproductive Rights, 2021c.

134 Council on Foreign Relations, 2022.

135 Center for Reproductive Rights, 2022.

136 UNFPA, WHO and ICM, 2021.

137 Regeringen Socialdepartementet, 2022.

138 The White House, 2021.

139 The White House, 2022.

140 WHO, 2022d.

141 Hall, 2022; Al Jazeera, 2021; McCool, 2021.

142 Measured as grant equivalents, official donors allocated $5.08 per woman of reproductive age in the developing world in 2018; in 2019, this fell to $3.70, the largest year-on-year decrease in the past 10 years. Source: United Nations Economic and Social Council, 2022.

143 WHO, 2020.

144 Ibid.

145 Ibid.

146 WHO, 2022e.

147 Countdown 2030 Europe, 2020.

148 Universal Access Project, n.d.(a), n.d.(b).

149 United Nations Secretary-General, 2022.

150 As part of its follow-up and review mechanisms, the 2030 Agenda for Sustainable Development encourages United Nations Member States to "conduct regular and inclusive reviews of progress at the national and sub-national levels, which are country-led and country-driven" (para 79). These national reviews are expected to serve as a basis for the regular reviews by the High-Level Political Forum, which meets under the auspices of the Economic and Social Council. As stipulated in the 2030 Agenda (para 84), regular reviews by the Forum are to be voluntary, State-led and undertaken by both developed and developing countries, and should involve multiple stakeholders.

151 UNFPA East and Southern Africa Regional Office, 2022b.

152 IPU, n.d.(a).

153 WHO, 2022b.

154 IPU, 2021.

155 IPU, 2022b

156 IPU, 2022a.

157 African Union Commission, n.d..

158 UNFPA's three zeros are: zero unmet need for family planning; zero maternal deaths; and zero violence and harmful practices against women and girls, including child marriage and female genital mutilation.

159 African Union Commission, n.d..

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