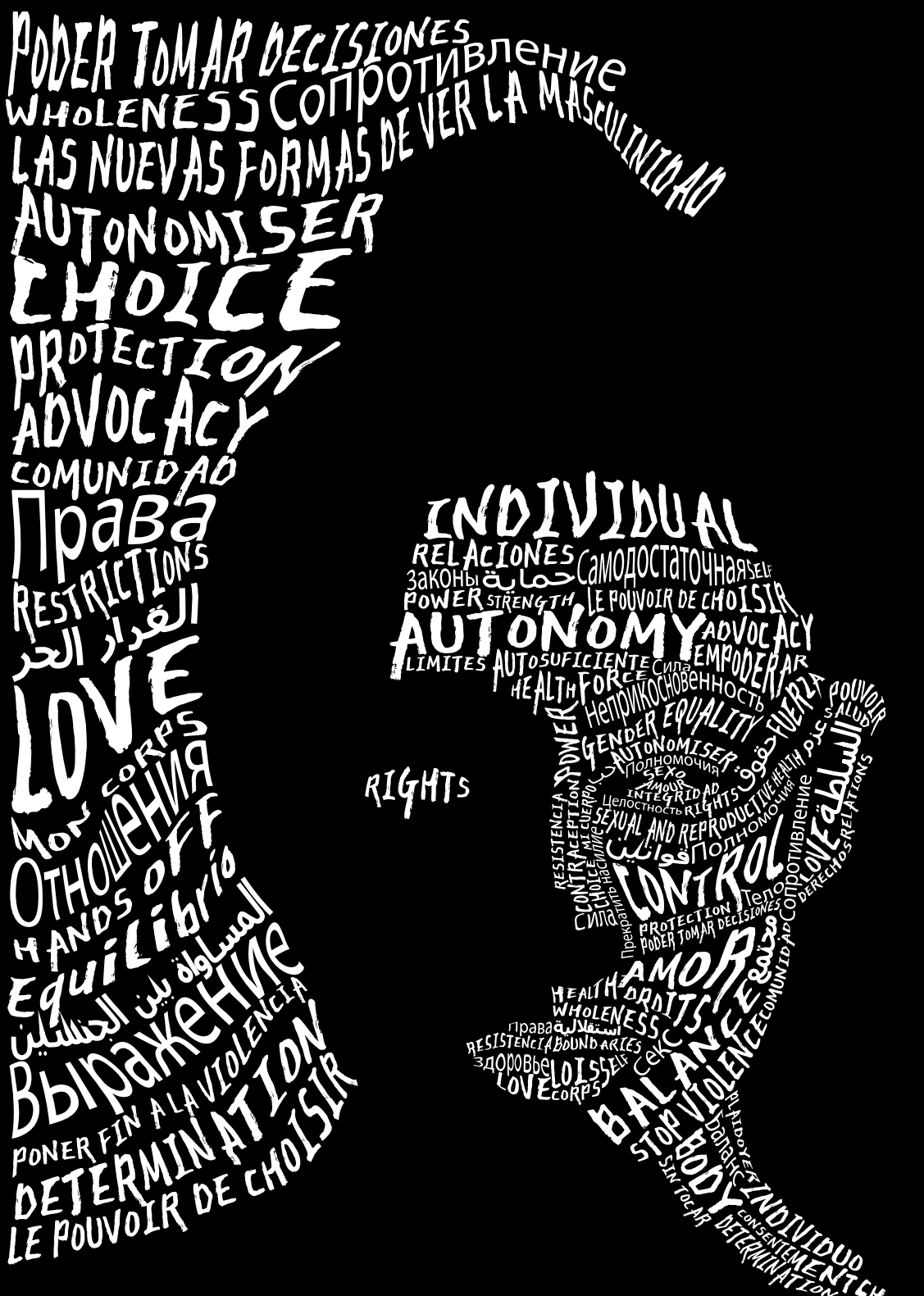
MY BODY IS MY OWN

CLAIMING THE RIGHT TO AUTONOMY AND SELF-DETERMINATION



UNFPA state of world population 2021

State of World Population 2021

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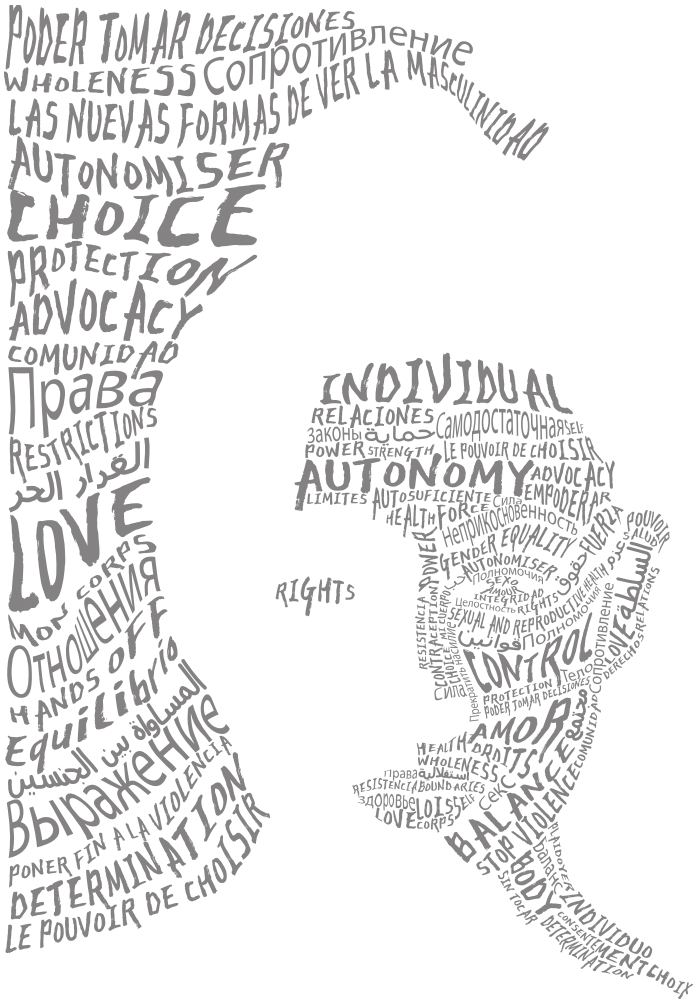
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Ensuring rights and choices for all since 1969



MY BODY IS MY OWN

CLAIMING THE RIGHT TO AUTONOMY AND SELF-DETERMINATION



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Artwork by Rebeka Artim

FOREWORD

My body is my own.

How many women and girls can freely make that claim?

Each of us has a right to bodily autonomy and should therefore have the power to make our own choices about our bodies, and to have those choices supported by everyone around us, and by our societies at large.

Yet, millions of people are denied their right to say no to sex. Or yes to the choice of a partner in marriage or to the right moment to have a child. Many are denied this right because of race, sex, sexual orientation, age or ability.

Their bodies do not belong to them.

Depriving women and girls of bodily autonomy is wrong. It causes and reinforces inequalities and violence, all of which arise from gender discrimination.

By contrast, when women and girls can make the most fundamental choices about their bodies, they not only gain in terms of autonomy, but also through advances in health and education, income and safety. These add up to a world of greater justice and human well-being, which benefits us all.

At UNFPA, we stand with women and girls in claiming their rights and choices, throughout their lives. Since 1994, our programmes have been guided by the International Conference on Population and Development Programme of Action, which made the empowerment and autonomy of women a basis for global action for sustainable economic and social progress. UNFPA also stands with countless others who are often excluded from making autonomous decisions about their bodies: people of diverse sexual orientations and gender identities, persons with disabilities, and ethnic and racial minorities.

The family planning programmes we support both increase the availability of contraceptives and dismantle barriers to services, thus empowering women to govern their own bodies. In 2019, for example, UNFPA procured more than 128 million cycles of the pill and doses of emergency and long-acting reversible contraception.

We support programmes that promote men's equitable involvement in parenting and encourage them to be better communicators with their spouses in matters of sexual and reproductive health, helping to clear the way for women to make decisions about their own sexual and reproductive health.

The UNFPA Maternal Health Thematic Fund is helping make life-saving services more accessible and affordable by training midwives and deploying them to underserved areas, and our joint programmes with UNICEF are helping

Artwork by Naomi Vona

end child marriage, a practice that denies girls' autonomy, and eliminating the harmful practice of female genital mutilation, a violation of bodily integrity.

In 2019, at the Nairobi Summit on ICPD25, nations, civil society, development institutions and others called for the protection of the right to bodily autonomy and integrity, building on international commitments in the 2030 Agenda for Sustainable Development. Further momentum has come in 2021 from the Generation Equality Forum, which is building on the singular achievements of the 1995 Fourth World Conference on Women to reach gender equality by 2030.

Through our leadership in the new Generation Equality Action Coalition on Bodily Autonomy and Sexual and Reproductive Health and Rights, and through this edition of the *State of World Population*, UNFPA is highlighting why bodily autonomy is a universal right that must be upheld. The report reveals how serious many of the shortfalls in bodily autonomy are; many have worsened under the pressures of the COVID-19 pandemic. Right now, for instance, record numbers of women and girls are at risk of gender-based violence and harmful practices such as early marriage.

The report also outlines solutions that are already at hand, while making the point that success requires much more than a disconnected series of projects or services, as important as these may be. Real, sustained progress largely depends on uprooting gender inequality and all forms of discrimination, and transforming the social and economic structures that maintain them.

In this, men must become allies. Many more must commit to stepping away from patterns of privilege and dominance that profoundly undercut bodily autonomy, and move towards ways of living that are more fair and harmonious, benefiting us all. And all of us must take action to challenge discrimination wherever and whenever we encounter it. Complacency equals complicity.

Our communities and countries can flourish only when every individual has the power to make decisions about their bodies and to chart their own futures.

Let us therefore claim the right for each individual to make decisions about their body and enjoy the freedom of informed choices. All of us want this. All of us should have it. It is at the core of our humanity, and we should never lose sight of just how much depends on it—for everyone.

Dr. Natalia Kanem
United Nations Under-Secretary-General and Executive Director of UNFPA, the United Nations sexual and reproductive health agency



Artwork by Rebeka Artim

OUR AUTONOMY OUR LIVES

A woman's power to control her own body is linked to how much control she has in other spheres of her life

We have the inherent right to choose what we do with our body, to ensure its protection and care, to pursue its expression. The quality of our lives depends on it. In fact, our lives themselves depend on it.

The right to the autonomy of our bodies means that we have the power and agency to make choices, without fear of violence or having someone else decide for us. It means being able to decide whether, when or with whom to have sex. It means making your own decisions about when or whether you want to become pregnant. It means the freedom to go to a doctor whenever you need one.

Saying no, saying yes, saying this is my choice for my body—this is the foundation of an empowered and dignified life. We can realize who we are, fully. We do not have to shrink to fit choices that are not ours, to be in any way "less than". Further, since claiming bodily autonomy is fundamental to the enjoyment of all other human rights, such as the right to health or the right to live free from violence, institutions in our societies are obligated to extend all the support and resources required for us to carry out our choices in a meaningful way (PWN, n.d.).

Intertwined with bodily autonomy is the right to bodily integrity, where people can live free from physical acts to which they do not consent. While many women and girls in the world today have the power to make autonomous decisions about their own bodies, many more still face constraints, some with devastating consequences to their health, well-being and potential in life.

My body, but not my choice

For many people, but especially women and girls, life is fraught with losses to bodily integrity and autonomy linked to a lack of agency in making their own decisions. These losses manifest when a lack of contraceptive choices leads to unplanned pregnancy. They result from terrible bargains where unwanted sex is exchanged for a home and food. They run through violations such as female genital mutilation and child marriage. They arise when people with diverse sexual orientations and gender identities cannot walk down a street without fearing assault or humiliation. They leave people with disabilities stripped of their rights to self-determination, to be free from violence and to enjoy a safe and satisfying sexual life.

WOMEN ENJOY JUST 75% OF THE LEGAL RIGHTS OF MEN

There are many dimensions to the forces that prevent women and adolescent girls from enjoying bodily autonomy and integrity. But a root cause is gender discrimination, which reflects and sustains patriarchal systems of power and spawns gender inequality and disempowerment.

Where there are gender-discriminatory social norms, women's and girls' bodies can be subject to choices made not by them, but by others, from intimate partners to legislatures. When control rests elsewhere, autonomy remains perpetually out of reach. While gender-discriminatory norms are by themselves harmful, they become even more so when they are compounded by other forms of discrimination, based on race, sexual orientation, age or disability, among other issues.

Discriminatory norms are perpetuated by the community and can be reinforced by political, economic, legal and social institutions, such as schools and the media, and even by health services, including those that provide sexual and reproductive health care. These services may, for example, undermine autonomy by being poor in quality and constrained in meeting all of the needs of women and adolescent girls.

Despite constitutional guarantees of gender equality in many countries, worldwide, on average, women enjoy just 75 per cent of the legal rights of men (United Nations Secretary-General, 2020). Women and girls in many instances lack the power to contest these disparities because of still low levels of participation in political and other forms of decision-making. Economic marginalization can detract from a woman's financial

independence, which in turn can weaken her authority to make autonomous decisions about sex, health care and contraception. The hardships brought on by the COVID-19 pandemic have only made matters worse.

For some women and girls, the impact of gender inequality is amplified by multiple sources of discrimination based on age, race, ethnicity, sexual orientation, disability or even geography. When diverse types of discrimination intersect, they leave women and girls even more at risk of not realizing bodily autonomy, not enjoying their rights, and even further away from gender equality.

No country in the world today can claim to have achieved gender equality in its totality. If it had, there would be no violence against women and girls, no pay gaps, no leadership gaps, no unfair burden of unpaid care work, no lack of quality and comprehensive reproductive health services, and no lack of bodily autonomy.

Voice, choice and agency

Sexual and reproductive health and rights have direct bearing on bodily autonomy and integrity for women and girls, with the body the locus of all sexual and reproductive functions and choices. These choices are subject to powerful, discriminatory subjugations of the rights of women and girls. It is here where their bodies are all too often bartered, bought and sold.

From a perspective of patriarchy, control of sexual and reproductive choices effectively becomes control in many other areas of life. A woman who cannot define whether, when or how many children to have, or choose to stay in school instead of marrying at a young age, or who accepts domestic violence as her fate, stands little chance of gaining empowerment in the workforce or community decision-making or anywhere else. She essentially loses rights not just in one part of her life, but in many or even every part.

Interests in sustaining patterns like these can be deeply entrenched in how societies and economies function. In some parts of the world,



Artwork by Rebeka Artim

for instance, bride price, where a man offers money, property or other assets to essentially "purchase" a wife, is a critically important economic mechanism for exchanging power and wealth (Shetty, 2007).

When women and adolescent girls have more choice in sexual and reproductive health care, multiple positive health outcomes result, including greater understanding of how to prevent HIV, and a greater likelihood of having the number of prenatal visits recommended by the World Health Organization as well as giving birth with the help of a doctor, nurse or midwife.

Failures to uphold bodily autonomy thus result first and foremost in profound losses for individual women and girls. But they also add up to broader deficits, potentially depressing economic productivity, undercutting valuable skills, and imposing extra costs for health-care and judicial services, including for responding to violence against women and girls (UN Women, 2013).

A mixture of low levels of bodily autonomy and the losses in human capacity associated with it can undermine social stability and resilience, leaving societies less equipped to confront and recover from crises and challenges, such as the COVID-19 pandemic.

In recent years, countries around the world have started prioritizing access to sexual and reproductive health care as an important means to advance gender equality (UN ECOSOC, 2019). Gains align with the 1994 Programme of Action of the landmark International Conference on Population and Development, the ICPD, the most comprehensive global endorsement of reproductive rights. The Programme of Action set forth a series of measures to achieve universal sexual and reproductive health and drew attention to women's and girls' limited power to make their own decisions not just about their bodies, but in all aspects of their lives.

Further, in 2015, most countries endorsed the 2030 Agenda for Sustainable Development, where gender equality is the fifth of 17 Sustainable Development Goals. The gender equality goal contains a series of targets, including one affirming the ICPD Programme of Action, by calling for universal access to sexual and reproductive health and reproductive rights. But the 2030 Agenda also takes a critical step further. For the first time in an international framework, it requires measuring progress towards universal access through two indicators: one that looks beyond the provision of services and focuses on whether girls and women can actually make their own decisions in terms of having sex, using contraception and seeking reproductive health care, and one that tracks laws and regulations that enable or impede full and equal access to care and information.

Information so far from 57 countries shows that only about half of adolescent girls and women can make their own decisions that underpin bodily autonomy and integrity as measured by these two indicators. The share drops as low as about one in 10 in some countries. Strikingly, once the choices are broken down, more women can make decisions around contraceptive use, which could be seen as offering benefits to men, but

fewer can say no to sex, where male privilege works in the opposite direction.

These indicators, which are the focus of this report, capture only a few dimensions of autonomous decision-making in sexual and reproductive health and only for women and girls aged 15 to 49 years who are married or partnered. The issue of bodily autonomy, however, also relates to a range of other issues, including abortion, age of consent, surrogacy, sex work and more, and is a concern for other groups too, such as women and girls who are not married, LGBTI communities, persons with disabilities and any other community marginalized or discriminated against because of race, ethnicity, wealth, disability or place of residence.

Because bodily autonomy and integrity influence so many aspects of health as well as a decent, dignified life, progress in realizing them will lead not just to achieving sexual and reproductive health and the fifth Sustainable Development Goal on gender equality, but many of the other Sustainable Development Goals too, including those related to promoting health, reducing inequalities and ending poverty. For example, if the discriminatory gender gap in lifetime earned income were closed, it would generate an astounding $172 trillion in human capital wealth and help lift millions of people out of poverty (United Nations Secretary-General, 2020).

Rapid progress must be made now, however, given there is just one "Decade of Action" before the 2030 endpoint of the global goals, when all women and girls should have full power to make choices in their lives.

New alliances stand behind bodily autonomy

In 2019, the Nairobi Summit marked the twenty-fifth anniversary of the ICPD. It was a moment to reflect on how much more needs to be done to realize women's bodily autonomy and integrity. While the use of modern contraception has more than doubled since 1994, 217 million women worldwide still have unmet contraceptive needs, for instance. Rates of female genital mutilation have declined among girls in countries where the practice is common. The share of girls who are child brides has dropped (Pantuliano, 2020). Yet as many as 4 million girls were still subjected to female genital mutilation and an estimated 12 million were still married as children in 2020, and that number is likely undercounted.

At the Nairobi Summit, governments and others committed to accelerating action in closing gaps, striving for three zeros by 2030: zero maternal mortality, zero unmet need for contraception and zero sexual and gender-based violence and harmful practices. Implicit in all three is the full realization of bodily autonomy for all women and girls.

In 2020, another milestone was the twenty-fifth anniversary of the 1995 United Nations Fourth World Conference on Women. The conference agreed on the Beijing Declaration and Platform for Action, which refers to the empowerment and autonomy of women as essential to sustainable development. For the anniversary, a United Nations "Generation Equality" campaign has brought together young and seasoned advocates to celebrate

Your body: an owner's manual

Few parents or community leaders object when a student brings home a chemistry or calculus textbook. Yet lessons in comprehensive sexuality education—accurate, age-appropriate information about one's own body, sexual and reproductive health, and human rights—are widely considered taboo. Many schools do not teach the subject, or provide only incomplete information. This leaves students both ill-prepared for the changes their bodies are undergoing and ill-equipped to protect themselves from harm.

"We are in a constant struggle to include this topic in the school curriculum," said Olga Lourenço, a coordinator for Project CAJ, a UNFPA-supported programme providing life skills and comprehensive sexuality education to youth in Angola. "Almost nothing is said about comprehensive sexual and reproductive health because of our taboos and prejudices."

Opponents of comprehensive sexuality education often contend that it promotes sexual activity, yet studies show that this is incorrect. Rather, evidence indicates that this education, when provided to international standards, improves young people's knowledge and constitutes a crucial and cost-effective strategy for preventing unintended pregnancy and sexually transmitted infections, including HIV. Some studies show it may actually help delay adolescents' sexual debut (UNESCO, 2016).

Lourenço explained that, because she lacked accurate information at a young age, she actually felt pressured to engage in sexual relationships before she was ready, at age 15. "My friends already had their boyfriends. They already had sexually active lives. They made fun of me for being the 'virgin of the group'," she said. "In a way, this psychologically affected me... I think that, in a way, it violated my bodily autonomy."

Dipika Paul, a longtime sexual and reproductive health researcher and an adviser at Ipas in Dhaka, Bangladesh, has seen the consequences of poor access to sexuality education in her own community. "When I was a student, I was in class seven, and there was just one chapter—on menstruation," she recalled. "The teacher

"They need to know how their bodies work."



Olga Lourenço is used to facing resistance when providing comprehensive sexuality education, but she is undeterred. Original artwork by Naomi Vona; photo © UNFPA/C. Cesar.

also did not feel comfortable teaching that section to us."

Without comprehensive sexuality education, young people are vulnerable to myths and misinformation. Boys and men, in particular, "have knowledge gaps, they have misconceptions," Paul said, explaining that she has seen men forbid their wives from using contraception because of the belief that "an IUD travels anywhere around in the body… they think they can feel pain from an IUD. This is not true."

Students who receive comprehensive sexuality education are not only empowered to make healthier sexual choices, but they are also better equipped to seek help when needed. "The information I share can significantly change a person's life," said Lourenço.

She recalled one girl who, while receiving sexuality education through a mentorship programme, revealed she had a chronic wound on her breast—something she regarded as an embarrassment but not an emergency. Another young woman disclosed that she was living with an uncle who had sexually abused her. "The girl locked herself up and couldn't speak with anyone for fear of being expelled from the home and ending up on the street," Lourenço described. Mentors were able to secure services for both girls, but Lourenço is haunted by what might have been: "If we did not intervene, what would become of these girls?"

Comprehensive sexuality education can also play a role in preventing gender-based violence. When taught to international standards, the lessons include messages about human rights, gender equality and respectful relationships (UNESCO and others, 2018). And experts are increasingly calling for this information to frame violence prevention as the responsibility of potential perpetrators, rather than the responsibility of victims and survivors (Schneider and Hirsch, 2020).

"They need to know what their rights and duties are in a society first," Lourenço said, explaining that this is the foundation of comprehensive sexuality education as she teaches it. "Then they need to know how their bodies work so that they can make decisions for themselves and not let others make decisions for them."



achievements to date and to demand that the next generation be the one where promises to realize gender equality are finally kept. Six action coalitions have formed, including one co-led by UNFPA on bodily autonomy and sexual and reproductive health, which is taking up issues such as how health-care and other services can more closely support the choices that women themselves say they want.

Ramped-up activism offers inspiration, but it is unfolding against a worrying backdrop, with the COVID-19 pandemic convulsing the world, and current economic growth models leading to extreme and destabilizing inequalities. Pushback against gender equality has grown, leading to new restrictions on sexual and reproductive health and rights and thus threatening progress towards bodily

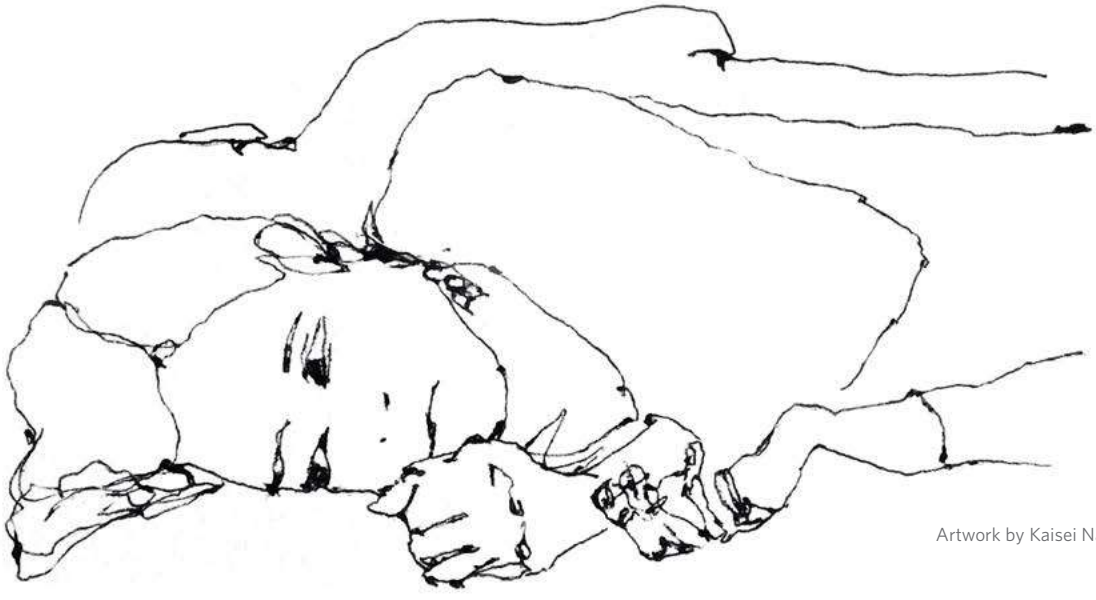
autonomy for women and girls worldwide. For example, there have been attempts to remove comprehensive sexuality education from school curricula (UN ECOSOC, 2019). And there is mounting evidence that critical sexual and reproductive health services have been deemed "less essential" and have suffered a diversion of capacity and funding during the response to COVID-19 (Pantuliano, 2020).

Surmounting these issues will not be easy. Yet, to some extent, bodily autonomy and integrity can unify action for gender equality, just as they often unify the opposition to it. Now is the moment for making a powerful, potentially transformative case for asserting what bodily autonomy and integrity really mean in practice, and what is really required to achieve them.

In broad terms, we already know that achieving bodily autonomy and integrity for women and girls depends on realizing gender equality on all fronts, and that sexual and reproductive health and reproductive rights are among the most important entry points. Progress here can, in turn, build on and support other efforts to empower women in the economy and decision-making, and to guarantee access to justice. Much depends on overturning gender and other discriminatory norms to prevent bias from operating in the first place.

Diverse constituencies are collectively galvanizing momentum for change. The Generation Equality campaign, for example, is forging new alliances among gender equality activists, between disabilities, gender and health advocates, and with LGBTI groups and organizations of persons with disabilities.

To look at bodily autonomy and imagine what it could and should mean is to see a vastly different future for human beings. A different path starts with rights and leads to choices, allowing people to care for and love their bodies and their lives as they see fit.



Artwork by Kaisei Nanke



Artwork by Hülya Özdemir

THREE DIMENSIONS OF AUTONOMY

Measuring the power to make decisions about health care, contraception and sex

The power to make decisions about sexuality and reproduction is fundamental to women's empowerment overall.

A woman who has control over her body is more likely to be empowered in other spheres of her life. A woman—or adolescent girl—with little bodily autonomy is less likely to have control over her home life, her health and her future, and less likely to enjoy her rights.

But what exactly is bodily autonomy? And how does one determine whether one has it? Is it something that can be measured?

The notion of autonomy in the context of women's empowerment emerged in the 1970s and was later taken up by the sexual and reproductive health and rights movement. In 1994, at the International Conference on Population and Development or ICPD, the term appeared in the pathbreaking Programme of Action, which acknowledged that "the goal of the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself and is essential for the achievement of sustainable development".

Since then, the word "bodily" has been joined with "autonomy" to create a term with a broad and sometimes ambiguous meaning. It is used today by advocates, activists and human rights experts surrounding issues related to sexuality, health, reproductive rights, sexual orientation, gender identity, transactional sex, surrogacy, disability status, abortion and more.

The term gained further prominence in 2019, when governments, civil society organizations, academics and members of the private sector came together for the Nairobi Summit on ICPD25, where they pledged to finally achieve all the goals set out in the ICPD Programme

of Action. Many of the delegates adopted the voluntary Nairobi Statement, which cited 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 the term has become part of the vernacular of the feminist and sexual and reproductive health and rights movements, it continues to elude simple definition and easy measurement. However, when the United Nations adopted its transformative 2030 Agenda for Sustainable Development and the accompanying 17 Sustainable Development Goals, it established indicators to help governments track progress towards achieving the goals and their related targets, such as target 5.6, the achievement of sexual and reproductive health and reproductive rights for all. Two indicators have been identified to measure progress in this area. The first, indicator 5.6.1, aims to measure the proportion of women aged 15 to 49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. The second indicator, 5.6.2, tracks the 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.

Indicator 5.6.1 is based on responses to questions posed to women aged 15 to 49 years in Demographic and Health Surveys, or DHS, in 57 countries:

- Who usually makes decisions about health care for yourself?
- Who usually makes the decision on whether or not you should use contraception?
- Can you say no to your husband or partner if you do not want to have sexual intercourse?

Only women who say they make their own decisions in *all three* of these areas are considered to have autonomy in reproductive health decision-making and to be empowered to exercise their reproductive rights.

DHS surveys rely on standard questionnaires that yield nationally representative data on marriage, fertility, mortality, family planning, reproductive health, child health, nutrition and HIV/AIDS. The DHS programme is implemented by ICF International and funded by the United States Agency for International Development with contributions from international organizations such as UNFPA.

The formulation of indicator 5.6.1 marks the first time that an international framework measures sexual and reproductive health—and bodily autonomy—in ways that look beyond access to services and explores the extent to which girls and women are able to make their own choices. UNFPA, the United Nations sexual and reproductive health agency, is responsible for managing the data included in this indicator, as well as indicator 5.6.2, covered in chapter 5 of this report.

A look at the numbers

Complete data on all three dimensions of indicator 5.6.1 are available only for 57 countries, most of which are in sub-Saharan Africa. However, future international surveys, such as UNICEF's Multiple Indicator Cluster Surveys, as well as regional survey programmes such as the Generations and Gender Survey, are expected to yield data for more countries over the next few years.

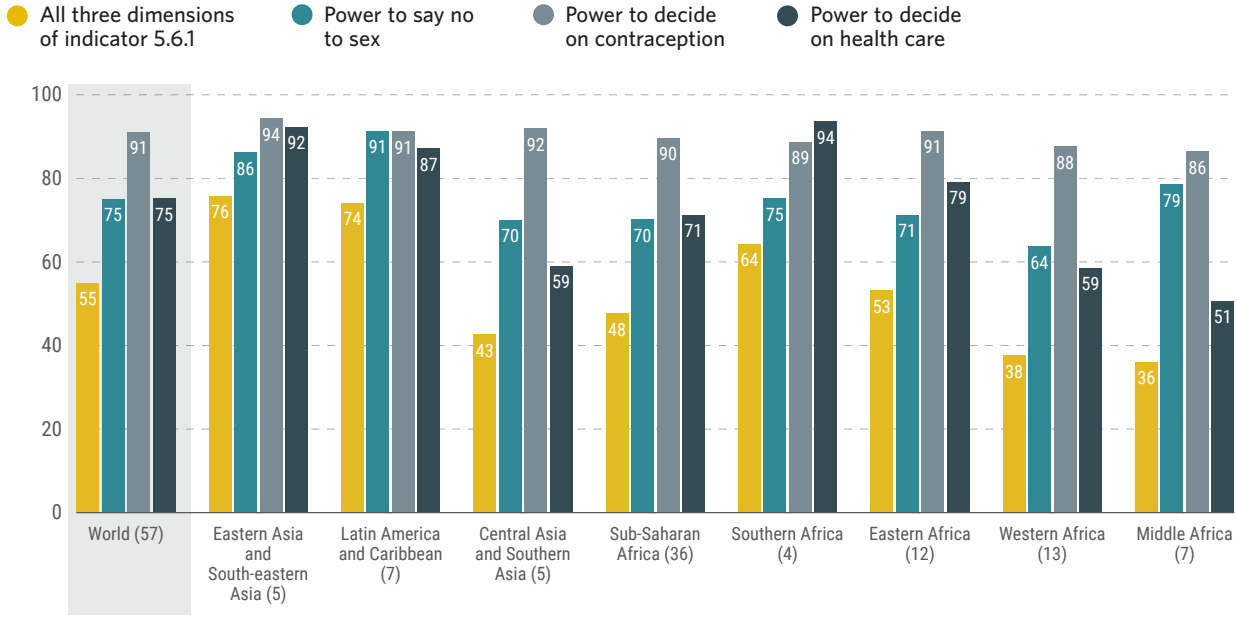
While data currently cover only about one in four of the world's countries, they paint an alarming picture of the state of bodily autonomy for millions of women and girls: only 55 per cent of girls and women are able to make their own decisions in all three dimensions of bodily autonomy.

That means that little more than one in two women and girls has the power to decide whether and when to seek health care, including sexual and reproductive health services, whether to use contraception and whether and when to have sex with their partner or husband (Figure 1).

Percentages vary across regions. For example, while 76 per cent of adolescent girls and women in

FIGURE 1

Proportion of women aged 15 to 49 years who 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), by SDG region, most recent data 2007–2018



Notes: The number of countries with comparable survey data included in the regional aggregations is presented in parentheses.

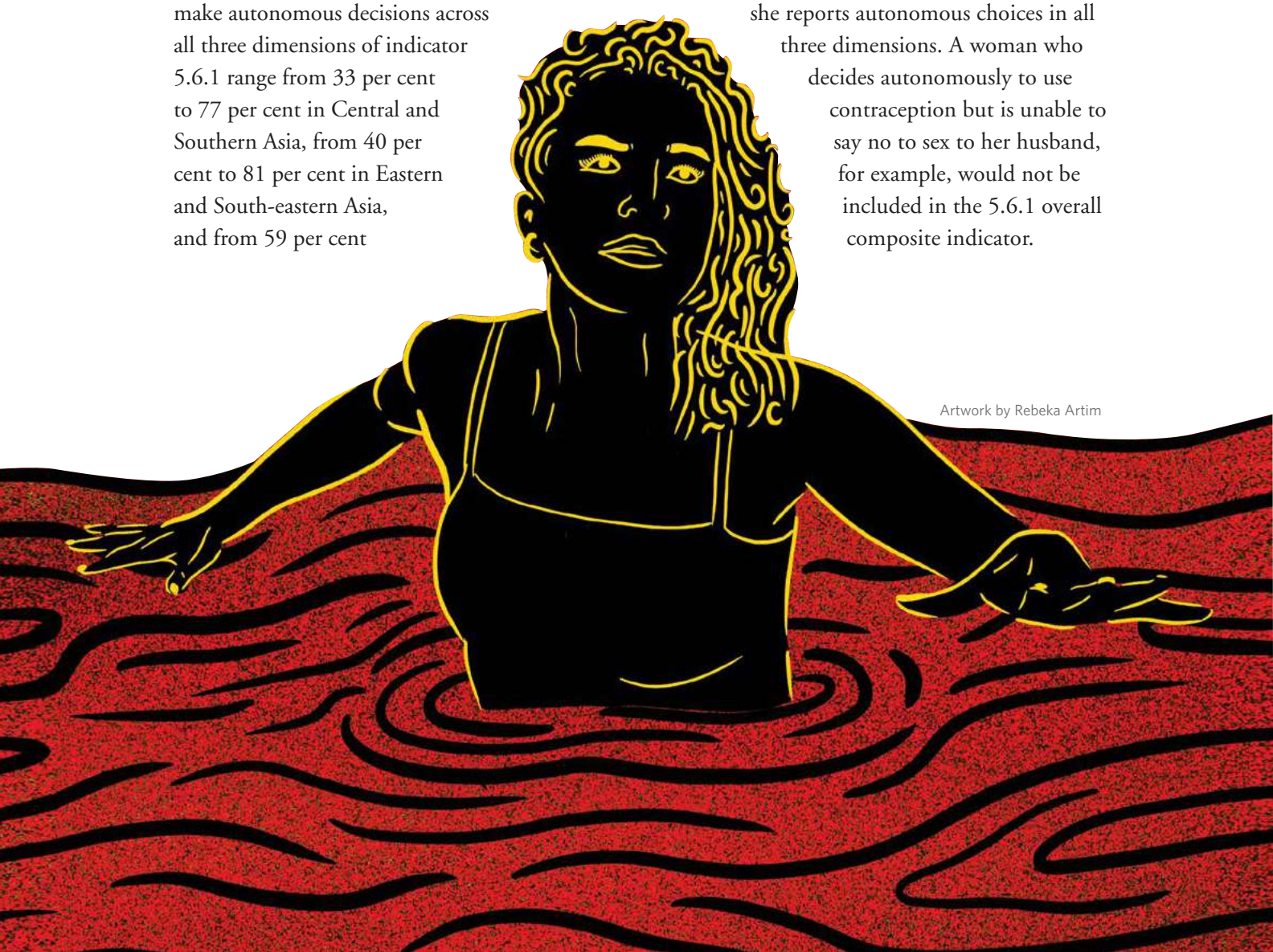
Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007–2018 period.

Eastern and South-eastern Asia and Latin America and the Caribbean make autonomous decisions in all three dimensions of indicator 5.6.1, this figure is less than 50 per cent in sub-Saharan Africa and Central and Southern Asia.

Regional aggregates mask substantial differences across countries (Figure 2). In sub-Saharan Africa, for example, where about 50 per cent of women make autonomous decisions, there are three countries, Mali, Niger and Senegal, where less than 10 per cent do.

In other regions, differences between countries are less pronounced but are nevertheless noteworthy. For example, the percentages of women who make autonomous decisions across all three dimensions of indicator 5.6.1 range from 33 per cent to 77 per cent in Central and Southern Asia, from 40 per cent to 81 per cent in Eastern and South-eastern Asia, and from 59 per cent to 87 per cent in Latin America and the Caribbean.

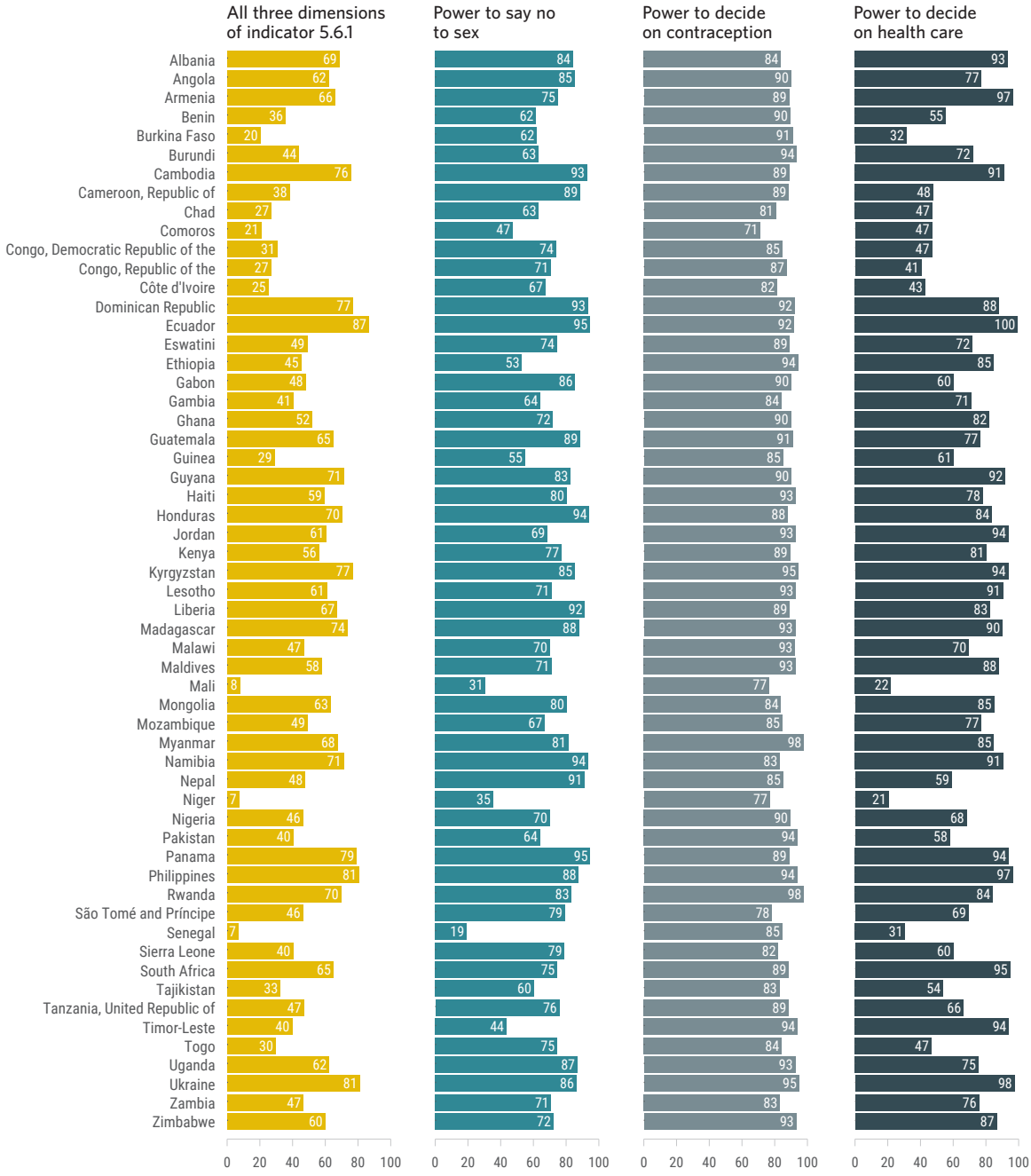
The data also show inconsistencies across the three dimensions: a high percentage in one dimension does not automatically mean high percentages in others. In Mali, for example, 77 per cent of women take independent or joint decisions on contraceptive use, but only 22 per cent are able to do the same in seeking health care. In Ethiopia, 53 per cent of women are able to say no to sex, but 94 per cent can independently or jointly make decisions about contraception. Such discrepancies help explain lower overall composite indicators in some countries: a woman is counted only when she reports autonomous choices in all three dimensions. A woman who decides autonomously to use contraception but is unable to say no to sex to her husband, for example, would not be included in the 5.6.1 overall composite indicator.



Artwork by Rebeka Artim

FIGURE 2

Proportion of women aged 15 to 49 years who make their own decisions regarding health care, contraception and sex with their husbands or partners, most recent data by country, 2007–2018



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007–2018 period.

What are the trends?

An analysis of trends in 22 low- and middle-income countries that have had at least two consecutive DHS surveys that asked women about the three dimensions of bodily autonomy shows that investments in programmes or services in one dimension do not necessarily lead to positive changes in the others. In fact, the trends in responses to the three standard questions for indicator 5.6.1 often move in different directions (Figure 3).

In Ghana, for example, massive investments have been made to improve maternal health through increased affordability, quality and reach of services, combined with community-outreach programmes to promote these services. As a result, the percentage of women able to make their own decisions regarding their own health care has risen continuously. At the same time, the percentage of women who make their own decisions about contraception has levelled off, and the percentage of women who are able to say no to sex has seen a considerable decrease. A similar situation has occurred in Benin, where the percentage of women who are able to make autonomous decisions about contraception and health care has shown little change in the past 10 years. Women's power to say no to sex, on the other hand, has decreased by 20 per cent over that same period (UNFPA, 2019).

Among the 22 countries, only Uganda and Rwanda have shown consistent positive trends in the percentage of women who make autonomous decisions in all three dimensions of indicator 5.6.1. Data show that Uganda had the largest increase: 12.3 per cent. The positive change can be attributed to a conducive legal and policy environment (including the abolition of user fees for maternal and under-5 child health services) combined with community-outreach approaches aiming at tackling gender inequality norms (UNFPA, 2019).

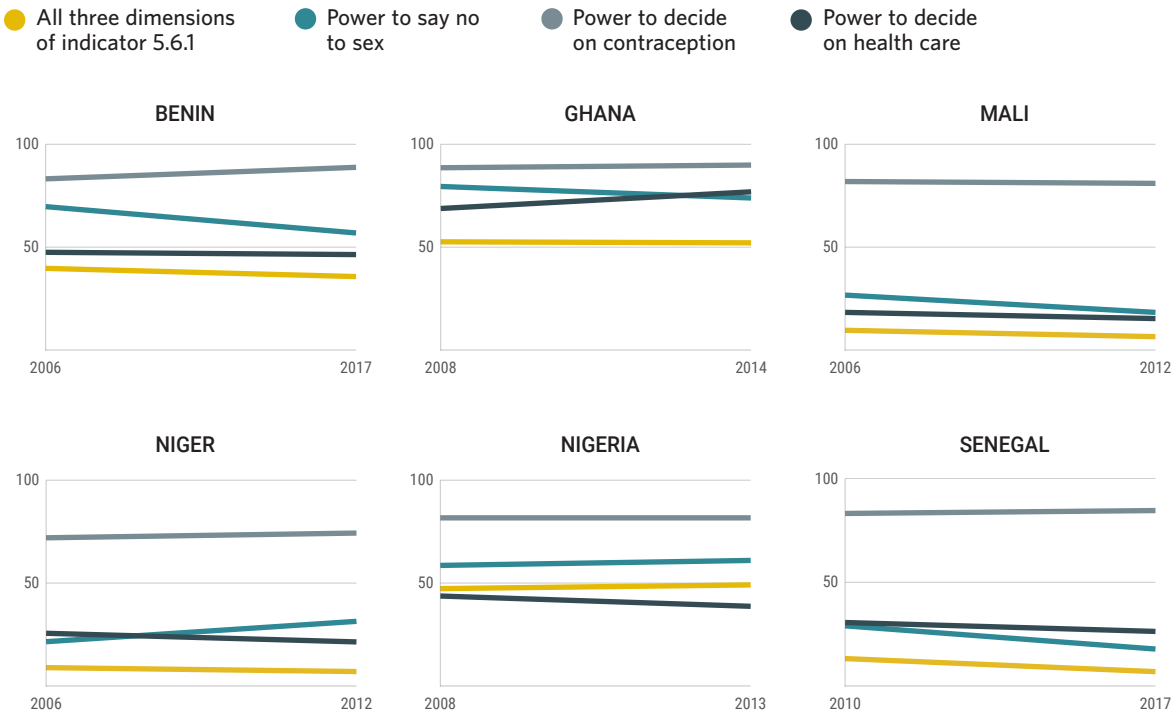
Figure 3 shows that overall indicator percentages can mask simultaneous negative and positive trends within a country. Positive trends are more common in responses to the question about autonomous decisions on seeking health care. Negative trends, however, are more common in responses to the question about having the power to say no to sex. In fact, women in more than half the countries with at least two data points lost ground between 2005 and 2018 in their power to say no to sex. It is difficult to pinpoint the exact cause of this negative trend or the apparent lack of progress. However, one study suggests that a combination of factors may be at play (UNFPA, 2019):

- Persistent taboos about sex and sexuality that are reinforced by social norms and attitudes, leaving women and adolescent girls little opportunity to negotiate openly about sex with their partners or husbands.

- Patriarchal systems that perpetuate unequal power dynamics in relationships, where male sexual demands are placed above those of women. Studies show that in Azerbaijan, Rwanda and Mexico, some women agree to forfeit their right to say no to sex in exchange for greater autonomy in other spheres of their lives, such as in making decisions for the household or deciding whether or when to venture outside the home.

FIGURE 3

Change in the percentage of women who report making autonomous decisions in the three components of indicator 5.6.1 in West Africa



- Qualitative research indicates that women may also comply with men's sexual demands as a trade-off to achieve more independence in their economic and personal endeavours. Such trade-offs have been reported in countries as diverse as Azerbaijan, Mexico, Niger and Nigeria (UNFPA, 2019).

The indicator's limitations

Indicator 5.6.1 is a picture of women's bodily autonomy painted with a broad brush and thus reveals few subtleties about the forces behind positive or negative trends. Data on women's use of contraception, for example, only reflect women who were married or in cohabiting unions and who were actually using contraception at the time survey data were collected. Also, the question used to elicit responses about decisions to access health care does not specifically refer to *reproductive* health care. And all three questions are asked only of girls and women aged 15 to 49, thus leaving out younger adolescents and women aged 50 or older.

Another limitation is that the data related to contraception and health care reflect both joint and individual choices. A woman may say, for example, that the decision to use contraception was made jointly with her husband or partner.

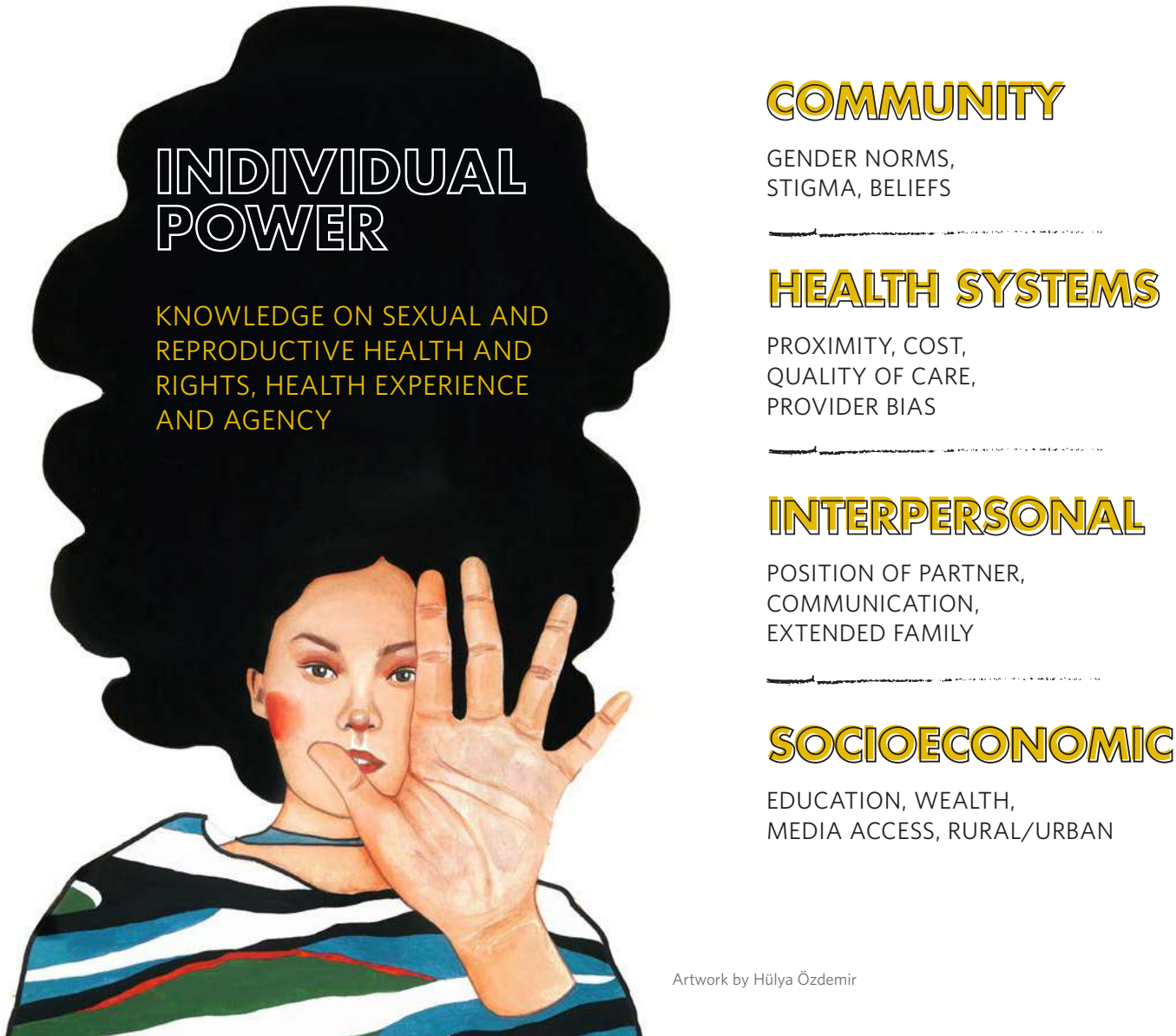
But there are likely instances where a "joint" decision was actually an individual one, made by the woman but overruled by her husband. Furthermore, women whose husbands forbid them from using contraception may still use it covertly, but this type of situation is not reflected in the indicator on making autonomous decisions about contraception. Quantitative surveys suggest that between 4 per cent and 29 per cent of women who use contraception do so without their husbands' or partners' knowledge. While covert contraceptive use is an individual choice, women generally describe the experience as negative and disempowering (UNFPA, 2019).

An ecological model of bodily autonomy

A range of social and economic factors influence a woman's decision-making in the three dimensions of indicator 5.6.1 (Figure 4).

FIGURE 4

Determinants of women's decision-making power



Artwork by Hülya Özdemir

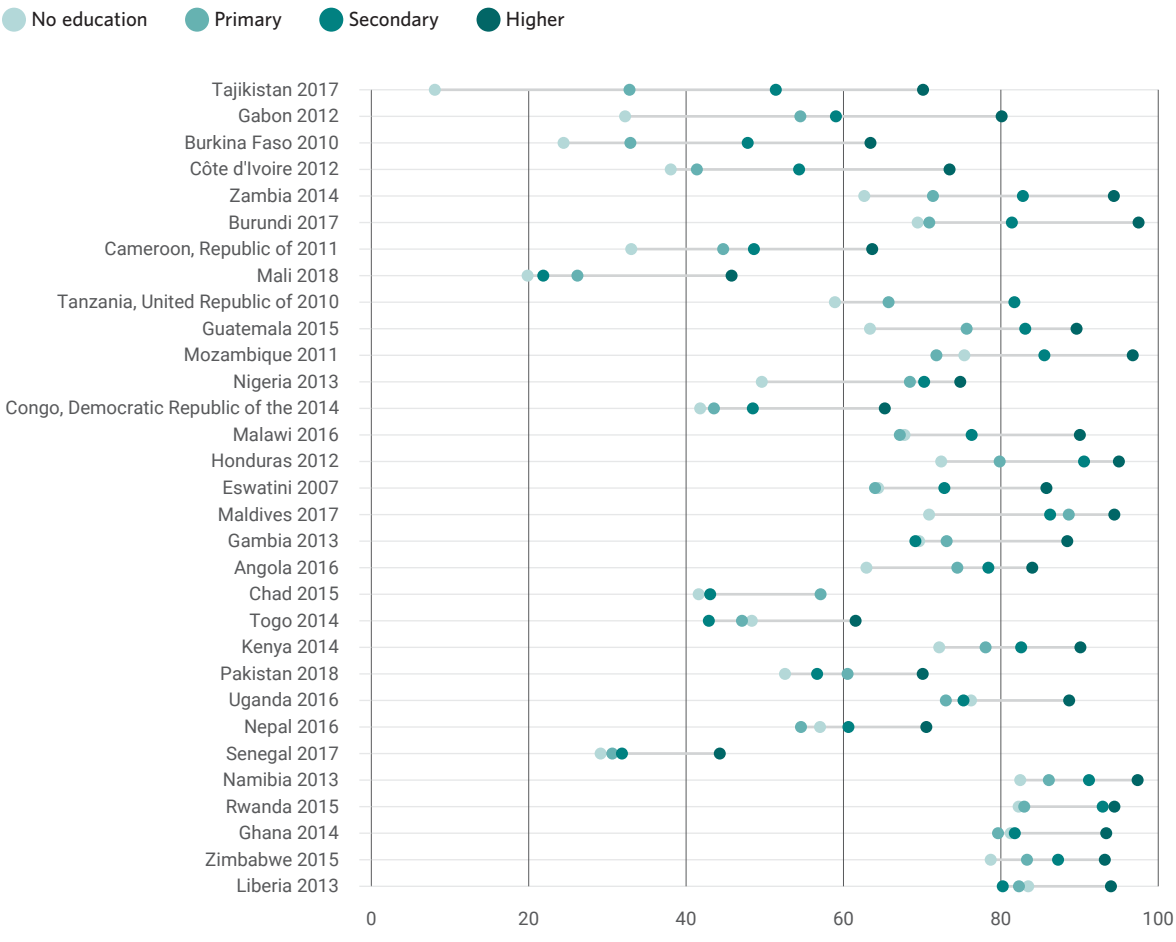
Socioeconomic circumstances

A woman's level of educational attainment is a key factor in determining how much power she has to say no to sex but it also correlates with her power to make her own decisions about contraception and health care (Figures 5a and 5b). The education level of her partner is also positively associated with her participation in decisions about contraception and health care. A woman who has less education than her husband or partner is more likely to be subjected to sexual violence than a woman whose education level is more or less equal to that of her husband (UNFPA, 2019). Meanwhile, girls and women in the two lower wealth quintiles are also more likely to have experienced unwanted sexual relations (Figure 6).

FIGURE 5A

More decision-making power linked to higher levels of education

Decision-making on women's own health care, by women's level of education, select countries, per cent



Interpersonal relations

Relationships and communication with husbands or partners as well as with extended family members influence a woman's ability to make autonomous decisions.

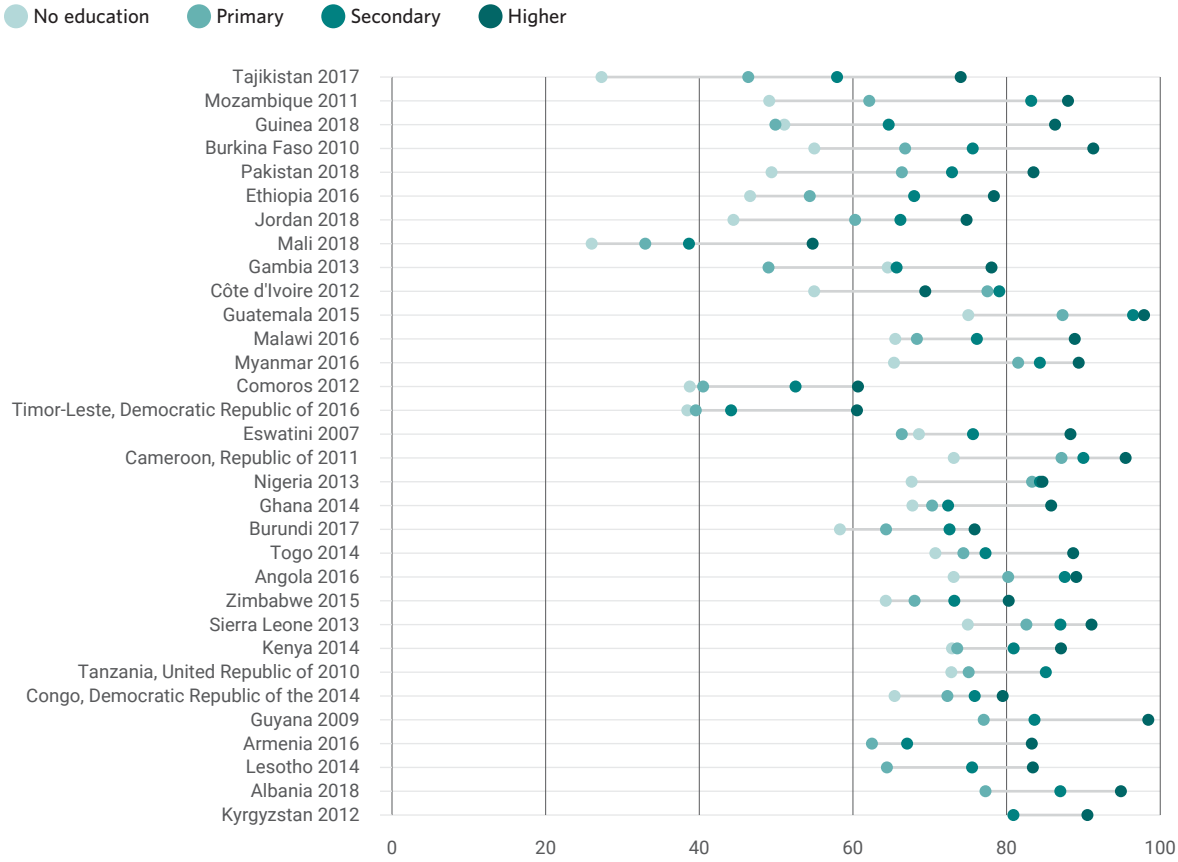
Men, as heads of households, often hold all the power and make many of the decisions, including those related to sexual and reproductive health issues, even though these issues are often perceived as "women's matters". Gender norms typically assign women the sole responsibility for reproductive health but at the same time deny them decision-making power.

Communication is a positive predictor for joint or autonomous decision-making. Couples who regularly communicate about matters of sexual and reproductive health are more likely to make decisions jointly about contraception and reproductive health care. The opinions of extended family members, particularly mothers-in-law, also play an important role in these decisions (UNFPA, 2019).

FIGURE 5B

More decision-making power linked to higher levels of education

Say no to sex, by women's level of education, select countries, per cent



The role of the community

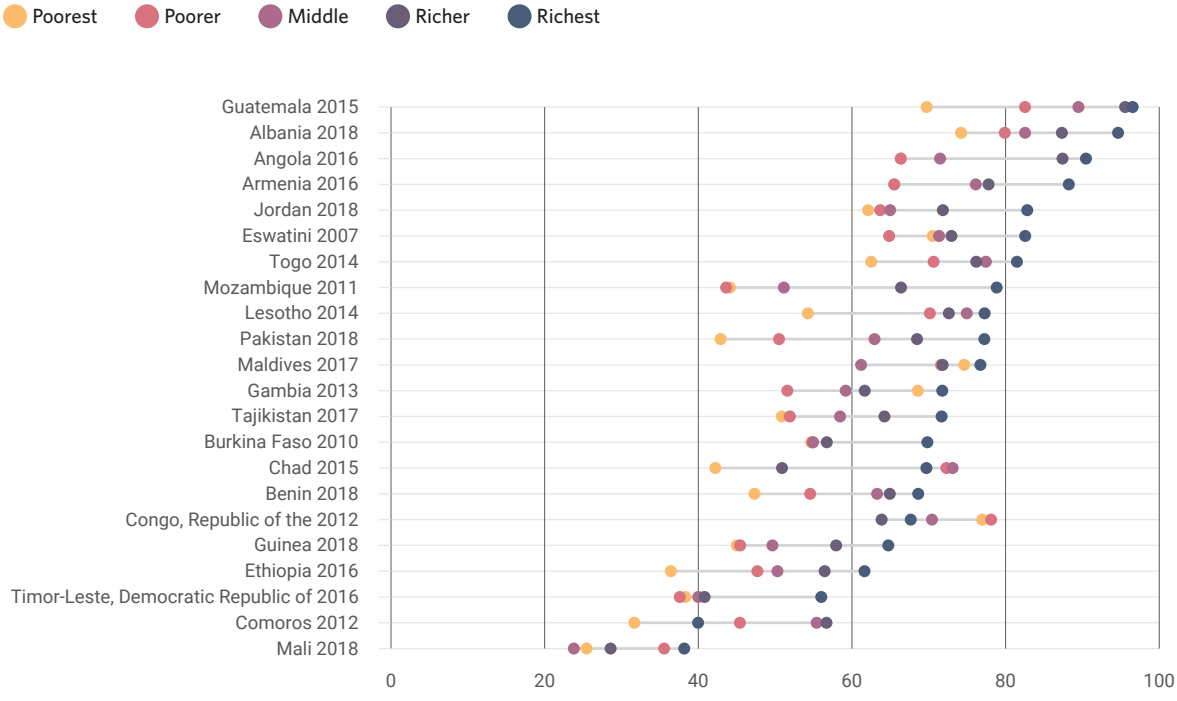
In certain communities, the notion of bodily autonomy may be seen as incompatible with local norms and values. Communities may pressure women to bear children and may generally perpetuate views that women should be submissive and passive in sexual relations. At the same time, community norms can often dissuade women from discussing matters of sexual and reproductive health with men, making it difficult, if not impossible, for women to negotiate sexual relations, contraceptive use and reproductive health care. Studies in nine countries have shown that some men report beliefs of entitlement to dominate women, with clear expressions of unequal power relations (e.g., Habibov and others, 2017; Fahmida and Doneys, 2013; Hattori and DeRose, 2008).

Adolescent girls face further barriers to information and services because of norms that discourage sexual activity out of wedlock. At the same time, norms in some communities may permit or even encourage

FIGURE 6

Greater power to say no to sex in higher wealth quintiles

Say no to sex, by household wealth, select countries, per cent



Healing bodies, minds, spirits

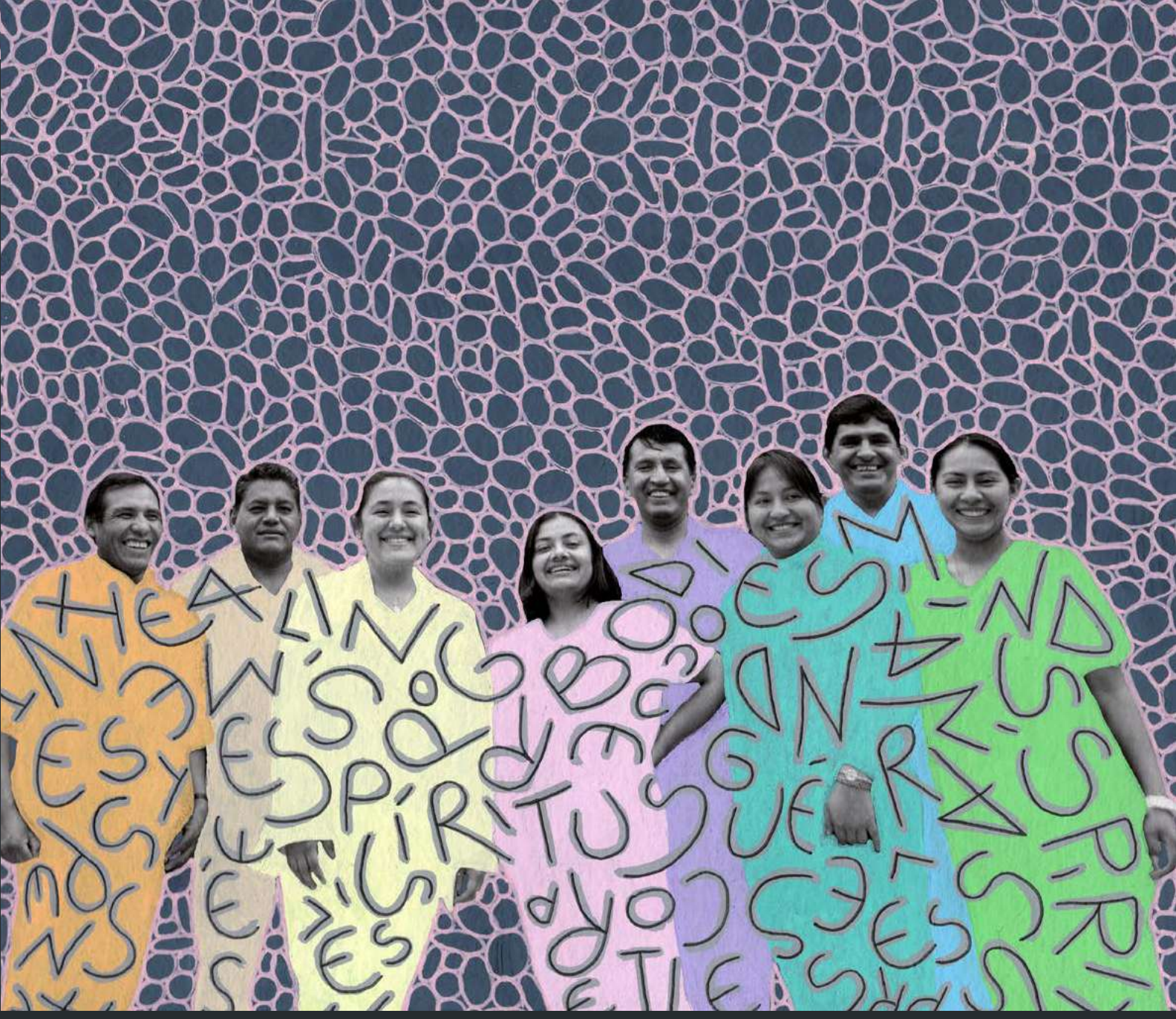
Health-care providers have a unique responsibility in affirming and safeguarding the bodily autonomy of their patients. "My advice for any health worker would be to have empathy," said Víctor Cazorla, a male midwife working in the Andes mountains of Peru. He has spent more than two decades working with indigenous communities in Ayacucho Region, and he knows all too well the challenges that threaten the well-being and autonomy of the most vulnerable patients.

"The work system for health workers often revolves around production, and production is synonymous with quantity," he said. "We're forgetting about quality in the care we give to our patients." There are also cultural barriers, he added. "Many colleagues, many people, have gone to rural areas without knowing Quechua, the mother tongue of the communities there," leading to misunderstandings and even discrimination.

At the same time, many patients are not sensitized to their sexual and reproductive rights. "Among the general population, maybe 80 to 90 per cent, I dare say, cannot make their own decisions about when to have sex with their partner... Male chauvinism prevails," he said. Women patients often feel unable to speak candidly about issues pertaining to their sexual health, and they can be shy about expressing their discomfort about gynaecological procedures, particularly with male health providers, he noted.

These factors, together, are a dangerous combination: doctors are left struggling to understand the needs and boundaries of their patients, and patients are

"Do they consent?... If they are not prepared psychologically, we must respect their choice."



Medical personnel at a health centre in the Ayacucho Region of Peru. Midwife Victor Cazorla is fifth from the left. Original artwork by Naomi Vona; photo © UNFPA/A. Castañeda.

left without the words or tools to advocate for themselves.

Such concerns are all the more harrowing when health workers tend to survivors of sexual and gender-based violence. "In Syria, more than half of women are ignorant of their sexual, physical and general rights," said Mouna Farhoud, a gynaecologist in Damascus who specializes in treating survivors. "Even the educated women are exposed to violence and unable to address it. They consider that talking about these topics harms their dignity and their reputation."

Dr. Farhoud says even health professionals hold views that undermine the health and rights of their patients. She recalled

teaching a course to health providers on treating sexual assault survivors: "There were many objections from the participants... There was a denial and lack of recognition about the existence of sexual assault cases."

Doctors must communicate non-judgmentally with their patients, and recognize when their patients are uncomfortable or when they may have experienced abuse. Sometimes, this means being a detective, Dr. Farhoud explained. "Maybe the patient's symptoms are not commensurate with her complaint. Her way of walking, her look, her words, her companion, the physical examination—all these come together to flag that there is a problem."

And health workers must know when to back away. "It is your right to refuse. When I examine the patient, such as a gynaecological exam, I explain its importance, especially for people who have been subjected to sexual assault," Dr. Farhoud said. "I make it clear that this is a medical procedure to find out if there are infections, wounds, bleeding, bruises or things that help document the case. Do they consent? Even when people realize that the goal is for documentation, if they are not prepared psychologically, we must respect their choice. Maybe this time we are not able to examine her, but next time we will be able to do so after she feels respected and valued."

Cazorla added that showing respect for one's culture is paramount. But what is most important, he says, is empowering patients themselves to become defenders of their own bodies and autonomy. "We teach them to expect respect, that nobody has a right to touch their bodies: not me, not their aunts, not their fathers, not their mothers, not staff, not police, nobody."

He and his colleagues conduct education sessions for the community, and issues such as rights, self-esteem, sexual health and healthy relationships are also discussed during individual and family counselling sessions. These efforts are making a difference, he said, especially among younger people. But the burden of providing this information falls heavily on health providers. "I am the only midwife, for example, working on a shift at the health centre and I have to stay there to attend to patients who arrive with emergencies." He says there is a need for more health resources, including staff, so that they can do more community education, such as targeted programmes for men and boys.

Dr. Farhoud echoes the call for support. Her organization also holds awareness sessions for the community. But she wants to see more education and accountability among health staff, as well. They have a special duty of care, as sexual and reproductive health service providers, to respect and empower their patients. "We have sworn a professional oath," she said.

adolescent girls to engage in transactional sex as a way to support their households or to cover the costs of their own education. As these girls typically come from poorer households, they have little power to say no to sex. Whether married or unmarried, they may have limited power to negotiate the use of condoms (November and Sandall, 2018; Moore and others, 2007). Married girls, however, may also face family and communal pressure to demonstrate their fertility, and experience coerced sex and opposition to their using contraception (Woog and Kågesten, 2017).

Barriers in the health system

Decisions about contraception and reproductive health care are sometimes impeded by the distance to clinics and facilities, especially in rural areas. Other impediments include the absence of adolescent- and youth-responsive services, shortages of preferred methods of contraception, poor-quality or poorly managed services, services that are staffed by judgmental providers and lack of privacy. In contrast, services that have convenient opening hours and employ health workers who have positive attitudes towards their clients and respect their privacy help empower women and adolescent girls to make autonomous decisions. Readily available and accurate contraceptive information, especially when provided in a respectful, private and friendly environment, also has a positive impact. Studies have shown that family planning services that are provided through community health workers lead to increased use of contraception, especially when services include family planning information and education for men (UNFPA, 2019).

Bodily autonomy still only a distant possibility for many

That only 55 per cent of women have the power to make their own decisions about their bodies should be a wake-up call to governments, policymakers and development institutions. In Mali, Niger and Senegal, more than 90 per cent of women are deprived of their bodily autonomy.

The data for indicator 5.6.1 provide insights into the challenges women face in claiming their right to bodily autonomy. But a deeper analysis of the data is needed to understand the scope and nature of the obstacles faced by groups such as women who are not married or in a union, persons with disabilities or ethnic and racial minorities.

What is clear from the data is that in 57 countries—and likely every other country in the world—women are not fully in control of their bodies.



Artwork by Rebeka Artim

WHEN DECISIONS ARE MADE BY OTHERS

The denial of bodily autonomy and integrity takes many forms

The feminist slogan "the personal is political" has been rallying women around the cause of bodily autonomy since the 1960s. Activists before and since have argued that if women and girls lack the power—or agency—to realize their rights to self-determination and autonomy, they are also unable to control other aspects of their lives.

Agency means having the power to make choices and decisions on one's own behalf. In matters of sex, sexuality and reproduction, agency can mean having the power to decide freely whether, when or with whom to have sex and whether, when or how often to become pregnant. Without agency, a person can never have autonomy.

According to the Positive Women's Network, when women have full bodily autonomy, not only are they empowered to make decisions about their health and future—without coercion or control by others—they also have the support and resources needed to meaningfully carry out these decisions.

Despite international agreements and declarations about the importance of autonomy in women's health and overall empowerment, untold millions of women and girls around the world today still lack the power to make their own decisions about health care, contraception and sex with their husbands or partners.

Often these decisions are made or influenced by others, whether partners, families, societies or even the government, and that means women and girls are denied their bodily autonomy.

Although there are many impediments to bodily autonomy, gender inequality is perhaps the most insidious and pervasive one. More than 160 years ago, American suffragist Lucy Stone wrote, "It is very little to me to have the right to vote, to own property, etc., if I may not keep my body, and its uses, in my absolute right. Not one wife in a thousand can do that now, and so long as she suffers this bondage, all other rights will not help her to her true position" (Hasday, 2000).

Gender inequality deters autonomous decision-making

Gender-unequal norms and attitudes lead to power imbalances in relationships that restrict women's decisions, particularly when it comes to saying no to sex. Patriarchal beliefs often translate into expectations that women defer to their husbands or partners in all aspects of their lives, including their sex lives. These expectations may not only mean that a woman should always engage in sex whenever her husband wants it, but also that she should not initiate sex or openly express her desires. At the same time, women may be expected to avoid conflict, thus reinforcing unequal power dynamics. Women may also refrain from saying no to sex out of fear of verbal abuse, withdrawal of financial support, divorce, or even beatings and rape.

Research has shown that girls and women are often unaware that they have the right to say no. One study in India, for example, showed that newly married women were less likely to refer to their first sex as forced or "against their will" because sex was expected within marriage. The notion of consent was irrelevant because sex, even if it was forced, was thought to be a marital duty and therefore not a matter of consent (UNFPA, 2019).

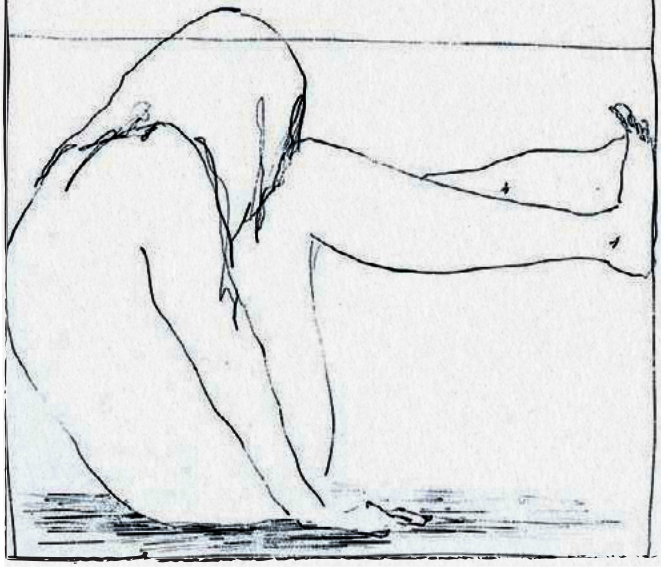
RESEARCH HAS SHOWN THAT GIRLS AND WOMEN ARE OFTEN UNAWARE THAT THEY HAVE THE RIGHT TO SAY NO

Gender-unequal norms and attitudes can undermine a woman's power to make her own decisions about contraception. For example, in a number of countries included in indicator 5.6.1, husbands, especially in rural areas, want more children than their wives do and consider it their right to make the decision about family size and about whether or when contraception should be used. Unequal power dynamics in relationships constitute yet another barrier for women who want to have conversations with their husbands or partners about contraception. Furthermore, even raising the topic of contraception may be perceived by men as an admission to extramarital relationships and can lead to conflicts resulting in violence, separation or divorce (UNFPA, 2019). The nexus between gender inequality and denial of bodily autonomy has a real impact on the lives of women and girls everywhere, every day. Attitudes and norms that subordinate a woman's or girl's well-being, needs and rights to those of a man or boy take away her power—her agency—and research has verified that this can have negative consequences that can last a lifetime and carry from one generation to the next (van Eerdewijk and others, 2017; O'Neil and others, 2014). This dynamic can play out in many ways, some more egregious than others, but it is particularly evident in marital laws and practices that subordinate women to men.

Persons with disabilities at greater risk of rape and coerced sex

Girls and young women with disabilities are more likely to experience violence than either their male peers with disabilities or girls and young women without disabilities (UNFPA and others, 2018). Girls and boys with disabilities are nearly three times more likely to be subjected to sexual violence, with girls at the greatest risk.

Consent is crucial when any person engages in sexual activity, but it plays an even bigger and potentially more complicated role when someone has a disability, according to RAINN (the Rape, Abuse and Incest National Network), an anti-sexual violence organization in the United States (RAINN, 2020).



Research on levels of sexual assault against persons with disabilities shows elevated levels when compared to people without disabilities. In the United States, for example, the U.S. Department of Justice found that girls and women with disabilities suffer violent crime, including sexual assault and rape, at a rate of 32.8 women per 1,000 each year, compared to 11.4 women per 1,000 for women who do not have disabilities (Harrell, 2017).

In the United States, an advocacy group, Disabled World, reported that an estimated 80 per cent of women and 30 per cent of men with intellectual disabilities are forced at some point into some form of non-consensual sex but only 3 per cent of such sexual abuses involving people with developmental disabilities are ever reported. Women with a disability were far more likely to have a history of undesired sex with, or marital rape by, an intimate partner. One study found that 54 per cent of boys who are deaf have been sexually abused in comparison to 10 per cent of boys who are hearing (Disabled World, 2012).

Insofar as societies do not equip persons with disabilities with the means to control whether, when or with whom to have sex and whether, when or how often to become pregnant, they are denying large numbers of people of their right to bodily autonomy.

Artwork by Kaisei Nanke



Artwork by Tyler Spangler

Forced and child marriage

The most obvious marital practices that deny a woman agency are marriages where she cannot make a free and informed choice about her own partner: forced and child marriage. Forced marriage is any marriage in which one or both of the partners enter into it "without full, free and informed consent". Child marriage, a subset of forced marriage, is any marriage where at least one of the parties is under the age of 18 and has therefore not reached the age when she or he can express full, free and informed consent (OHCHR, 2020). Both forms of marriage violate an individual's rights, including rights associated with bodily autonomy and integrity.

These marriages are rooted in patriarchal attitudes and deny women and girls autonomy in general, and their power to make decisions about health care, contraception and sex in particular.

Child marriage is a form of gender-based violence. It is also a powerful constraint on the agency of women and girls, forcing them into lifelong subordinate relationships before they achieve the legal capacity to make decisions that affect their entire lives. The most recent estimates indicate that there are 650 million women alive today who were married before the age of 18, and every year another 12 million girls are married before they become adults (UNFPA, 2020; UNICEF, 2020).

Even though all but one of the world's countries has ratified the Convention on the Rights of the Child, many countries still allow marriage under the age of 18, sometimes with the consent of a parent, guardian, judge or other governmental official.

But even where child marriage is prohibited by law, it continues in practice. Many such marriages take place through traditional or religious ceremonies and are never registered with civil authorities. In some parts of the world, cohabitation where one or both partners are minors is also common. With continued high rates of child marriage in South Asia and sub-Saharan Africa and parts of Latin America and the Caribbean, it is projected that by 2030, in the absence of high-impact interventions, there could be as many as an additional 120 million women and girls who will have been married by the age of 18 (UNFPA, 2020; UNICEF, 2020).

Forced marriages are driven by institutionalized patriarchal practices, including payment of dowry or bride price, bride kidnapping, marriage of widows to in-laws, or "widow inheritance", and marriage of rape survivors to their assaulters. Through these practices, brides become a commodity, or property, to be owned, bought, sold or traded, with no regard for their rights or autonomy.

Through dowries, the bride's family pays, in cash or in kind, the groom's family to "take her off their hands". Dowries ostensibly provide for the welfare of the bride but a closer look reveals a system that is "as ugly and corrosive to women's rights as child marriage, female genital mutilation, and systems of male guardianship" (McCarthy, 2017).

In almost all cases, the dowry practice directly or indirectly oppresses women, often leading to abuse and violence and maintaining a system of gender inequality. It encourages child marriage because families pay smaller dowries for younger brides. It also results in violence: about 8,000 dowry deaths, where women are killed because families are not paid the expected dowry, are recorded each year in India alone, according to that country's National Crimes Statistics Bureau (Dhillon, 2018).

Bride price is the opposite of dowry: a girl or woman is "bought" by the groom's family to become a wife for their son. The practice is common in some parts of Africa where "a bride price is the conditional exchange of property, usually cows or money, from the groom to the parents of the bride in return for marriage" (Turner, 2009). It relegates the woman to the status of property and supports the notion that a man has purchased his wife's reproductive and productive capacity as well as, most importantly, her obedience. The payment of a price can give the man licence to use violence against his wife to make her obey (Thiara, 2011).

Moreover, the bride price must be refunded if a man decides to divorce or separate from his wife: "this practice hangs like a threat over her head and that of her parents, ensuring the wife's compliance" (Turner, 2009). The tradition of refunding the bride price is especially problematic because it means that if a woman or her family cannot afford to repay it, then she can be trapped in an abusive relationship with no recourse. Bride price also takes place in other parts of the world, including some Pacific Island countries.

There are other, less common, traditional patriarchal marriage customs that take away female autonomy. In some parts of the world, for example, there is a tradition of bride kidnapping: physically removing a girl or woman to take her to the home of a man who wants to marry her. According to a 2016 UNFPA study in Kyrgyzstan, the tradition of bride kidnapping persists, despite being illegal. Under the custom, a man may abduct a woman or girl from her home or school or work and take her to his family's home, where she is usually forced to write a letter asking consent from her family. The letter is accompanied by a bride price payment from the groom's family. Fewer than one in 10 such "proposals" is turned down by the woman's or girl's family. The UNFPA study found that almost one fifth of marriages in Kyrgyzstan follow the traditional practice of "kidnapping", and an estimated one quarter of those are without the bride's "consent" (UNFPA in the Kyrgyz Republic, 2016).

Another still-practised tradition is that of widow inheritance, whereby a woman whose husband has died is forced to marry a relative of the deceased, usually a brother. Traditionally, this was seen as a means of providing protection for the woman and her children and of keeping the woman in her husband's family, especially after dowry had been paid. But the widow does not give her consent and often ends up in a relationship she did not want or ask for.

Marital practices that subordinate women and undermine health

The more pernicious of the female-subordinating marital practices, which violate a woman's right to bodily autonomy, have also been shown to have negative consequences for sexual and reproductive health. Widow inheritance, for example, requires a woman to engage in sexual relations with the man who "inherits" her, regardless of how many sexual partners he may have had in the past, increasing the risk of HIV transmission (Mabumba and others, 2007). A study in the Bondo district of Kenya found that 56.3 per cent of widows had been "inherited" through a traditional ceremony. Among those women, the ones who had taken part in a sexual ritual known as "widow cleansing" were found to be more likely to be infected with HIV (Agot and others, 2010). Widow cleansing is a ritualized dissolution of the bond of the spirit of a dead man with his wife, through her submission to sexual intercourse with one of his living relatives.

Child marriage has countless deleterious effects on a girl's sexual and reproductive health and bodily autonomy. Forced sex and early and frequent pregnancies are closely linked to high maternal and infant morbidity and mortality rates, as well as poor mental health. In low- and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among girls aged 15 to 19 years, and adolescent mothers face much higher rates of complications during pregnancy and childbirth, with higher rates of stillbirths and newborn deaths, than mothers just a few years older, 20 to 24 years (WHO, 2020).

Girls and women who are subjected to child and forced marriage are often denied their right to make decisions about, or lack accurate information about, their sexual and reproductive health. A large-scale study in India, for example, documented negative reproductive health consequences of child marriages: young women who had married at the age of 18 or older were more likely than those who had married before the age of 18 to have been involved in planning their marriage, to refuse to tolerate domestic violence, to have used contraceptives to delay their first pregnancy and to have had their first birth in a health facility. They were less likely than women who had married early to have experienced physical violence or sexual violence in their marriage or to have had a miscarriage or stillbirth (Santhya and others, 2010).

Another study in Nepal found that a combination of pressure to give birth soon after marriage, limited autonomy, and little knowledge about reproductive health issues make young married girls vulnerable to high-risk pregnancies (Maharjan and others, 2019).

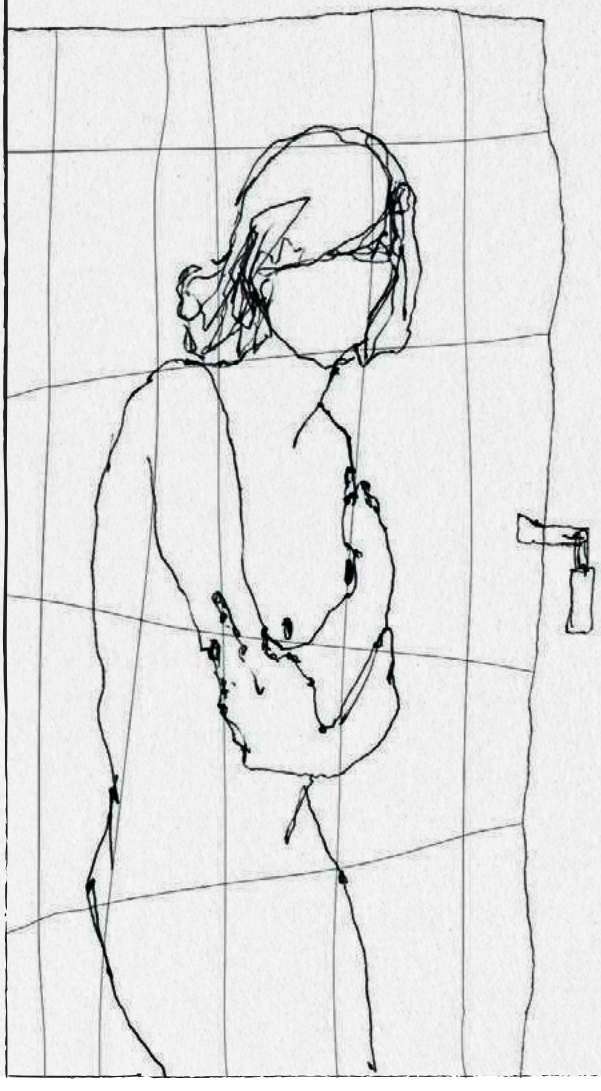
Besides the violation to bodily autonomy, child marriage impinges on other human rights, such as the right to education. Differential education rates between genders is one of the major impediments to full gender equality and the empowerment of women and girls, and child marriage and early childbearing are significant obstacles to ensuring educational, employment and other economic opportunities for girls and young women.

An extensive World Bank study undertook to test whether women worldwide who had married as children had less decision-making power in the marriage, with specific questions

Slavery: the ultimate violation of the right to autonomy

People who are enslaved have no power to make any decisions about their bodies or lives.

An estimated 40 million people are in some form of modern slavery (United Nations, n.d.).



Although modern slavery is not defined in law, it is an umbrella term covering practices such as forced labour, debt bondage, forced marriage and human trafficking. It refers to situations of exploitation that a person cannot refuse or leave because of threats, violence, coercion, deception or abuse of power.

There are more than five victims of modern slavery for every 1,000 people in the world. One in four victims is a child. More than seven in 10 victims are female.

Embedded in Sustainable Development Goal 8—to achieve inclusive economic growth and decent work by 2030—is a target to eradicate forced labour and end modern slavery and human trafficking.

Victims are often the most vulnerable in our societies: those suffering multiple forms of discrimination—women, children, indigenous peoples, people of African descent and persons with disabilities, United Nations Deputy Secretary-General Amina J. Mohammed said in 2020. "Modern slavery is a blight in our world that we must eradicate," she added, calling modern slavery and human trafficking "international crimes with significant costs to society and economy".

Artwork by Kaisei Nanke

Able to choose

In 1999, Lizzie Kiama was commuting to work in Mombasa, Kenya, when her minibus collided, head-on, into another vehicle. "I was seated in the front," she remembered. "The accident resulted in me becoming disabled." But it would be 11 years before she fully accepted this new reality.

"I did not identify as a person with a disability for a long time," Kiama said. "That's because there was always a very negative connotation that surrounded the word 'disabled'."

The turning point was becoming a mother and deciding she would improve the world for her children. For her, that meant identifying as a person with a disability—and redefining what it means, she explained. Kiama went on to found This Ability Trust, a social enterprise focusing on the rights of persons with disabilities, through which she has observed the many ways people with disabilities are denied agency, particularly when it comes to their sexual and reproductive health and rights.

Those with visual or hearing disabilities seldom have access to interpreters or Braille when seeking health services, she said, and persons with caregivers face reduced privacy and confidentiality. Many persons with disabilities lack accessible transport options, and many health facilities lack the infrastructure, equipment and trained staff to serve them.

"Families collude with medical professionals to sterilize them."

And then there are the horror stories.

"I have heard stories of women who would rather give birth at home than face nurses or midwives who question why, in their disabled condition, they would be having children or getting pregnant," Kiama said. "Society, in general, has associated persons with disabilities, women in particular, as being asexual... Simple things like legal capacity, bodily autonomy, the right to decision-making are not considered the norm."

Women and girls with disabilities face high rates of gender-based violence in Kenya (Salome and others, 2013). But too often, in response, their bodily autonomy is further violated, Kiama said. "You find in some cases girls with disabilities whose families collude with medical professionals to sterilize them as a means of 'protecting them', because they are constant victims of sexual violence," she explained. "Nothing happens to the perpetrators."



Lizzie Kiama is a champion for the rights of persons with disabilities. Original artwork by Naomi Vona; image courtesy of Lizzie Kiama.

But these issues are in no way unique to Kenya alone. People with disabilities confront serious obstacles to sexual and reproductive health decision-making almost everywhere.

In Mongolia, for example, there have been reports of health workers performing abortions on women with disabilities without consulting them. Instead, the doctors seek consent from the women's guardians, according to Enkhjargal Banzragch, a social worker at the Mongolian National Wheelchair Users Association. One study by the

Association found 22 per cent of persons with disabilities have been forced by family members or health-care providers to use contraception.

Refusing contraception can have consequences. Women with intellectual disabilities are often denied their allowances or extension of their disability status if they have not received required doses of injectable contraceptives, Banzragch explained.

Individuals with disabilities and their caregivers may be given little to no explanation, says UNFPA Assistant Representative in Mongolia Iliza Azyei, who worked with activists and the health ministry to raise these issues.

She recalled the story of one girl: "As soon as she turned 16, the public health doctor came to her house and they started providing quarterly injectable contraceptives." Azyei asked the girl's mother if they had questioned what was happening. "She said, 'No, I trust my doctor.'"

Still, there are reasons for hope.

"Looking at policies and the legal framework from an advocacy point of view, there has been progress," Kiama said, citing Kenya's 2003 disability act, the country's constitution, the ratification of international conventions on disability rights, and increasingly accessible building standards.

Mongolia, too, has seen progress. During a 2015 review of Mongolia's human rights records, reproductive health violations against persons with disabilities were brought to light. The Government "made immediate revisions in the health ministerial order to provide sexual and reproductive health services to women, including disabled women," Azyei said.

Policy-level change is just one step, she added. "But how do we deal with the actual practices?"

For that, experts agree, attitudes must also change. "Women with disabilities have a right to fall in love, have a baby, get services and have a life," Azyei emphasized.

Persons with disabilities must be protected from sexual abuse, but these protections must support—rather than undermine—their bodily autonomy. And they must be empowered to claim their rights.

"As persons with disabilities, we imagine that we need to have our hands held and to ask for permission," Kiama said. But she sees change in the younger generation of persons with disabilities. "We're seeing more young women taking up space and using social media for advocacy. They are advocating for sexual and reproductive rights in different ways, and that's incredible to see."

about seeking reproductive health services and use of contraception. The study found that, in the case of both contraceptive use and decision-making power, the variable with the most impact was years of education. What the study validated was that child marriage did have an effect on reproductive health and decision-making power mostly through its indirect impact on educational attainment (Wodon and others, 2017). The shortening of formal education for girl brides has economic implications for them and society, but it also has a real impact on their sexual and reproductive health and their ability to exercise their agency and make autonomous decisions.

Humanitarian crises negatively impact women's bodily autonomy

Evidence from humanitarian crises around the world shows that a breakdown of family, social and legal networks increases the risk of sexual violence as well as fuelling widespread perceptions that the "honour" of girls and women, and therefore their families, is in danger. This fear of "damage" to family honour may underpin families' decisions to marry girls at an early age, resulting in higher numbers of forced and child marriages. Fear of sexual violence against women and girls has been found to be a leading cause for families to flee their homes in emergencies—and an incentive to marry off their daughters at a young age in the belief that marriage will protect them (UN HRC, 2019).

Within countries with high prevalence rates of child marriage, girls who are displaced or impacted by crisis are some of the most vulnerable. Niger, for example, has the highest child marriage prevalence rate in the world (76 per cent of girls are married before 18), but the rates in regions with large numbers of persons receiving humanitarian assistance are even higher—up to 89 per cent in Maradi. In another example, an Oxfam report found 70 per cent of girls in a northern town in Sudan were married before the age of 18 after an outbreak of fighting in the region, much higher than the national average (UN HRC, 2019).

Conflict and post-conflict settings are particularly conducive to gender-based violence, including forced and child marriage, because of such factors as the breakdown of the rule of law and security, changes in traditional gender roles and constraints on the freedom of women and girls, cultures of impunity, loss of economic and social capital, and even extremist ideologies that encourage the abduction of women and girls into armed groups (Swaine and others, 2019).

In the case of these extreme ideologies, in recent years armed non-state actors have enforced a social order that perceives women and girls as either tools of their movements or as threats. In some cases, girls and women have been forced to marry members of these groups to serve as sex slaves. For example, beginning in 2014, Yazidi girls and women in Iraq were forced to marry members of Islamic State in Iraq and the Levant (ISIL).

ISIL in the Syrian Arab Republic, Boko Haram in Nigeria and Cameroon and Al-Shabaab in Somalia abducted girls and women to be raped, sold and forced into marriage. The ideological exploitation of child and forced marriage has been reported in the Central African Republic,

Libya, Mali and Somalia, while armed and organized crime groups in Malaysia and Nigeria have been reported to use child and forced marriage as a cover for sexual exploitation and human trafficking (UN HRC, 2019).

While there is ample evidence that gender-based violence increases in conflict and displacement settings, there is less evidence about how crises impact women's decision-making capacity in sexual relations. Although crises often lead to a deterioration of public services, there is also evidence to suggest that women's agency in accessing health care and using contraception can actually be enhanced in such times. One reason for this is the diminished influence of gender-unequal community norms in crisis-affected settings, which allow greater latitude in making autonomous decisions.

In crisis-affected countries such as Eritrea and Liberia, the progressive dissolution of community norms enabled some women to have not only more autonomy, but also greater freedom of speech and decision-making authority at the household level. This phenomenon has also been seen in places affected by natural disasters, such as droughts, where more women chose to use contraception. Another reason why some women have more power to make decisions about health care is that contraceptive information and services are often readily available in refugee camps (UNFPA, 2019). However, during and after crises, gender inequality and discrimination can also compound the challenges women and girls face in securing their bodily autonomy and integrity. As a result, many endure increased insecurity, restricted mobility, gender-based violence and harmful practices, including female genital mutilation (ICRC, 2020).

Programmes to end or prevent female genital mutilation are often left out of humanitarian response plans. During the initial phases of the COVID-19 pandemic, for example, most countries where female genital mutilation is prevalent did not prioritize the elimination of the practice in their national humanitarian response plans (UNFPA and UNICEF, 2020). Yet, several assessments indicated an increased risk of girls undergoing the practice: a UNFPA assessment in Somalia showed that 31 per cent of community members who were interviewed said they believed there had been an increase in this harmful practice since the pandemic began (UNFPA, 2020a). A survey by Save the Children in September 2020 in the Dadaab refugee camp in Kenya explored the impact of COVID-19 and found that 75 per cent of child-protection workers reported a 20 per cent increase in female genital mutilation (Save the Children, 2020).

In countries such as Ethiopia, Kenya, Nigeria and Sudan, girls are also reportedly at an increased risk of undergoing female genital mutilation as a precursor to marriage, suggesting a negative coping strategy associated with economic fallout and school closures (UNFPA and UNICEF, 2020).

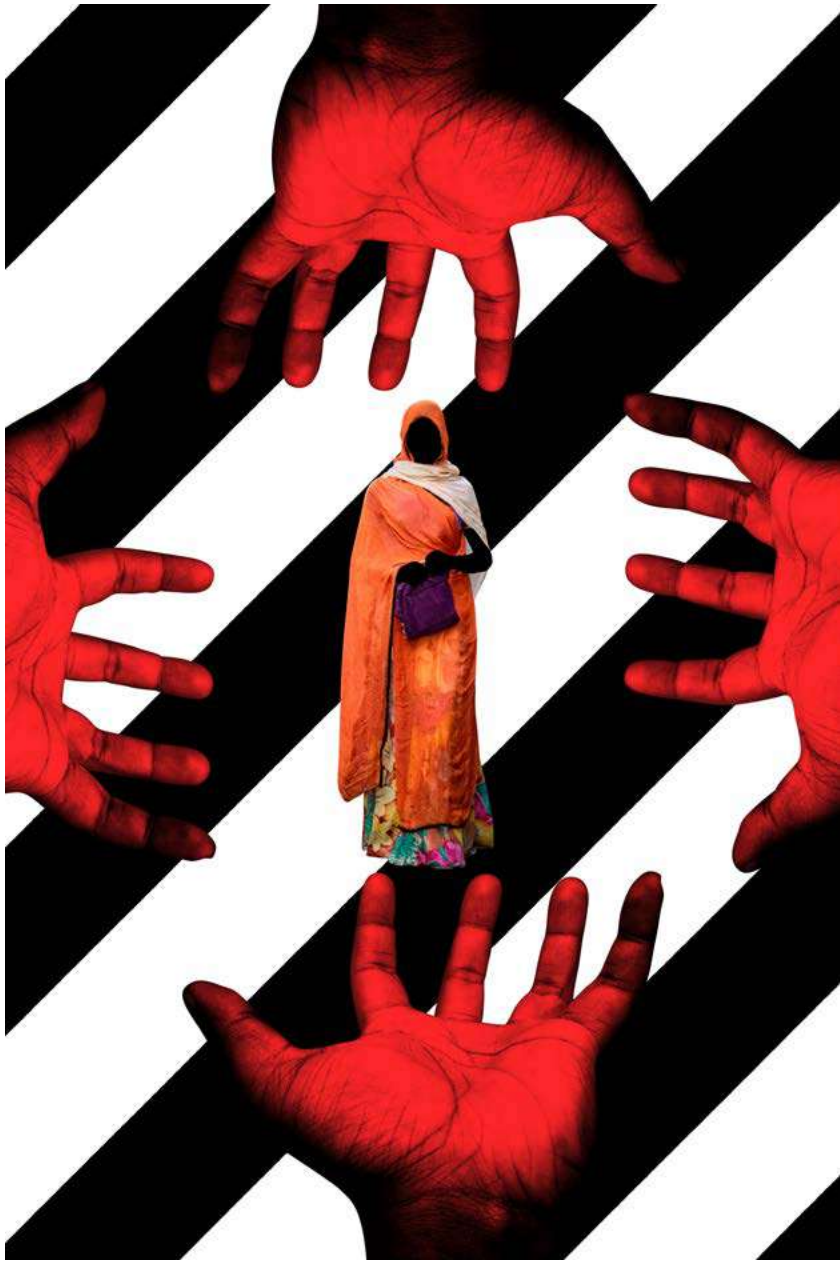
According to estimates by UNFPA, the pandemic may result in 2 million cases of female genital mutilation that would otherwise have been averted, or a one third reduction in progress towards Sustainable Development Goal target 5.3 to eliminate female genital mutilation by 2030 (UNFPA, 2020b).

"Honour killings": an extreme denial of bodily autonomy

Honour killings occur in communities where the "honour" of the family is considered to be more important than the life of the person, usually a woman, who violates certain so-called norms or codes (Gibbs and others, 2019).

Rationalizations for honour killings have included separation from a spouse who paid a bride price, refusing to enter into an arranged marriage, entering into a relationship with a person from a different religion, ethnic group or caste, engaging in premarital or extramarital sex, being the victim of rape or assault, or being identified as gay (Selby, 2016).

Although both men and women can commit or be victims of honour killings, the "code of honour" has different standards for men and women, including stricter standards of chastity for women and a perceived duty for men to commit violent acts to secure their honour or that of their family. In all cases, the honour code is part of the patriarchal social system that subjugates women to men. The result is that honour killings are disproportionately violence against women. Although it is not possible to know the true number of these killings, it is estimated that there are approximately 5,000 such murders every year, of which most take place in the Middle East and South Asia (Gibbs and others, 2019). It is important to note that an estimated 58 per cent of female victims of murder were killed by an intimate partner or member of their own family, amounting to 137 women every day (WHO, 2013). This has been exacerbated by the COVID-19 pandemic—and violence against women has been deemed the "shadow pandemic".



Artwork by Tyler Spangler

Threatened by a woman's sexuality

Culture, tradition and religion are among the most commonly cited motivations for performing female genital mutilation. Yet curtailed sexual desire is almost universally understood to be an outcome of the practice and, in fact, it is also a key motivator. Many proponents of female genital mutilation have argued that unbridled female sexuality is somehow a threat to chastity, honour and virtue (Berg and Denison, 2013).

Frank conversations about female sexuality, bodily integrity and bodily autonomy may offer an unexpected antidote to the practice, experts say.

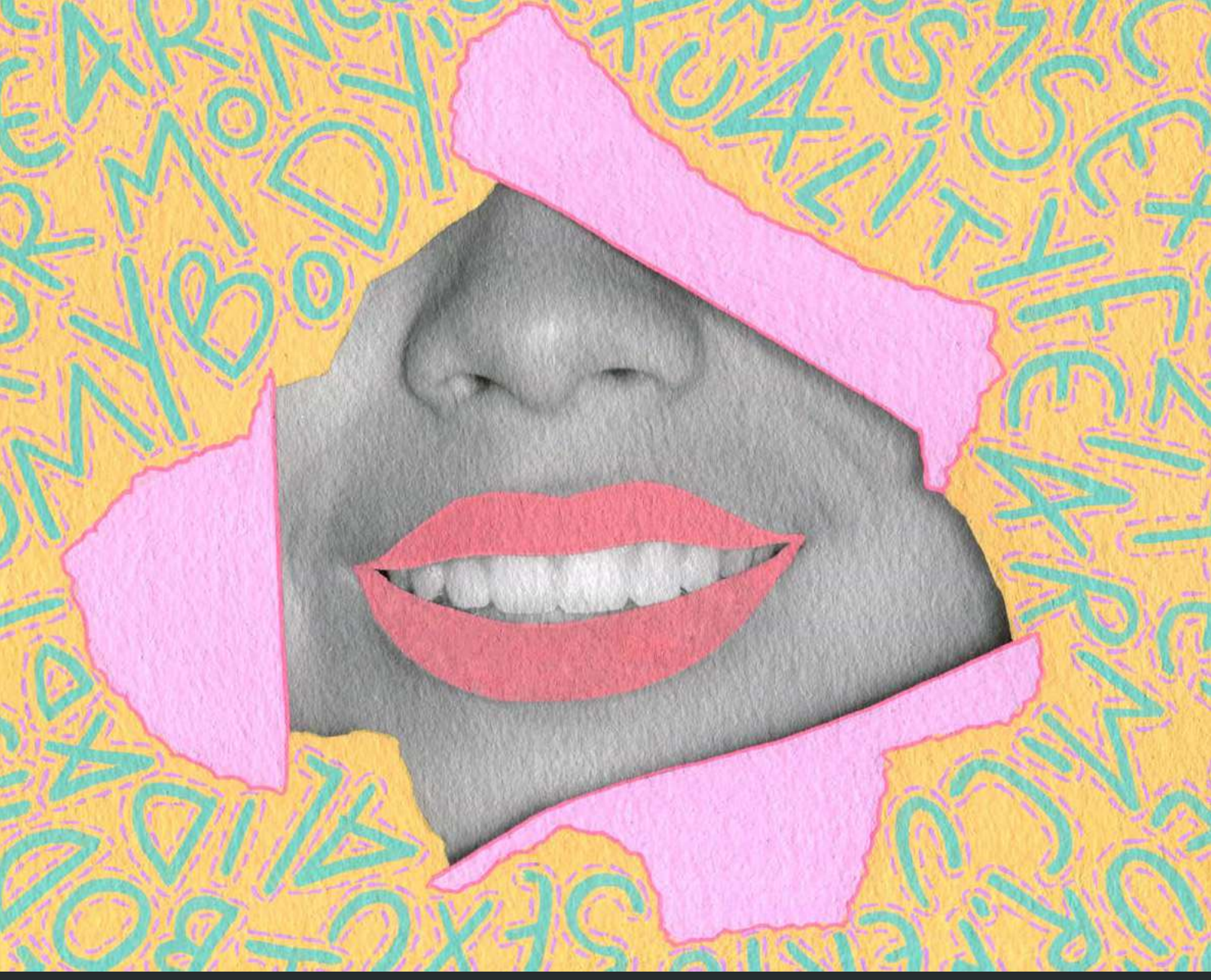
Efforts to end female genital mutilation have historically underscored the physical harms caused by the practice, which can include haemorrhage, sepsis, future childbirth complications and even death. Emphasis on the physical consequences is more easily received in conservative communities, where discussing female sexuality is often taboo. But a sole focus on physical harms may risk inadvertently leading to the medicalization of the practice, or the practice of alternative types of cutting, rather than its abandonment altogether (Powell and Yussuf, 2021).

Broadening these conversations to include an honest accounting of the sexual harms caused by female genital mutilation has helped Wafaa Benjamin Basta, an obstetrician and gynaecologist in Egypt, convince parents to reject the practice. Clearly articulating harms, like inability to experience orgasm, pain during intercourse, and aversion to sex due to post-traumatic stress disorder, has been an effective deterrent, especially "if the mother had a very bad experience while undergoing female genital mutilation when she was young or had troubles in her marital life because of the circumcision," Dr. Basta said.

She speaks with ease about the social and psychological repercussions women can experience. "This may affect her mental health, social well-being and her relation with her partner, which may affect deeply the concept of the family itself."

One reason Dr. Basta is able to have these forthright discussions is her role as a physician. "There is this bond between the patient and the doctor," she said. But even more critical is the growing acceptance of women's rights and empowerment in Egypt.

"Minds are changing, especially for the new generations."



Female genital mutilation is not simply a health issue. It is a sexuality issue. Original artwork by Naomi Vona; photo by Hana Lopez on Unsplash.

"Minds are changing, especially for the new generations."

As fears of female sexuality diminish, and sexual well-being is increasingly considered within the frame of psychological and social health, it becomes easier to rethink the practice of female genital mutilation.

Dr. Basta says her observations are limited to the confidential conversations she is able to have with her patients, and that comfort with these topics will vary by community and practitioner. Still, she has seen great progress in recent years, and is hopeful about the future, both for ending female genital mutilation and for promoting women's sexual health and well-being. "There's no shame to talk about that," she said.

Marital rape and "marry-your-rapist" laws

It is clear that the data points chosen for indicator 5.6.1 are inexact measures for all the ways that the agency of women is attenuated by patriarchal marital structures, but there is a direct relation in the case of one component: can a woman say no to her husband or partner if she does not want sexual intercourse? Whatever the interpersonal dynamics inside a marriage, it is the case that in some countries the law permits the husband to have sexual intercourse whether the wife wants it or not, and there are countries where a man who rapes a woman can escape penalties if he marries her against her will.

Whether a woman has been forced into a marriage or entered into it freely, traditional patriarchal norms have held that once a marriage has taken place a man "owns" his wife's body and can use it for sex whenever he wants. It is only within the last few decades that "marital rape" has been recognized as a concept and as constituting an egregious human rights violation. The victims of marital rape are subject to the manifold harms suffered by all rape survivors: psychological damage as well as the physical injuries associated with forced sex, unintended pregnancies, miscarriages and sexually transmitted infections (Yllö and Torres, 2016).

This human rights violation has important reproductive health consequences. The risk of HIV and other sexually transmitted infections is increased because of forced vaginal penetration and abrasion, which facilitates entry of the virus into the body (Jewkes and others, 2011). Women experiencing abuse in marriage are one-and-a-half to three times more likely to test positive for HIV and two to four times more likely to report another sexually transmitted infection (WHO, 2015).

The various practices that enforce male control and violate the bodily autonomy rights of women are interrelated. Studies have found a strong correlation, for example, between marital rape and child marriage: a 2011 study found that most cases of marital rape in Uganda were committed against 15- to 19-year-old girls whose older husbands had paid a bride price to obtain their wives (Hague and others, 2011).

Forty-three countries do not have any legislation that addresses the issue of marital rape. Even in countries that recognize the concept, the penalties for non-consensual sex within marriage may be significantly lower than in other cases. Likening marriage to a "get-out-of-jail-free card", a 2020 study found that among the 54 Commonwealth countries 35 still apply some form of marital exemption to criminal sexual offences (Richardson, 2020).

In some countries and territories, marriage may be considered a legal "cure" for rape by allowing perpetrators to marry their victims and thereby avoid any penalties for their crime. Laws allow men convicted of rape to have the verdict overturned if they marry the women they have assaulted in Algeria, Angola, Bahrain, Bolivia, Cameroon, Dominican Republic, Equatorial

Guinea, Eritrea, Gaza, Iraq, Kuwait, Libya, Philippines, the Russian Federation, Serbia, Syria, Tajikistan, Thailand, Tonga and Venezuela (Equality Now, 2020).

In 2017, the NGO Equality Now undertook an extensive review of "marry-your-rapist" laws. It found, for example, that in Iraq, if the perpetrator marries the victim, any legal action against him becomes void, and any ongoing investigation or legal case is discontinued. If a sentence has already been handed down, it is reversed and not carried out, but it can be reinstated if there is divorce within three years. In Kuwait, if the perpetrator legally marries his victim with the permission of her guardian and the guardian requests that he not be punished, the perpetrator is set free. In Russia, if the perpetrator has reached 18 years of age and has committed statutory rape with a minor below 16, he is exempt from punishment if he marries the victim. In Serbia, "cohabiting with a minor" is prohibited; however, "if a marriage is concluded, prosecution shall not be undertaken and if undertaken it shall be discontinued". In Thailand, marriage can be considered as a settlement for statutory rape if the offender is over 18 and the victim is over 15 years old, if she "consented" to the offence and if the court grants permission for marriage (Equality Now, 2017).

Marriage laws and practices that subordinate women and deny them agency are widespread and difficult to root out. However, they are far from the only ways in which patriarchal structures reinforce male dominance and circumscribe female sexuality.

Female genital mutilation

Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2020a).

Female genital mutilation is a violation of women's and girls' human rights and an extreme form of discrimination and violence directed exclusively at girls and women. It is also a part of wider patriarchal practices, rooted in gender inequality and aimed at controlling women's and girls' sexuality, their bodies and their sexual and reproductive rights.

The practice denies women and girls their rights to: physical and mental integrity; freedom from violence; the highest attainable standard of health; freedom from gender discrimination; and freedom from torture and cruel, inhuman and degrading treatment, among others. Yet, more than 200 million girls and women live with the consequences of female genital mutilation, and at least 4 million girls are at risk of undergoing the practice each year (UNFPA, 2020c; UNICEF, 2020a).

Female genital mutilation deprives women and girls of their right to make autonomous decisions about an intervention that has a lasting effect on their bodies and infringes on their autonomy and control over their lives. Female genital mutilation is a deprivation of capabilities, affecting the ability of women and girls to achieve full functioning in the world because of the physical, sexual and emotional consequences of the practice. These consequences, in turn, may adversely affect their individual well-being,

Putting the unity in community

Daniyar realized he was transgender at age 7, but believed for years that he was alone. "When I was 15 or 16, I was very depressed. I was not accepting myself... I didn't know that there were LGBTI communities or organizations in Kyrgyzstan." It was not until someone tipped him off about a local LGBTI group that he felt equipped to take control over his body and life. "I understood that this is my environment," he said. "Before that, I felt I was not living in my own body. But I learned about transgender people, and started reading about it, and then I started my transition."

Daniyar, now 23, knows this experience is far from unique. In fact, advocates and researchers have long observed the creative and collective ways people come together to reclaim their bodily autonomy when it is threatened. LGBTI people have created safe spaces for each other in even the most restrictive settings around the world. And there are other examples. Sex workers come together to share information about violent clients. Women help each other conceal contraceptives, escape abusive partners, or terminate unwanted pregnancies in countries where abortion is hard to access or illegal. When and where possible, these informal networks tend to formalize into advocacy groups that are a driving force for change.

That is happening in Kyrgyzstan, said Ayim, a 24-year-old transgender woman. She, too, felt isolated for years before finding acceptance and solidarity in the LGBTI community. "I would wear my mom's skirts. My mom would make fun of me and scold me at the same time... When I started my studies at a university, I understood that I needed to disclose who I am. If I disguised it all my life, I would be trapped. In 2016, I started actively getting acquainted with people from the LGBTI community."

"We have common problems and we know how to support each other."



Ayim says she felt isolated before finding the LGBTI community. Original artwork by Naomi Vona; image courtesy of Ayim.

Today, both Daniyar and Ayim are LGBTI activists. They work with a local non-governmental organization, Kyrgyz Indigo, to provide services to LGBTI people in need, including housing assistance and access to health information and care. This support is critical in a country where LGBTI people face frequent discrimination. Transgender people are especially vulnerable, they say, with high rates of unemployment in part because they cannot update their identification documents to reflect their gender identity.

"The latest amendments in the law prohibit people from changing their passports to correct their gender," said Daniyar. There are also very few medical specialists helping transgender people transition, making the process extremely costly. "Many sacrifice their nutrition or do not sleep [to work around the clock], so they can save money for surgery to correct their bodies."

There is always a threat of violence looming over them. Both Daniyar and Ayim have been threatened, and they have friends who have been assaulted. "There are many stories like this," Daniyar said. "They beat up or take the person somewhere, to the mountains, outside of the city... beat them almost to death or maybe to death and leave them in a wasteland."

Despite these risks, they are motivated by an intimate understanding of the struggles in their community. "We have common problems and we know how to support each other," explained Ayim. "We stick with each other." And expressing one's authentic gender identity is non-negotiable, they say. It is a matter of life or death. If transgender people were forced to hide completely, "I think there would be many suicides," said Daniyar. Or they would "leave Kyrgyzstan and become a refugee, because living in a body that is not yours is terrible," added Ayim.

Circumstances for the community have worsened under the COVID-19 pandemic, with job losses leaving many homeless, hungry or unable to afford medication. Kyrgyz Indigo has been delivering food and essential supplies, including soap, toilet paper and sanitary napkins, to those in need. It is helping ensure continued access to hormone therapy for transgender people and antiretrovirals for people living with HIV. And it has been operating three shelters throughout the pandemic to meet the increased need for emergency housing.

Their experiences hold lessons for other marginalized communities working to advocate for their rights and bodily autonomy, they say. Firstly, "there is a need to empower the community and to increase visibility," Ayim noted. Acceptance of LGBTI issues within the country is greatest in Bishkek, the capital, thanks to the presence of activist groups and efforts there, she explained.

But advocates must also be prepared for opposition, and they must protect themselves: "You need to be ready for any reactions and move with no fear," Ayim said. "When you fully devote yourself to activism, to such work, you burn out." And most important, she said, is trust: "The main thing is to trust yourself, trust your power... Do not be afraid of anyone. Because there is you, there is us, and together we can all go further."

including opportunities for sexual satisfaction and for choice in matters of reproduction (Nussbaum, 2000).

While families and communities cite cultural, religious and social reasons for practising female genital mutilation, justifications centre on the need to reduce women's sexual desire (Gamal and others, 2018). Female genital mutilation is directly linked to gendered power relations and social control over women's bodies and sexuality, and to the status of women and girls in a given society and their level of empowerment or agency (Toubia and Sharief, 2003).

Women living in communities that practise female genital mutilation are subject to a strong patriarchal social and economic regime with very few options for choices in livelihood, which leaves them little opportunity for negotiating a limited amount of power (Toubia and Sharief, 2003). The lack of choice over their own lives means that having their daughters undergo female genital mutilation, and complying with other social norms, especially those linked to sexuality and the economics of reproduction, is an essential requirement for "silent power negotiations" (Toubia and Sharief, 2003).

Women may protect and practise female genital mutilation because they use it as a power-gaining tool (MIGS, 2015). Women may even forego autonomy over their body in exchange for social inclusion, economic survival (marriage) and other freedoms (MIGS, 2015; Toubia and Sharief, 2003).

No gender equality without control over one's own body

Forced and child marriage, marital rape and female genital mutilation are some of the more stark examples of the relationship between gender-unequal norms and the erosion of a woman's or girl's power to make autonomous decisions in life. Assaults on this power come from many other directions as well, ranging from legal and economic systems that deny women financial independence, to patrilineal inheritance traditions and education systems that fail to impart knowledge to girls about their bodies and rights.

Breaking through the many economic, social and institutional barriers to full gender equity and equality is complex and difficult, but any achievements that are made are of little consequence unless they provide the most fundamental right: the right to control one's own body. This has become globally recognized through the Sustainable Development Goals, which acknowledge that Goal 5 to achieve gender equality and the empowerment of all women and girls has to include universal access to sexual and reproductive health and reproductive rights. And one of the measurements of achievement is the proportion of women who make their own informed decisions about sexual and reproductive choices—in other words, the extent to which women control their own bodies.



Artwork by Hülya Özdemir

MY BODY MY RIGHTS

International treaties and declarations provide foundations for the right to bodily autonomy and integrity

Do people have rights to make decisions about their own health care, including reproductive health care? Do these rights include making choices about contraception? Does a woman have a right to say no—or yes—to sex, when she wants and with whom she wants?

According to international human rights law, the answer to these questions is an emphatic "yes".

Even though bodily autonomy is a foundation upon which human rights are built, it is rarely articulated as a right in and of itself (UN General Assembly, 2007). Rather, bodily autonomy underpins or is subsumed in a number of rights that are spelled out in treaties and international agreements.

Bodily autonomy in the context of sexual and reproductive matters encompasses rights that enable individuals to make informed choices and decisions regarding their sexual and reproductive health needs, and to do so free from discrimination, coercion and violence. These rights were first articulated in the Programme of Action of the 1994 International Conference on Population and Development (ICPD), and the Platform for Action of the 1995 Fourth World Conference on Women (United Nations, 1995; UNFPA, 1994).

Depending on the treaty or agreement, "autonomy" in matters related to sexuality and reproductive health and decision-making may encompass access to comprehensive sexuality

education, contraceptive information and services, maternal health care, infertility treatment, gender-affirming interventions, such as hormonal and surgical treatment, and comprehensive abortion care. Autonomy also touches on matters of civil status, ranging from marriage and divorce to the legal capacity to make decisions about one's own body and the power to express one's gender identity.

Rights to bodily *autonomy* are aligned with rights to bodily *integrity*, which are tied physically to liberty and security of the person, and to freedom from torture and cruel, inhuman or degrading treatment, as well as the inviolability of one's self: body and mind. In the context of reproduction and sexuality, violations of bodily integrity include practices such as female genital mutilation, virginity testing and punitive anal examinations, as well as rape, including rape by a spouse or partner, and other forms of gender-based violence.

Rights related to bodily autonomy and integrity enable individuals to make their own decisions in the realms of reproduction and sexuality. States affirm and regulate these rights through policies and laws that define "legal capacity" or determine the age of consent for sex, marriage or accessing services such as contraception.

Autonomy rights are interdependent and mutually supporting, regardless of how they are expressed, whether as a "right to respect for… physical and mental integrity" (European Union, 2012, Article 3(1)), as "rights to life, physical and mental integrity, liberty and security of the person" (UN General Assembly, 2007a, Article 7(1)), as freedom from torture, cruel, inhuman and degrading treatment, or as a right to dignity and privacy, or in the right to health as expressed in many national constitutions (Viens, 2020).

Bodily autonomy and reproductive decision-making

Human rights law robustly affirms the right to information and means to make decisions about childbearing. Article 16.1(e) of the Convention on the Elimination of All Forms of Discrimination against Women, commonly known as the Women's Convention, requires States Parties to uphold women's rights "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (UN General Assembly, 1979).

The Convention on the Rights of Persons with Disabilities, known as the Disabilities Convention, specifies that the right to make decisions about the number and spacing of children applies to persons with disabilities (UN General Assembly, 2007). The right to decide on the number and spacing of children is mirrored in the African Charter on Human and Peoples' Rights, in its Protocol on the Rights of Women in Africa, the "Maputo Protocol" (African Union, 2003). Similar language is also found in the ICPD Programme of Action and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women.

Human rights and the United Nations treaty system

Human rights are basic guarantees, which the international community recognizes and promises to uphold. These rights cover civil, political, social, economic and cultural matters and establish what governments can and cannot do, as well as what they should do for all of us without discrimination. Everyone, regardless of sex, gender, race, ethnic origin, religion, nationality, language, disability, place of residence or any other status, has these rights.

Human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law (OHCHR, n.d.).

Human rights treaties are overseen by the United Nations through treaty-monitoring committees, known as treaty bodies, which ensure that States Parties honour their commitments under each treaty. For example, the United Nations Committee on the Elimination of Discrimination against Women monitors progress for women made in countries that are States Parties to the 1979 Convention on the Elimination of All Forms of Discrimination against Women. The Committee also makes recommendations on issues to which it believes the States Parties should devote more attention.

Similar bodies have been established to monitor progress in meeting obligations to other treaties, such as the Convention on the Rights of the Child.

Treaty bodies may issue non-binding recommendations, or Concluding Observations, which suggest certain actions countries should take to better meet their human rights obligations. They may also issue General Comments or Recommendations to help governments understand their treaty obligations and provide authoritative interpretation as to the meaning of treaties. In certain cases, treaty bodies can act like courts and issue opinions that are meant to settle disputes and points of law.

Another important source of human rights norms comes from political consensus agreements, such as the ICPD Programme of Action and the Platform for Action of the 1995 Fourth World Conference on Women. These agreements, together with the United Nations Sustainable Development Goals, establish global policies and targets for the realization of rights, including sexual and reproductive rights.



Artwork by Kaisei Nanke

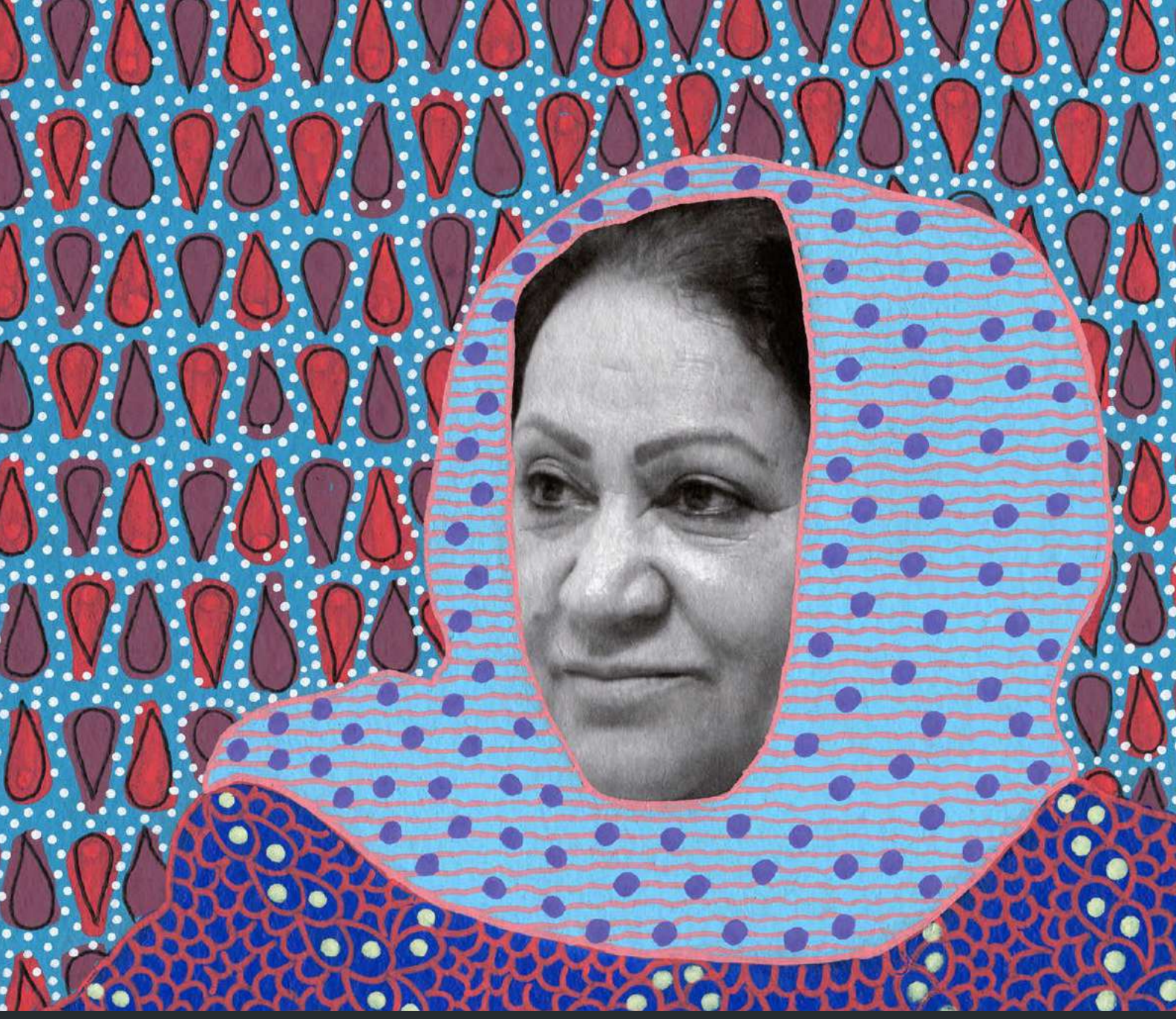
First, do no harm

Virginity testing violates individuals' human rights and dignity, the United Nations has resoundingly asserted. When performed without consent, it constitutes torture and a form of sexual violence. It is also scientifically useless, and a violation of medical ethics (WHO and others, 2018). Yet it persists in every region of the world; its continued practice has recently made headlines in the United Kingdom, for instance, where a bill is under review to ban the practice. Virginity tests are used to enforce or encourage abstinence among unmarried women and girls, with justifications ranging from the preservation of their "purity" and family "honour" to the prevention of HIV transmission and adolescent pregnancy (Olson and García-Moreno, 2017). And yet many of its defenders invoke feminist language to argue for its continuation.

A virginity test, also known as a hymen exam or "two-finger" test, typically involves an examination of the hymen, a thin tissue often, but not always, present in the vagina. The test relies on the assumption that physical characteristics of the hymen or vagina can demonstrate whether a woman or girl has engaged in vaginal intercourse—a belief overwhelmingly discredited by medical studies. Unscientific examinations to "prove" or "disprove" intercourse only reinforce harmful social norms and must be banned, medical and human rights experts assert. These include not only virginity tests but also forced anal exams, which involve the insertion of fingers or objects into the anus of a man or transgender woman with the purported objective of finding "proof" of homosexual conduct. Forced anal tests have been reported throughout the Arab States and East and Southern Africa regions, yet they are "medically worthless" and "amount to torture or ill-treatment", said the 2018 report of an independent expert to the United Nations Human Rights Council (UN HRC, 2018).

Virginity tests, as well as forced anal exams, are physically invasive, painful and stigmatizing. Suraya Sobhrang, a medical doctor and former human rights commissioner in Afghanistan, says the tests used to be

"This is a violation of human rights and it's against human dignity"



Suraya Sobhrang describes how medical and legal personnel perpetuated nonconsensual virginity testing in Afghanistan. Original artwork by Naomi Vona; photo © UNFPA/A. Mohaqqeq.

ordered punitively after any perceived transgression, such as sitting next to a member of the opposite sex. "All this was a 'moral crime'," Dr. Sobhrang described.

Examination conditions were often neither sanitary nor private, and women could be forced to undergo the test repeatedly, she said. "This was traumatizing these women... One woman told me, 'I feel that the second time, somebody raped me.'"

Women could be imprisoned for failing a virginity test.



"Some women did self-immolation after this testing," Dr. Sobhrang recalled. Others were killed by their families.

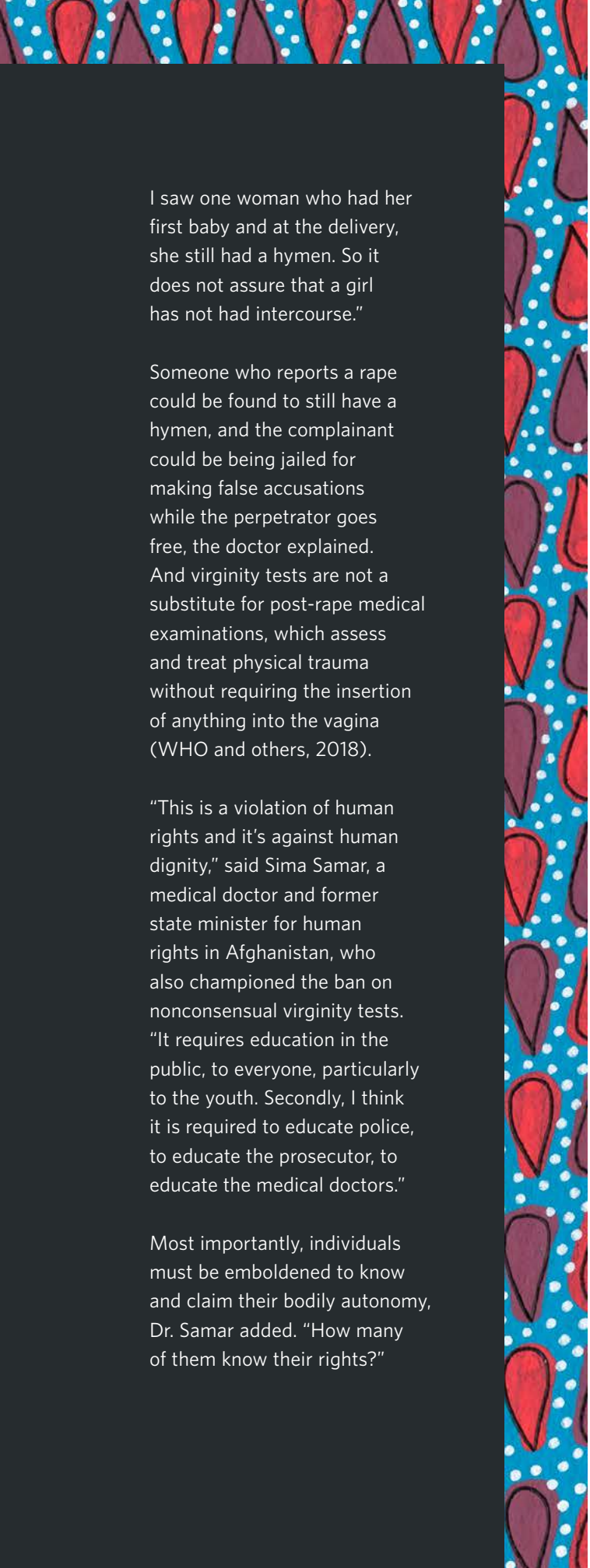
Dr. Sobhrang and her colleagues helped to ban nonconsensual virginity tests in Afghanistan in 2018. Today, virginity tests can only be performed in Afghanistan when there is a court order and consent of the patient—though enforcement of this rule remains a concern, especially in rural areas. And both doctors and patients can still face consequences if they decline the test. Mozhgan Azami, a forensic medicine specialist in Kabul, recalled one girl who refused twice, despite a court order: "The third time, the court sent her back to us saying that if the doctors do not perform the test this time, they will be placed under investigation. Therefore, after two hours of talking to the girl, we convinced her to do the test."

Dr. Azami agrees that virginity tests, particularly when performed under duress, can "hurt them psychologically". Yet she defends the test in some instances, if performed confidentially, with dignity and full informed consent. Those views are shaped by real fears and realities: in places without scientifically sound medical procedures, such as DNA testing, virginity testing offers one of the few ways survivors can submit evidence to support an allegation of rape. "For the victim, the hymen test is a tool through which to seek justice and fight back against social and traditional blame," Dr. Azami said.

The test, if its results are favourable, can also help women avoid violence in places where a perceived loss of virginity can be a death sentence. "On a marriage night, a white cloth or paper is given to the couple that should be coloured red by the blood of the hymen after the marriage is consummated," Dr. Azami added. If "the man doesn't see the signs of virginity, the virginity test will be performed... based on the request of the girl," typically in the hope that her hymen will show an indication of tearing.

In some communities, such as in South Africa's KwaZulu-Natal Province, virginity testing is also seen by some as protection from adolescent pregnancy, HIV and other harms (UN HRC, 2016). "It is believed that virginity testing will prevent girls being coerced into having sexual relations and abuse by 'iintsizwa' [older men], especially girls in grades 10, 11 and 12," said Chief Msingaphansi of Umzimkhulu in KwaZulu-Natal. He suggests the tests, largely performed by women elders, emphasize the cultural value on abstinence, thereby encouraging girls to reject peer pressure and delay sexual activity. Chief Msingaphansi couches the ritual in the language of empowerment: "Following the tests, the girls are made aware of their rights," he said, adding that they learn to identify exploitative relationships. Yet these tests are often nonconsensual, making them illegal. "The parents decide," acknowledged a "virginity inspector" from uMgungundlovu and uThukela districts.

Despite these justifications, the test contributes to the erroneous belief that a woman's virtue is dependent on her sexual history, and it perpetuates a flawed understanding of human anatomy. Lending credibility to the test will inevitably lead to harm, Dr. Sobhrang stressed. "The hymen, some women don't have one. And sometimes the structure is very elastic.



I saw one woman who had her first baby and at the delivery, she still had a hymen. So it does not assure that a girl has not had intercourse."

Someone who reports a rape could be found to still have a hymen, and the complainant could be being jailed for making false accusations while the perpetrator goes free, the doctor explained. And virginity tests are not a substitute for post-rape medical examinations, which assess and treat physical trauma without requiring the insertion of anything into the vagina (WHO and others, 2018).

"This is a violation of human rights and it's against human dignity," said Sima Samar, a medical doctor and former state minister for human rights in Afghanistan, who also championed the ban on nonconsensual virginity tests. "It requires education in the public, to everyone, particularly to the youth. Secondly, I think it is required to educate police, to educate the prosecutor, to educate the medical doctors."

Most importantly, individuals must be emboldened to know and claim their bodily autonomy, Dr. Samar added. "How many of them know their rights?"

Bodily autonomy and health

Deciding for oneself, seeking and receiving information, and accessing services for reproductive and sexual matters are understood and included in the right to health, according to the United Nations Committee on Economic, Social and Cultural Rights (UN CESCR, 2016). At the same time, enjoying sexual and reproductive health is "indispensable to [women's] autonomy" and "intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy" (UN CESCR, 2016, para. 34).

The rights "to make free and responsible decisions and choices, free of violence, coercion and discrimination regarding matters concerning one's body and sexual and reproductive health", and to have "unhindered access to a whole range of health facilities, goods, services and information" are therefore two sides of the same coin (UN CESCR, 2016, para. 5).

According to the United Nations Committee on the Elimination of Discrimination against Women, health services must create an enabling environment where people can exercise their autonomous choices and States should "[r]equire all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice" (UN CEDAW, 1999).

Rights and infertility treatment

Access to infertility treatment is part of reproductive health care and includes techniques such as in vitro fertilization (Zegers-Hochschild and others, 2009). International human rights require all reproductive and sexual health-care services to be available and accessible on the basis of non-discrimination and equality. Various treaty bodies have concluded that where in vitro fertilization is available within a State, it must not be unduly restricted, or offered in such a way as to violate other human rights (UN CESCR 2019; UN CCPR, 2016; UN CEDAW, 2015).



Artwork by Kaisei Nanke

Bodily autonomy and privacy

Being able to make decisions about private and family life are additional aspects of rights to bodily autonomy. For example, the Political Rights Covenant provides that "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation" (UN General Assembly, 1966, Article 17(1)).

Similar formulations of the right to privacy are also included in other international and regional human rights treaties, notably the Children's Convention (UN General Assembly, 1989, Article 16), the American Convention on Human Rights (OAS, 1969, Article 11), the European Convention on Human Rights (Council of Europe, 1950, Article 8), the African Charter on the Rights and Welfare of the Child (African Union, 1990, Article 10) and the ASEAN Human Rights Declaration (ASEAN, 2012, Article 21).

The European Court of Human Rights and Inter-American Court of Human Rights have interpreted their treaties in a similar way, emphasizing that "the notion of personal autonomy is an important principle underlying the interpretation of its [Article 8 privacy] guarantees" (ECtHR, 2002).

In the United States more than a century ago, Samuel Warren and Louis Brandeis articulated a right to privacy as the "right to be left alone" (Warren and Brandeis, 1890). Since then, privacy has gained a much broader definition in the United States and elsewhere and applies

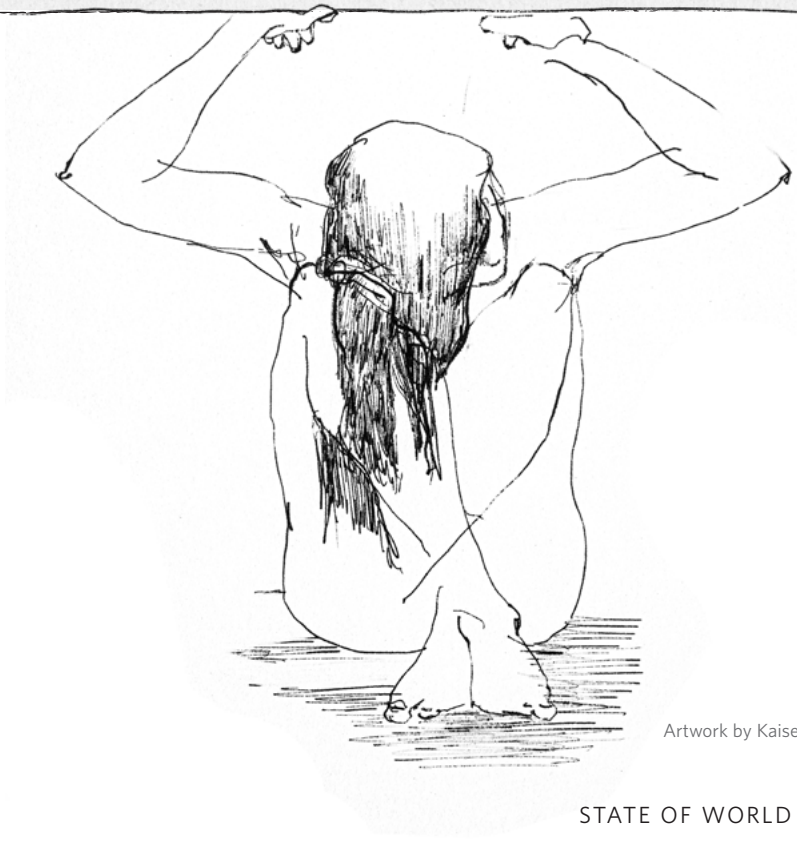
Abortion and bodily integrity and autonomy

United Nations treaty bodies, the committees that monitor governments' application of their human rights obligations, have called on States to reform abortion laws to protect women's bodily integrity and autonomy. According to the United Nations Committee on Civil and Political Rights, for example, laws must permit women the choice to end pregnancies that endanger their lives (UN CCPR, 2019).

Laws that compel women against their wishes to continue non-viable pregnancies, or impel them to travel outside their countries to terminate such pregnancies, or those which endanger their lives, violate a range of recognized human rights (UN CCPR, 2017). States must also ensure that where their laws permit women to elect an abortion, no barriers are erected to impede them in exercising their choice (UN CCPR, 2011, 2005).

The ICPD Programme of Action is a foundational document that has guided the work of UNFPA since 1994. It stresses that measures or changes related to abortion within the health system are matters left to national legislative process. The Programme of Action also affirms that where abortion is legal, it should always be safe; and, in all cases, women should be provided quality care for the consequences of abortion.

Meanwhile, international, regional and national human rights bodies and courts increasingly recommend ensuring that even where access is restrictive, women's health and lives should be promoted and protected. Moreover, they direct States to decriminalize abortion—both for the women who seek services and the health-care practitioners who provide services—thereby reducing the stigma and discrimination that they might face.



Artwork by Kaisei Nanke

to decisions about sexual and reproductive health, including contraceptive information and services, access to abortion, infertility treatments, sexual relations, sexual orientation and gender identity. International, regional and national courts have found that rights to privacy prohibit governmental interference with private, consensual sexual and reproductive behaviour between adults (UN CCPR, 1994). The United States Supreme Court based its decision in Roe v. Wade on such a right to privacy.

Legalized same-sex relationships mean greater autonomy for previously excluded groups

Mirroring laws that discriminate against people, particularly women, within marriage or coerce them into unwanted marriage, there are widespread legal restrictions on sexual relations between consenting adults of the same sex, as well as restrictions on same-sex partners contracting a legal marriage.

In recent years, the Office of the High Commissioner for Human Rights of the United Nations and other international organizations concerned with human rights have recognized that LGBTI persons' autonomy rights are violated through discriminatory laws and actions. The 2015 report of the High Commissioner for Human Rights stated forthrightly: "States that criminalize consensual homosexual acts are in breach of international human rights law since these laws, by their mere existence, violate the rights to privacy and non-discrimination" (OHCHR, 2015).

In a groundbreaking address at a ministerial meeting of the United Nations General Assembly in 2017, the High Commissioner for Human Rights said: "But the premise for dialogue must be clear: not whether to end these abuses, but how. LGBTI people are full members of the human family. They are not lesser than the rest of us; they are equal—and, as such, they are entitled to enjoy the same rights as everyone else." The High Commissioner called on all governments to allow individuals to love whom they choose and to enjoy the same rights as others (OHCHR, 2017).

In this statement the High Commissioner was acknowledging that such a change in laws and attitudes concerning our understanding of bodily autonomy would have a liberating effect on the estimated 300 million people worldwide who identify as LGBTI (Patterson and D'Augelli, 2012).

However, the High Commissioner acknowledged that not only was progress slow, it was regressing due to political agendas that cater to prejudice and bigotry. In fact, there are 69 countries in the world today where consensual same-sex sexual relations are illegal (ILGA World, 2020).

Along with the human rights implications of such laws, discrimination against LGBTI people has important implications in many other spheres, such as health. The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity of the United Nations Office of the High Commissioner for Human Rights has found that such laws "hinder the ability of relevant government departments and other actors involved in health responses", in, for example, the response to HIV and AIDS. A recent report pointed out that punitive legal environments,



Artwork by Kaisei Nanke

combined with stigma, discrimination and high levels of violence, placed gay men and other men who have sex with men at high risk of HIV infection because they are driven underground out of fear of prosecution or other negative consequences. As a result, they do not receive appropriate health education, and are reluctant to seek health-care services, testing and treatment (UN HRC, 2018).

An important part of achieving full equality under the law is the ability of LGBTI individuals to form unions with the same legal standing as that of opposite sex unions: "The United Nations and regional human rights bodies… have urged States to provide legal recognition of same-sex couples and their children and ensure that same-sex couples are not discriminated against compared to different-sex couples… It is up to the State to determine the form of recognition, but whatever form is chosen, there should be no difference in treatment between same-sex and different-sex couples" (United Nations, 2016). This recognition is far from being achieved throughout the world.

But things are changing. In 1989, same-sex registered partnerships became a reality in Denmark. Two years later, the Netherlands legalized same-sex marriage. Since then, the legal right of same-sex partners to marry and establish families has also been recognized in Argentina, Austria, Belgium, Brazil, Canada, Colombia, Ecuador, Finland, France, Germany, Greenland, Iceland, Ireland, Luxembourg, Malta, New Zealand, Norway, Portugal, South Africa, Spain, Sweden, Taiwan Province of China, the United Kingdom, the United States of America and Uruguay (World Population Review, 2020).

Going to labour: the job of a surrogate

Josefina remembers making the choice to become a surrogate. "Part of it was for the money, but what really moved me was having the power to make real the dream of many women of having a baby," she said. What she did not anticipate was how poorly run—and abusive—the surrogacy agency would turn out to be.

"I thought there would be other women like me: confident in their decision, with a minimum of one child, just like the requirements established. But the place where I arrived wasn't like that. There were a lot of young women who had not had any children before. I remember thinking 'where am I?'" A few months into her pregnancy, she, along with two or three other surrogates and some of their children, were taken to a dilapidated house with no water, electricity or food—and then locked inside.

The situation was only temporary. But Josefina (not her real name), who lives in Mexico, said she suddenly started worrying that the pregnancy wasn't actually for the purpose of being a surrogate. "A lot of ideas came to my mind such as child trafficking or organ trafficking." She still had her mobile phone and was able to surreptitiously contact the intended parents of the baby, something she had been expressly forbidden to do. "I found the parents through Facebook," she said. "They were very nice to me and supportive." They moved to another surrogacy agency, bringing Josefina with them. "I continued the process in a safer place, where I felt more confident."

Yet even after that perilous experience, Josefina says she never doubted her decision. "I was sure that I wanted to have the baby. I don't regret it.

"I saw this opportunity of helping others get something they really desired: a baby."



Policymakers seldom consider the perspectives of surrogates when crafting surrogacy laws, experts say. Original artwork by Naomi Vona; photo by Alexander Krivitskiyz on Unsplash.

It was an adventure," she said. "Once I met the parents, I was pleased with the process."

She would even consider doing it again.

The issue of surrogacy has long been considered ethically and legally fraught. Highly publicized lawsuits and custody battles in the United States, India and elsewhere have raised questions about the rights and responsibilities of surrogates and intended parents, as well as the rights of the baby produced by the surrogacy arrangement (Nadimpally

and others, 2016). Laws vary widely across and within countries. Some ban surrogacy; some ban commercial, also called compensated, surrogacy but allow so-called altruistic surrogacy; some permit both; and others have no specific surrogacy laws at all (UCLS, 2019).

Where compensated surrogacy is permitted, a lucrative industry often emerges, comprising assisted reproductive technology clinics, medical tour operators, law firms, recruiters and others. Countries with lower costs can become sought-after destinations for commissioning parents. Yet, in such places, surrogacy is often one of the few well-paying opportunities available to economically marginalized women, creating the potential for exploitation. Brokers and agencies may control the exchange of money and information as well as the provision of health care. Surrogates may be left underpaid, underinformed and medically underserved (Nadimpally and others, 2016).

The highly gendered nature of surrogacy and motherhood also creates vulnerabilities on both sides of the agreement. Infertile women may face intense cultural pressure to become mothers while same-sex couples or single parents are often barred from commissioning surrogates because they fail to meet accepted norms of parenthood. And surrogates may be criticized for betraying the perceived sacred bond between a woman and the fetus she carries. Josefina kept her surrogacy arrangement quiet for just this reason. "It's a taboo. A lot of people get scared when they hear about it, so I decided not to tell that many people. Actually, a lot of people from my own family don't know," she said.

"Stigma has grown a lot in the last 10 years," said Isabel Fulda, Deputy Director of Grupo de Información en Reproducción Elegida, a reproductive justice organization in Mexico, which has advocated on behalf of both surrogates and commissioning parents. Surrogacy laws vary across Mexico, but have generally grown more restrictive in recent years. "Even if the initial intentions of reform are good, and intended for better protection of every party, it has unfortunate consequences, especially for surrogate women," she said. In places that have implemented strict prohibitions, "the practice still goes on, but now in an underground and unsafe way."

Josefina bore many of these consequences. "When I was with the first agency, we didn't even have a contract. A contract would have given me safety that everything would be okay." She believes the restrictions are only pushing surrogacy further into the shadows, where unethical agencies can thrive without regulation and surrogates themselves are penalized. "If it was legal, people would feel safer," she said.

Rather than bans, there must be more nuanced policies that account for the input and perspectives of those affected, said Sarojini Nadimpally, a founding member of the Sama Resource Group for Women and Health in India and expert on the social and legal issues surrounding surrogacy. "Have the surrogates and infertile couples been involved in the policy formulations? Were they asked what they want in the policy or in the legislation? How accessible will these legal provisions be for surrogates?"

Not only are surrogates' experiences neglected in the crafting of legislation, but

stigmas and punitive rules have made it harder for them to raise their voices. "The more political the issue becomes, the more they are silenced," Fulda said. In place of surrogates' real stories, a caricature has emerged, in which compensated surrogates are depicted as victims while altruistic surrogates "are often portrayed as angels who are willing to breed for nine months, and expose themselves to possible risks just for the love their hearts carry. It becomes unbelievable to think they would want money for it," Fulda said.

The distinction between compensated and altruistic surrogacy doesn't make sense to Josefina. For her, being a surrogate was both a job and a gift. She did not resort to it because of poverty: "My economic situation at that time was not really that bad. My choice was made because I wanted to do something different with my life and to do something positive for someone else... I am a mother as well, and I know the happiness a child can bring."

Even in cases of alleged harmful sexual behaviour, the European Court of Human Rights directs governments to carefully balance the State's interests against an individual's autonomy interests and right to engage in private, consensual sexual activity (ECtHR, 1997).

Privacy, especially as it relates to family life, is capacious enough to encompass all manners of decision-making related to sexuality and reproduction, embracing "the right to respect for both the decisions to become and not to become a parent" (ECtHR, 2010, 2007). The privacy jurisprudence of the European Court of Human Rights is most developed; abortion as well as medically assisted reproduction for heterosexual and same-sex couples and individuals (including surrogacy, both compensated and altruistic) have been interpreted under the private and family life protections of Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Roseman, 2020).

Non-discrimination and gender equality

Enjoying autonomy and having the capacity to make decisions free from discrimination are central to human rights.

Being free from discrimination and enjoying equal treatment means that States may not make any distinction in law or policy on the basis of characteristics such as sex, age, race, ethnicity, gender expression, religion, nationality, marital status, health or disabilities (UN CESCR, 2009). Discrimination based on sex, for example, would include distinctions made "not only on physiological characteristics

but also the social construction of gender stereotypes, prejudices and expected roles" (UN CESCR, 2009, para. 20). Unequal access by adolescents to sexual and reproductive health information and services is an example of age-based discrimination (UN CESCR, 2009).

States must respect individuals' bodily autonomy and integrity irrespective of social context. According to a human rights working group on the issue of discrimination against women in law and in practice, "The right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy" (UN Working Group on Discrimination Against Women in Law and Practice, 2017).

Women and girls have often been denied rights to make their own decisions because of social and cultural stereotyped beliefs or attitudes that assign more value to the opinion of men and parents. International human rights law views these beliefs and attitudes as gender-based stereotypes associated with harmful practices, including female genital mutilation, marital and "curative" rape (against individuals based on their sexual orientation or gender identity), child marriage, forced marriage and forced childbearing.

These beliefs and attitudes have also resulted in exclusion from comprehensive sexuality education, denial of contraceptive information and services, and forced abortion, as well as violence against people of diverse sexual orientation and gender identities (UN CEDAW and UN CRC, 2014). These coercive and violent



Artwork by Hülya Özdemir

UNEQUAL ACCESS BY ADOLESCENTS ... IS AN EXAMPLE OF AGE-BASED DISCRIMINATION

practices are all predicated on social beliefs that privilege heteronormativity and seek to control and subordinate women's sexual and reproductive capacities.

States have a duty "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (OAS, 1994, Article 8(b); UN General Assembly, 1979, Article 5(a)).

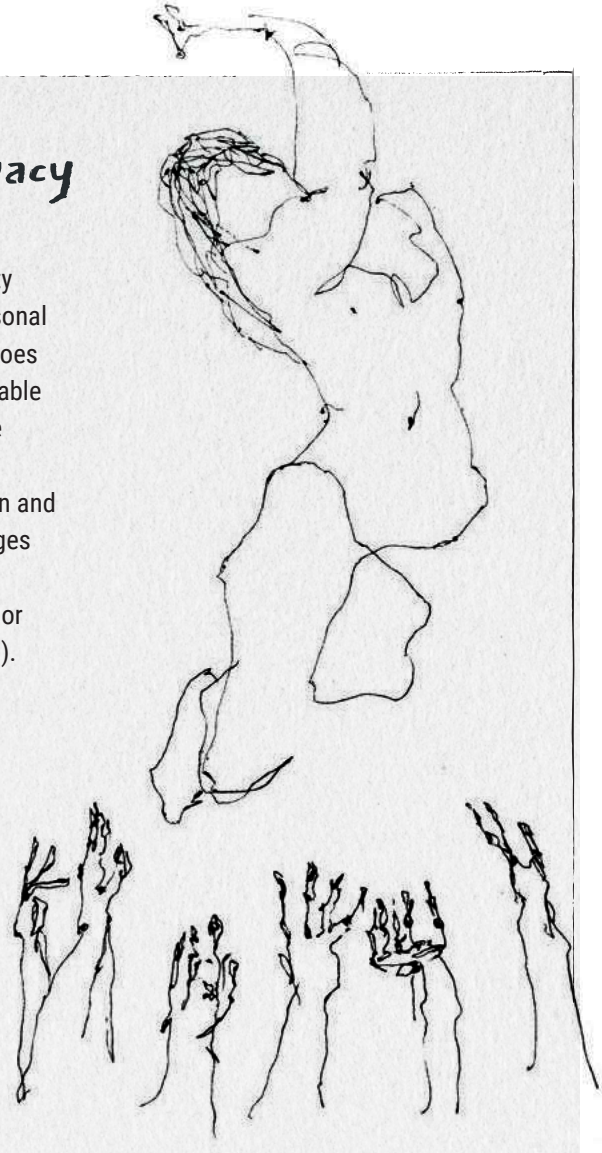
Governments can, and sometimes must, treat people differently; however, there must be a legitimate justification for the disparate

Transactional sex and surrogacy

What are the limits for exercising bodily autonomy in sexuality and reproduction? According to human rights principles, personal choices that do no harm to others should be permitted. But does the exchange of money do no harm? Should an individual be able to be financially compensated for sexual acts or reproductive services? There is great variability in national laws and regulations regarding sex work, prostitution, gamete provision and gestational surrogacy. Some governments see these exchanges as inherently exploitative and criminalize them. Others view sex work and gestational surrogacy as legitimate livelihoods or forms of labour (UN HRC, 2018a; UN General Assembly, 2010).

Human rights law does not provide definitive answers, although rights-based arguments have been invoked to support both prohibition and legalization.

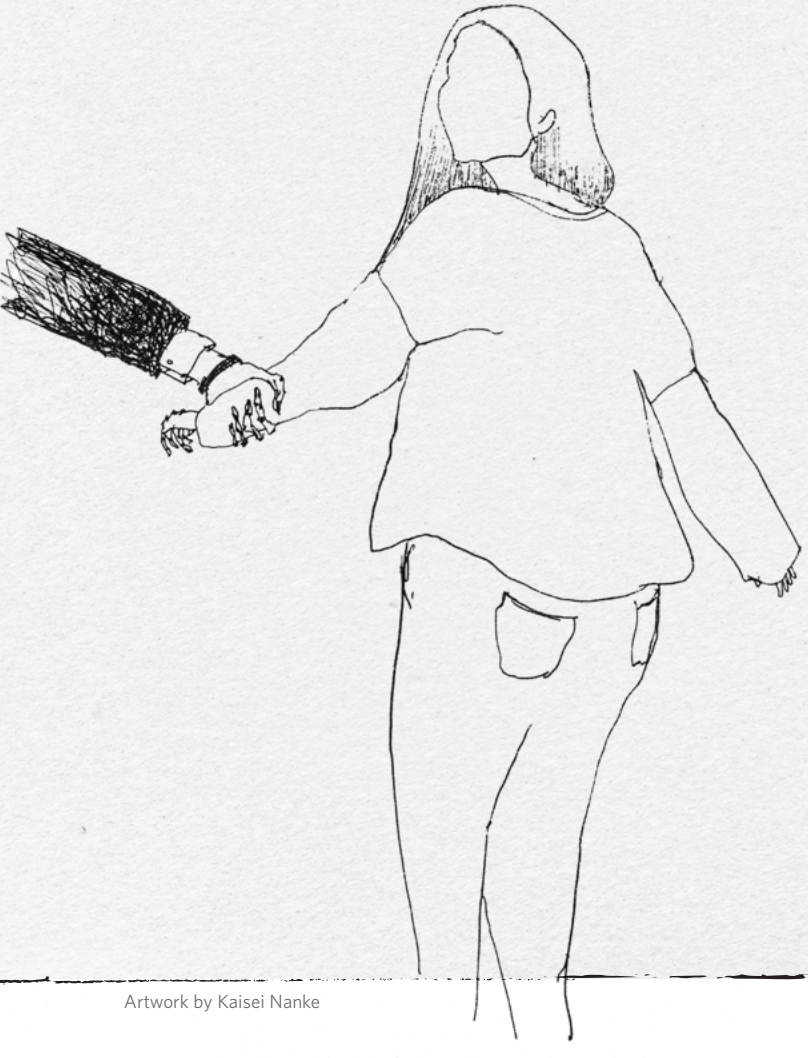
For example, the UNAIDS Global Commission on HIV/AIDS and the Law has recommended decriminalizing sex work, while the Human Rights Council has recommended that in cases of compensated surrogacy the human rights of all parties involved must be considered and respected appropriately in law (UN HRC, 2019a; UNDP, 2012).



Artwork by Kaisei Nanke

Legal capacity and age of consent

The Office of the High Commissioner for Human Rights defines legal capacity as "the capacity and power to exercise rights and undertake obligations by way of one's own conduct, i.e., without assistance or representation by a third party" (OHCHR, 2005). Recognition in law of having "capacity" means a person can give or withhold consent to sexual activity, health services, marriage and more.



Artwork by Kaisei Nanke

A legacy of deeming women, children and persons living with disabilities "incompetent" to make decisions for themselves or in need of protection from exploitation is what international human rights redress. For example, the Women's Convention directs that "States Parties shall accord to women, in civil matters, a legal capacity identical to that of men" and they shall have "the same opportunities to exercise that capacity" (UN General Assembly, 1979, Article 15(2)).

Given the history of discrimination faced by women with disabilities, the Convention on the Rights of Persons with Disabilities emphasized the importance of legal capacity for autonomous decision-making by women with disabilities: "All women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired, with regard to medical and/or therapeutic treatment, including by taking their own decisions on retaining their fertility and reproductive autonomy… Restricting or removing legal capacity can facilitate forced interventions, such as sterilization, abortion, contraception, female genital mutilation, surgery or treatment performed on intersex children without their informed consent and forced detention in institutions" (UN CRPD, 2016).

Another way of understanding legal capacity is "age of consent". Minimum ages of consent vary among and sometimes within nations by activity and sometimes by sex (although this is considered incompatible with human rights standards). The Children's Convention directs States to recognize the evolving capacities of children, specifically adolescents, with regard to consent to sexual activity as well as access to sexual and reproductive health services and

information. The Committee on the Rights of the Child urges governments to put supportive laws and policies in place so that "children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality" (UN CRC, 2013). These policies include providing confidential counselling to children, without the need for parental or guardian consent, as well as conferring presumptive legal competency for adolescents to seek and obtain sexual and reproductive health services, commodities and information (UN CRC, 2016). According to the Committee on the Rights of the Child, governments should avoid criminalizing consensual, non-exploitative sexual activity among adolescents of similar ages (UN CRC, 2016).

The right to marry and found a family is recognized in both the Universal Declaration of Human Rights, Article 16 (UN General Assembly, 1948), and the Political Covenant, Article 23, specifying that "no marriage shall be entered into without the free and full consent of the intending spouses" (UN General Assembly, 1966). Any marriage entered into without such consent is forced and is always a human rights violation. The Women's Convention clearly states that child betrothal and marriage is legally null and void and directs States to establish minimum ages for consent to marriage (UN General Assembly, 1979, Article 16(2)). In keeping with the principle of evolving capacities, most nations, following the Children's Convention, establish a minimum age of consent to marriage at 18, although in some settings the minimum age varies, depending on the sex of the individual (Pew Research Center, 2016). In over half of the world's nations, parental consent can override any age-related minimum (Arthur and others, 2018).

treatment, balancing all the respective rights (Clapham, 2015). The general principle of "best interests" in the Children's Convention is an illustration of this approach. While parents and guardians make decisions on behalf of their children, children have a right to participate meaningfully in decisions that affect them, with no clear line delimiting an appropriate age (Coyne and Harder, 2011). As children's capacities evolve, the Children's Convention expects parents to include them and eventually cede final control over such decisions to them when they are mature. One example of respecting children's evolving capacities is in the shift in thinking about intersex infants. In the past, it was widely accepted that surgery should be performed immediately to assign the genitalia to one sex or the other. That attitude has largely been replaced by one of waiting for the children to make their own choice about surgery (Reis, 2019; Zillén and others, 2017). Without intersex children's meaningful consent, such surgeries have been labelled violations of bodily integrity, tantamount to torture (UN HRC, 2016a).

Similarly, the categorical denial of the sexual and reproductive desires and choices of persons living with physical or developmental disabilities evidenced by giving authority to parents, guardians and institutions, or "substituted decision-making", has been transformed into the standard of "supported decision-making", where every effort is made to educate and ascertain the person's will and enable them to execute it (UN CRPD, 2018, 2014).

Bodily integrity

As a general principle, rights related to bodily integrity prevent the State or third parties from intruding on someone's physical body without obtaining free and informed consent.

The foundation for the notion of informed consent in relation to bodily integrity flows from Article 7 of the Political Convention: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation" (UN General Assembly, 1966). This idea has been echoed in international and regional human rights treaties, including the Disability Rights Convention, Article 15 (UN General Assembly, 2007); the Children's Convention, Article 37(a) (UN General Assembly, 1989); and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly, 1984).

Bodily integrity has been interpreted by the Human Rights Committee as protected by the right to liberty and security of the person in the Political Convention (UN HRC, 2014) and by Article 7 of the Political Convention, which protects all individuals from cruel, inhuman or degrading treatment.

Rights to bodily integrity are formally recognized in human rights instruments. The Disabilities Rights Convention, for example, notes that "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others" (UN General Assembly, 2007, Article 17). A number of regional human rights treaties recognize bodily integrity outright or as part of the right to humane treatment, for example, the African Union Banjul Charter (African Union, 1981, Article 4); the African Union Maputo Protocol (African Union, 2003, Article 4(1)); and the American Convention on Human Rights (OAS, 1969, Article 5(1)).

RIGHTS TO BODILY AUTONOMY AND INTEGRITY ARE FORMALLY RECOGNIZED UNDER INTERNATIONAL HUMAN RIGHTS LAW

An array of sexual and reproductive health and rights matters have been adjudicated by regional human rights courts. For example, the Inter-American Court of Human Rights has found violations of the right to bodily integrity in cases of forced nudity and vaginal inspections (IACtHR, 2006), threats of rape and sexually transmissible infection (IACtHR, 2014) and a wide range of other forms of sexual violence (IACtHR, 2013, 2010).

Obligations of States Parties

Rights to bodily autonomy and integrity are formally recognized under international human rights laws and address a range of reproductive and sexual health and rights matters. But how do these rights translate into what governments can, cannot or must do for the people and populations they serve?

Governments primarily observe their human rights duties through legislation, policy and budgetary appropriation; some actions can be taken immediately and others may be taken progressively over time so that rights are respected, protected and fulfilled (UN CESCR, 2016; Gruskin and Tarantola, 2002).

Remove barriers to individual decision-making

Respecting the rights to bodily autonomy and integrity requires governments to ensure that their laws, policies and programmes do not infringe on individuals' ability to make decisions about their reproductive and sexual lives. This means removing barriers that interfere with access to comprehensive sexual and reproductive health services, goods, education and information (UN CESCR, 2016).

Laws, policies and programming must take into account the differing needs and vulnerabilities of women, children, LGBTI communities, migrants, racial and ethnic minorities and people in rural areas, and ensure that measures to protect one group do not infringe on others along the way (UN CESCR, 2000).

According to the United Nations Committee on Civil and Political Rights, criminal laws related to contraception, comprehensive sexuality education, abortion and accessing information about sexual and reproductive health violate rights to bodily autonomy and integrity (UN CCPR, 2019; UN CESCR, 2016). Laws that require third-party authorization or consent (taking account of the evolving capacities of children) also violate rights (UN CEDAW, 1999).

Human rights treaty bodies have criticized States that have permitted third parties, whether parents, spouses or others, to obstruct individuals from making decisions about their own bodies and reproductive and sexual lives (UN CCPR, 2005).

Human rights treaties and agreements direct governments not to interfere with "adult consensual sexual activity in private" or to enact criminal laws against same-sex sexual activity among adults in "private" (UN CCPR, 1994, para. 8.2). Furthermore, laws that "criminalize" abortion, non-disclosure of HIV status and transgender identity or expression run afoul of bodily autonomy and integrity rights (UN CESCR, 2016, para. 40).

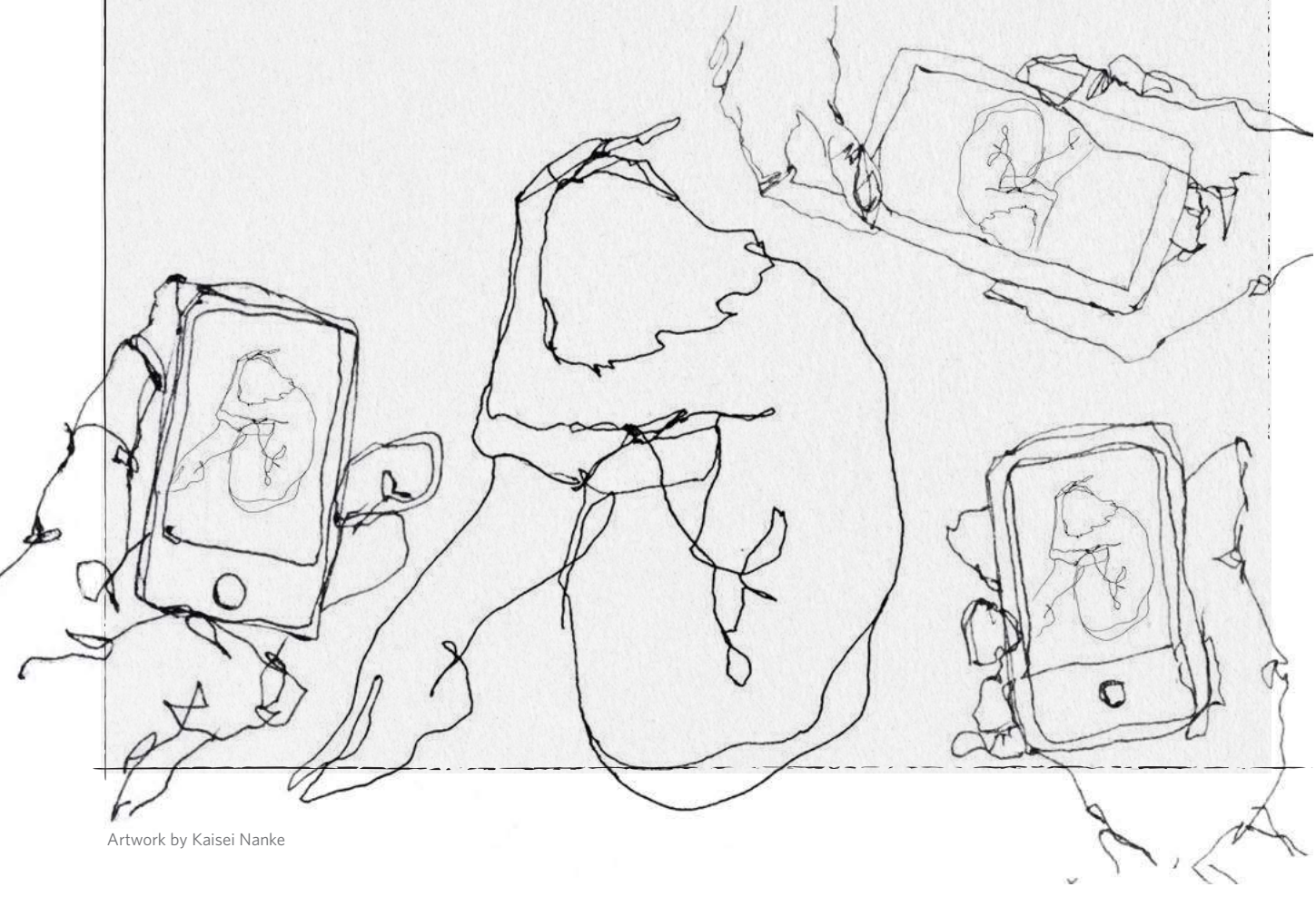
The United Nations Committee on Economic, Social and Cultural Rights states that laws and policies can fulfil a government's human rights obligations provided they are enabling and guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, liberalize restrictive abortion laws, guarantee women and girls access to safe abortion services and quality post-abortion care, and

"Conversion therapy"

"Conversion therapy" aims to change sexual orientation and gender identities that do not conform to heteronormative social and cultural expectations. It employs methods such as "corrective rape", aversion therapy, chemical castration and hormonal treatments, and even exorcism.

In 2020, the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity published a report on practices of so-called conversion therapy. In it, he observed that all such practices share "the specific aim of interfering in [an individual's] personal integrity and autonomy" (UN HRC, 2020, para. 59). He detailed the psychological and physical pain and suffering conversion therapy causes and noted that treaty bodies have found these practices to violate the rights to equality and non-discrimination, health and freedom from torture and ill-treatment.

The Independent Expert recommended that States ban the practice of conversion therapy and take affirmative measures to protect bodily autonomy and integrity through interventions including eliminating prejudice and discrimination against LGBTI communities (UN HRC, 2020).



Artwork by Kaisei Nanke

respect women's right to make autonomous decisions about their sexual and reproductive health (UN CESCR, 2016).

Uphold adolescents' rights

Having accurate information about one's own body and health and understanding what it means is indispensable to exercising bodily autonomy (UN CESCR, 2016). This means ensuring that adolescents have such access "regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality" (UN CESCR, 2016, para. 44).

Some States have criminalized child marriage and sex under the age of 18, in the interest of protecting vulnerable populations from exploitation or harm (Khosla and others, 2017). But human rights advocates are generally sceptical about criminal prohibitions, despite their symbolic importance, because they disproportionately affect communities that are already marginalized and comparatively disempowered, and have few alternatives. Advocates instead recommend redressing the conditions that render such individuals and communities vulnerable to exploitation in the first place, such as providing economic opportunities for young women (Miller and Roseman, 2019).

Establish systems to redress rights violations

Protecting rights to bodily autonomy and integrity requires a functioning system to redress rights violations. The United Nations Committee on Economic, Social and Cultural Rights in 2016 called on governments to put into place laws, policies and programmes that "prevent, address and remediate violations of the right of all individuals to autonomous decision-making on matters regarding their sexual and reproductive health, free from violence, coercion and discrimination" (UN CESCR, 2016).

ACCURATE INFORMATION ABOUT ONE'S OWN BODY AND HEALTH... IS INDISPENSABLE TO EXERCISING BODILY AUTONOMY

In addition to removing requirements for third-party authorization to access services and information, the Committee called for ending health-care professionals' "conscientious objection" to the provision of services and for requiring referrals to providers "capable of and willing to provide the services being sought" (UN CESCR, 2016, para. 43).

Laws that are aligned with human rights guarantee equal protection for all individuals aiming to exercise their rights to bodily autonomy and integrity. But all around the

The language of violation

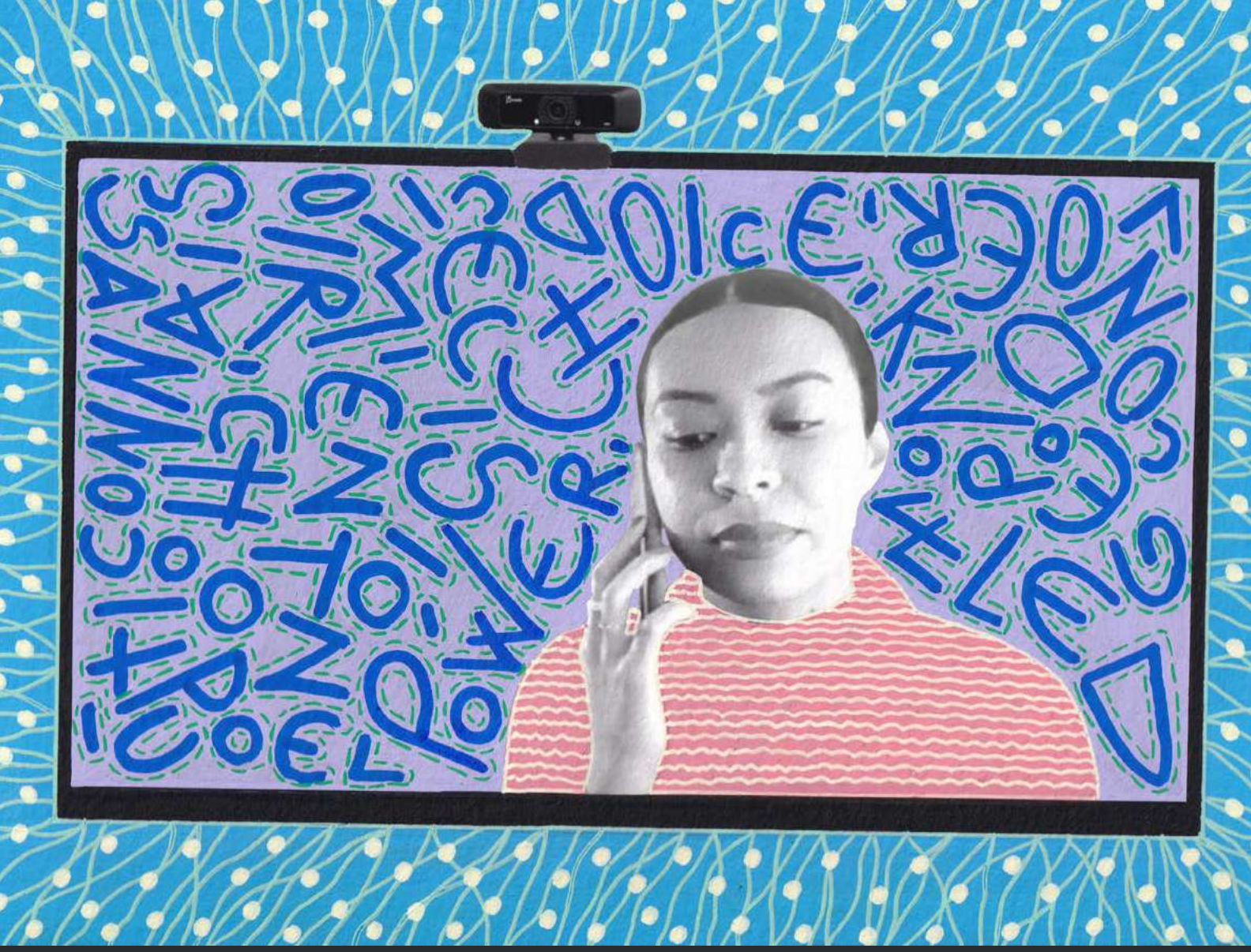
In her years as a survivors' advocate in the United States, Leidy Londono has grown accustomed to the language of shock, fear and shame that people use when grappling with the aftermath of sexual assault. And she has listened to people struggle to put into words one particular form of sexual violation, a phenomenon that is pervasive yet poorly understood, even by those who experience or perpetrate it: reproductive coercion.

"It involves behaviours that a partner or someone uses to maintain power and control in a relationship that are connected to reproductive health," explained Londono, who has accompanied survivors to hospitals and provided hotline counselling. She now works as an educator and programme manager at Planned Parenthood in Washington, DC. "It can take a lot of different forms. There are explicit attempts to impregnate a partner against their own wishes. It could be about controlling the outcomes of a pregnancy, coercing a partner to have unprotected sex, interfering either explicitly or implicitly with birth control methods, or lying or deceit around birth control methods."

Survivors lack a common language to describe the specific violation felt when they are denied ownership of their fertility or sexual health, whether or not they consented to a sexual encounter. Without the words to identify this experience, they often express confusion and self-recrimination. Londono recalled one young person who discovered that their partner had secretly removed a condom during consensual sex—a practice known as stealthing. "At first they were like, 'Am I just exaggerating this?'"

The concept of reproductive coercion is relatively new, with most studies on the topic taking place in the last 20 years, often in the United States, where the prevalence of reproductive coercion is estimated at 15 to 25 per

"There's a universal involved here, and it is male entitlement to control female partners."



Leidy Londono has worked in person, over the phone and via online chat to provide support and information to survivors of sexual assault. Original artwork by Naomi Vona; photo © UNFPA/R. Zerzan.

cent (Park and others, 2016). But recent inquiries show that it is widespread globally, perpetrated not only by partners but even by families and community members (Grace and Fleming, 2016). It may even be abetted by health systems, via policies that require husbands' permission before a woman can use family planning, for example.

Dipika Paul has worked for decades as a researcher in sexual and reproductive health in Bangladesh, yet even she says she was not familiar with the term reproductive coercion. Rather, she and health workers and advocates spoke more generally about "barriers in family planning".

Today, Paul is an expert in the topic. As an adviser at Ipas in Dhaka, she sees many forms of

reproductive coercion. "With husbands... it can start with telling them, 'do not use any contraception', then women will follow their husband's opinion. And it also ranges to severe violence. Sometimes husbands withhold food or money if she wants to continue using contraception," Paul said. Often this pressure is related to "husbands' or other family members' desire for more children or desire for sons". Forced use of contraception and forced abortion are also seen, she added.

These coercive acts are not widely regarded as forms of violence because reproduction may be seen as a family decision. "In-laws, they play a big role," Paul said. This is particularly true for younger and underage wives; the median age of marriage is 16, according to a Demographic and Health Survey from 2018. "It is difficult for young women to take decisions alone."

And yet there is a clear link between reproductive coercion and violence. Paul estimates that, in a study she is currently conducting, about three in five women who said they had experienced reproductive coercion also experienced sexual or physical violence from their husbands.

Jay Silverman, a professor at the University of California, San Diego School of Medicine, began his career working with men and boys who had perpetrated intimate partner violence. He has since studied reproductive coercion in Bangladesh, India, Kenya, Niger and the United States. Even though reproductive coercion may sometimes be carried out by female family members, the violation is rooted in gender inequality, Silverman said.

"There's a universal involved here," he explained, "and it is male entitlement to control female partners... On some level, that sense that men do have, that entitlement to that control, is something that's ubiquitous in, I think, most of our societies."

Silverman and his colleagues, including Ipas in Bangladesh, are piloting tools to help health workers identify reproductive coercion, such as questions about partner attitudes and behaviour. Once coercion is acknowledged, women can reassert bodily autonomy by, for example, selecting family planning methods that are undetectable by a partner.

Even as women lack the language to describe reproductive coercion, Silverman explained, "I also believe human beings innately resist against being controlled... There are many different coping strategies that women in communities around the world have developed to cope with reproductive coercion, including women supporting women. That is something that is just happening organically, everywhere. It always has, whether it be a neighbour or female family member hiding your pills for you or helping you get to a clinic." Where clinics give out pamphlets about reproductive coercion, partner violence and how to seek help, women often "take handfuls" so they can share the information with other women.

Much of the burden of addressing reproductive coercion falls to service providers, who often face a double bind: they must strike a balance between engaging men in reproductive health matters without ceding full decision-making power to them. "The ideal of male engagement in sexual and reproductive health and maternal and child health internationally has become a priority," Silverman said. Male involvement has been associated with increased family planning and contraceptive use and improved maternal and child

health outcomes (Kriel and others, 2019; Assaf and Davis, 2018). But when men wish to control the reproductive choices of their partner, "involving men is obviously detrimental".

And men—indeed, people of all genders and sexual orientations—can also be victims of reproductive coercion. "Anyone can experience reproductive coercion," said Londono. "Women in marginalized communities experience levels of violence at disproportionate rates, and that includes reproductive coercion... but that doesn't negate the fact that I have talked to young boys and young men—men in general—who are trying to identify their own experiences and put it into words and contextualize it."

Fluency in the language of reproductive coercion is needed, particularly among policymakers. "When our laws and our policies are vague and our language is ambiguous, it doesn't provide for survivors," Londono said.

And learning about bodily autonomy is also crucial. In one recent project, Paul said, "we talked to women, and they chose this terminology: 'my body, my rights.'... They all agreed that we need to disseminate this among the population—that my body is mine."

world, there are examples where protections are anything but equal. Violence and discrimination against people of diverse sexual orientation or gender identities, for example, is well-documented and has been perpetrated by State and non-State actors (UN HRC, 2016b).

Similarly, women and girls, especially those facing intersectional discrimination, such as those with disabilities or those who are members of ethnic or religious minorities, face higher rates of gender-based violence and disparities in access to justice and fair policing (UN CEDAW, 2015a). Impunity for sexual and gender-based violence, marital rape and "curative rape" targeted at gender-non-conforming individuals are other egregious examples of unequal protection under the law (UN CESCR, 2016).

Enabling everyone to exercise the rights to bodily autonomy and integrity

Fulfilling rights to bodily autonomy and integrity requires that governments make quality sexual and reproductive health information, services and methods available and accessible (UN CESCR, 2016, 2000). According to United Nations treaty bodies, this would entail services and information that support decisions about family formation (contraception, infertility treatment, maternal health care, safe abortion) and about sexual health (prevention of sexually transmitted infections, including HIV, comprehensive sexuality education, treatment for sexual dysfunction, prevention of sexual violence and care for survivors), and gender-affirmative

The right to reproductive health and rights in the Programme of Action



"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.… Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents" (UNFPA, 1994). —Excerpts from the Programme of Action of the International Conference on Population and Development

Artwork by Kaisei Nanke

health care (World Professional Association for Transgender Health, 2011).

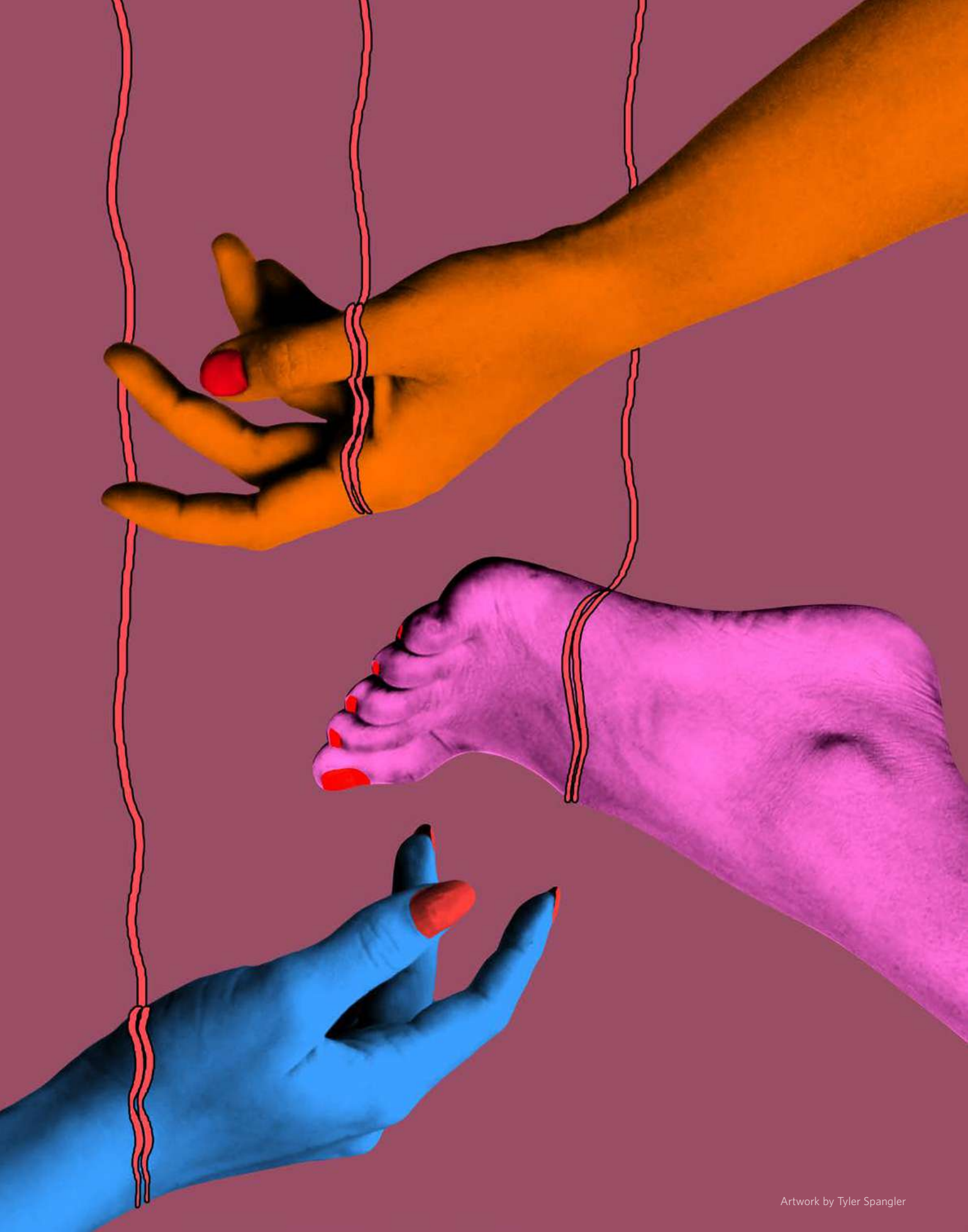
Services and information, as detailed by the United Nations Committee on Economic, Social and Cultural Rights, must be:

- *Available*—in sufficient quantities;
- *Accessible*—reachable and affordable by all;
- *Acceptable*—sensitive to gender, culture, age and medically ethical;
- *Quality*—meeting scientific and medical standards of care and delivered with respect for rights.

Having the means to exercise the rights related to bodily autonomy and integrity through reproductive and sexual health services is inseparable from the recognition of those rights in the first place. According to the United Nations Human Rights Council, "Health settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them, to make their own choices about their health, including sexual and reproductive health, and their treatment, with appropriate support where needed" (UN HRC, 2017, para. 43).

International human rights to bodily autonomy and integrity ensure that every person can make decisions that affect their sexual and reproductive lives and have the means to do so. This requires States to provide comprehensive, age- and culturally appropriate information about sexuality and reproduction, as well as the quality goods and services to effectuate those decisions, free from discrimination, coercion and violence.

Human rights provide the common ground upon which States build their national legal and policy standards to promote and protect bodily autonomy and integrity in the context of sexual and reproductive health. But many States still have a long way to go to ensure all people have the power to make their own decisions about health care, contraception and sex—and about many other dimensions of bodily autonomy.



Artwork by Tyler Spangler

LAWS THAT EMPOWER LAWS THAT CONTROL

A look at how laws and regulations impact bodily autonomy

Every country has laws that protect or deny bodily autonomy.

Laws can help support bodily autonomy by, for example, guaranteeing everyone's access to sexual and reproductive health services, mandating schools to provide comprehensive sexuality education and requiring informed consent in the provision of health care.

Governments can also use laws to control people's bodies by, for example, limiting adolescents' access to sexual and reproductive health services and information, or forbidding same-sex relationships. Laws that are not well formulated or are unclear can also be detrimental to bodily autonomy, even if they were not intended to have that effect.

Laws in some countries still require married women to obey their husbands, still fall short of making domestic violence a criminal offence, still treat divorce in ways giving more rights to men, and still do not criminalize rape in marriage. More than 30 countries restrict women's right to move around outside the home (World Bank, 2020).

National laws can also be the primary instruments used by governments to fulfil their obligations under international human rights law. But to make these rights meaningful in people's lives, governments must go beyond enacting laws and take action to effect change.

The World Health Organization has called on governments to establish supportive legislative and regulatory frameworks that improve access to sexual and reproductive health services and remove unnecessary restrictions that have the effect of preventing women from enjoying their right to bodily autonomy (WHO, 2004).

Understanding how national legal frameworks affect bodily autonomy—where they might be supportive and where legal reform might be needed—is a critical starting point for action. Sometimes the law changes to reflect evolution in public opinion; at other times, legal change precedes changes in societal attitudes, in which case substantial social and behavioural communication-change efforts may be required for the law to become widely accepted and to ease implementation. Once a law is enacted, its intended impact may not be realized for years, depending on political will or the commitment to implement or enforce it. Policies may need to be formulated to add operational detail to the law, a budget may need to be allocated, or an accountability system may need to be created.

Even when a law is broadly supportive, it may not benefit everyone equally. For example, many countries have laws that guarantee access to free antiretroviral therapy to treat HIV, but access to it may not be universal. In Botswana, treatment was available to citizens only, including those in prison, but that excluded prisoners who were from other countries. The law changed in 2019 to expand access to all prisoners, regardless of nationality (UNAIDS, 2019).

Conflicting laws

No single law or policy can be considered in isolation from a country's entire legal and policy framework. Many countries, for example, have age-of-consent laws in relation to sexual activity that are inconsistent with minimum-age laws for accessing sexual and reproductive health information and services (Figure 7). This means that adolescents may legally have sex before they can legally access any information or services relating to safer sex practices or contraception (Sexual Rights Initiative, 2020; Committee on Adolescence, 2017; Dennis and others, 2009).

Where conflicting laws exist, there may be confusion about which law takes precedence. The confusion can sometimes affect not only individuals but also the people who are responsible for enforcing it.

Even in the absence of conflicting legislation, lack of clarity can remain a problem. What are health workers required to do in cases where they are unsure of their legal obligations or potential criminal liabilities arising from any given action? For example, where abortion is legal under certain circumstances, providers may still be reluctant to provide this service for fear of being accused of breaking the law, and health systems' guidelines and policies may be based on a more conservative interpretation of the law. Post-abortion care, which 179 governments agreed at the International Conference on Population and Development (ICPD) in 1994 should be available irrespective

FIGURE 7

Age of consent for sex and age at which parental consent is not required for selected services in selected countries

	Belize	Croatia	Italy	Jamaica	North Macedonia	Malaysia	Palau	Poland
Legal age of marriage	18	18	18	18	18	18	No minimum age for citizens; 18 for others	18
Legal age of marriage with parental, judicial or other consent	16	16	16	16	16	16	None needed for citizens; 16 for others	16
Age of consent for sex	16*	15	14	16	14	16*	15	15
Access to abortion *without* parental consent	18	16	18	18	18	18	18	18
Access to emergency contraception without parental consent	18	16	14	16	18	18	18	18
Access to oral contraception without parental consent	18	18	14	16	18	18	18	18

* Applies to girls only
Source: Sexual Rights Initiative, 2020

Artwork by Tyler Spangler



When sex is work

"Knowing that I have a say and that I'm in control of my own body, I really only learned those things after becoming a sex worker," Liana explained through a translator in Indonesia.

By now, Liana is used to shattering expectations; as a middle-class university graduate and former accountant, she does not fit the stereotype of a sex worker. "When my baby was four months old, my husband passed away," she recalled. Her income did not stretch far enough and, at the same time, her family's business was struggling and her sister was facing financial hardship.

"I visited one of the established venues for sex work and applied to work there," she said, emphasizing that this was her choice. "I did it independently and without force."

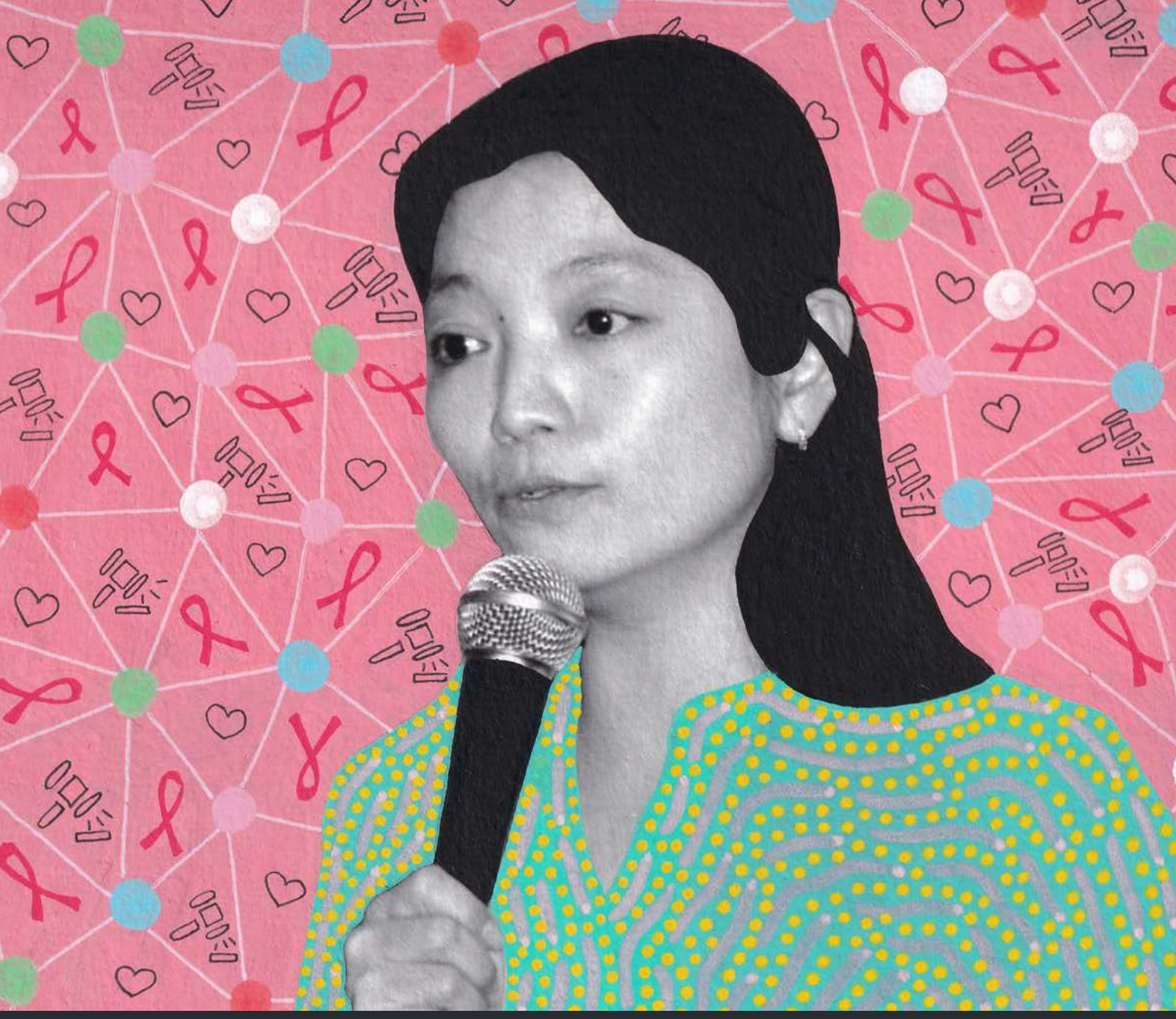
These days, Liana is the national coordinator of OPSI, a network that supports sex workers with services including health care. OPSI is supported by UNFPA. "Sex workers are actually quite diverse," she explained. "There are male sex workers, transgender sex workers, and the reasons people choose to engage in sex work vary from person to person. The majority are seeking a source of income."

Monika, in North Macedonia, became a sex worker after she lost her job and got divorced. She, too, is firm when she says this was her decision. "I was 19 or 20 years old. I was sufficiently aware and mature to think about what I did and what I didn't want." Today—as the regional coordinator of STAR, the first sex workers collective in the Balkans, also a UNFPA partner—she says she has observed that this is the norm: "I am most often surrounded by sex workers who voluntarily engage in sex work."

Still, both Liana and Monika acknowledge that sex trafficking—sexual exploitation through force, coercion, fraud or deception—is a serious concern within the industry. Their respective organizations work closely with victims and survivors, helping them to secure services and exit sex work if they choose.

The prevalence of exploitation and abuse has driven much of the conversation around the legal status of sex work. Both proponents and opponents of

"I learned that actually, hey, I can control my own body. My body is my own."



Liana advocates for the rights of sex workers in Indonesia. Original artwork by Naomi Vona; image courtesy of Liana.

decriminalization cite the need to protect people from abuses.

But for opponents of decriminalization, the notion of consent within the sex industry is inherently fraught. Indeed, studies show that many entrants into sex work have experienced heightened vulnerablities, such as a history of childhood poverty, abuse and family instability, as well as barriers to the formal economy, including lack of education (McCarthy and others, 2014). These

conditions are seen as undermining their free and informed consent. Additionally, a significant proportion of sex workers—estimated at between 20 and 40 per cent—report entering sex work as children (Parcesepe and others, 2016), a clear human rights violation.

Human rights instruments have responded to these vulnerabilities. The Convention on the Elimination of all Forms of Discrimination against Women calls for "all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women". And the Protocols of the United Nations Convention against Transnational Organized Crime include "the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation" within the definition of trafficking in persons.

But many sex worker advocates say the focus on vulnerability actually strips away their safety and autonomy. Both Liana and Monika say they freely chose to continue sex work even while earning decent incomes outside the sex trade.

"Please don't assume that all sex workers are victims of trafficking. There are people like me who choose this work intentionally. We're not being tricked," Liana said. "When we ask OPSI members whether they would want to stop sex work if they could find other jobs, most of the time the answer is no." Other jobs available to sex workers are often low wage, she explained, and sex work offers flexibility that many find desirable. "They can manage their own time. They can fulfil their obligations in society, and they can feel closer to their kids."

Sex work, or aspects of it (such as facilitation), is illegal in the majority of countries, according to the Global Network of Sex Work Projects. Liana and Monika say such laws only drive the profession underground, where sex workers have a harder time screening out violent clients. Criminalization also leaves sex workers vulnerable to arrest and fearful of reporting abusers, they assert. Some police also harass and abuse sex workers, Monika said, "knowing that sex work is not legal and thinking that we cannot report it and that there is nothing we can do".

They want to see the criminalization—and prosecution—of sexual violence and exploitation rather than sex work. "Violence is not just an issue among sex workers. It's an issue for all women and minority groups," Liana emphasized.

The movement to decriminalize sex work has gained ground in recent years at the United Nations, with many agencies and programmes, such as the World Health Organization and UNAIDS, embracing it as an effective means to prevent HIV transmission and end discrimination against vulnerable populations (WHO, 2014; UNAIDS, 2012).

At the same time, the United Nations is stepping up efforts to eliminate sexual exploitation and abuse. Concerns over peacekeepers and humanitarian workers entering exploitative relationships with sex workers and vulnerable and marginalized individuals have prompted the institution to strengthen the enforcement of rules that prohibit staff from exchanging money, goods or

services for sex, even in countries where sex work is legal. These positions—that decriminalization will help safeguard the health and rights of sex workers, and also that staff members must not purchase sex, even where legal—are not contradictory, say United Nations officials.

"UN personnel must not participate in any activity that could even potentially result in sexual exploitation. This is not a judgment on voluntary sex work by consenting, informed adults, but we must acknowledge the reality that legality alone does not ensure that participation in sex work is voluntary," said Eva Bolkart, who coordinates UNFPA's efforts to prevent sexual exploitation and abuse.

Monika and Liana agree that legality alone is not enough. For them, decriminalization must come alongside destigmatization. Until sex workers are afforded the respect and dignity of normal citizens, they will continue to be forced to operate in the shadows, where abuses can be hidden. "We are parents. We are someone's children. We have families," Monika said. "There is no need for anyone to treat us differently from others because of the choice of our profession. Sex work is work."

of the legal status of abortion, is still lacking in many places and is sometimes denied by health workers who fear prosecution or stigmatization for providing services to someone who has had an illegal abortion.

Structural obstacles

At the structural level, adequate budgets are critical to ensuring a law's effectiveness. Mexico, for example, enacted a law requiring that contraceptives be available to all, regardless of age or marital status. Nevertheless, fertility rates remained high among adolescents, especially those from the poorest households. A number of civil society organizations looked at budgets for, and spending on, sexual and reproductive health services at federal and state levels and identified bottlenecks and inefficiencies in making funds available to local programmes. The analysis led to better earmarking of funds so they reached poorer communities, where the need for contraceptive information and services for adolescents had not been fully met (Rajan, n.d.).

Ensuring that health systems have the capacity to fully implement a law may require actions ranging from creating medical guidelines on the provision of services, to training health workers on the law's content and its implications for their work, strengthening logistics and procurement systems to ensure uninterrupted access to appropriate drugs and equipment, ensuring that information systems can capture data on service uptake, quality and impact, adjusting health financing mechanisms to promote the affordability of services and monitoring the acceptability and quality of services being provided.

Societal factors, including religion and gender norms, can influence the extent to which laws are implemented or enforced. For example, in societies where sex before marriage is considered unacceptable, laws allowing adolescents to access contraception may not translate into use of contraception if the stigma associated with teenage sex is too great.

Even where supportive laws exist, other concerns may impact people's ability to protect their bodily autonomy or access appropriate health services. People may face immediate challenges such as hunger, poverty or difficult living situations. Services may be unaffordable, childcare may be unavailable, or a husband or relative may interfere with decisions about health care or contraception.

Structural factors that perpetuate or exacerbate poverty, impede access to education or employment, and lead to discrimination based on race, ethnicity, sexual orientation or gender identity must be understood and addressed by policymakers because they can interfere with the intended benefits of supportive laws for certain groups. For example, even in countries where sexual and reproductive health services are available to all under the law, health-care providers may nevertheless deny access to people living with HIV, sex workers, men who have sex with men or transgender people (UNAIDS, 2017).

Furthermore, individuals may not be aware of a law or may find it an abstraction far removed from their daily lives.

Laws and policies can empower women to make their own decisions and can play an important role in ensuring accountability, including in health care for diverse populations, by guaranteeing access to justice, redress and reparation mechanisms for people whose human rights are violated (WHO, 2015).

Indicator 5.6.2 tracks supportive laws and legal barriers

To help governments track progress towards target 5.6 of the Sustainable Development Goals—to ensure universal sexual and reproductive health and reproductive rights in line with the ICPD Programme of Action and the Beijing Platform for Action—the United Nations developed indicator 5.6.2. This indicator is an assessment of "the 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" (UNFPA, 2020d).

Guided by international human rights law, international consensus documents and human rights standards, this composite indicator seeks to assess the legal environment related to sexual and reproductive health and rights. It covers four broad topics: maternity care, contraception and family planning, comprehensive sexuality education and information, and sexual health and well-being (Figure 8). Each of the 13 components within these four topics addresses areas that are susceptible to regulation by law. For each of the components, data are collected on the existence of legal enablers (supportive laws and regulations) and legal barriers. Such barriers

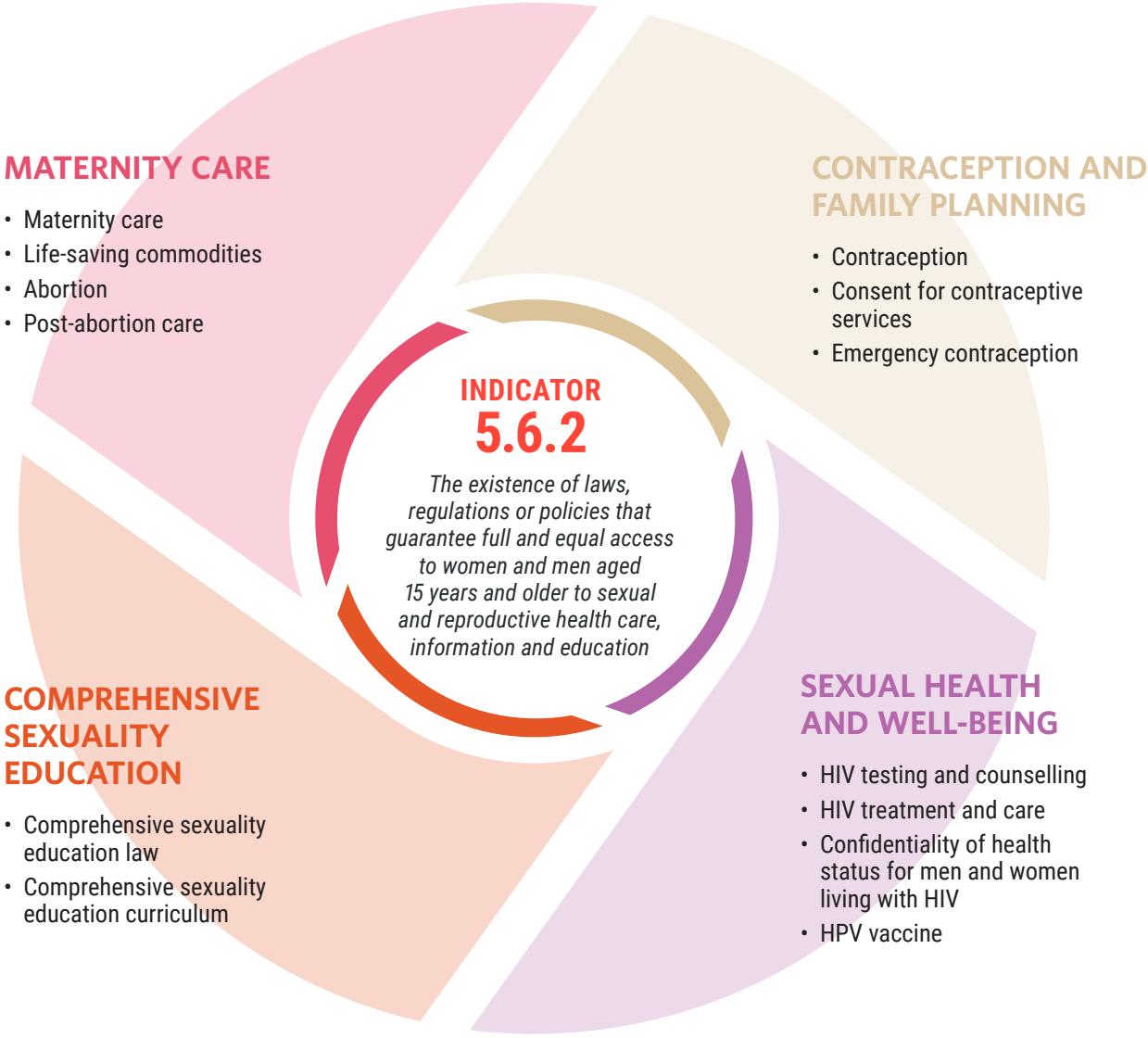
encompass restrictions to supportive laws and regulations—for example, requirements for third-party authorization that compel individuals to obtain consent from a parent, spouse, judge or medical committee to access certain health service.

All aspects of this indicator are relevant to bodily autonomy.

Within each of these components, the indicator assesses whether a supportive law exists and whether there are potential

FIGURE 8

The four topics and 13 components tracked by indicator 5.6.2



restrictions, such as limitations according to age or a requirement for spousal permission. It also assesses whether there are plural legal systems—those that are traditional, customary or determined by religion—that exist alongside national law and that can restrict the applicability of national law for certain population groups (UNDESA, 2018).

Thus indicator 5.6.2 captures information on the existence of a supportive law and also on some additional factors that might impede that law's positive impact. Data on all of these aspects are used to calculate a value for each country for each of the 13 components, which are then aggregated up to the four broad topics and then to an overall value (Figures 9 and 10).

The indicator is a percentage scale up to 100, indicating a country's status and progress in the existence of national laws and regulations to guarantee full and equal sexual and reproductive health and rights. Indicator 5.6.2 measures only the existence of laws and regulations; it does not measure their implementation.

Among all countries that reported data for this indicator, the five countries with the highest overall value for indicator 5.6.2 are Sweden (100), Uruguay (99), Cambodia (98), Finland (98) and the Netherlands (98). The five countries with the lowest values are South Sudan (16), Trinidad and Tobago (32), Libya (33), Iraq (39) and Belize (42).

Guaranteeing sexual and reproductive health and rights

Data for indicator 5.6.2 and its individual components are reported by 107 national governments, including national statistics authorities and line ministries. There are, however, only 75 countries with complete data for the overall indicator.

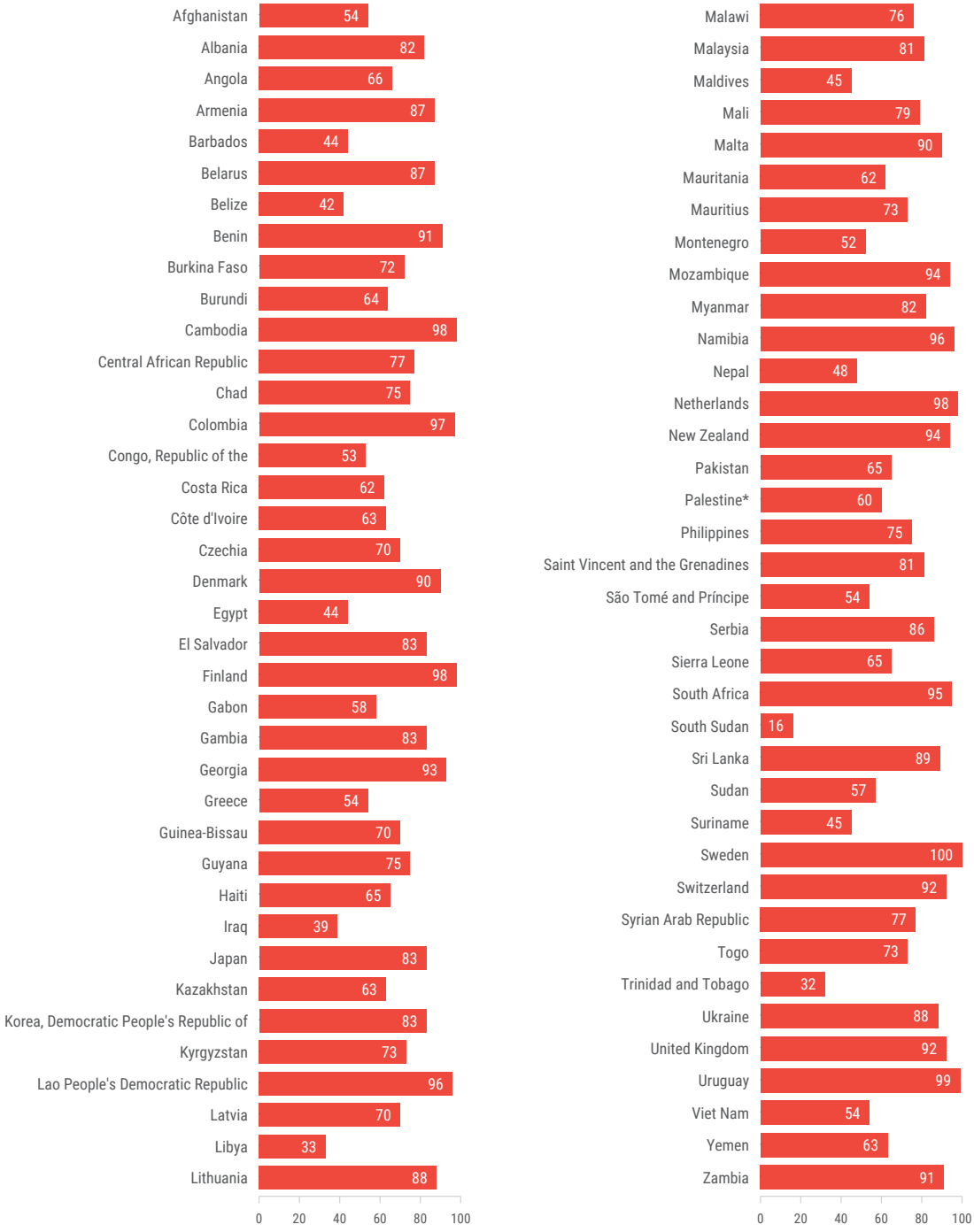
Within the overall indicator, each of the four sections has a different number of reporting countries: 79 countries for maternity care, 104 countries for contraception and family planning, 98 countries for comprehensive sexuality education and 101 countries for sexual health and well-being.

In the 75 countries reporting complete data, on average, 73 per cent of the laws and regulations needed to guarantee full and equal access to sexual and reproductive health and rights were reported to be in place. However, 20 per cent of the countries that have enabling laws also have plural legal systems, which suggests that not everyone in those countries benefits from the enabling laws.

About 80 per cent of the countries with data report having laws to protect or support sexual health and well-being. About 75 per cent report having laws and regulations needed to guarantee full and equal access to contraception. About 71 per cent have laws guaranteeing access to overall "maternity care", which could include maternal health services and supplies, abortion or post-abortion care, and 56 per cent

FIGURE 9

Indicator 5.6.2 combined value (per cent) for 13 sexual and reproductive health components, by country



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

FIGURE 10

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 (values expressed as percentages)

	Maternity Care					Contraceptive Services				Sexuality Education			HIV and HPV					Overall value for all categories, SDG indicator 5.6.2
	Maternity Care	Life Saving Commod-ities	Abortion	Post–Abortion Care	Category Average	Contra-ceptive Services	Contra-ceptive Consent	Emergency Contra-ception	Category Average	Sexuality Education Curriculum Laws	Sexuality Education Curriculum Topics	Category Average	HIV Counselling and Test Services	HIV Treatment and Care Services	HIV Confiden-tiality	HPV Vaccine	Category Average	
Afghanistan	100	92	0	100	**73**	60	0	50	**37**	0	0	**0**	100	100	100	0	75	**54**
Albania	100	77	50	100	**82**	80	100	75	**85**	100	100	**100**	80	100	100	0	70	**82**
Angola	100	62	0	100	**65**	100	100	100	**100**	0	0	**0**	100	100	100	0	75	**66**
Antigua and Barbuda	–	85	0	100	**–**	0	100	0	**33**	0	0	**0**	100	100	100	0	75	**–**
Armenia	75	100	100	100	**94**	80	100	100	**93**	100	100	**100**	80	100	100	0	70	**87**
Australia	100	–	0	100	**–**	80	100	100	**93**	0	0	**0**	100	100	100	0	75	**–**
Bangladesh	0	85	–	100	**–**	0	0	0	**0**	100	88	**94**	40	40	75	0	39	**–**
Barbados	100	77	75	0	**63**	60	0	0	**20**	0	0	**0**	80	80	100	0	65	**44**
Belarus	100	85	75	100	**90**	100	100	100	**100**	100	100	**100**	100	100	75	0	69	**87**
Belgium	–	–	100	0	**–**	100	100	100	**100**	100	100	**100**	100	100	100	100	100	**–**
Belize	0	100	0	100	**50**	0	0	0	**0**	0	100	**50**	60	80	100	0	60	**42**
Benin	100	100	50	100	**88**	80	100	50	**77**	100	100	**100**	100	100	100	100	100	**91**
Botswana	100	92	–	0	**–**	80	100	100	**93**	100	88	**94**	40	80	100	100	80	**–**
Burkina Faso	75	100	0	100	**69**	80	0	75	**52**	100	50	**75**	60	100	100	100	90	**72**
Burundi	75	92	50	100	**79**	40	0	75	**38**	0	100	**50**	100	100	100	0	75	**64**
Cambodia	100	100	75	100	**94**	100	100	100	**100**	100	100	**100**	100	100	100	100	100	**98**
Cameroon, Rep of	100	92	25	100	**79**	100	100	100	**100**	0	0	**0**	–	–	–	0	–	**–**
Central African Republic	100	100	0	100	**75**	60	100	50	**70**	100	88	**94**	100	100	100	0	75	**77**
Chad	100	100	75	100	**94**	100	100	100	**100**	0	0	**0**	100	100	100	0	75	**75**
China	100	62	–	100	**–**	100	100	100	**100**	–	–	**–**	100	100	100	0	75	**–**
Colombia	100	92	75	100	**92**	100	100	100	**100**	100	100	**100**	100	100	100	100	100	**97**
Congo, Democratic Republic of the	100	92	–	100	**–**	80	100	75	**85**	–	–	**–**	100	100	100	0	75	**–**
Congo, Rep of	100	100	-25	0	**44**	100	100	75	**92**	0	0	**0**	60	80	100	0	60	**53**
Costa Rica	100	77	25	0	**50**	100	100	0	**67**	0	0	**0**	100	100	100	100	100	**62**
Côte d'Ivoire	100	100	25	0	**56**	100	100	100	**100**	0	0	**0**	100	100	100	0	75	**63**
Czechia	100	15	100	100	**79**	0	0	0	**0**	100	100	**100**	100	100	100	100	100	**70**
Denmark	100	100	50	100	**88**	80	100	75	**85**	100	100	**100**	80	80	100	100	90	**90**
Egypt	100	54	-50	100	**51**	60	0	50	**37**	0	0	**0**	80	80	100	0	65	**44**

	Maternity Care					Contraceptive Services				Sexuality Education			HIV and HPV					Overall value for all categories, SDG indicator 5.6.2
	Maternity Care	Life Saving Commod-ities	Abortion	Post–Abortion Care	Category Average	Contra-ceptive Services	Contra-ceptive Consent	Emergency Contra-ception	Category Average	Sexuality Education Curriculum Laws	Sexuality Education Curriculum Topics	Category Average	HIV Counselling and Test Services	HIV Treatment and Care Services	HIV Confiden-tiality	HPV Vaccine	Category Average	
El Salvador	100	100	-25	100	**69**	100	100	100	**100**	100	100	**100**	100	100	100	0	**75**	**83**
Equatorial Guinea	–	100	–	–	**–**	–	–	–	**–**	0	0	**0**	100	100	100	0	**75**	**–**
Finland	100	100	75	100	**94**	100	100	100	**100**	100	100	**100**	100	100	100	100	**100**	**98**
Gabon	100	100	0	100	**75**	40	0	25	**22**	100	100	**100**	40	100	50	0	**48**	**58**
Gambia	100	100	25	100	**81**	100	100	100	**100**	100	100	**100**	40	20	100	100	**65**	**83**
Georgia	100	85	75	100	**90**	100	100	100	**100**	100	88	**94**	80	80	100	100	**90**	**93**
Germany	100	46	50	75	**68**	80	100	75	**85**	–	–	**–**	100	100	100	100	**100**	**–**
Greece	100	62	75	0	**59**	100	0	0	**33**	0	0	**0**	80	80	100	100	**90**	**54**
Guatemala	100	85	–	0	**–**	80	100	75	**85**	100	100	**100**	80	80	100	0	**65**	**–**
Guinea	100	100	–	100	**–**	100	100	100	**100**	–	100	**–**	100	100	100	0	**75**	**–**
Guinea-Bissau	100	100	100	0	**75**	80	100	75	**85**	0	100	**50**	80	80	100	0	**65**	**70**
Guyana	100	92	75	100	**92**	60	100	50	**70**	100	100	**100**	60	60	75	0	**49**	**75**
Haiti	100	92	0	100	**73**	80	100	75	**85**	0	0	**0**	100	100	100	0	**75**	**65**
Honduras	50	–	-25	0	**–**	80	100	0	**60**	0	0	**0**	100	100	100	0	**75**	**–**
India	–	85	75	–	**–**	100	100	100	**100**	0	0	**0**	60	100	100	–	**–**	**–**
Iran, Islamic Rep of	100	100	0	–	**–**	100	100	100	**100**	0	0	**0**	100	100	100	0	**75**	**–**
Iraq	75	77	0	0	**38**	80	0	0	**27**	0	0	**0**	80	100	100	0	**70**	**39**
Japan	100	85	0	0	**46**	100	100	100	**100**	100	100	**100**	100	100	100	100	**100**	**83**
Kazakhstan	75	69	75	100	**80**	100	100	0	**67**	0	0	**0**	100	100	100	0	**75**	**63**
Korea, Democratic People's Republic of	75	77	100	100	**88**	100	100	100	**100**	100	25	**63**	100	100	100	0	**75**	**83**
Kyrgyzstan	100	92	50	50	**73**	60	100	50	**70**	100	88	**94**	60	100	100	0	**65**	**73**
Lao People's Democratic Republic	100	100	50	100	**88**	100	100	100	**100**	100	100	**100**	100	100	100	100	**100**	**96**
Latvia	100	31	75	0	**51**	0	100	0	**33**	100	100	**100**	100	100	100	100	**100**	**70**
Liberia	100	92	–	100	**–**	80	100	75	**85**	0	0	**0**	100	100	100	0	**75**	**–**
Libya	75	77	-25	0	**32**	0	0	0	**0**	0	0	**0**	100	100	100	0	**75**	**33**
Lithuania	100	92	75	100	**92**	80	100	75	**85**	100	100	**100**	60	60	100	100	**80**	**88**
Malawi	25	100	-50	75	**38**	80	100	100	**93**	100	100	**100**	80	80	100	100	**90**	**76**
Malaysia	75	77	-25	75	**50**	80	100	75	**85**	100	100	**100**	100	100	100	100	**100**	**81**
Maldives	0	92	25	0	**29**	0	0	0	**0**	100	63	**81**	100	100	100	0	**75**	**45**
Mali	100	100	50	100	**88**	80	100	100	**93**	0	0	**0**	100	100	100	100	**100**	**79**
Malta	100	100	-25	100	**69**	100	100	100	**100**	100	100	**100**	100	100	100	100	**100**	**90**
Mauritania	50	85	-25	0	**27**	100	100	100	**100**	0	0	**0**	100	100	100	100	**100**	**62**
Mauritius	100	85	50	100	**84**	60	100	50	**70**	0	0	**0**	100	100	100	100	**100**	**73**

	Maternity Care					Contraceptive Services				Sexuality Education			HIV and HPV					Overall value for all categories, SDG indicator 5.6.2
	Maternity Care	Life Saving Commod-ities	Abortion	Post–Abortion Care	Category Average	Contra-ceptive Services	Contra-ceptive Consent	Emergency Contra-ception	Category Average	Sexuality Education Curriculum Laws	Sexuality Education Curriculum Topics	Category Average	HIV Counselling and Test Services	HIV Treatment and Care Services	HIV Confiden-tiality	HPV Vaccine	Category Average	
Mexico	100	–	–	0	–	100	100	100	100	100	88	94	–	–	–	100	–	–
Moldova, Republic of	75	100	75	100	88	100	100	0	67	100	–	–	80	80	75	100	84	–
Montenegro	75	100	75	75	81	60	0	50	37	0	0	0	80	80	75	0	59	52
Mozambique	100	92	25	100	79	100	100	100	100	100	100	100	100	100	100	100	100	94
Myanmar	100	92	-25	100	67	100	100	100	100	100	100	100	100	100	100	0	75	82
Namibia	100	100	50	100	88	100	100	100	100	100	100	100	100	100	100	100	100	96
Nepal	100	77	50	100	82	100	100	0	67	0	0	0	0	0	100	0	25	48
Netherlands	100	100	75	100	94	100	100	100	100	100	100	100	100	100	100	100	100	98
New Zealand	100	100	25	100	81	100	100	100	100	100	100	100	100	100	100	100	100	94
Niger	100	100	–	100	–	100	100	100	100	100	100	100	80	100	100	100	95	–
Nigeria	–	100	75	0	–	100	100	100	100	100	100	100	100	100	100	100	100	–
Pakistan	100	92	-50	100	61	100	100	100	100	0	0	0	100	100	100	0	75	65
Palestine*	100	77	-50	100	57	80	100	75	85	0	0	0	100	100	100	0	75	60
Peru	100	–	–	100	–	80	100	100	93	100	100	100	100	100	100	100	100	–
Philippines	100	77	-25	100	63	60	100	0	53	100	100	100	80	80	100	100	90	75
Romania	–	–	–	–	–	–	–	–	–	0	0	0	–	–	–	–	–	–
Russian Federation	100	77	–	100	–	100	100	100	100	0	0	0	100	100	100	0	75	–
Saint Lucia	100	92	–	100	–	60	100	50	70	100	100	100	80	80	75	100	84	–
Saint Vincent and the Grenadines	100	62	25	100	72	80	100	100	93	100	100	100	80	100	100	0	70	81
São Tomé and Príncipe	0	100	0	100	50	0	0	0	0	100	0	50	100	100	100	100	100	54
Saudi Arabia	75	–	–	–	–	100	100	100	100	–	–	–	100	100	100	0	75	–
Senegal	25	92	–	100	–	40	0	25	22	0	0	0	40	80	75	–	–	–
Serbia	100	92	25	100	79	100	100	100	100	100	0	50	100	100	100	100	100	86
Sierra Leone	100	100	50	0	63	100	100	100	100	0	0	0	100	100	100	0	75	65
Slovenia	100	54	–	100	–	100	100	100	100	–	–	–	100	100	100	100	100	–
Somalia	0	85	–	100	–	0	0	0	0	0	0	0	100	100	100	0	75	–
South Africa	100	100	75	100	94	80	100	75	85	100	100	100	100	100	100	100	100	95
South Sudan	0	100	0	0	25	20	0	0	7	0	88	44	0	0	0	0	0	16
Sri Lanka	100	77	-25	100	63	100	100	100	100	100	100	100	100	100	100	100	100	89
Sudan	100	85	25	100	77	60	0	75	45	0	0	0	100	100	100	0	75	57
Suriname	100	62	0	0	40	60	0	0	20	0	0	0	80	80	100	100	90	45
Sweden	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Switzerland	100	100	0	100	75	100	100	100	100	100	100	100	100	100	100	100	100	92
Syrian Arab Republic	100	85	-50	100	59	80	100	100	93	100	88	94	100	100	100	0	75	77

	Maternity Care					Contraceptive Services				Sexuality Education			HIV and HPV					Overall value for all categories, SDG indicator 5.6.2
	Maternity Care	Life Saving Commod-ities	Abortion	Post-Abortion Care	Category Average	Contra-ceptive Services	Contra-ceptive Consent	Emergency Contra-ception	Category Average	Sexuality Education Curriculum Laws	Sexuality Education Curriculum Topics	Category Average	HIV Counselling and Test Services	HIV Treatment and Care Services	HIV Confiden-tiality	HPV Vaccine	Category Average	
Tanzania, United Republic of	100	100	–	100	–	100	100	100	100	100	100	100	100	100	100	100	100	–
Togo	100	100	50	100	88	100	100	100	100	0	0	0	100	100	100	0	75	73
Trinidad and Tobago	25	85	0	25	34	0	0	0	0	100	100	100	40	40	0	0	20	32
Tunisia	100	100	–	100	–	100	–	–	–	0	0	0	0	0	75	0	19	–
Turkey	100	100	0	100	75	80	100	75	85	–	–	–	80	100	100	0	70	–
Ukraine	100	69	75	100	86	100	100	100	100	100	100	100	100	100	100	0	75	88
United Kingdom	100	100	0	100	75	100	100	100	100	100	100	100	100	100	100	100	100	92
Uruguay	100	85	100	100	96	100	100	100	100	100	100	100	100	100	100	100	100	99
Uzbekistan	100	69	75	–	–	100	100	0	67	–	–	–	–	–	–	0	–	–
Viet Nam	50	77	25	0	38	80	0	75	52	0	100	50	100	100	100	0	75	54
Yemen	25	100	0	100	56	100	100	100	100	0	0	0	100	100	100	0	75	63
Zambia	100	100	50	100	88	60	100	75	78	100	100	100	100	100	100	100	100	91

Source: UNFPA, global databases, 2020. Based on official responses to the United Nations 12th Inquiry among Governments on Population and Development.

Negative values reflect the existence of more legal restrictions than supportive laws. This may mean, for example, that a country or territory has restrictions on abortion, such as requiring a husband's consent for a married woman to access abortion, and that it criminalizes obtaining an abortion.

"–" signifies missing data

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

say they have laws supporting comprehensive sexuality education.

Analysis of the overall values for indicator 5.6.2 reveals that countries of any income level can perform either well or poorly. Countries of any income level can create a supportive legal and regulatory environment (Figure 11).

Sexual health and well-being

In the context of HIV, almost all countries reported laws and regulations that guarantee access to voluntary HIV counselling and testing services, treatment and care, and protection of privacy. But in some of these countries, plural legal systems may impede access, and some have age restrictions or require third-party consent.

A little more than 50 per cent of the reporting countries have laws or regulations in place to guarantee adolescent girls' access to the HPV vaccine. A recent review of experience introducing HPV vaccines in 45 low- and middle-income countries showed that success depended above all on securing political will and financing, but also required solid planning, social mobilization and clear communications (Howard and others, 2017).

Contraception and family planning

Ninety-one per cent of 104 countries reported having laws and regulations that guarantee access to contraceptive services, but in a number of these countries access depends on a minimum age, third-party authorization or marital status.

In 12 per cent of 104 countries where laws protect access to contraceptive services, plural legal systems contradict the enabling laws and regulations. Although 87 per cent of reporting countries reported having laws and regulations that ensure full, free and informed consent of individuals before receiving contraceptive services, including sterilization, 9 per cent of these countries reported plural legal systems that contradict these laws.

Maternity care

The maternity care dimension of indicator 5.6.2 covers four components: laws that guarantee access to maternity care services, life-saving medicines and supplies, or "commodities", abortion and post-abortion care. Data on each of these are explored below.

Ninety-five per cent of 79 countries reported having laws and regulations to guarantee access to maternity care. However, access to services in some of these countries depends on marital status, age or authorization by a third party, such as a parent or spouse.

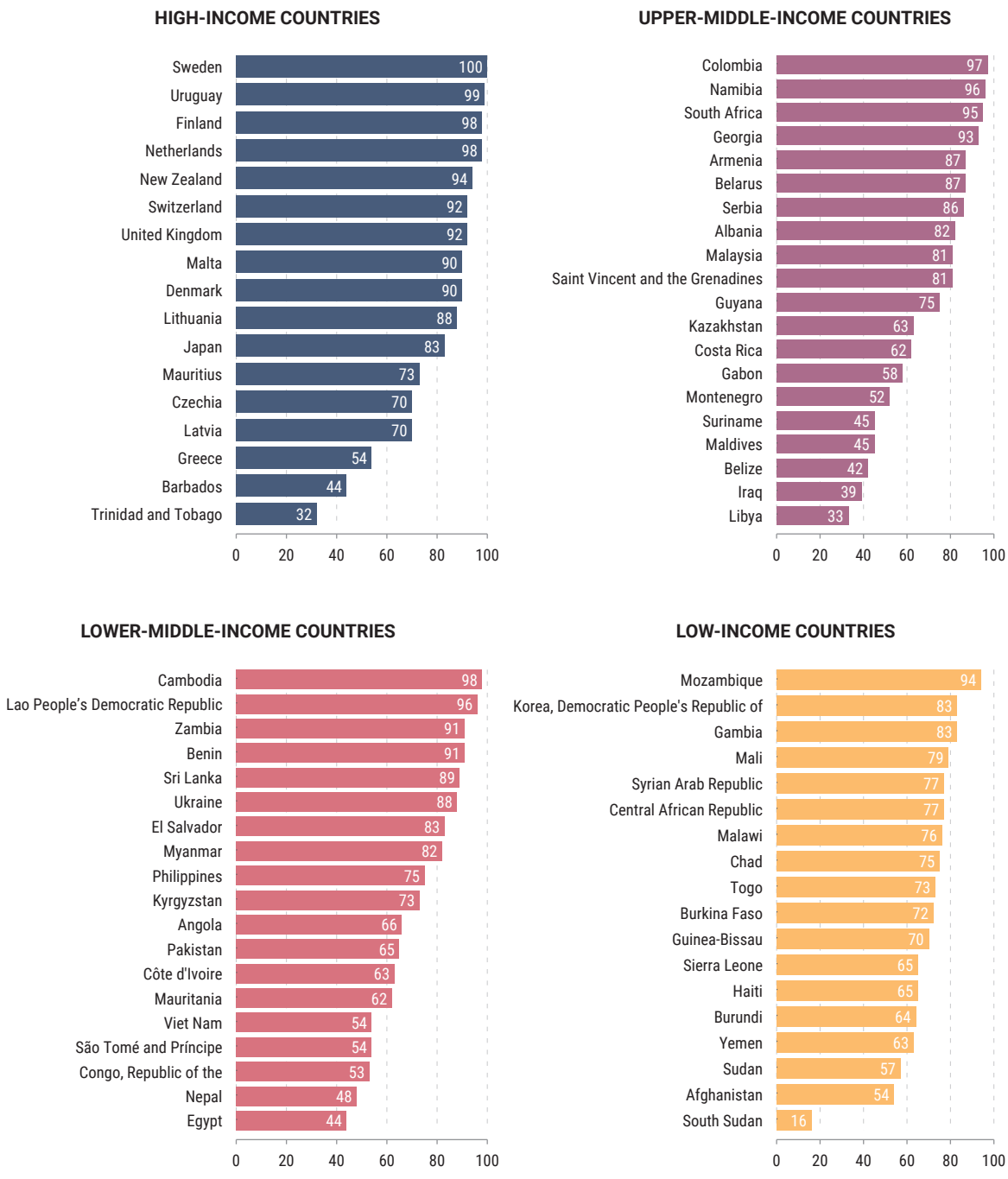
Only 44 per cent of these countries reported that their national essential medicines list included all 13 of the commodities deemed by the United Nations Commission on Life-Saving Commodities for Women and Children to be "life-saving" across reproductive, maternal, newborn and child health.



Artwork by Tyler Spangler

FIGURE 11

Overall values for indicator 5.6.2 showing that the existence of supportive sexual and reproductive health laws and regulations does not depend on a country's income level (values expressed as percentages)



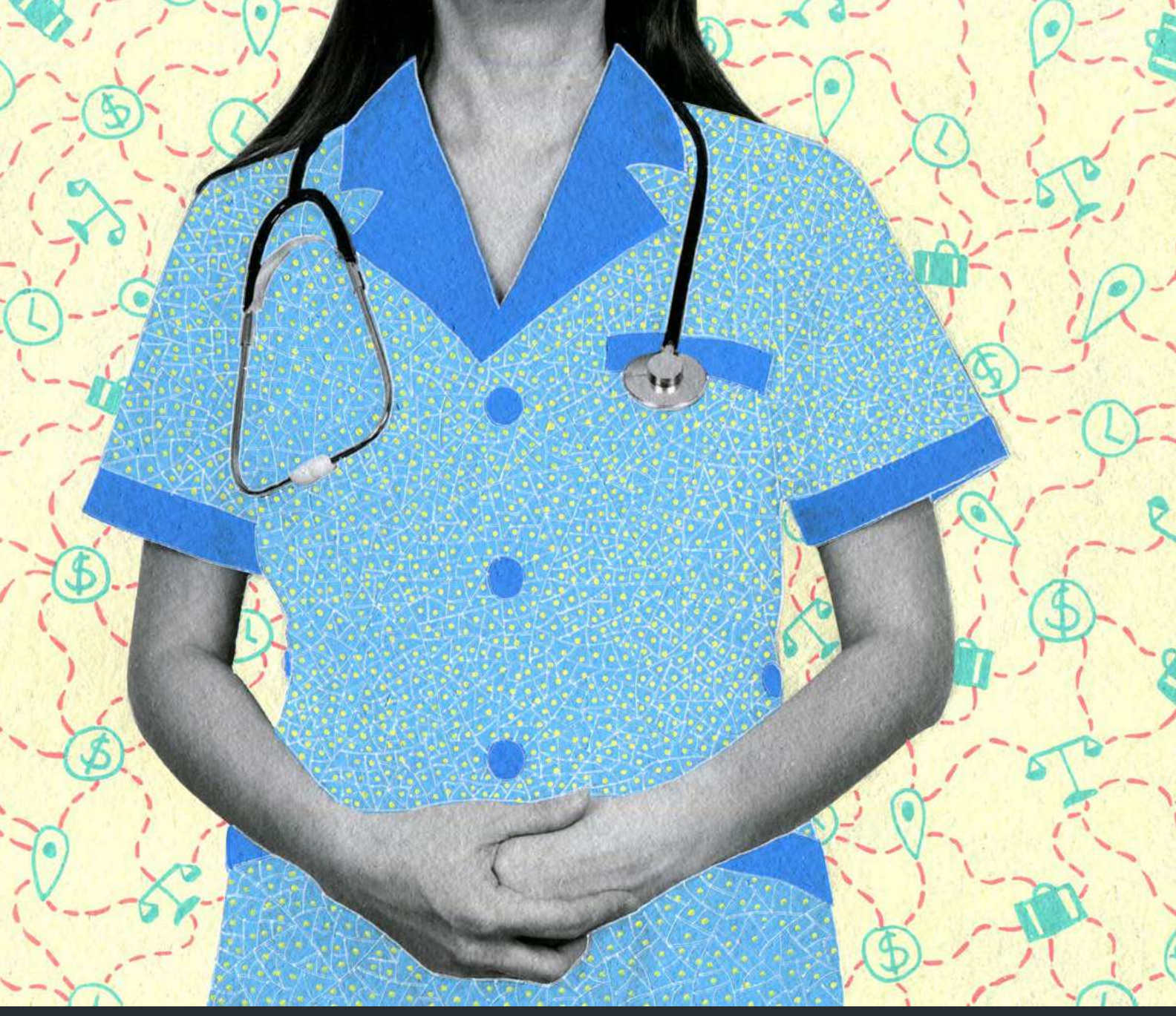
Laws aside: the reality of unequal abortion access

"One woman, she was brought from a remote village and she was in very severe condition... She'd tried to induce an abortion by herself," recalled Nuriye Ortayli, who worked as an obstetrician and gynaecologist in Turkey in the 1980s and 1990s. "Everybody, younger residents, more senior people, tried for more than 12 hours, close to 24 hours. We tried everything we could. But she died."

Yet Dr. Ortayli's story is not about an illegal, back-alley abortion. Safe abortion services were legally available in Turkey at the time. "If she had been able to come to the hospital... you could do it under local anaesthesia," she said. Instead, her story is about a reality facing women and health providers around the world: abortions happen, frequently, even in places where the procedure is highly restricted or illegal (Bearak and others, 2020), and women are regularly denied access to safe abortion even in places where it is legally permitted (Gerdts and others, 2015). No matter the law, then, it is often other factors—such as economic resources, distance from services or social norms—that determine whether a woman will be able to access a safe abortion.

Dr. Ortayli saw this phenomenon play out both as a physician in Turkey and as a programme manager and reproductive health adviser for health organizations, including UNFPA, in Eastern Europe, the Middle East, West Africa and the Americas. "We see it again and again. Independent of the legal status of abortion in a country, women make those decisions and they find a way," she said. "Those who are affluent, somehow they manage to have better health than others, because they

"Independent of the legal status of abortion in a country, women make those decisions and they find a way."



No matter the legal status of abortion, women with means tend to find a way to access the procedure while women without resources face heightened risks. Original artwork by Naomi Vona; photo by JESHOOTS on Unsplash.

have opportunities, they have money, they have networks. Those who are disadvantaged economically or socially or culturally, they suffer more."

By contrast, even when abortion was strictly banned in almost all circumstances in Ireland, large numbers of women who wanted the procedure were able to travel overseas to obtain it. "In an awful lot of cases, if women were determined to have an abortion, they would eventually manage to do it," said Caitríona Henchion, the medical director at the Irish Family Planning Association.

For many—even most—women, the law did not prevent abortion, but it "often might result in a long delay in

actually being able to get it," Dr. Henchion said. "All of the time that they were waiting is a period of great stress and anxiety... [and] there would have obviously been the higher risk attached to the procedure that they were then having."

Those who were unable to obtain an abortion by travelling internationally were "a, relatively speaking, small group," she said, "particularly women who had either poor English or who didn't have full citizenship and those rights that would go with it"—such as the ability to easily leave the country and return—"teenagers who might've required parental consent, people who didn't have the money to travel at all... or people who did not have anybody that they could disclose [the pregnancy] to or nobody that could have helped them."

Though Dr. Henchion could not provide abortions at the time, she could and did perform post-abortion care, typically after women illegally obtained pills to induce a medical abortion. "In most cases, it is safe and straightforward and people won't have problems or complications," so only a fraction of abortions performed this way came to the attention of the health system, she explained. Still, it was "regular enough" to receive patients with heavy or prolonged bleeding and "women who maybe took abortion pills at home at a more advanced gestation than either they thought they were, or than they should have been if they were going to use that method."

These circumstances were challenging for doctors, Dr. Henchion recalled. Sometimes, patients literally begged for abortion information or referrals she legally could not provide. In the end, the rules seemed to create one outcome for people with money and resources, and another outcome for those without. "That's how I always felt," she said. She was a leading proponent for the legalization of abortion in Ireland, a change that took place following a referendum in 2018.

But even today, those who are most disadvantaged continue to experience higher barriers and greater risks. "There are some parts of the country that really have almost no access in terms of providers," Dr. Henchion said. Some women still have to travel to access safe abortion, incurring all the associated delays and costs. Undocumented immigrants and people who do not speak English also continue to face challenges.

Dr. Ortayli described a similar frustration. "I had a private practice for seven or eight years in Istanbul, and I had many clients coming from the Gulf, where [abortion] is more restricted. Of course, these women were women who could afford it." At the same time, she knew that vulnerable women in her own country were struggling to receive the same level of care, whether because of distance to services or spousal permission rules. "I have seen men sometimes use this as a weapon towards women. For example, if a woman wants a divorce, but she gets pregnant, and he doesn't let her have an abortion in order to tie her up."

Still, she was glad the option to terminate a pregnancy was available in Turkey, even if access was uneven. She remembers being bereft when her patient died following the unsafe abortion. A more senior physician told her it used to be worse. "He said, before the liberalization of the [abortion] law, in the same ward, we lost women like her, maybe two or three of them every week."

And paradoxically, Dr. Henchion says, the legalization of

abortion in Ireland has given many women one more option: the choice to change their minds. Before, when women had to travel internationally for an abortion, they might feel compelled to undergo the procedure after spending the time and resources to arrange it. "The pressure on them to actually make the decision was huge... This is your only chance either to have it, or don't." But today, she says, "you can actually give people all of the information and give them space and time."

She says these changes make an even bigger difference now during the COVID-19 pandemic. "When you think about the [pandemic-related] limitations on travel, we would be looking at a really, really serious situation if we hadn't legalized when we did... There have been a lot of crisis pregnancies because of COVID, people who maybe have lost jobs or their situations have totally changed, and they can still access this care."

Of the 13 commodities on this list, three are contraceptives—female condoms, contraceptive implants and emergency contraception—and their inclusion on national essential medicines lists was lower than any of the other 10 commodities.

Ninety-three per cent of the 79 countries reported that abortion is legal on some or all grounds, with about 90 per cent of them allowing abortion to save a woman's life, about 80 per cent allowing it to preserve a woman's physical health or in cases of fetal impairment, and a little more than 60 per cent allowing it in cases of rape.

The most frequently cited restriction on abortion in these countries is a requirement for authorization by a medical professional. This restriction may be construed as discrimination against people who face barriers accessing health services in general or whose health-care providers refuse to provide abortion because of personal or prevailing societal beliefs against this procedure. Medical abortion is one safe option that does not necessarily require the direct involvement a doctor. With this type of abortion, counselling may be provided by a lay person at pharmacies where pills are dispensed, by other health professionals, or through telemedicine and safe-abortion hotlines.

Countries where women can legally access abortion services and are provided with access to information and to all methods of contraception, have the lowest abortion rates (UN Working Group on Discrimination Against Women in Law and Practice, 2017).

One study drawing on data from 61 countries found that in countries where abortion is completely banned or allowed only to save a woman's life or her physical health, only 25 per cent of abortions were safe. In countries where abortion is legal on broader grounds nearly 90 per cent of abortions were safe (Ganatra and others, 2017). Abortions are considered safe when they are carried out by a method recommended by the World Health Organization that is appropriate to the pregnancy duration, and when the person carrying out the abortion has the necessary skills. Such abortions can be done using tablets (medical abortions) or through outpatient procedures.

International declarations such as the ICPD Programme of Action say that post-abortion care should be universally available irrespective of the legal status of abortion. However, only about 80 per cent of the 79 countries with data have laws or regulations that ensure access to post-abortion care irrespective of the legal status of abortion. This inconsistency between international legal frameworks and national laws in some countries creates gaps in services that can contribute to maternal mortality and morbidity.

Comprehensive sexuality education and information

Only 62 per cent of reporting countries have laws, regulations or national policies that make comprehensive sexuality education a mandatory component of national school curricula.

Indicator limitations

No single indicator can ever capture the whole story with regard to legal and regulatory environments. The complexity of these frameworks on paper, with multiple laws and regulations impacting health outcomes and a long pathway from the existence of laws to their full implementation, makes it impossible. As a result, there are few clear associations between a country's performance on indicator 5.6.2 and relevant sexual and reproductive health outcomes in that country. The data from indicator 5.6.2 provide an entry point for deeper investigation into the strengths and weaknesses of laws and regulations as they exist on paper, and into their implementation.

All of the laws and regulations assessed under indicator 5.6.2 relate only to the supply side of health services, which paints a critical but incomplete picture. What is also needed is a deeper understanding of the laws and many other forces that support or diminish women's autonomy and empowerment in general and how those forces more directly affect the decision-making power of the individual in matters of sexual and reproductive health.

Also, indicator 5.6.2 encompasses only a selection of the areas of health that are associated with bodily autonomy. The indicator does not cover laws governing other important matters, such as rape within marriage, self-determination in gender identity, genital surgeries in the case of intersex infants and same-sex sexual activity.

Other laws governing health-care service delivery are also relevant to bodily

autonomy but are not included in indicator 5.6.2. These laws include provisions for non-discrimination, privacy and access to justice. For example, where people's identities or professions might be criminalized, such as transgender people or sex workers, stigma and discrimination in health facilities is often known to be high, acting as a barrier to access to services that can play a role in protecting bodily autonomy (Global Commission on HIV and the Law, 2012).

Recent legal reforms paving way to change

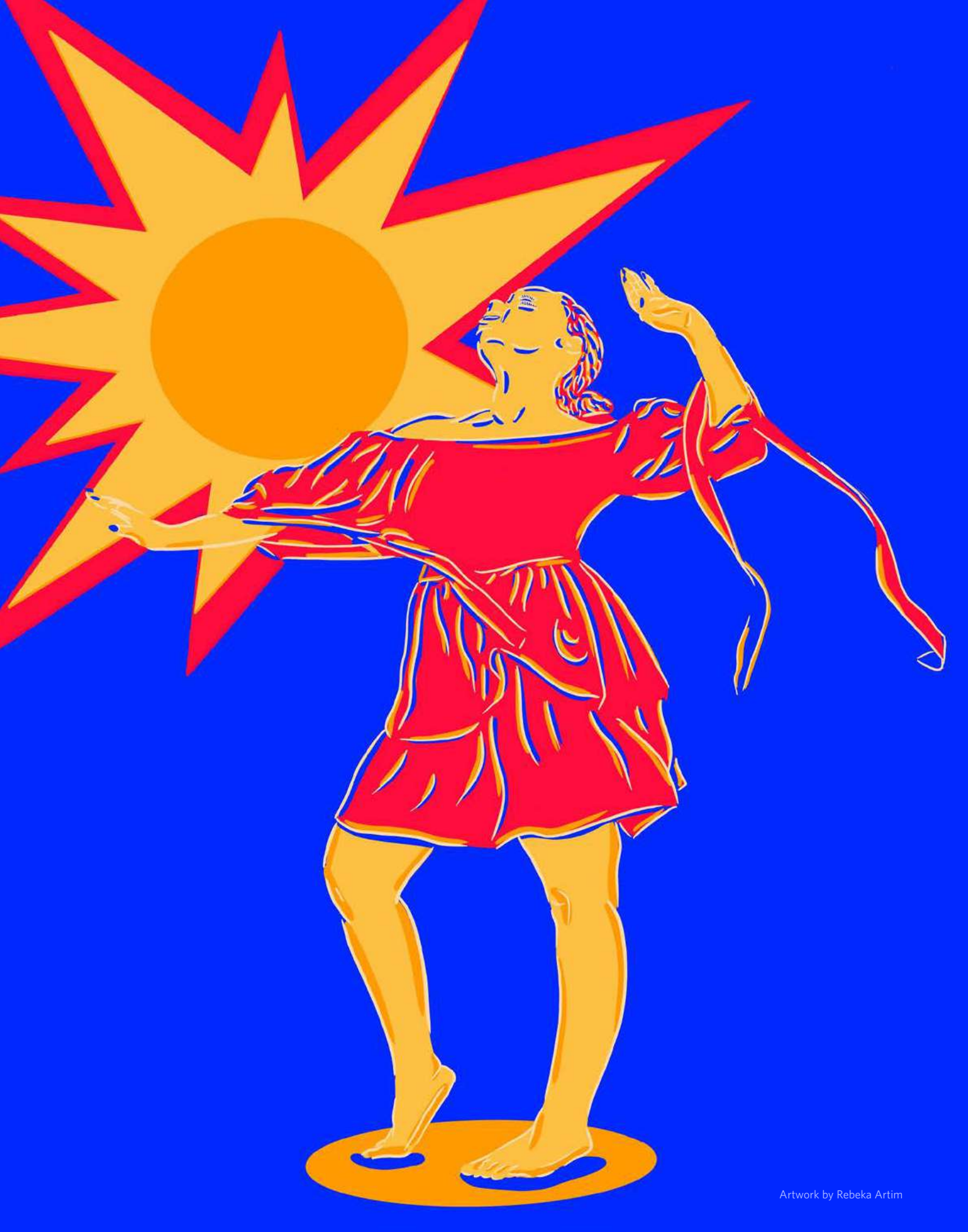
Countries around the globe are enacting laws and regulations with the intention of guaranteeing full and equal sexual and reproductive health and rights. While the impact of these positive changes is yet to be assessed, they are important first steps towards ensuring bodily autonomy.

In Tunisia, for example, marital rape was once not considered a crime. However, in 2017, the Parliament passed a comprehensive gender-based violence law that included the explicit criminalization of marital rape. The new law also eliminated a pre-existing loophole that allowed rapists to escape punishment if they married the woman (or girl) they had raped (McCormick-Cavanagh, 2017).

In Malta, the 2015 Gender Identity, Gender Expression and Sex Characteristics Act recognized a right to "bodily integrity and physical autonomy" as part of the right to gender identity. The law prohibits "any sex assignment treatment and/or surgical intervention on the sex characteristics of a minor which treatment and/or intervention can be deferred until the person to be treated can provide informed consent" (Cabral, 2015).

In Ireland in 2015, a law was passed allowing transgender people over the age of 18 to self-declare their gender without the need for a medical certificate or other interventions by state authorities (Transgender Europe, 2015). Ireland was the fourth country in the world, after Denmark, Malta and Argentina, to introduce such a law (Heidari, 2015).

And Botswana, in 2019, became the latest country in Africa to decriminalize same-sex sexual conduct or acts among consenting adults, citing rights to privacy, dignity and non-discrimination (Esterhuizen, 2019).



Artwork by Rebeka Artim

THE POWER TO SAY YES THE RIGHT TO SAY NO

Achieving bodily autonomy depends on gender equality and expanding choices and opportunities for women, girls and excluded groups

Women and women's movements have always known, at the core, that choice is power. And that there are no more fundamental choices than those related to one's own body.

Claiming the right to make choices seems like a modern concept, but it was in 400 BC that the Greek gynaecologist Agnodice refused to acknowledge a law banning women physicians and depriving women of the power of choice. Taken to court for treating patients anyway, she won her case, and the law was revoked.

The centuries since then have echoed with the voices of women insisting on autonomy and choice, all the way to the women's movements of recent decades that have claimed "our bodies, our choice" as a rallying cry.

Bodily autonomy involves many issues, but they all come back to the power to make one's own decisions. Tracking bodily autonomy under the Sustainable Development Goals emphasizes three critical dimensions: the ability to make your own decisions on health care, contraception

and sex. But many other issues influence these decisions. Little progress will be made without demolishing an underlying barrier to making choices: gender discrimination, which is woven throughout the fabric of our societies, economies and political arrangements, sustained by privilege and power still mostly held by men.

The power to make choices is so important because it underpins many other rights, and because the benefits run in many directions. A woman who can make her own decisions about sex, contraception and reproductive health is also likely to enjoy better health overall, own property, be gainfully employed, have more time for leisure and avoid gender-based violence. If she chooses to have children, they are more likely to be healthy (UNFPA, 2020e).

THE POWER TO MAKE CHOICES IS SO IMPORTANT BECAUSE IT UNDERPINS MANY OTHER RIGHTS, AND BECAUSE THE BENEFITS RUN IN MANY DIRECTIONS

There is no question that today women and girls are starting to face less gender discrimination. Gains in gender equality and the choices available to women and girls are evident everywhere. And yet, the goal of equality and the power to make decisions are far from realized. Women and girls face continued, blatant violations of their rights, even more so if they are also experiencing discrimination because of their race, age, sexual orientation, income or disability status.

Being able to make meaningful decisions depends on both empowered individuals, who have information and agency, and on an environment, from families to legal systems, that fully upholds and respects individual choices. These twin notions sit at the core of the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Declaration and Platform for Action. These notions are reflected as well in the 2030 Agenda for Sustainable Development and the 2019 Nairobi Statement on ICPD25, which called for protecting and ensuring "all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights".

Such commitments now serve as touchstones for a new global Generation Equality campaign mobilizing around the Beijing Platform's twenty-fifth anniversary and committed to achieving gender equality by 2030. Linking people of all ages and backgrounds, who are outspoken and passionate in calls for change, Generation Equality has a chance to see choice and autonomy finally, irrevocably, reaching everyone. What is still required to get there?

Autonomy depends on gender equality

Achieving bodily autonomy for women and girls depends above all on achieving gender equality. While a bold goal, gender equality is also an internationally agreed one, as the fifth Sustainable Development Goal, and as the purpose of the Beijing Declaration and Platform for Action. All countries can do more to achieve gender equality, since none is yet there.

Governments have a lead role to play in reaching that goal. By fulfilling their obligations under human rights treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, governments can alter the social, political, institutional and economic structures that reinforce and thrive on gender-unequal norms.

One foundational advance comes from ending inequalities in civil services, legislatures and leadership positions, so that women's perspectives inform and guide policies and regulations that affect women's rights and choices. Some countries have made strides in bringing more women into elected positions, including through the use of quotas and other special measures. But such shifts can have a greater impact when they are accompanied by stronger and adequately financed systems, institutions or "machineries", as they are referred to in the Beijing Platform for Action, for promoting gender equality.

As it stands now, many national machineries for gender equality are poorly funded, or are funded by donor countries, whose priorities may not align with those of developing countries. And while around three quarters of countries claim that gender equality is central to their national strategy for implementing the Sustainable Development Goals, only half involve national institutions for gender equality in formulating these strategies (UN ECOSOC, 2019).

An increasing number of governments, starting with Sweden in 2014, have adopted a "feminist foreign policy". Such a policy, according to the Centre for Feminist Foreign Policy, is a "multidimensional policy framework that aims to elevate women's and marginalized groups' experiences and agency…." While an encouraging development, feminist foreign policy will only make a difference if it goes beyond "fem-washing", where rhetoric does not meet reality.

One place to start might be with official international development and humanitarian aid. In 2018, only about 4 per cent of the total aid provided by the 30 largest donors supported programmes with gender equality and women's empowerment as the primary objective.

Looking ahead, an urgent issue will likely revolve around record levels of public debt. Many countries are on the cusp of a new wave of fiscal austerity, affecting, by one pre-pandemic estimate, almost three quarters of women and girls globally. Decisions on such austerity measures rarely reflect alignment with gender equality. They tend to reduce public services, wages and the overall quality of employment, hitting poor women with particular force. Even amid major challenges, governments can shape monetary and fiscal policies so they protect services essential to equality and autonomy, and promote full employment and the creation of

At UNFPA, realizing bodily autonomy is everything we do

For over 50 years, UNFPA has been the leading global champion of the right to bodily autonomy. As the United Nations sexual and reproductive health agency, our mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. Our programmes operate in more than 150 countries and territories with 80 per cent of the world's population, and all programmes in one way or another further the realization of the rights and choices that define autonomy.

For women, girls and young people all over the world, UNFPA provides accessible and quality health care, a variety of modern contraceptives, accurate and empowering information, and protection from harmful practices such as early marriage and all other forms of gender-based violence.

We are the world's single-largest provider of donated contraceptives to developing countries. In 2019, these contraceptives empowered women to make decisions that helped avert an estimated 14 million unintended pregnancies and 3.9 million unsafe abortions.

Our support for women's maternal health options worldwide is especially significant in the 32 countries in five regions with the highest rates of maternal mortality and morbidity. In 2019, 29,000 midwives received education and training while 2,700 midwifery tutors upgraded their skills, expanding affordable, quality health-care choices for women.

Since early pregnancy is often a consequence of little or no access to school, information or health care, UNFPA helps protect and fulfil the rights and choices of adolescent girls through comprehensive sexuality education and by advocating for girls to complete their schooling.

Collaboration with UNICEF sustains the world's largest global programme to accelerate the abandonment of female genital mutilation in 17 countries where the practice is most prevalent. Among other achievements, the programme has pioneered strategies to shift social norms towards ending a practice that undermines bodily integrity early in life.

Collaboration with UNICEF also sustains programmes to eliminate child marriage by 2030. Every year, as many as 12 million girls are subjected to this practice, which can undermine their power to make decisions not only about health care, contraception and sex, but also about schooling, livelihoods and participation in community affairs.

As one of the lead entities in the United Nations committed to furthering gender equality and women's empowerment, UNFPA acts to protect survivors of gender-based violence, providing a combination of essential services, including in humanitarian crises.

The realization of bodily autonomy is in some sense the measure of the role of UNFPA in the world: it is our purpose. And only when every woman and girl realizes it, without exception, will our mission be complete.



Artwork by Kaisei Nanke

decent work (UN ECOSOC, 2019), but this would in part require latitude in international debt servicing, something that could be advocated under a feminist foreign policy.

Autonomy demands seeing the connections

This report focuses on choices and bodily autonomy related to sexual and reproductive health and rights, in line with some of the gender equality targets defined under the Sustainable Development Goals. This is an important starting point, since the power to decide in these areas can determine decisions in many other parts of life. Women's choice and bodily autonomy are compromised on many fronts, however, and these are highly interconnected and mutually reinforcing. Industries and entire sectors of economies, for instance, thrive because women do tedious, poorly paid jobs in marginal working conditions that may undermine their health and longevity. Women in many societies suffer the indignities, if not worse, of sexual harassment, which can define decisions about choices to move in or even go to public spaces.

Impetus to consider the diverse elements of autonomy and the numerous ways they intersect comes from the new United Nations Action Coalition on Bodily Autonomy and Sexual and Reproductive Health and Rights. An integral part of preparations for the Generation Equality Forum to mark the twenty-fifth anniversary of the Beijing Declaration, the coalition is charged with putting ambitious actions on the table to boost improvements in women's rights within the next five years. UNFPA is the



Artwork by Kaisei Nanke

United Nations agency designated as one of the coalition's leaders.

Overall, women and adolescents need more options that support their choices in immediate and practical terms, such as through equal opportunities for high-quality education and decent work. But even well-intentioned measures can fall short if they do not make links and actively contribute to transforming systems that entrench gender discrimination. Women's entrepreneurship programmes, for example, while popular in many quarters and with the potential to improve women's economic well-being and ability to make choices, can only go so far without eliminating multiple biases at work and in social protection systems, health care, pension schemes, access to assets and financial services, access to markets and labour protections (UN ESCAP and UN Women, 2020).

Autonomy requires changing norms and opening opportunities

Important advances have been in made in understanding how to alter the social norms that keep gender and other forms of discrimination intact. These include advocacy and communications campaigns, and work within communities to raise awareness about how everyone—women, men, boys and girls—can benefit from gender-equal societies.

The UNFPA-supported MenCare programme in Georgia may be a model that other countries could adapt to local circumstances. It promotes men's involvement as equitable fathers and caregivers in order to achieve better health and family well-being, and encourage men to support gender equality. It also contributes to better couples' communication, consent and decision-making, which in turn can foster better bodily autonomy for women and girls.

Steps like these must be combined with broader, more systemic ones that support and even incentivize new ways of thinking. Rebalancing the unfair burden of unpaid care work placed on

women and girls, for instance, requires not just that men step up and do their fair share, but that families enjoy affordable access to essential services that lighten the load of this kind of labour, from quality child- and eldercare to reliable water and electricity supplies.

Autonomy depends on laws that enable, not constrain

Laws may not be a panacea for correcting deficits in choice and autonomy, but they do set standards and ensure accountability by guaranteeing recourse for when those standards are broken. They can have the greatest impact when they align with globally agreed human rights principles and commitments that countries have made to women's rights, gender equality and sexual and reproductive health.

In most countries, having explicit constitutional commitments to women's rights and gender equality opens the door to correcting discrimination in law and legal practice. Yet, while 191 constitutions now include some provisions on equality and non-discrimination, only 24 have stand-alone provisions on women's rights (UN ECOSOC, 2019).

Explicit constitutional provisions for applying international treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women, have been successful in advancing women's rights, providing an extra source of law to resolve contradictions domestically. A recent review of 62 court decisions in 30 countries found the most frequent references to the Convention were in decisions related to family law or the family, followed by cases of gender-based violence. This may demonstrate the challenges courts face in advancing women's equality in relation to customs that are widely supported and practised (UN Women and IDEA, 2017).

Reviewing laws for gender responsiveness and alignment with human rights standards can be a step towards removing vestiges of discrimination and inequality. In some countries, a national human rights institution can comprehensively advise on legal reform, looking at discrimination in all its forms, and across civil, political, economic, social and cultural rights (UNFPA, 2020c). Such a process could encourage adopting laws that guarantee universal access to sexual and reproductive health services without discrimination of any kind, if these do not already exist. It could help in removing contradictions such as requirements for third-party consent and constraints related to marital status. Misalignment between the age of consent for sexual activity and for accessing sexual and reproductive health information and services should be resolved, so that as soon as adolescents can legally have sex, they can access information and services.

Making choices must be upheld in legal practice

Since discriminatory social norms infiltrate justice systems just as efficiently as other institutions in a society, they can lead to discriminatory outcomes, even if the letter of the law is correctly aligned with human rights and gender equality. The social backdrop can

in fact be as much of a determinant of justice as the law itself.

Nepal, for example, has a highly patriarchal society and acute gender disparities. To counteract these patterns and ensure that substantial recent legal reforms supporting gender equality would actually be implemented, it has proactively established strong mechanisms for enforcement and accountability. These have included a National Women's Commission mandated by the Constitution to regularly investigate issues related to women and the law. Steps to increase the number of women police officers have encompassed establishing units of women officers in all 77 districts of the country. Since doing so, reporting of domestic violence cases has increased more than eight-fold (Akhmetova and others, 2020).

There are some indications of growing judicial recognition that patriarchal rules and practices, whatever their source, cannot be sustained in conflict with changing societal attitudes and constitutional values. A number of gender-based violence cases have seen courts defining discrimination based on religious or cultural grounds as unconstitutional, as was the case with female genital mutilation in Uganda. In Pakistan, the Lahore High Court not only rejected an argument based on religion, but referred to Islamic principles to maintain the sentence passed for the murder of the perpetrator's daughter, son-in-law and grandchild (UN Women and IDEA, 2017).

Moving in such directions requires members of the judiciary and police not only to be fully aware of laws designed to uphold women's rights and autonomy, but to be able to examine their own assumptions and biases, and how these may operate as they adjudicate or report cases. With this knowledge, judicial officials can be encouraged to apply innovative interpretative techniques, such as analysis that factors in social context, and routine gender assessments of whether groups of women or girls would be negatively affected by a judgment.

Women and girls also need to be aware of rights guaranteed by the law and where they can find recourse if these are violated. Since many issues around bodily autonomy operate in deeply personal realms, behind barriers reinforced by notions of public and private spaces as well as gender discrimination, it can be important to support women's rights organizations as the vanguard for this outreach. With often better access to women in families and communities, they can help provide a bridge between women and their legal rights. They can also detect patterns of discrimination among marginalized groups that could potentially be rectified through public interest legislation.

Choices in health care centre on the patient

Women and girls cannot realize bodily autonomy without access to health care, including essential sexual and reproductive health services. Twenty-six years ago, the Beijing Declaration, the political statement accompanying the Platform for Action, recognized that "the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment". More recently, the Sustainable Development Goals set the first global goal for achieving universal health coverage, defined as



Artwork by Hülya Özdemir

all people accessing the essential health services they need, without being exposed to financial hardship (Hogan and others, 2017).

Universal health coverage depends on prioritizing care in national development planning, developing effective health systems, providing adequate budgetary allocations, and generating and using sound data to adapt services and social protection to different population groups as well as needs across the life cycle.

But given the ways in which gender discrimination operates, including in health systems, universal health coverage that supports bodily autonomy must go beyond the notion

that it is enough to provide services based solely on narrow definitions of medical needs, without attention to gender dynamics that influence those needs as well as health-seeking behaviour. As the Beijing Platform for Action noted, "Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women." Similar issues apply to people with disabilities and those with diverse sexual orientations and gender identities, and others.

While much attention has been paid to whether health services are technically sound and affordable, there is often less emphasis on acceptability, safety and empowerment from the perspective of women and girls as users. Tolerance or acceptance of discriminatory norms can quickly lead health-care providers to put aside the notions of informed consent and patient autonomy, which require them to support and educate patients to make choices, without making decisions for them (Bernstein, 2018). Outcomes may include the denial of services, such as a refusal to provide contraceptives or safe abortion or post-abortion care to unmarried girls and women, even where that is not against the formal law, as well as obstetric violence, defined as experiencing, in pregnancy or childbirth, mistreatment or being forced into procedures against one's will, at the hands of medical personnel.

A number of options can help correct biases in health care. Medical guidelines can stipulate how services should be provided in line with the law; training can make health-care workers aware of legal statutes so they can work in line with them. Specific gender-sensitivity training for health-care providers could include developing skills to understand, probe and respond to the barriers to choice faced by some patients. Regular monitoring for compliance with principles of non-discrimination and quality of care could include patient monitoring, such as through simple text message surveys.

Services that support choice and autonomy offer multiple options for contraception, ensure that if women prefer a female doctor they will be able to find one, and provide channels to communicate with health-care providers in a variety of languages. Posting a patient bill of rights emphasizing dignity, rights and choices in hospitals and health-care service centres, with provisions to communicate this information to women who are illiterate or have a disability, sets a tone that services are grounded in what patients want and decide. Service relevance is also key, underscoring the importance of prioritizing health-care interventions that respond to demand from patients, starting with a strong focus on groups with the highest unmet need for sexual and reproductive health care or low service use. Also needed is an environment that enables sexual and reproductive health workers, the majority of whom are women, to do their jobs with professionalism and compassion.

Encouraging service use and the exercise of choice also depends on basic elements of quality health care, such as proximity, convenient operating hours and affordability. Services must guarantee privacy and employ health workers with positive attitudes and full respect for their clients. Providing family planning services through community health workers who share correct information and help educate men has been shown to increase uptake of contraceptives

(UNFPA, 2019). Community-level advocacy of the health benefits of sexual and reproductive health information and services for unmarried adolescents can diminish stigma and foster use.

Uganda's "SASA!" programme, backed by UNFPA, uses multiple forums to catalyse community-led changes in norms and behaviours that perpetuate gender inequality, violence and increased HIV vulnerability among women. Health workers, local authorities and activists start with a critical analysis of power and inequalities, and then introduce concepts learned through community conversations, door-to-door discussions, film shows, soap opera groups and other events. The programme has significantly decreased social acceptance of intimate partner violence, and increased agreement that a woman can refuse sex. Rates of physical intimate partner violence among women in communities with the programme have fallen by up to 52 per cent (Starmann and others, 2017; Kyegombe and others, 2014).

Midwives offer potentially unique opportunities as primary caregivers for pregnant women all over the world. They also provide a host of other services essential to realizing sexual and reproductive health and rights, from counselling on family planning to screening for nutrition and cervical cancer. In their practices, midwives, almost all of whom are women, can model and shift norms around what choice and bodily autonomy can mean, especially if they themselves are skilled and empowered. Since they may have a clearer sense of the issues that other women face around bodily autonomy, health-care systems should encourage channels where they can share knowledge that supports more gender-responsive service delivery. Midwifery also requires continued and scaled-up investment in cultivating, deploying and retaining skilled practitioners.

All health-care systems need to respond to the ways in which gender discrimination intersects with other forms of exclusion to undermine autonomy and choice. If left unrecognized, this can result in services that are inappropriate or not available or are even based on blatant rights violations. This danger has been realized, for instance, by many indigenous women and women with disabilities, who have been subject to practices such as forced sterilization. To rectify disempowerment and discrimination, the United Nations Inter-Agency Support Group on Indigenous Issues has emphasized several measures to ensure indigenous peoples fully realize their sexual and reproductive health and rights, including through their active engagement in designing culturally appropriate health policies and programmes. This has increased access among indigenous women, girls and youth to critical services for sexual and reproductive health, HIV prevention and gender-based violence, especially in rural and underserved areas (UN IASG, 2014).

Autonomy requires information

Realizing bodily autonomy depends on the ability not just to make choices, but to make informed choices, grounded in a careful weighing of facts and options. Women with more education are more likely to make their own decisions about contraception and health care, and to be able to say no to sex. With less education than her husband

or partner, a woman is more likely to face sexual violence. Further, a correlation exists between women and girls with more access to mass media and using contraception and seeking health care (UNFPA, 2019).

Among 75 countries with data on laws and regulations supporting sexual and reproductive health, fewer than two thirds have statutes or policies making comprehensive sexuality education mandatory in national school curricula. Such education is age-appropriate, based on a clearly defined curriculum, aligned with human rights and gender equality, and culturally relevant. It is ideally available in and out of school (UNESCO and others, 2018).

The United Nations Educational, Scientific and Cultural Organization stresses that evidence-based comprehensive sexuality education from early childhood encourages greater autonomy and safety during young adulthood without leading to earlier sexual activity (UNESCO, 2009). Comprehensive courses can support more respectful relationships and more autonomous decisions about sexuality late in life (Marí-Ytarte and others, 2020).

Since much information on sex and reproduction can come from health-care providers, they need to be attuned to offering it respectfully and without judgment, and accounting for different needs based on age, ability or socioeconomic standing. This is particularly necessary for adolescents and other groups who have been traditionally overlooked or marginalized in access to sexuality education. Providers should be prepared to counter myths that circulate and undermine the ability to make informed choices. One novel approach being pursued by UNFPA in Colombia and the Philippines is to "scrape" Twitter conversations to identify common myths about issues from contraception to sexually transmitted infections. This information can then be used to shape sexuality education and health-care programmes.

Reinforcing empowering messages around choice could operate in education more broadly by encouraging girls to pursue diverse fields of study, unfettered by gender norms around what "girls should do". Making such a choice is empowering in and of itself, and could lead to further empowerment and autonomy as girls cross into potentially more lucrative and rewarding jobs. Much of the current gender pay gap is explained by labour market segregation that shunts women into lower-paying jobs. A mere 3 per cent of students joining information and communication technology courses across the globe are women, for instance (United Nations, n.d.a).

Autonomy demands defending the defenders of women's empowerment and rights

Women's movements have long advocated and defended the right to choice and bodily autonomy, often with minimal resources. The same is true for organizations of LGBTI people, indigenous peoples, youth and people with disabilities. Today, however, space for them to operate is increasingly under pressure, and there is evidence of backtracking on hard-won gains. More vocal and organized

opposition to gender equality and women's rights activism has emerged around the world, including by religious and conservative groups, populist and nationalist groups, men's rights groups and anti-gender ideology movements (Roggeband and Krizsán, 2020).

Women politicians, journalists, activists and human rights defenders have been increasingly subject to harassment, violence and cyberbullying. Between 2014 and 2018, the Special Rapporteur on Human Rights Defenders issued 181 communications to 60 States on women human rights defenders. Documented attacks have included defamation campaigns; physical or sexual violence, torture, killings and forced disappearances; threats to and attacks on family members, or by family members, because of their activities; and attacks against their collectives and movements (UN ECOSOC, 2019).

Decisive action should counter and prevent such violations. Some countries have passed specific laws criminalizing violence against women in politics and public life, often under pressure from women's activists, as in Costa Rica, Ecuador, Mexico and Peru. The Organization of American States in 2017 issued its Inter-American Model Law on the Prevention, Punishment and Eradication of Violence against Women in Political Life. Since the fear of violence is a major deterrent to women taking more public roles in many places, adopting and implementing measures like these could reshape the conditions under which women can participate, lead and make choices. Complementary actions might include advocacy campaigns and work with media and schools to eliminate gender stereotypes.

Political parties should be encouraged to recognize women's political value and rights, and move beyond lip service and tokenism (O'Neil and Domingo, 2016).

Women's groups and movements are highly diverse, with enormous stores of knowledge about the issues women face in realizing autonomy and rights. But from grass-roots service providers to women's professional associations, they are not always well connected. Sustained support and resources to systematically bring them together could advance organizing around common problems (O'Neil and Domingo, 2016) and presenting a more unified, powerful response to regressive forces.

WOMEN POLITICIANS, JOURNALISTS, ACTIVISTS AND HUMAN RIGHTS DEFENDERS HAVE BEEN INCREASINGLY SUBJECT TO HARASSMENT, VIOLENCE AND CYBERBULLYING

Similarly, bodily autonomy presents a unifying concern for diverse groups of activists, including around disability, LGBTI rights and the rights of indigenous communities. Linking different issues and the intersections among them could shape a collective, influential agenda and activism for realizing fundamental human rights in all economic priorities, justice systems, health and social services and safety nets.



Artwork by Rebeka Artim

Autonomy requires shifts in men's attitudes

Women can claim their rights. States can uphold them. Yet progress fundamentally depends on men, individually and collectively, being willing to step away from dominating roles that privilege their power and choices at the expense of women's power and choices. This is now happening, with a shift in attitudes towards gender equality among younger men in particular, but still has far to go.

Part of the way forward may be more men understanding the downside of male dominance, such as risks to their own health and that of their wives or partners, and interpersonal conflicts. A regional survey of Europe by the World Health Organization found that gender equality benefits men's health, including through lower mortality rates, half the chance of being depressed and a 40 per cent reduced risk of violent death (WHO Regional Office for Europe, 2018). Adolescent boys in particular need exposure to positive notions of masculinity, especially at a time of life when harmful gender norms start to crystallize, causing long-term harm to themselves and girls (UNFPA and Promundo, 2016).

The #MeToo movement as well as survey data show that one of the areas where women are most behind in terms of choice and autonomy is in the power to say no to sex. Notions of respectful, non-violent relationships are ideally modelled to children in households from the beginning, but regardless, they should be integral to comprehensive sexuality education in school. They can feature more prominently

in the media and entertainment, in the ways religion is taught, and even in workplaces in terms of clear and enforced policies on sexual harassment. Ending impunity for sexual violence in all its forms, from single violations to the mass crimes that occur when rape is used as a weapon of war, is also essential. In 2000, the United Nations Security Council issued Resolution 1325, which called on parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict. Since then, the Security Council has issued seven other resolutions condemning this form of violence.

Improving women's opportunities for livelihoods and leadership roles in their community and beyond can increase their power to make decisions within households and about their bodies. Such support may need to build in explicit work with men and communities, however, to ease a transition to more progressive gender norms and limit the risk of backlash from some men who may feel threatened by women's gains.

Another important element is to engage men in transforming patterns of unpaid care, so that it is not performed primarily by women, and household dynamics in power and choice to achieve greater equilibrium. Paternity and parental leave policies can encourage men to participate in caregiving, especially if leave cannot be transferred to the other parent. These provisions are becoming more common, but still reach a limited number of families in developing countries, particularly in the informal workforce. Public policies could also do more to encourage men to break stereotypes and enter female-dominated care professions such as child- and eldercare (UN ECOSOC, 2019).

GENDER EQUALITY BENEFITS MEN'S HEALTH, INCLUDING THROUGH LOWER MORTALITY RATES, HALF THE CHANCE OF BEING DEPRESSED AND A 40 PER CENT REDUCED RISK OF VIOLENT DEATH

Other opportunities exist to promote gender-equitable attitudes among men and adolescent boys through sexual and reproductive health services, where providers can share knowledge about equitable relationships, parenting and communications (IPPF and UNFPA, 2017). Community mobilization programmes can also challenge unequal power relations and discriminatory social norms, building on a strong grounding in theories of gender and power. Initiatives involving women, men, girls and boys together have proven more effective than those for men and boys alone (UN ECOSOC, 2019).

The masculinity trap

The lush beauty of Guatemala's central highlands hides a dark reality for women and girls, says Alexander Armando Morales Tecún, an indigenous youth educator and gender equality advocate in the rural department of Quiché. "In many places, women are blamed if they are attacked, said to have tempted or seduced their aggressors or rapists, because of the way they are dressed, for example, or because of their way of acting."

These attitudes are not unique to Guatemala, which ranks in the bottom third of countries and territories on measures of women's safety and welfare, according to Georgetown University's 2019 Women, Peace and Security Index. In fact, victims around the world are routinely blamed for inviting gender-based violence by being in the wrong place, wearing the wrong clothing, behaving the wrong way or simply being physically developed at an early age. And such factors are often considered mitigating or exculpatory for perpetrators.

In 1998, for instance, Italy's Supreme Court overturned the rape conviction of a man whose accuser was wearing tight blue jeans at the time of the attack. In 2010, when an 11-year-old girl was gang-raped by more than a dozen boys and men in the United States, national media reported that she was known to dress inappropriately for her age. In Afghanistan, rape survivors may be imprisoned for "morality crimes".

"Women are blamed if they are attacked, said to have tempted or seduced their aggressors or rapists."

The blaming and shaming of victims rather than perpetrators can be traced back to norms that encourage men to take control—not only of women's bodies but also of their families. Tecún recalled asking a group of young men why they wanted to get married. One of them answered, "I want to rule my family. Because I want someone to cook for me, someone to wash my clothes, someone to give me children and someone to keep my house."

Jay Silverman, a professor at the University of California, San Diego School of Medicine who studies reproductive coercion, says these attitudes are universal. "Male entitlement to control female partners often also extends to children. The perception of that right is maintained by all sorts of different structures and



Alexander Armando Morales Tecún educates young people about gender equality. Original artwork by Naomi Vona; photo © UNFPA/J. Serrano.

norms in communities and nations across the globe."

But the result is not a simple male-versus-female dynamic, Tecún cautioned. These gender norms—which he calls "a hegemonic model of masculinity"—can leave men feeling trapped, as well. "If you are not married, you are not a man. If you are not in a relationship, you are not a man."

And women play a role in perpetuating these beliefs as well, he added. "Many

women also reaffirm that it is acceptable to beat a woman when she has not fulfilled her duties, because she did not wash her husband's clothes, because her husband's food was burned... It is said that it is good that they beat you because you did not comply with satisfying your husband."

These ideas are instilled early and reinforced "from music, games, images, advertising," Tecún said. "In the locality where I am from, when a boy is born, a good creole chicken broth is made. When a girl is born, it is totally silent, as if the event were a wake."

Anything that undermines these norms—including the very concept of bodily autonomy—can be regarded as a threat, according to Romeo Alejandro Méndez Zúñiga, another indigenous youth educator and activist in Quiché. "The few people who have heard of bodily autonomy associate it with negative ideas because it affects the patriarchal male chauvinist system," he said.

Zúñiga wants men and boys to embrace new norms that liberate both men and women from traditional masculine ideals. "What our society deserves... are new masculinities, new ways of seeing manhood, ways that strengthen and promote equality of opportunity for development, that enable all of us to live with dignity."

Autonomy requires investment

Gender discrimination poses multiple steep barriers to women's empowerment and autonomy. Taking these down requires substantial and sustained investment, in line with principles of fairness and equity, and with particular attention to intersecting inequalities. Yet financing typically falls far short of what it should be, for reasons that start with economies structured to concentrate resources in a few privileged hands, mostly belonging to men.

Substantial and sustained investments in integrated social protection, health and education services could address the multiple risks and vulnerabilities that women and girls face throughout their lives, and build in empowerment and autonomy by putting a central emphasis on sexual and reproductive health and rights (UN ECOSOC, 2019). Such approaches have never been more important than in COVID-19 recovery plans, with poor and increasingly desperate families struggling to cope with the economic downturn by, for example, marrying off their daughters.

National gender equality action plans and institutions for gender equality need adequate resources, as many remain chronically underfunded and unable to fulfil their

mandates (UN ECOSOC, 2019). So do women's civil society organizations, which are often on the front lines of protecting women's autonomy and rights. They provide many of the services to assist survivors of gender-based violence, for instance, yet were significantly underfunded even before the COVID-19 pandemic. While the need for such services rose dramatically during the crisis, funding in many cases did not. In the Asia and the Pacific region, 12 per cent of civil society organizations working on eliminating violence against women completely suspended their services as a result, and 71 per cent are only partially operational (UN ESCAP and UN Women, 2020). Smaller groups doing pioneering work and with a dedicated women's rights agenda tend to be among those most often missed by international aid and other donors.

The price tag for ending preventable maternal deaths, covering all unmet needs for family planning and stopping gender-based violence worldwide by 2030 will total $264 billion, according to a joint study by UNFPA and Johns Hopkins University, in collaboration with Victoria University, the University of Washington and Avenir Health. Achieving these goals would contribute to women's bodily autonomy (UNFPA, 2020f).

Autonomy means measurement

The Sustainable Development Goals represent an advance in calling for the measurement of progress on gender equality, including whether women and adolescent girls can make choices about their bodies. Yet gaps in data broken down by gender remain large. Gender data may not be collected, or if they are, may not be used or shared. Inconsistencies in collection prevent essential analysis of how trends move over time.

This lack of information on what is actually taking place in the lives of women and girls automatically diminishes the possibility of developing services and policies that most effectively support gender equality and autonomy. It can be a driver of discrimination where issues like gender-based violence and unpaid care work remain invisible, uncounted and unaddressed.

Only an estimated 13 per cent of countries have a dedicated budget to collect and analyse gender statistics. For the 54 gender-specific indicators in the Sustainable Development Goals, regular data are produced for only 22 per cent worldwide (UN Women, 2018). Major shortfalls exist in data on women over reproductive age; digital literacy among girls; and gender and the environment, among others (Data2x, 2020).

Women's informed decision-making is poorly measured, and data are missing or not regularly produced on women's use of health services as well as on laws guaranteeing full and equal access to sexual and reproductive health care. Also missed are intersectional needs, especially for women and adolescent girls in humanitarian crises, LGBTI individuals and women with disabilities. Health data for adolescents are not always sex-disaggregated, and data on socially excluded girls are particularly scarce (Data2x, 2020a).

Data systems need to be strategically designed to capture the common experiences of women and girls, while being nuanced enough to reflect their diversity (Data2x, 2020). Such systems need to be systematic and comprehensive, and should apply human rights principles to prevent marginalization and discrimination, a direction that should be set through national policy.

Another priority is to avoid compartmentalizing gender within certain issues or areas of work, which is happening even now under the Sustainable Development Goals, where six of 17 goals are dubbed "gender-blind", meaning that they make no mention of gender even though achievement of the goal will require addressing some aspects of gender inequality (UN Women, 2018). More questions reflecting broader dimensions of choice and bodily autonomy could be included in national surveys. Measurement also falls short in capturing links across the global goals (Data2x, 2020), a problem reflected as well in the "sectoral" divisions of many national statistical systems.

Bolstering investment in gender data requires a fully funded national gender action plan covering all sources of data and statistics, and guided by measurable milestones. Work with national statistics offices could start by clearly demonstrating the value of collecting gender data and addressing sex differentials within important administrative data such as civil registration and vital statistics, building on some momentum now evident on the issue (Pryor, 2020).

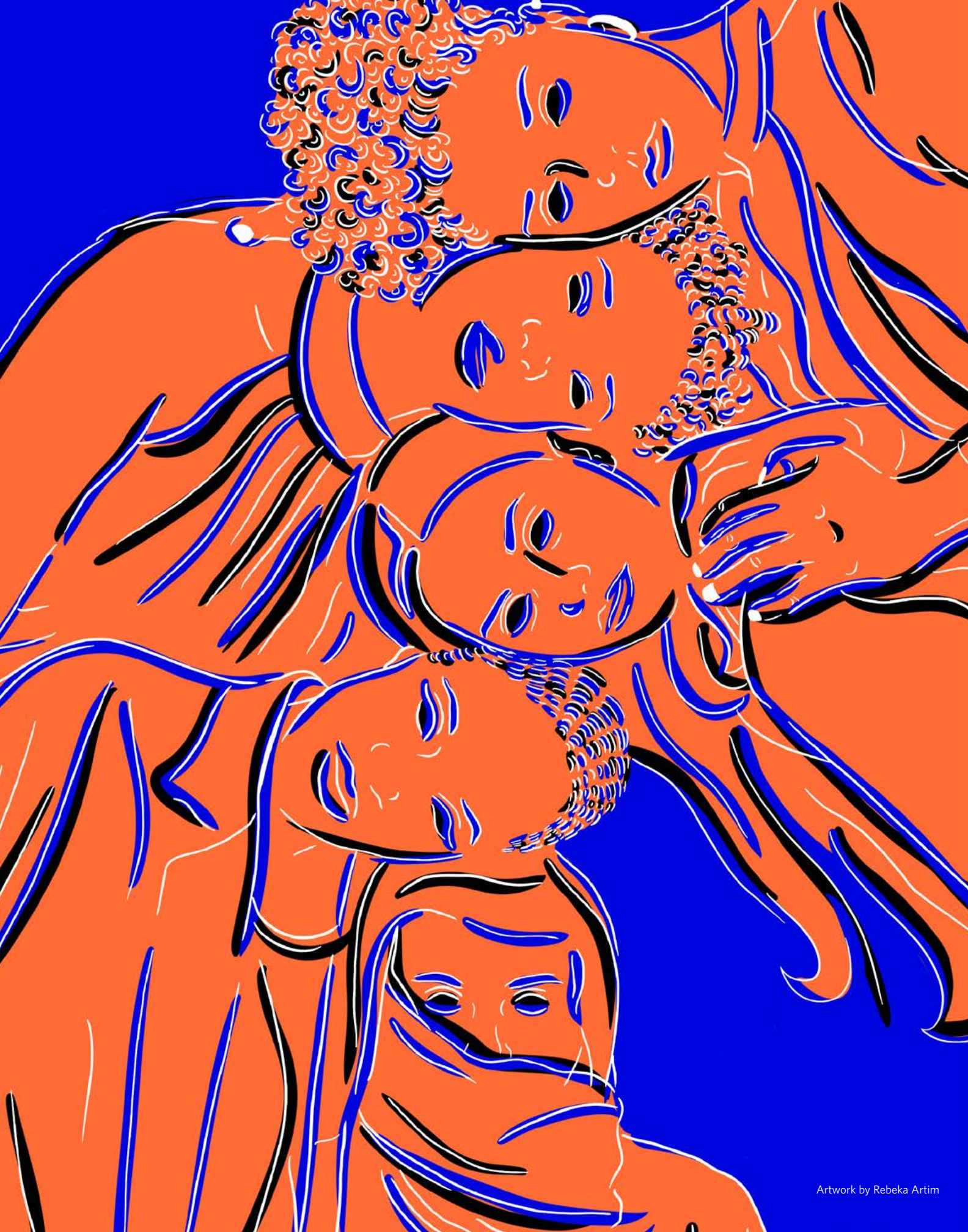
A world of rights, choices, autonomy

Many justifications, rationalizations and theories have been put forward to justify depriving women and girls of their rights and choices and for making their bodies subject to the whims of others. But if these excuses are allowed to continue, virtually none of the United Nations Sustainable Development Goals will be achieved by 2030. And that means the potential for human, social and economic progress envisioned by the international community in the 2030 Agenda for Sustainable Development would go unrealized, to everyone's detriment.

Gender equality is a critical variable in the equation for success. So is realizing the rights of people who identify as LGBTI, people with disabilities, and anyone else who is discriminated against or denied autonomy because of their race, ethnicity or economic status. Everyone should have the power to make their own decisions about health care, contraception and sex.

Governments, all social and economic institutions, communities, families and men have roles in upholding women's rights and ending discrimination more broadly. All must do a better job. The new "Generation Equality" is here, and it won't wait for change. Nor should it.

Individuals alone have the right to decide and make choices about their bodies and lives. They alone have the right to say yes or no. We together can make it happen.



Artwork by Rebeka Artim

Sexual and Reproductive Health

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
						ANY METHOD		MODERN METHOD					
						All	Married or in union	All	Married or in union	All	Married or in union		
World and regional areas	2017	2017	2017	2014–2019	2018	2021		2021		2021		2021	2019
World	**211**	**199**	**243**	**81**	**0.24**	**49**	**63**	**45**	**57**	**9**	**11**	**77**	**73**
More developed regions	12	11	13	99	–	59	71	53	62	7	9	80	84
Less developed regions	232	219	268	79	–	47	62	43	56	9	12	76	69
Least developed countries	415	396	477	61	0.58	32	42	28	37	16	20	59	71
UNFPA regions													
Arab States	151	121	208	90	–	34	53	29	45	10	16	65	53
Asia and the Pacific	120	108	140	85	–	52	67	48	62	7	9	80	72
Eastern Europe and Central Asia	20	18	22	99	–	46	64	36	49	8	12	66	82
Latin America and the Caribbean	74	70	80	94	–	59	75	56	70	8	10	83	66
East and Southern Africa	391	361	463	64	–	34	43	31	39	16	21	62	75
West and Central Africa	717	606	917	55	–	20	22	17	18	17	22	46	70
Countries, territories, other areas	2017	2017	2017	2014–2019	2018	2021		2021		2021		2021	2019
Afghanistan	638	427	1010	59	0.02	19	26	17	23	17	24	47	54
Albania	15	8	26	–	–	31	44	4	5	12	17	10	82
Algeria	112	64	206	–	0.03	35	64	31	57	6	9	76	–
Angola	241	167	346	47	1.01	16	17	15	15	27	36	35	66
Antigua and Barbuda	42	24	69	100	–	45	64	43	61	10	13	78	–
Argentina	39	35	43	94	0.15	60	71	57	67	9	11	84	–
Armenia	26	21	32	100	0.06	39	59	21	31	8	12	44	87
Aruba	–	–	–	–	–	–	–	–	–	–	–	–	–
Australia	6	5	8	97	0.04	59	67	57	64	8	11	85	–
Austria	5	4	7	98	–	65	70	62	68	6	8	88	–
Azerbaijan	26	21	32	99	–	37	57	15	22	9	14	32	–
Bahamas	70	48	110	99	0.55	45	67	43	65	9	12	80	–
Bahrain	14	10	21	100	–	31	67	21	46	5	10	59	–
Bangladesh	173	131	234	53	0.01	55	66	48	57	9	11	75	–
Barbados	27	17	39	99	0.58	50	63	47	61	12	14	76	44
Belarus	2	1	4	100	0.22	61	70	52	58	6	8	78	87
Belgium	5	4	7	–	–	59	67	58	66	6	8	90	–
Belize	36	26	48	94	0.81	44	57	42	53	14	18	71	42
Benin	397	291	570	78	0.34	17	18	14	14	25	31	33	91
Bhutan	183	127	292	96	0.11	39	60	38	58	8	13	80	–
Bolivia (Plurinational State of)	155	113	213	72	0.13	48	67	35	49	12	16	59	–
Bosnia and Herzegovina	10	5	16	100	0.01	38	49	19	21	11	14	38	–
Botswana	144	124	170	100	4.36	57	69	56	68	8	10	86	–
Brazil	60	58	61	99	–	65	80	63	77	6	7	89	–
Brunei Darussalam	31	21	45	100	–	–	–	–	–	–	–	–	–
Bulgaria	10	6	14	100	0.05	65	79	50	57	5	7	71	–
Burkina Faso	320	220	454	80	0.12	30	34	29	33	20	24	58	72
Burundi	548	413	728	85	0.16	19	31	17	28	17	28	47	64
Cambodia	160	116	221	89	0.05	43	63	32	46	7	11	63	98
Cameroon, Republic of	529	376	790	69	1.02	27	23	22	17	16	23	51	–
Canada	10	8	14	98	–	74	82	70	77	3	5	91	–
Cape Verde	58	45	75	92	0.19	49	68	47	65	11	11	79	–
Central African Republic	829	463	1470	–	1.20	23	26	17	20	18	22	42	77

Sexual and Reproductive Health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
						ANY METHOD		MODERN METHOD					
						All	Married or in union	All	Married or in union	All	Married or in union		
	2017	2017	2017	2014–2019	2018	2021		2021		2021		2021	2019
Chad	1140	847	1590	24	0.44	7	8	6	7	18	24	25	75
Chile	13	11	14	100	0.27	63	77	59	71	6	8	85	–
China	29	22	35	100	–	69	85	67	83	4	3	91	–
China, Hong Kong SAR	–	–	–	–	–	48	70	45	67	8	9	81	–
China, Macao SAR	–	–	–	–	–	–	–	–	–	–	–	–	–
Colombia	83	71	98	99	0.14	64	82	60	77	6	7	87	97
Comoros	273	167	435	–	0.00	20	27	16	22	19	29	41	–
Congo, Democratic Republic of the	473	341	693	80	0.21	23	25	12	12	21	26	28	–
Congo, Republic of the	378	271	523	91	1.03	42	43	28	27	15	19	50	53
Costa Rica	27	24	31	99	0.21	55	73	53	71	9	11	84	62
Côte d'Ivoire	617	426	896	74	0.70	26	26	23	22	21	27	49	63
Croatia	8	6	11	100	0.02	51	71	36	47	7	8	63	–
Cuba	36	33	40	100	0.15	70	75	69	74	7	8	89	–
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	6	4	10	98	–	–	–	–	–	–	–	–	–
Czechia	3	2	5	100	0.05	63	85	56	76	3	4	85	70
Denmark	4	3	5	95	0.02	65	78	61	74	5	7	88	90
Djibouti	248	116	527	–	0.57	16	29	16	28	15	27	50	–
Dominica	–	–	–	100	–	–	–	–	–	–	–	–	–
Dominican Republic	95	88	102	100	0.26	57	72	55	70	9	10	84	–
Ecuador	59	53	65	96	0.13	60	81	54	73	6	6	82	–
Egypt	37	27	47	92	0.04	44	61	43	59	9	12	81	44
El Salvador	46	36	57	100	0.11	52	73	49	69	8	10	81	83
Equatorial Guinea	301	181	504	–	4.21	17	17	15	14	23	31	37	–
Eritrea	480	327	718	–	0.15	9	14	9	13	18	29	32	–
Estonia	9	5	13	99	0.23	57	65	52	58	7	11	81	–
Eswatini	437	255	792	–	8.62	54	68	53	66	10	13	83	–
Ethiopia	401	298	573	28	0.24	29	42	29	41	15	21	66	–
Fiji	34	27	43	100	–	35	51	30	44	12	16	65	–
Finland	3	2	4	100	0.04	79	82	74	78	3	5	91	98
France	8	6	9	98	0.09	65	78	63	75	4	4	91	–
French Guiana	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	252	165	407	–	1.01	38	37	30	27	18	24	53	58
Gambia	597	440	808	–	1.06	11	15	11	15	17	25	39	83
Georgia	25	21	29	99	0.18	32	47	24	34	13	19	52	93
Germany	7	5	9	99	0.03	61	78	60	78	5	5	91	–
Ghana	308	223	420	78	0.70	27	36	23	31	19	26	51	–
Greece	3	2	4	100	–	54	74	39	50	6	7	64	54
Grenada	25	15	39	100	–	45	64	42	59	10	13	76	–
Guadeloupe	–	–	–	–	–	46	60	41	53	11	15	73	–
Guam	–	–	–	–	–	42	66	36	56	7	10	75	–
Guatemala	95	86	104	70	0.14	42	64	36	53	9	13	70	–
Guinea	576	437	779	55	0.52	12	10	10	9	20	25	33	–
Guinea-Bissau	667	457	995	45	1.43	29	20	27	19	16	20	60	70
Guyana	169	132	215	96	0.51	34	46	32	44	17	25	63	75

Sexual and Reproductive Health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
						ANY METHOD		MODERN METHOD					
						All	Married or in union	All	Married or in union	All	Married or in union		
	2017	2017	2017	2014–2019	2018	2021		2021		2021		2021	2019
Haiti	480	346	680	42	0.69	28	38	26	35	23	34	50	65
Honduras	65	55	76	74	0.09	52	76	47	67	7	9	78	–
Hungary	12	9	16	100	0.02	49	70	45	63	6	9	81	–
Iceland	4	2	6	98	0.05	–	–	–	–	–	–	–	–
India	145	117	177	81	–	43	57	39	51	9	12	74	–
Indonesia	177	127	254	95	0.17	44	62	42	59	8	11	81	–
Iran (Islamic Republic of)	16	13	20	99	0.05	58	81	46	65	4	5	75	–
Iraq	79	53	113	96	–	37	56	26	39	9	13	57	39
Ireland	5	3	7	100	0.08	66	71	63	66	6	9	88	–
Israel	3	2	4	–	0.05	39	74	30	56	5	8	68	–
Italy	2	1	2	100	0.05	59	67	48	51	7	9	73	–
Jamaica	80	67	98	100	–	42	68	40	64	9	11	78	–
Japan	5	3	6	100	0.01	48	56	41	44	12	16	68	83
Jordan	46	31	65	100	0.00	30	54	22	38	8	14	56	–
Kazakhstan	10	8	12	100	0.14	43	53	40	51	11	15	75	63
Kenya	342	253	476	62	1.02	46	64	45	62	12	14	77	–
Kiribati	92	49	158	–	–	20	26	16	21	18	26	44	–
Korea, Democratic People's Republic of	89	38	203	100	–	58	74	55	71	8	9	84	83
Korea, Republic of	11	9	13	100	–	56	81	51	73	6	5	82	–
Kuwait	12	8	17	100	0.04	41	60	34	49	9	14	67	–
Kyrgyzstan	60	50	76	100	0.09	29	41	27	39	13	18	66	73
Lao People's Democratic Republic	185	139	253	64	0.08	39	61	34	54	8	11	74	96
Latvia	19	15	26	100	0.19	61	72	54	62	6	9	81	70
Lebanon	29	22	40	–	0.02	29	62	21	46	6	12	61	–
Lesotho	544	391	788	87	7.80	53	66	52	65	11	15	81	–
Liberia	661	481	943	–	0.39	28	30	27	29	25	28	51	–
Libya	72	30	164	–	0.07	25	39	16	25	17	26	38	33
Lithuania	8	5	12	100	–	46	66	38	53	8	11	70	88
Luxembourg	5	3	8	–	0.09	–	–	–	–	–	–	–	–
Madagascar	335	229	484	46	0.24	41	50	36	44	15	16	65	–
Malawi	349	244	507	90	2.28	48	64	48	63	13	15	77	76
Malaysia	29	24	36	100	0.18	35	57	25	41	9	14	57	81
Maldives	53	35	84	100	–	15	22	12	17	22	30	33	45
Mali	562	419	784	67	0.78	18	19	17	19	21	24	45	79
Malta	6	4	11	100	–	64	85	50	66	4	3	74	90
Martinique	–	–	–	–	–	47	62	43	56	11	14	74	–
Mauritania	766	528	1140	69	0.03	12	18	11	16	18	29	35	62
Mauritius	61	46	85	100	0.70	43	67	28	43	8	10	56	73
Mexico	33	32	35	96	0.08	56	73	53	70	9	10	82	–
Micronesia (Federated States of)	88	40	193	–	–	–	–	–	–	–	–	–	–
Moldova, Republic of	19	15	24	100	0.25	53	64	42	50	9	12	67	–
Mongolia	45	36	56	99	0.01	41	56	37	51	13	15	70	–
Montenegro	6	3	10	99	0.08	26	26	18	15	17	22	43	52
Morocco	70	54	91	87	0.03	43	71	37	61	7	11	74	–
Mozambique	289	206	418	73	5.25	26	28	25	27	19	22	56	94
Myanmar	250	182	351	60	0.20	33	58	33	56	8	14	78	82

Sexual and Reproductive Health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a] 2017	Range of MMR uncertainty (UI 80%), lower estimate[a] 2017	Range of MMR uncertainty (UI 80%), upper estimate[a] 2017	Births attended by skilled health personnel, per cent 2014–2019	Number of new HIV infections, all ages, per 1,000 uninfected population 2018	Contraceptive prevalence rate, women aged 15–49, per cent 2021				Unmet need for family planning, women aged 15–49, per cent 2021		Proportion of demand satisfied with modern methods, all women aged 15–49 2021	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent 2019
						ANY METHOD		MODERN METHOD					
						All	Married or in union	All	Married or in union	All	Married or in union		
Namibia	195	144	281	–	2.82	52	61	52	60	10	15	83	96
Nepal	186	135	267	58	0.03	43	55	38	48	17	21	63	48
Netherlands	5	4	7	–	0.03	63	73	61	71	6	7	89	98
New Caledonia	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	9	7	11	97	0.03	65	80	61	75	5	5	88	94
Nicaragua	98	77	127	96	0.07	53	82	51	79	5	6	88	–
Niger	509	368	724	39	0.08	16	19	16	18	16	18	49	–
Nigeria	917	658	1320	43	0.65	17	20	13	15	15	19	41	–
North Macedonia	7	5	10	100	0.02	40	48	21	21	13	17	40	–
Norway	2	2	3	99	0.02	67	86	63	80	4	4	89	–
Oman	19	16	22	99	0.07	21	35	14	24	15	26	40	–
Pakistan	140	85	229	69	0.11	25	37	19	28	12	17	52	65
Palestine[1]	–	–	–	100	–	41	62	31	47	7	11	65	60
Panama	52	45	59	93	0.32	48	60	45	56	14	17	73	–
Papua New Guinea	145	67	318	56	0.26	28	38	23	32	18	25	51	–
Paraguay	84	72	96	98	0.16	58	72	54	67	8	9	82	–
Peru	88	69	110	92	0.10	55	77	42	57	5	7	70	–
Philippines	121	91	168	84	0.13	36	57	27	43	10	16	58	75
Poland	2	2	3	100	–	53	73	43	57	6	8	72	–
Portugal	8	6	11	99	0.07	61	75	52	65	7	7	78	–
Puerto Rico	21	16	29	–	–	57	82	52	74	6	5	82	–
Qatar	9	6	14	100	–	30	48	26	40	10	16	64	–
Réunion	–	–	–	–	–	49	72	48	71	9	9	83	–
Romania	19	14	25	97	0.04	55	72	45	58	5	8	75	–
Russian Federation	17	13	23	100	–	49	68	41	57	6	10	75	–
Rwanda	248	184	347	91	0.29	34	58	31	53	12	17	69	–
Saint Kitts and Nevis	–	–	–	100	–	–	–	–	–	–	–	–	–
Saint Lucia	117	71	197	100	–	49	61	46	57	12	15	76	–
Saint Vincent and the Grenadines	68	44	100	99	–	50	67	48	64	10	12	80	81
Samoa	43	20	97	83	–	17	29	16	27	24	41	39	–
San Marino	–	–	–	–	–	–	–	–	–	–	–	–	–
São Tomé and Príncipe	130	73	217	93	–	36	46	33	43	21	27	59	54
Saudi Arabia	17	10	30	99	–	19	30	15	24	15	25	44	–
Senegal	315	237	434	74	0.08	22	31	21	29	16	22	56	–
Serbia	12	9	17	98	0.02	49	56	33	30	10	13	56	86
Seychelles	53	26	109	–	–	–	–	–	–	–	–	–	–
Sierra Leone	1120	808	1620	87	0.55	28	25	27	25	20	24	57	65
Singapore	8	5	13	100	0.04	40	69	36	61	6	10	77	–
Sint Maarten	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	5	4	7	98	0.02	56	79	48	66	4	6	79	–
Slovenia	7	5	9	–	–	54	80	45	67	6	5	76	–
Solomon Islands	104	70	157	86	–	24	33	20	27	13	17	54	–
Somalia	829	385	1590	–	0.03	16	27	7	12	16	27	23	–
South Africa	119	96	153	97	4.94	50	58	50	57	11	14	82	95
South Sudan	1150	789	1710	–	1.56	6	8	5	7	20	30	21	16
Spain	4	3	5	–	0.07	60	63	58	62	9	13	84	–

Sexual and Reproductive Health

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
						ANY METHOD		MODERN METHOD					
						All	Married or in union	All	Married or in union	All	Married or in union		
	2017	2017	2017	2014–2019	2018	2021		2021		2021		2021	2019
Sri Lanka	36	31	41	100	0.01	45	67	37	55	5	7	74	89
Sudan	295	207	408	78	0.13	11	16	10	14	18	28	34	57
Suriname	120	96	144	98	0.49	33	46	33	45	15	23	68	45
Sweden	4	3	6	–	–	62	73	57	66	6	8	84	100
Switzerland	5	3	7	–	–	72	73	68	69	4	7	89	92
Syrian Arab Republic	31	20	50	–	0.00	37	62	28	46	8	13	62	77
Tajikistan	17	10	26	95	0.09	24	32	22	29	16	22	55	–
Tanzania, United Republic of	524	399	712	64	1.41	36	44	32	39	16	20	61	–
Thailand	37	32	44	99	0.09	56	80	54	78	4	5	91	–
Timor-Leste, Democratic Republic of	142	102	192	57	–	19	32	17	29	14	24	52	–
Togo	396	270	557	69	0.70	24	26	22	24	22	31	48	73
Tonga	52	24	116	–	–	20	37	17	32	13	25	52	–
Trinidad and Tobago	67	50	90	100	–	40	49	36	45	14	20	66	32
Tunisia	43	33	54	100	0.02	30	58	26	50	7	13	69	–
Turkey	17	14	20	98	–	48	71	33	49	7	10	61	–
Turkmenistan	7	5	10	100	–	37	55	34	51	10	14	74	–
Turks and Caicos Islands	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–	–	–	–
Uganda	375	278	523	74	1.40	35	45	32	41	19	25	59	–
Ukraine	19	14	26	100	0.28	53	68	44	55	6	9	74	88
United Arab Emirates	3	2	5	100	–	36	51	29	41	12	17	60	–
United Kingdom	7	6	8	–	–	73	82	67	74	4	5	87	92
United States of America	19	17	21	99	–	64	76	57	67	5	6	83	–
United States Virgin Islands	–	–	–	–	–	52	75	49	70	8	8	81	–
Uruguay	17	14	21	100	0.26	57	79	55	77	6	7	87	99
Uzbekistan	29	23	37	100	0.16	49	69	46	65	6	9	83	–
Vanuatu	–	–	–	–	–	36	48	31	41	15	20	61	–
Venezuela (Bolivarian Republic of)	125	97	170	99	–	56	76	52	71	8	10	82	–
Viet Nam	43	32	61	94	0.06	59	80	50	67	4	5	79	54
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	164	109	235	–	0.04	27	43	20	31	15	24	48	63
Zambia	213	159	289	63	2.97	37	53	35	50	15	18	68	91
Zimbabwe	458	360	577	86	2.79	49	69	49	68	8	10	85	–

NOTES

– Data not available.
a The MMR has been rounded according to the following scheme: <100, rounded to nearest 1; 100–999, rounded to nearest 1; and ≥1,000, rounded to nearest 10.
1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

DEFINITIONS OF THE INDICATORS

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

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

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

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

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

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

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

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

MAIN DATA SOURCES

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

Births attended by skilled health personnel: Joint global database on skilled attendance at birth, 2020, United Nations Children's Fund (UNICEF) and World Health Organization (WHO). Regional aggregates calculated by UNFPA based on data from the joint global database.

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

Contraceptive prevalence rate: United Nations Population Division.

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

Unmet need for family planning: United Nations Population Division.

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

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

Gender, Rights and Human Capital

World and regional areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Total net enrolment rate, primary education, per cent	Gender parity index, total net enrolment rate, primary education	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2020	2019	2019	2018	2020	2019	2019	2019	2019	2019	2019
World	**41**	**20**	**–**	**13**	**55**	**–**	**–**	**85**	**1.00**	**65**	**0.99**
More developed regions	12	–	–	–	–	–	–	98	1.00	93	1.01
Less developed regions	45	27	–	–	54	–	–	83	1.00	62	0.99
Least developed countries	91	38	–	22	50	–	–	66	0.97	44	0.89
UNFPA regions											
Arab States	48	20	55	–	–	–	–	81	0.94	60	0.91
Asia and the Pacific	23	26	–	–	59	–	–	87	1.02	63	1.03
Eastern Europe and Central Asia	27	12	–	–	75	–	–	96	0.99	85	1.00
Latin America and the Caribbean	61	25	–	–	74	–	–	93	1.00	79	1.03
East and Southern Africa	95	32	24	–	53	–	–	66	0.96	44	0.84
West and Central Africa	108	39	23	–	37	–	–	62	0.96	43	0.86

Countries, territories, other areas	2003–2018	2005–2019	2004–2018	2000–2019	2007–2018	2010–2020	2010–2020	2010–2019	2010–2019	2009–2019	2009–2019
Afghanistan	62	28	–	46	–	–	–	–	–	44	0.56
Albania	16	12	–	–	69	98	1.04	96	1.05	82	1.07
Algeria	10	3	–	–	–	100	0.99	–	–	–	–
Angola	163	30	–	26	62	82	0.78	76	0.76	18	0.71
Antigua and Barbuda	28	–	–	–	–	99	1.01	99	0.99	87	1.02
Argentina	54	–	–	–	–	100	0.99	100	1.00	90	1.10
Armenia	21	5	–	4	66	91	1.00	90	1.02	89	1.15
Aruba	26	–	–	–	–	100	1.00	–	–	–	–
Australia	10	–	–	2[b]	–	100	1.00	98	1.00	92	1.04
Austria	7	–	–	4[c]	–	100	1.00	100	1.00	90	1.01
Azerbaijan	45	11	–	10	–	92	1.03	100	1.00	100	1.00
Bahamas	29	–	–	–	–	76	1.02	71	1.02	67	1.06
Bahrain	14	–	–	–	–	98	0.99	96	1.07	87	1.14
Bangladesh	74	59	–	29	–	95	1.11	74	1.10	62	1.08
Barbados	50	29	–	–	–	99	0.98	95	1.04	95	1.05
Belarus	14	5	–	–	–	99	0.98	99	1.00	99	1.02
Belgium	6	–	–	8[c]	–	99	1.00	99	0.99	99	1.00
Belize	64	34	–	–	–	100	1.01	90	0.98	64	1.04
Benin	108	31	2	14	36	94	0.94	66	0.78	44	0.63
Bhutan	28	26	–	7	–	96	1.03	88	1.15	72	1.16
Bolivia (Plurinational State of)	71	20	–	27	–	93	1.00	87	0.99	79	1.00
Bosnia and Herzegovina	11	4	–	–	–	–	–	–	–	79	1.04
Botswana	50	–	–	–	–	89	1.01	–	–	–	–
Brazil	53	26	–	–	–	96	0.99	97	1.00	85	1.07
Brunei Darussalam	10	–	–	–	–	99	1.01	97	1.00	82	1.04
Bulgaria	38	–	–	9[c]	–	87	1.00	87	0.99	88	0.95
Burkina Faso	132	52	58	9	20	78	0.99	54	1.08	34	1.04
Burundi	58	19	–	28	44	92	1.04	66	1.08	35	1.15
Cambodia	57	19	–	9	76	91	1.00	87	0.98	–	–
Cameroon, Republic of	119	31	0.4	22	38	92	0.91	63	0.89	46	0.83

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Total net enrolment rate, primary education, per cent	Gender parity index, total net enrolment rate, primary education	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2003–2018	2005–2019	2004–2018	2000–2019	2007–2018	2010–2020	2010–2020	2010–2019	2010–2019	2009–2019	2009–2019
Canada	8	–	–	–	–	100	1.00	100	1.00	94	0.99
Cape Verde	80	18	–	8	–	94	0.98	87	1.01	73	1.08
Central African Republic	229	68	18	26	–	67	0.80	44	0.61	16	0.48
Chad	179	67	32	18	27	74	0.79	38	0.68	22	0.51
Chile	26	–	–	–	–	99	0.99	95	0.99	95	1.00
China	9	–	–	–	–	–	–	–	–	–	–
China, Hong Kong SAR	2	–	–	–	–	97	1.05	99	1.00	99	1.00
China, Macao SAR	3	–	–	–	–	99	0.99	98	1.02	87	1.06
Colombia	61	23	–	18	–	98	1.01	94	1.01	79	1.03
Comoros	70	32	–	5	21	82	1.00	81	1.02	50	1.07
Congo, Democratic Republic of the	138	37	–	37	31	–	–	–	–	–	–
Congo, Republic of the	111	27	–	–	27	89	1.09	–	–	–	–
Costa Rica	50	21	–	–	–	100	1.00	98	1.01	94	1.03
Côte d'Ivoire	123	27	27	22	25	95	0.93	56	0.87	42	0.74
Croatia	9	–	–	4[c]	–	98	1.03	99	1.02	86	1.05
Cuba	52	26	–	–	–	99	1.00	90	1.00	82	1.07
Curaçao	23	–	–	–	–	–	–	–	–	–	–
Cyprus	4	–	–	3[c]	–	99	1.00	100	1.00	93	0.98
Czechia	12	–	–	6[c]	–	100	1.01	99	1.00	97	1.00
Denmark	3	–	–	7[c]	–	99	1.01	99	0.99	90	1.02
Djibouti	21	5	80	–	–	67	0.96	52	1.00	34	0.95
Dominica	48	–	–	–	–	96	1.01	99	1.02	82	1.03
Dominican Republic	51	36	–	16	77	96	1.01	94	1.00	78	1.02
Ecuador	71	20	–	11	87	99	1.03	95	1.03	80	1.01
Egypt	52	17	70	14	–	99	1.01	98	1.02	77	0.98
El Salvador	74	26	–	7	–	86	1.01	83	0.99	66	0.97
Equatorial Guinea	176	30	–	44	–	45	1.02	–	–	–	–
Eritrea	76	41	69	–	–	53	0.91	64	0.88	51	0.86
Estonia	11	–	–	4[c]	–	98	1.00	99	1.02	99	0.99
Eswatini	87	5	–	–	49	84	0.98	97	1.00	84	0.96
Ethiopia	80	40	47	20	45	86	0.93	53	0.92	26	0.91
Fiji	23	–	–	30[c]	–	99	0.97	96	–	74	1.09
Finland	5	–	–	8[c]	–	99	1.00	100	1.00	96	0.98
France	9	–	–	7[c]	–	100	1.00	99	1.00	95	1.01
French Guiana	76	–	–	–	–	–	–	–	–	–	–
French Polynesia	42	–	–	–	–	–	–	–	–	–	–
Gabon	91	22	–	32	48	–	–	–	–	–	–
Gambia	86	26	75	7	40	85	1.12	69	1.03	–	–
Georgia	32	14	–	1[d]	–	99	1.01	100	1.00	94	1.04
Germany	6	–	–	5[c]	–	99	1.01	95	1.02	86	0.96
Ghana	75	21	2	19	52	99	1.01	89	1.05	72	1.00
Greece	9	–	–	8[c]	–	99	1.00	96	0.99	95	0.98
Grenada	36	–	–	–	–	99	1.02	97	–	97	1.00

Gender, Rights and Human Capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Total net enrolment rate, primary education, per cent	Gender parity index, total net enrolment rate, primary education	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2003–2018	2005–2019	2004–2018	2000–2019	2007–2018	2010–2020	2010–2020	2010–2019	2010–2019	2009–2019	2009–2019
Guadeloupe	16	–	–	–	–	–	–	–	–	–	–
Guam	35	–	–	–	–	–	–	–	–	–	–
Guatemala	79	30	–	9	65	89	1.01	67	0.93	41	0.90
Guinea	120	47	92	–	29	78	0.83	49	0.70	33	0.59
Guinea-Bissau	106	24	42	–	–	73	0.95	–	–	–	–
Guyana	74	30	–	–	71	98	0.96	93	1.02	70	1.11
Haiti	55	15	–	14	59	–	–	–	–	–	–
Honduras	89	34	–	11	70	87	0.97	62	1.23	44	1.11
Hungary	23	–	–	8[c]	–	96	1.00	97	1.00	88	1.01
Iceland	6	–	–	–	–	100	1.00	100	1.00	87	1.04
India	11	27	–	22	–	98	1.02	85	1.07	52	0.98
Indonesia	36	16	–	5[d]	–	94	0.95	84	1.07	77	1.01
Iran (Islamic Republic of)	33	17	–	–	–	100	1.00	95	0.97	74	0.97
Iraq	82	28	4	–	–	–	–	–	–	–	–
Ireland	7	–	–	4[c]	–	100	1.00	99	–	99	1.01
Israel	10	–	–	–	–	100	1.01	100	–	98	–
Italy	4	–	–	7[c]	–	97	1.00	98	1.00	95	1.01
Jamaica	52	8	–	9	–	83	1.00	82	1.02	76	1.04
Japan	3	–	–	–	–	–	–	–	–	–	–
Jordan	27	10	–	14	61	81	0.98	70	1.00	54	1.09
Kazakhstan	26	7	–	6[c]	–	99	1.02	100	–	99	–
Kenya	96	23	11	26	56	81	1.04	–	–	–	–
Kiribati	49	20	–	43	–	96	1.08	–	–	–	–
Korea, Democratic People's Republic of	1	–	–	–	–	–	–	–	–	–	–
Korea, Republic of	1	–	–	–	–	99	1.00	97	1.00	96	0.99
Kuwait	6	–	–	–	–	83	1.22	94	1.05	82	1.03
Kyrgyzstan	34	13	–	17	77	100	0.99	98	0.99	72	1.05
Lao People's Democratic Republic	83	33	–	6	–	92	0.98	72	1.00	56	0.92
Latvia	16	–	–	7[c]	–	99	1.01	99	1.01	96	1.01
Lebanon	13	6	–	35	–	–	–	–	–	–	–
Lesotho	94	16	–	–	61	98	1.01	83	1.11	66	1.15
Liberia	150	36	26[a]	35	67	79	1.01	79	0.90	74	0.86
Libya	11	–	–	–	–	–	–	–	–	–	–
Lithuania	13	–	–	6[c]	–	100	1.00	100	1.00	97	1.02
Luxembourg	4	–	–	3[c]	–	99	0.98	96	0.98	81	1.06
Madagascar	152	40	–	–	74	98	1.05	70	1.03	36	0.97
Malawi	138	42	–	24	47	98	1.04	81	1.01	31	0.64
Malaysia	9	–	–	–	–	100	1.01	87	1.03	63	1.16
Maldives	9	2	1	6	58	98	1.03	91	–	–	–
Mali	164	54	86	21	8	59	0.90	47	0.86	25	0.74
Malta	13	–	–	5[c]	–	100	1.01	99	1.01	90	1.05
Martinique	17	–	–	–	–	–	–	–	–	–	–
Mauritania	84	37	63	–	–	77	1.05	72	1.08	39	1.12

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Total net enrolment rate, primary education, per cent	Gender parity index, total net enrolment rate, primary education	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2003–2018	2005–2019	2004–2018	2000–2019	2007–2018	2010–2020	2010–2020	2010–2019	2010–2019	2009–2019	2009–2019
Mauritius	24	–	–	–	–	99	1.03	95	1.02	79	1.10
Mexico	71	26	–	10	–	99	1.01	92	1.02	74	1.05
Micronesia (Federated States of)	44	–	–	26	–	90	0.98	87	1.06	–	–
Moldova, Republic of	21	12	–	15	–	90	0.98	84	0.98	65	1.02
Mongolia	33	12	–	15	63	99	0.99	–	–	–	–
Montenegro	10	6	–	–	–	100	1.00	92	1.01	89	1.02
Morocco	19	14	–	–	–	100	1.01	91	0.96	72	0.94
Mozambique	180	53	–	16	49	98	0.97	57	0.87	31	0.76
Myanmar	28	16	–	11	67	98	0.96	79	1.03	57	1.16
Namibia	64	7	–	20	71	98	1.03	–	–	–	–
Nepal	88	40	–	11	48	96	0.93	97	1.03	81	1.18
Netherlands	3	–	–	7[c]	–	100	1.01	97	1.01	100	1.00
New Caledonia	15	–	–	–	–	–	–	–	–	–	–
New Zealand	14	–	–	–	–	100	1.01	99	1.00	98	1.03
Nicaragua	92	35	–	8	–	96	1.03	88	1.03	64	1.08
Niger	154	76	1	–	7	59	0.88	35	0.79	14	0.67
Nigeria	106	43	14	14	46	66	0.84	–	–	–	–
North Macedonia	15	7	–	–	–	99	1.00	–	–	–	–
Norway	3	–	–	–	–	100	1.00	99	0.99	92	1.01
Oman	12	4	–	–	–	97	1.06	98	1.02	90	0.90
Pakistan	46	18	–	15	40	–	–	–	–	–	–
Palestine[1]	48	15	–	–	–	97	1.00	97	1.04	75	1.21
Panama	76	26	–	10	79	87	0.99	88	1.01	56	1.08
Papua New Guinea	68	27	–	48	–	93	0.94	86	0.89	54	0.82
Paraguay	72	22	–	8[e]	–	89	1.00	90	0.90	68	1.05
Peru	44	17	–	11	–	98	0.96	98	1.00	92	0.94
Philippines	39	17	–	6	81	96	0.99	89	1.07	79	1.09
Poland	11	–	–	3[c]	–	98	1.01	98	0.98	96	1.00
Portugal	8	–	–	6[f]	–	100	0.99	100	1.00	99	0.99
Puerto Rico	22	–	–	–	–	78	1.03	80	1.10	83	1.07
Qatar	9	4	–	–	–	98	1.03	95	0.92	91	0.97
Réunion	30	–	–	–	–	–	–	–	–	–	–
Romania	38	–	–	7[c]	–	87	1.00	91	1.00	80	1.03
Russian Federation	22	–	–	–	–	100	1.00	100	1.01	97	1.00
Rwanda	41	7	–	21	70	94	1.00	96	1.04	50	1.02
Saint Kitts and Nevis	46	–	–	–	–	99	0.98	87	0.95	96	0.99
Saint Lucia	36	24	–	–	–	98	1.03	90	0.98	79	0.99
Saint Vincent and the Grenadines	52	–	–	–	–	97	1.06	98	0.99	85	1.02
Samoa	39	11	–	22	–	99	1.02	100	–	90	1.11
San Marino	1	–	–	–	–	95	1.10	99	–	46	0.89
São Tomé and Príncipe	92	35	–	26	46	94	1.00	90	1.06	83	1.03
Saudi Arabia	9	–	–	–	–	98	0.98	99	0.98	96	0.94
Senegal	78	29	21	8	7	74	1.14	–	–	–	–
Serbia	15	3	–	–	–	98	1.00	98	1.00	88	1.03

Gender, Rights and Human Capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Total net enrolment rate, primary education, per cent	Gender parity index, total net enrolment rate, primary education	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
	2003–2018	2005–2019	2004–2018	2000–2019	2007–2018	2010–2020	2010–2020	2010–2019	2010–2019	2009–2019	2009–2019
Seychelles	68	–	–	–	–	98	1.05	99	–	82	1.16
Sierra Leone	101	30	64	29	40	99	1.03	51	0.99	35	0.93
Singapore	3	–	–	–	–	100	1.00	99	0.99	100	–
Sint Maarten	–	–	–	–	–	97	1.07	–	–	–	–
Slovakia	27	–	–	8[c]	–	96	1.00	95	1.00	89	1.00
Slovenia	4	–	–	2[c]	–	100	1.00	98	1.01	98	1.01
Solomon Islands	78	21	–	42	–	96	1.01	–	–	–	–
Somalia	123	45	97	–	–	–	–	–	–	–	–
South Africa	41	4	–	11	65	89	1.02	86	1.03	79	1.02
South Sudan	158	52	–	–	–	38	0.77	44	0.72	36	0.65
Spain	7	–	–	2[c]	–	97	1.00	100	1.00	98	1.01
Sri Lanka	21	10	–	6[g]	–	99	0.99	100	1.00	84	1.06
Sudan	87	34	82	–	–	62	0.98	45	0.88	43	0.96
Suriname	57	36	–	–	–	88	1.04	85	1.09	62	1.15
Sweden	5	–	–	6[c]	–	100	1.00	100	1.01	99	0.99
Switzerland	2	–	–	–	–	100	1.00	99	0.99	82	0.96
Syrian Arab Republic	54	13	–	–	–	72	0.98	62	0.97	34	1.00
Tajikistan	54	9	–	19	33	99	0.99	94	0.94	61	0.74
Tanzania, United Republic of	139	31	5	30	47	87	1.04	–	–	14	0.76
Thailand	38	23	–	–	–	–	–	–	–	79	1.00
Timor-Leste, Democratic Republic of	42	15	–	35	40	95	1.04	90	1.04	76	1.07
Togo	89	25	1	13	30	97	0.98	79	0.85	43	0.64
Tonga	30	6	–	19	–	99	1.02	95	1.02	62	1.17
Trinidad and Tobago	38	11	–	7	–	99	0.99	–	–	–	–
Tunisia	4	2	–	–	–	99	1.02	–	–	–	–
Turkey	21	15	–	11	–	95	0.99	94	0.99	83	0.99
Turkmenistan	28	6	–	–	–	–	–	92	0.98	83	0.99
Turks and Caicos Islands	15	–	–	–	–	99	1.03	80	1.06	68	0.90
Tuvalu	27	10	–	25	–	85	0.96	71	0.92	50	1.57
Uganda	132	34	0.1	30	62	96	1.03	–	–	–	–
Ukraine	19	9	–	10	81	92	1.02	96	1.01	94	1.03
United Arab Emirates	5	–	–	–	–	99	0.97	99	0.99	88	0.86
United Kingdom	12	–	–	6[c]	–	99	1.00	100	1.00	96	1.01
United States of America	19	–	–	–	–	99	1.00	100	1.02	96	1.00
United States Virgin Islands	25	–	–	–	–	–	–	–	–	–	–
Uruguay	36	25	–	3	–	100	1.00	100	1.01	88	1.08
Uzbekistan	19	7	–	–	–	99	0.99	99	0.98	86	0.99
Vanuatu	51	21	–	44	–	–	–	–	–	–	–
Venezuela (Bolivarian Republic of)	95	–	–	–	–	90	1.00	86	1.02	77	1.12
Viet Nam	30	11	–	10	–	99	1.03	–	–	–	–
Western Sahara	–	–	–	–	–	–	–	–	–	–	–
Yemen	67	32	16	–	–	84	0.88	72	0.85	44	0.59
Zambia	135	29	–	25	47	85	1.05	–	–	–	–
Zimbabwe	78	34	–	20	60	100	1.01	98	0.95	52	0.90

NOTES

– Data not available.

a Percentage of girls aged 15 to 19 years who are members of the Sande society. Membership in Sande society is a proxy for female genital mutilation.

b For ever-partnered women aged 18+.

c For ever-partnered women aged 18 to 49.

d For ever-partnered women aged 15 to 64.

e For ever-partnered women aged 15 to 44.

f For ever-partnered women aged 18 to 50.

g For ever-partnered women aged 15+.

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

DEFINITIONS OF THE INDICATORS

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

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

Female genital mutilation prevalence among girls aged 15–19: Proportion of girls aged 15 to 19 years who have undergone female genital mutilation. (SDG indicator 5.3.2)

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

Decision-making on sexual and reproductive health and reproductive rights: Percentage of women aged 15-49 years who are married (or in union), who make their own decisions in three areas—their health care, use of contraception, and sexual intercourse with their partners. (SDG indicator 5.6.1) As this report went to press, updated data for this SDG indicator became available. The updated figures are available at https://unstats.un.org/sdgs/indicators/database/.

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

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

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

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

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

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

MAIN DATA SOURCES

Adolescent birth rate: United Nations Population Division.

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

Female genital mutilation: prevalence among girls aged 15 to 19: UNFPA.

Intimate partner violence, past 12 months: UNFPA. Regional estimates generated by Violence Against Women Inter-Agency Group on Estimation and Data (WHO, UN Women, UNICEF, UNSD, UNODC, and UNFPA).

Decision-making on sexual and reproductive health and reproductive rights: UNFPA. As this report went to press, updated data for this SDG indicator became available. The updated figures are available at https://unstats.un.org/sdgs/indicators/database/.

Total net enrolment rate, primary education: UNESCO Institute for Statistics (UIS).

Gender parity index, total net enrolment rate, primary education: UNESCO Institute for Statistics (UIS).

Total net enrolment rate, lower secondary education: UNESCO Institute for Statistics (UIS).

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

Total net enrolment rate, upper secondary education: UNESCO Institute for Statistics (UIS).

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

Demographic Indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2021	
World and regional areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
World	**7,875**	**1.1**	**25.3**	**16.0**	**23.6**	**65.1**	**9.6**	**2.4**	**71**	**75**
More developed regions	1,276	0.3	16.3	11.0	16.6	64.0	19.7	1.6	77	83
Less developed regions	6,599	1.3	27.0	17.0	25.0	65.4	7.6	2.5	69	74
Least developed countries	1,082	2.3	38.5	22.3	31.7	57.8	3.6	3.8	64	68
UNFPA regions										
Arab States	385	1.9	33.8	19.2	27.6	61.0	5.1	3.2	70	74
Asia and the Pacific	4,116	0.9	23.4	15.6	23.3	67.9	8.6	2.1	71	75
Eastern Europe and Central Asia	251	0.9	23.4	14.4	21.2	66.2	10.5	2.1	71	78
Latin America and the Caribbean	656	1.0	23.7	16.0	24.2	67.2	9.2	2.0	73	79
East and Southern Africa	633	2.6	40.9	23.0	32.3	55.9	3.2	4.2	62	67
West and Central Africa	471	2.7	42.9	23.3	32.3	54.3	2.8	4.9	57	60
Countries, territories, other areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
Afghanistan	39.8	2.5	41.2	25.0	35.2	56.1	2.7	4.0	64	67
Albania	2.9	-0.1	17.1	12.2	19.8	67.7	15.2	1.6	77	80
Algeria	44.6	2.0	30.9	15.8	22.3	62.2	6.9	2.9	76	79
Angola	33.9	3.3	46.2	24.1	32.9	51.6	2.2	5.3	59	65
Antigua and Barbuda	0.1	0.9	21.7	14.0	21.6	68.6	9.7	2.0	76	78
Argentina	45.6	1.0	24.3	15.7	23.3	64.2	11.5	2.2	74	80
Armenia	3.0	0.3	20.8	12.7	18.4	66.9	12.3	1.8	72	79
Aruba[1]	0.1	0.5	17.3	12.8	19.8	67.5	15.1	1.9	74	79
Australia[2]	25.8	1.3	19.3	12.4	18.5	64.2	16.5	1.8	82	86
Austria	9.0	0.7	14.5	9.6	15.1	66.1	19.5	1.6	80	84
Azerbaijan[3]	10.2	1.0	23.4	13.4	20.2	69.5	7.1	2.0	71	76
Bahamas	0.4	1.0	21.3	15.9	24.3	70.7	8.0	1.7	72	76
Bahrain	1.7	4.3	18.0	11.1	17.0	79.1	2.9	1.9	77	79
Bangladesh	166.3	1.1	26.3	18.3	27.5	68.4	5.3	2.0	71	75
Barbados	0.3	0.1	16.6	12.5	19.0	66.3	17.2	1.6	78	81
Belarus	9.4	0.0	17.3	10.2	14.5	66.6	16.1	1.7	70	80
Belgium	11.6	0.5	17.0	11.4	17.0	63.5	19.6	1.7	80	84
Belize	0.4	1.9	28.8	19.2	29.0	66.1	5.2	2.2	72	78
Benin	12.5	2.7	41.7	22.9	32.1	55.0	3.3	4.6	61	64
Bhutan	0.8	1.2	24.6	17.2	26.6	69.1	6.3	1.9	72	73
Bolivia (Plurinational State of)	11.8	1.4	29.8	19.5	28.6	62.6	7.6	2.6	69	75
Bosnia and Herzegovina	3.3	-0.9	14.3	10.5	17.0	67.2	18.5	1.2	75	80
Botswana	2.4	2.1	33.0	20.1	28.7	62.3	4.7	2.8	67	73
Brazil	214.0	0.8	20.5	14.4	22.3	69.6	9.9	1.7	73	80
Brunei Darussalam	0.4	1.1	21.9	14.7	22.7	72.1	6.0	1.8	75	77
Bulgaria	6.9	-0.7	14.7	10.1	14.3	63.6	21.7	1.6	72	79
Burkina Faso	21.5	2.9	44.1	24.1	33.3	53.5	2.4	5.0	62	63
Burundi	12.3	3.1	45.1	23.1	31.8	52.5	2.5	5.2	60	64
Cambodia	16.9	1.5	30.7	18.5	27.4	64.3	5.0	2.4	68	72
Cameroon, Republic of	27.2	2.6	41.8	23.3	32.4	55.5	2.7	4.4	59	61
Canada	38.1	0.9	15.8	10.5	16.6	65.7	18.6	1.5	81	85
Cape Verde	0.6	1.2	27.7	17.7	25.8	67.4	4.9	2.2	70	77
Central African Republic	4.9	1.4	43.0	26.1	36.3	54.1	2.8	4.5	52	56
Chad	16.9	3.0	46.2	24.6	33.9	51.3	2.5	5.5	53	56
Chile	19.2	1.2	19.0	13.0	20.1	68.3	12.7	1.6	78	83

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2021	
Countries, territories, other areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
China[4]	1,444.2	0.5	17.6	7.4	17.5	70.0	12.4	1.7	75	80
China, Hong Kong SAR[5]	7.6	0.8	13.0	11.6	12.1	68.1	18.9	1.4	82	88
China, Macao SAR[6]	0.7	1.5	14.6	7.4	12.5	72.6	12.7	1.3	82	87
Colombia	51.3	1.4	21.9	15.6	24.1	68.7	9.4	1.8	75	80
Comoros	0.9	2.2	38.7	22.0	31.1	58.1	3.2	4.0	63	67
Congo, Democratic Republic of the	92.4	3.2	45.6	23.6	32.2	51.4	3.0	5.6	60	63
Congo, Republic of the	5.7	2.6	41.0	23.0	31.7	56.2	2.8	4.3	63	67
Costa Rica	5.1	1.0	20.6	13.9	21.6	68.8	10.6	1.7	78	83
Côte d'Ivoire	27.1	2.5	41.4	23.0	32.6	55.7	2.9	4.5	57	60
Croatia	4.1	-0.6	14.5	10.0	15.6	63.9	21.7	1.4	76	82
Cuba	11.3	0.0	15.7	10.9	17.0	68.1	16.2	1.6	77	81
Curaçao[1]	0.2	0.5	17.8	13.0	19.0	64.0	18.2	1.7	76	82
Cyprus[7]	1.2	0.8	16.5	11.7	19.1	68.8	14.7	1.3	79	83
Czechia	10.7	0.2	15.8	10.1	14.4	63.8	20.4	1.7	77	82
Denmark[8]	5.8	0.4	16.3	11.6	17.9	63.4	20.3	1.8	79	83
Djibouti	1.0	1.6	28.6	18.0	27.0	66.6	4.8	2.6	66	70
Dominica	0.1	0.2	–	–	–	–	–	–	–	–
Dominican Republic	11.0	1.1	27.2	17.7	26.2	65.1	7.8	2.3	71	78
Ecuador	17.9	1.7	27.2	17.4	26.2	65.0	7.8	2.4	75	80
Egypt	104.3	2.0	33.8	18.2	26.3	60.7	5.4	3.2	70	75
El Salvador	6.5	0.5	26.3	17.6	27.1	64.9	8.8	2.0	69	78
Equatorial Guinea	1.4	3.7	36.8	19.4	29.2	60.8	2.4	4.3	58	61
Eritrea	3.6	1.2	40.7	24.5	32.6	54.8	4.5	3.9	65	69
Estonia	1.3	0.2	16.5	10.7	14.9	62.8	20.8	1.6	75	83
Eswatini	1.2	1.0	37.0	23.7	33.4	59.0	4.0	2.9	57	66
Ethiopia	117.9	2.6	39.6	23.1	33.3	56.9	3.6	4.0	65	69
Fiji	0.9	0.6	28.9	17.7	25.6	65.1	6.0	2.7	66	70
Finland[9]	5.5	0.2	15.6	11.0	16.6	61.4	23.0	1.4	80	85
France[10]	65.4	0.3	17.5	12.1	17.8	61.4	21.1	1.8	80	86
French Guiana[11]	0.3	2.7	31.7	19.0	27.6	62.5	5.8	3.2	77	83
French Polynesia[11]	0.3	0.6	22.0	15.5	23.1	68.6	9.4	1.9	76	80
Gabon	2.3	2.7	37.4	19.2	27.1	59.1	3.5	3.8	65	69
Gambia	2.5	2.9	43.8	23.1	32.4	53.7	2.5	5.0	61	64
Georgia[12]	4.0	-0.2	20.3	12.1	17.8	64.2	15.6	2.0	70	78
Germany	83.9	0.5	14.0	9.4	14.8	64.0	22.0	1.6	79	84
Ghana	31.7	2.2	36.9	21.3	30.4	59.9	3.2	3.7	63	66
Greece	10.4	-0.4	13.4	10.2	15.3	63.9	22.6	1.3	80	85
Grenada	0.1	0.5	23.8	14.4	21.8	66.2	10.0	2.0	70	75
Guadeloupe[11]	0.4	0.0	18.2	14.2	21.5	61.9	19.9	2.1	79	86
Guam[13]	0.2	0.8	23.6	15.8	24.0	65.5	10.9	2.3	77	84
Guatemala	18.2	1.9	32.9	21.2	31.3	62.0	5.1	2.7	72	78
Guinea	13.5	2.8	42.7	24.2	34.1	54.3	3.0	4.5	61	63
Guinea-Bissau	2.0	2.5	41.7	22.9	32.1	55.4	2.9	4.3	57	61
Guyana	0.8	0.5	27.5	18.1	27.8	65.2	7.3	2.4	67	73
Haiti	11.5	1.3	32.1	20.4	29.7	62.6	5.3	2.8	62	67
Honduras	10.1	1.7	30.1	20.4	30.6	64.8	5.1	2.4	73	78
Hungary	9.6	-0.2	14.5	10.0	15.2	65.0	20.6	1.5	74	81
Iceland	0.3	0.7	19.2	13.2	19.5	64.8	16.1	1.7	82	85

Demographic Indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2021	
Countries, territories, other areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
India	1,393.4	1.0	25.8	18.0	26.9	67.4	6.8	2.2	69	71
Indonesia	276.4	1.1	25.6	16.8	25.1	67.9	6.5	2.2	70	74
Iran (Islamic Republic of)	85.0	1.4	24.8	14.1	20.5	68.4	6.8	2.1	76	78
Iraq	41.2	2.5	37.3	21.6	31.1	59.2	3.5	3.5	69	73
Ireland	5.0	1.2	20.5	13.8	19.7	64.6	14.9	1.8	81	84
Israel	8.8	1.6	27.7	16.3	23.6	59.7	12.6	3.0	82	85
Italy	60.4	0.0	12.8	9.5	14.4	63.6	23.6	1.3	82	86
Jamaica	3.0	0.5	23.1	15.5	24.1	67.6	9.3	1.9	73	76
Japan	126.1	-0.2	12.3	8.9	13.6	59.0	28.7	1.4	82	88
Jordan	10.3	1.9	32.1	21.3	30.5	63.9	4.0	2.6	73	77
Kazakhstan	19.0	1.3	29.2	15.2	20.8	62.7	8.2	2.7	70	78
Kenya	55.0	2.3	38.0	23.6	33.4	59.4	2.6	3.3	65	70
Kiribati	0.1	1.5	35.8	20.0	28.8	59.8	4.3	3.5	65	73
Korea, Democratic People's Republic of	25.9	0.5	19.8	13.6	21.0	70.6	9.6	1.9	69	76
Korea, Republic of	51.3	0.2	12.3	9.1	15.1	71.2	16.6	1.1	80	86
Kuwait	4.3	2.1	21.1	13.1	18.5	75.5	3.4	2.1	75	77
Kyrgyzstan	6.6	1.8	32.6	17.3	24.9	62.5	4.9	2.9	68	76
Lao People's Democratic Republic	7.4	1.5	31.6	20.0	29.3	64.0	4.4	2.5	67	70
Latvia	1.9	-1.1	16.8	10.2	13.7	62.2	21.0	1.7	71	80
Lebanon	6.8	0.9	24.5	16.3	24.8	67.6	7.9	2.0	77	81
Lesotho	2.2	0.8	32.1	19.7	29.1	62.8	5.0	3.0	52	59
Liberia	5.2	2.5	40.0	23.2	32.4	56.6	3.4	4.1	63	66
Libya	7.0	1.4	27.4	17.4	25.2	68.0	4.6	2.1	70	76
Lithuania	2.7	-1.5	15.6	9.0	13.7	63.3	21.1	1.7	71	82
Luxembourg	0.6	2.0	15.6	10.5	16.8	69.8	14.6	1.4	81	85
Madagascar	28.4	2.7	39.8	22.7	32.4	57.0	3.2	3.9	66	69
Malawi	19.6	2.7	42.5	24.7	34.4	54.8	2.7	4.0	62	68
Malaysia[14]	32.8	1.3	23.3	15.5	24.1	69.3	7.4	1.9	75	79
Maldives	0.5	3.4	19.8	11.3	19.3	76.4	3.8	1.8	78	81
Mali	20.9	3.0	46.7	24.8	33.7	50.8	2.5	5.6	59	61
Malta	0.4	0.4	14.4	9.3	14.7	63.8	21.8	1.5	81	85
Martinique[11]	0.4	-0.2	15.5	12.2	18.8	62.2	22.3	1.8	80	86
Mauritania	4.8	2.8	39.5	21.7	30.6	57.3	3.2	4.4	64	67
Mauritius[15]	1.3	0.2	16.4	13.4	20.7	70.6	13.0	1.4	72	79
Mexico	130.3	1.1	25.5	17.2	25.6	66.7	7.8	2.1	72	78
Micronesia (Federated States of)	0.1	1.1	31.0	19.9	29.8	64.4	4.6	2.9	66	70
Moldova, Republic of[16]	4.0	-0.2	15.8	10.5	16.2	71.2	13.0	1.3	68	76
Mongolia	3.3	1.8	31.2	15.8	22.4	64.3	4.5	2.8	66	75
Montenegro	0.6	0.0	18.0	12.4	18.9	65.9	16.2	1.7	75	80
Morocco	37.3	1.3	26.5	16.5	24.2	65.6	7.9	2.3	76	78
Mozambique	32.2	2.9	43.8	24.2	33.6	53.3	2.9	4.6	59	65
Myanmar	54.8	0.6	25.1	17.9	26.7	68.4	6.5	2.1	64	71
Namibia	2.6	1.9	36.7	20.8	30.2	59.7	3.6	3.2	61	67
Nepal	29.7	1.5	28.1	20.3	31.2	66.0	5.9	1.8	70	73
Netherlands[17]	17.2	0.2	15.5	11.3	17.2	64.0	20.5	1.7	81	84
New Caledonia[11]	0.3	1.0	21.7	15.0	23.2	68.3	10.0	1.9	75	81
New Zealand[18]	4.9	0.9	19.3	13.0	19.5	64.0	16.7	1.9	81	84

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2021	
Countries, territories, other areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
Nicaragua	6.7	1.3	29.1	18.6	27.3	65.0	5.9	2.3	71	78
Niger	25.1	3.8	49.5	24.4	33.1	47.9	2.6	6.6	62	64
Nigeria	211.4	2.6	43.3	23.2	32.0	53.9	2.8	5.2	54	56
North Macedonia	2.1	0.0	16.2	11.1	17.2	68.9	14.9	1.5	74	78
Norway[19]	5.5	0.8	17.1	11.9	18.3	65.1	17.8	1.7	81	85
Oman	5.2	3.6	22.9	11.1	17.1	74.5	2.6	2.7	77	81
Pakistan	225.2	2.0	34.6	20.4	29.7	61.0	4.4	3.3	67	69
Palestine[20]	5.2	2.4	38.0	21.8	31.4	58.8	3.3	3.4	73	76
Panama	4.4	1.7	26.2	16.7	24.8	65.0	8.8	2.4	76	82
Papua New Guinea	9.1	2.0	34.8	21.3	30.7	61.5	3.7	3.4	64	66
Paraguay	7.2	1.3	28.6	18.5	27.8	64.4	7.0	2.4	72	77
Peru	33.4	1.6	24.7	15.5	23.1	66.4	9.0	2.2	75	80
Philippines	111.0	1.4	29.5	19.4	28.6	64.7	5.7	2.5	68	76
Poland	37.8	-0.1	15.2	9.9	14.9	65.4	19.4	1.5	75	83
Portugal	10.2	-0.3	12.9	9.9	15.2	64.0	23.1	1.3	79	85
Puerto Rico[13]	2.8	-3.3	14.9	14.1	19.4	63.9	21.3	1.2	77	84
Qatar	2.9	2.3	13.7	8.4	16.5	84.5	1.9	1.8	79	82
Réunion[11]	0.9	0.7	22.0	15.3	22.6	64.8	13.2	2.2	78	84
Romania	19.1	-0.7	15.5	10.8	16.1	64.9	19.7	1.6	73	80
Russian Federation	145.9	0.1	18.5	10.8	15.3	65.5	16.0	1.8	67	78
Rwanda	13.3	2.6	39.2	22.3	31.5	57.5	3.2	3.9	67	72
Saint Kitts and Nevis	0.1	0.8	–	–	–	–	–	–	–	–
Saint Lucia	0.2	0.5	17.7	12.8	21.2	71.7	10.6	1.4	75	78
Saint Vincent and the Grenadines	0.1	0.3	21.6	15.4	23.8	68.3	10.2	1.8	71	75
Samoa	0.2	0.5	37.1	21.2	29.5	57.7	5.2	3.7	72	76
San Marino	0.0	0.4	–	–	–	–	–	–	–	–
São Tomé and Príncipe	0.2	1.9	41.3	24.7	33.5	55.6	3.1	4.2	68	73
Saudi Arabia	35.3	1.9	24.5	14.2	20.8	71.8	3.6	2.2	74	77
Senegal	17.2	2.8	42.3	23.2	32.3	54.6	3.1	4.4	66	70
Serbia[21]	8.7	-0.3	15.2	11.3	17.3	65.4	19.4	1.4	74	79
Seychelles	0.1	0.7	23.7	14.3	20.6	67.9	8.4	2.4	70	78
Sierra Leone	8.1	2.1	40.0	23.4	32.8	57.1	2.9	4.0	55	56
Singapore	5.9	0.9	12.4	8.4	14.8	73.3	14.3	1.2	82	86
Sint Maarten[1]	0.0	1.4	–	–	–	–	–	–	–	–
Slovakia	5.5	0.1	15.6	10.1	15.2	67.2	17.2	1.5	74	81
Slovenia	2.1	0.1	15.1	9.6	14.2	63.6	21.3	1.6	79	84
Solomon Islands	0.7	2.6	39.9	21.7	30.6	56.4	3.7	4.3	72	75
Somalia	16.4	2.8	46.0	24.6	34.3	51.1	2.9	5.8	56	60
South Africa	60.0	1.4	28.6	17.7	25.8	65.8	5.6	2.3	61	68
South Sudan	11.4	0.9	41.1	23.0	32.5	55.6	3.4	4.5	57	60
Spain[22]	46.7	0.0	14.2	10.2	15.0	65.5	20.3	1.4	81	86
Sri Lanka	21.5	0.5	23.4	15.8	22.7	64.9	11.6	2.2	74	81
Sudan	44.9	2.4	39.5	23.0	32.5	56.8	3.7	4.2	64	68
Suriname	0.6	1.0	26.4	17.3	25.6	66.3	7.3	2.3	69	75
Sweden	10.2	0.7	17.7	11.3	16.5	61.9	20.5	1.8	81	85
Switzerland	8.7	0.8	15.0	9.7	15.1	65.6	19.4	1.6	82	86
Syrian Arab Republic	18.3	-0.6	30.7	18.3	27.1	64.4	4.9	2.7	71	79
Tajikistan	9.7	2.4	37.4	19.0	27.4	59.3	3.3	3.5	69	74

Demographic Indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2021	
Countries, territories, other areas	2021	2015–2020	2021	2021	2021	2021	2021	2021	male	female
Tanzania, United Republic of[23]	61.5	3.0	43.3	23.6	32.5	54.0	2.7	4.7	64	68
Thailand	70.0	0.3	16.3	12.0	18.7	70.2	13.5	1.5	74	81
Timor-Leste, Democratic Republic of	1.3	1.9	36.6	22.8	32.7	59.1	4.3	3.8	68	72
Togo	8.5	2.5	40.3	23.1	32.2	56.8	2.9	4.1	61	63
Tonga	0.1	1.0	34.4	22.1	31.5	59.7	6.0	3.4	69	73
Trinidad and Tobago	1.4	0.4	19.8	13.4	19.4	68.3	11.9	1.7	71	76
Tunisia	11.9	1.1	24.2	14.0	20.8	66.6	9.2	2.1	75	79
Turkey	85.0	1.4	23.6	15.9	23.9	67.1	9.3	2.0	75	81
Turkmenistan	6.1	1.6	30.6	17.0	24.5	64.4	5.0	2.7	65	72
Turks and Caicos Islands	0.0	1.5	–	–	–	–	–	–	–	–
Tuvalu	0.0	1.2	–	–	–	–	–	–	–	–
Uganda	47.1	3.6	45.5	25.0	34.6	52.4	2.0	4.6	62	66
Ukraine[24]	43.5	-0.5	15.9	10.3	15.1	66.8	17.3	1.4	67	77
United Arab Emirates	10.0	1.3	14.9	9.1	16.5	83.7	1.4	1.4	78	80
United Kingdom[25]	68.2	0.6	17.6	11.4	17.3	63.5	18.8	1.7	80	83
United States of America[26]	332.9	0.6	18.2	12.7	19.4	64.7	17.0	1.8	76	82
United States Virgin Islands[13]	0.1	-0.1	18.9	13.4	19.6	59.9	21.1	2.0	78	83
Uruguay	3.5	0.4	20.2	13.6	20.9	64.5	15.3	1.9	74	82
Uzbekistan	33.9	1.6	28.7	16.4	24.4	66.2	5.0	2.4	70	74
Vanuatu	0.3	2.5	38.2	21.9	30.3	58.2	3.6	3.7	69	72
Venezuela (Bolivarian Republic of)	28.7	-1.1	26.5	18.2	25.9	65.3	8.2	2.2	68	76
Viet Nam	98.2	1.0	23.2	14.0	20.7	68.6	8.2	2.0	72	80
Western Sahara	0.6	2.5	26.9	16.5	24.8	69.5	3.6	2.3	69	73
Yemen	30.5	2.4	38.4	22.6	32.2	58.6	3.0	3.5	65	68
Zambia	18.9	2.9	43.6	24.7	34.3	54.3	2.2	4.4	61	68
Zimbabwe	15.1	1.5	41.3	24.2	33.6	55.6	3.1	3.4	60	63

NOTES

– Data not available.

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

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

3 Including Nagorno-Karabakh.

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

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

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

7 Refers to the whole country.

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

9 Including Åland Islands.

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

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

12 Including Abkhazia and South Ossetia.

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

14 Including Sabah and Sarawak.

15 Including Agalega, Rodrigues and Saint Brandon.

16 Including Transnistria.

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

18 For statistical purposes, the data for New Zealand do not include Cook Islands, Niue or Tokelau.

19 Including Svalbard and Jan Mayen Islands.

20 Including East Jerusalem.

21 Including Kosovo.

22 Including Canary Islands, Ceuta and Melilla.

23 Including Zanzibar.

24 Refers to the territory of the country at the time of the 2001 census.

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

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

DEFINITIONS OF THE INDICATORS

Total population: Estimated size of national populations at mid-year.

Average annual rate of population change: Average exponential rate of growth of the population over a given period, based on a medium variant projection.

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

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

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

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

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

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

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

MAIN DATA SOURCES

Total population: United Nations Population Division.

Average annual rate of population change: United Nations Population Division.

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

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

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

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

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

Total fertility rate: United Nations Population Division.

Life expectancy at birth: United Nations Population Division.

Technical notes

The statistical tables in the *State of World Population 2021* include indicators that track progress toward the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD) and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education and reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled.

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

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates and inter-agency estimates. They also include the latest population estimates and projections from *World Population Prospects: The 2019 Revision*, and *Estimates and Projections of Family Planning Indicators 2020* (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources and notes. The statistical tables in the *State of World Population 2021* generally reflect information available as of January 2021.

Tracking Progress Towards ICPD Goals

Sexual and Reproductive Health

Maternal mortality ratio (MMR), (deaths per 100,000 live births) and range of MMR uncertainty (UI 80%), lower and upper estimates (2017).
Source: United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG). This indicator presents the number of maternal deaths during a given time period per 100,000 live births during the same time period (SDG indicator 3.1.1). The estimates are produced by the MMEIG using data from vital registration systems, household surveys and population censuses. UNFPA, WHO, the World Bank, UNICEF and the United Nations Population Division are members of the MMEIG. Estimates and methodologies are reviewed regularly by the MMEIG and other agencies and academic institutions and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel, per cent (2014–2019).
Source: Joint global database on skilled attendance at birth, 2020, UNICEF and WHO. Regional aggregates calculated by UNFPA based on data from the joint global database. Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns (SDG indicator 3.1.2). Traditional birth attendants, even if they receive a short training course, are not included.

Number of new HIV infections per 1,000 uninfected population (2018).
Source: UNAIDS. Number of new HIV infections per 1,000 person-years among the uninfected population (SDG indicator 3.3.1).

Contraceptive prevalence rate, women aged 15–49, any method (2021).
Source: United Nations Population Division. Percentage of women aged 15 to 49 who are currently using any method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using any method of contraception.

Contraceptive prevalence rate, women aged 15–49, modern methods (2021).
Source: United Nations Population Division. Percentage of women aged 15 to 49 who are currently using any modern method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using any modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods.

Unmet need for family planning, women aged 15–49 (2021).
Source: United Nations Population Division. Percentage of women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Women who are using a traditional method of contraception are not considered as having an unmet need for family planning. All women or all married and in-union women are assumed to be sexually active and at risk of pregnancy. The assumption of universal exposure among all women or all married or in-union women may lead to lower estimates compared to the actual risks among the exposed. It might be possible, in particular at low levels of contraceptive prevalence, that when contraceptive prevalence increases, unmet need for family planning also increases. Both indicators, therefore, need to be interpreted together.

Proportion of demand for family planning satisfied by any modern methods, women aged 15–49 (2021).
Source: United Nations Population Division. Percentage of total demand for family planning among women aged 15 to 49 that is satisfied by the use of modern contraception (SDG indicator 3.7.1). Modern contraceptive prevalence divided by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Laws and regulations that guarantee access to sexual and reproductive health care, information and education (2019).
Source: UNFPA. The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG indicator 5.6.2).

Gender, Rights and Human Capital

Adolescent birth rate per 1,000 girls aged 15–19 (2003–2018).
Source: United Nations Population Division. Number of births per 1,000 adolescent girls aged 15 to 19 years (SDG indicator 3.7.2). The adolescent birth rate represents the risk of childbearing among adolescent women aged 15 to 19 years. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but which die before registration or within the first 24 hours of life, the quality of the reported information relating to the age of the mother and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child and sampling variability in the case of surveys.

Child marriage by age 18, per cent (2005–2019).
Source: UNICEF. Regional aggregates calculated by UNFPA based on data from UNICEF. Proportion of women aged 20 to 24 years who were married or in a union before the age of 18 (SDG indicator 5.3.1).

Female genital mutilation prevalence among girls aged 15–19, per cent (2004–2018).
Source: UNFPA. Proportion of girls aged 15 to 19 years who have undergone female genital mutilation (SDG indicator 5.3.2).

Intimate partner violence, past 12 months, per cent (2000–2019).
Source: UNFPA. Regional and global estimates generated by Violence Against Women Inter-Agency Group on Estimation and Data (WHO, UN Women, UNICEF, UNSD, UNODC and UNFPA). Percentage of ever-partnered women and girls aged 15 to 49 who have experienced physical and/or sexual partner violence in the previous 12 months (SDG indicator 5.2.1).

Decision-making on sexual and reproductive health and reproductive rights, per cent (2007–2018).
Source: UNFPA. Percentage of women aged 15 to 49 years who are married (or in union), who make their own decisions on three areas—their health care, use of contraception, and sexual intercourse with their partners (SDG indicator 5.6.1). As this report went to press, updated data for this SDG indicator became available. The updated figures are available at https://unstats.un.org/sdgs/indicators/database/.

Total net enrolment rate, primary education, per cent (2010–2020).
Source: UNESCO Institute for Statistics (UIS). Total number of students of the official age group for primary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, primary education (2010–2020).
Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of total net enrolment rate for primary education.

Total net enrolment rate, lower secondary education, per cent (2010–2019).
Source: UNESCO Institute for Statistics (UIS). Total number of students of the official age group for lower secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, lower secondary education (2010–2019).
Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of total net enrolment rate for lower secondary education.

Total net enrolment rate, upper secondary education, per cent (2009–2019).
Source: UNESCO Institute for Statistics (UIS). Total number of students of the official age group for upper secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, upper secondary education (2009–2019).
Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of total net enrolment rate for upper secondary education.

Demographic indicators

Population

Total population in millions (2021).
Source: United Nations Population Division. Estimated size of national populations at mid-year.

Population change

Average annual rate of population change, per cent (2015–2020).
Source: United Nations Population Division. Average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population composition

Population aged 0–14, per cent (2021).
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 0 and age 14.

Population aged 10–19, per cent (2021).
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 10 and age 19.

Population aged 10–24, per cent (2021).
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 10 and age 24.

Population aged 15–64, per cent (2021).
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent (2021).
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population aged 65 and older.

Fertility

Total fertility rate, per woman (2021).
Source: United Nations Population Division. Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy

Life expectancy at birth, years (2021).
Source: United Nations Population Division. Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Regional classifications

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

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

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

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

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

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

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

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

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

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18) included 47 countries (as of December 2018): 33 in Africa, 9 in Asia, 4 in Oceania and 1 in Latin America and the Caribbean—Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; Central African Republic; Chad; Comoros; Congo, Democratic Republic of the; Djibouti; Eritrea; Ethiopia; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mozambique; Myanmar; Nepal; Niger; Rwanda; São Tomé and Príncipe; Senegal; Sierra Leone; Solomon Islands; Somalia; South Sudan; Sudan; Tanzania, United Republic of; Timor-Leste, Democratic Republic of; Togo; Tuvalu; Uganda; Vanuatu; Yemen; Zambia. These countries are also included in the less developed regions. Further information is available at http://unohrlls.org/about-ldcs/.

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