3 Laws, norms and practices: Barriers or levers for sexual and reproductive health and rights?

Discriminatory social institutions impede women and men from realising their sexual and reproductive health and rights (SRHR) across the world. Laws, practices and social norms disproportionally undermine adolescents' and women's access to and realisation of SRHR as they are shaped and embedded in patriarchal systems. This chapter first looks at adolescents' SRHR as a decisive factor for a person's lifelong health, rights and development. It then analyses three aspects of SRHR that are globally relevant and locally essential to accelerate inclusive development in developing countries: maternal and newborn health; contraception use and family planning; and access to safe and legal abortion. The chapter provides actionable and evidence-based policy recommendations on how to address the discriminatory social institutions that limit access to and realisation of SRHR, including a focus on adolescents.

In Brief

Safeguarding adolescents' and women's SRHR is fundamental to achieving gender equality

Adolescence – it's time to set the right course for SRHR

- Failure to enable and empower adolescents to realise their SRHR has implications on their life trajectories with spillover effects on communities and societies.
- Parental consent laws, legal loopholes in laws on gender-based violence and harmful practices and education bans for pregnant students undermine adolescents' SRHR.
- Adolescents reproduce prevailing social norms with gendered implications for their SRHR. They are further exposed to social stigma and discrimination from health providers which can limit their access to services.
- Comprehensive sexuality education can play a key role to alter the status quo by providing adolescents with high quality information on SRHR alongside education on gender norms, values and power dynamics.

Progress reducing maternal and newborn mortality is staggering

- Significant progress in reducing preventable maternal and newborn deaths was achieved from 2000 to 2015 but has been staggering over the past years (2016-20).
- Conflict and crises can disrupt access to healthcare facilities and services with devastating implications for the number of maternal and newborn deaths.
- Women's dependency on men, as dictated by social norms that grant men decision-making power including over finances and women's movement, undermine women's reproductive autonomy.

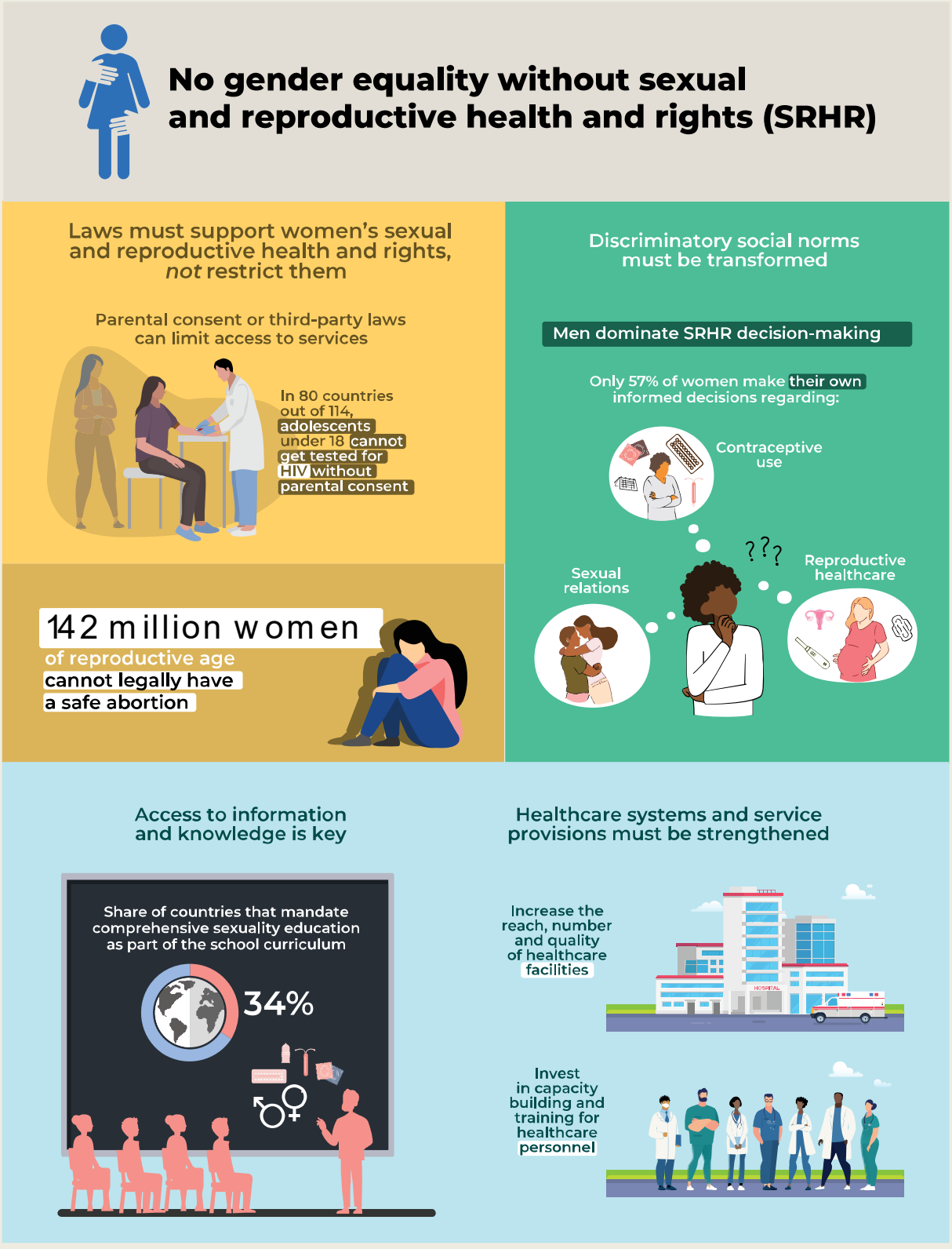
Social norms limit decision-making power over contraception and family planning

- Patriarchal norms and power systems undermine a person's ability to choose, voice and act on contraception and family planning preferences.
- Legal barriers, including third-party consent laws can prevent girls and women from accessing contraception and family planning services. The average unmet need for family planning is 7 percentage points higher in countries where the law requires women to obey their husbands.
- Personal beliefs on who should take contraception and family planning decisions shape the behaviour in practice to the detriment of women's rights, autonomy and health.

Access to safe and legal abortion is uneven across the world

- Less than 40% of women of reproductive age worldwide can have a legal abortion in all essential circumstances as recommended by the CEDAW – but with important regional discrepancies.
- The share of unsafe abortions is higher in countries with restrictive abortion laws. It is estimated that every year more than 45% of abortions are unsafe among which the majority occur in developing countries.

Infographic 3.1. Transforming discriminatory social institutions is key to achieving SRHR



Sexual and reproductive health and rights (SRHR) are recognised as a basic and inalienable human right[1] although the recognition and realisation of SRHR vary across countries and regions (see Box 3.1). Beyond being a global health imperative and a human right, SRHR are fundamental to achieving gender equality, reducing poverty, and promoting sustainable and inclusive development (UNFPA, 2014[1]). Yet, millions of people are (partially) deprived of their sexual and reproductive rights, impeding them from achieving the best possible health outcomes and making decisions about their own lives (Guttmacher-Lancet Commission, 2018[2]). This in turn can have spill-over effects on the welfare and development of societies. For instance, early pregnancies increase the risk of complications during childbirth, putting both the mother's and baby's health at risk, but they can also interrupt girls' education with negative consequences on their socio-economic opportunities and independence. Combined, (unintended) early pregnancies can thus put pressure on the health system of a country and limit women's decisions about their own lives and, in turn, contribution to the economy and to society. The importance of SRHR has been anchored in the International Conference on Population and Development Programme of Action[2] and the Sustainable Development Goals 3 (Good Health and Well Being), 4 (Quality Education) and 5 (Gender Equality) (United Nations, 2023[3]; UNFPA, 1994[4]).

Intersecting forms of discrimination disproportionately threaten women's and marginalised groups' SRHR. Increasingly, attention is paid to intersectional discrimination based on gender, race, ethnicity, socio-economic status, class, religion, disability, etc. and how they affect a person's ability to realise their SRHR (Luna and Luker, 2013[5]). Such discrimination can be amplified in developing countries where resource constraints affect access to information, service provision and quality of care (Guttmacher-Lancet Commission, 2018[2]). Crises and conflict further exacerbate such inequalities through various channels. For instance, climate-related disasters can strain the capacity of health systems, thus limiting access to essential SRHR services (Women Deliver, 2021[6]). The COVID-19 pandemic caused disruptions in family planning services leading to 1.4 million unintended pregnancies in 2020 (UNFPA, 2020[7]). Humanitarian emergencies can disrupt access to contraception and healthcare facilities and can increase women's and marginalised populations' risk of suffering from gender-based violence (UNOCHA, 2021[8]).

Discriminatory social institutions – formal and informal laws, attitudes, and practices – are at the heart of gender inequalities regarding SRHR. Traditional gender roles and norms according to which men are the ultimate decision makers undermine women's agency over their own bodies and health. Men, but also women may act as gatekeepers, restricting adolescents' and women's access to sexual and reproductive information and services. Unequal power hierarchies between partners, parents and children or between service providers and service seekers can deter the more vulnerable people from voicing and realising their preferred choices including, for example, on contraception use. Social stigma can prevent help-seeking, for example in the case of sexually transmitted infections (STIs). Harmful practices such as child marriage and female genital mutilation and cutting (FGM/C) undermine girls' human rights, bodily autonomy and integrity. Both informal and formal laws create inequalities in access but also in decision making over SRHR. Together, attitudes, practices and laws create a discriminatory "web" of social institutions limiting particularly women, adolescent and vulnerable groups – including indigenous people, persons with disabilities or LGBTI+ (lesbian, gay, bisexual, transgender, intersex and more) persons.

With the objective to provide actionable recommendations for policy makers, development partners and civil society, this chapter uncovers the discriminatory social institutions limiting equitable access to and realisation of selected SRHR aspects that are both of global relevance and/or that could fast track advances in developing countries: (i) adolescents' SRHR; (ii) maternal and newborn health; (iii) contraception and family planning; and (iv) access to safe and legal abortion.

Box 3.1. Defining sexual and reproductive health and rights – from 1968 to present

The understanding, meaning and scope of SRHR have evolved over time. In 1968 at the International Conference on Human Rights in Teheran, reproductive rights were for the first time intrinsically linked to human rights: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children." More than 25 years later, in 1994 at the International Conference on Population and Development in Cairo, 179 countries reiterated that reproductive rights embrace existing human rights and that sexual and reproductive health and reproductive rights are fundamental to development and women's empowerment.

Since then, the global understanding of SRHR has significantly advanced, including increasing recognition of how discrimination, stigma and poor quality of care undermine people's access to and realisation of SRHR. Up to present, the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights provides the most holistic definition of SRHR, grounded in human rights and the right to health as put forward by the World Health Organization. Yet, this definition is not adopted by all countries and organisations due to the lack of consensus on certain aspects of SRHR.

According to the Guttmacher-*Lancet* Commission, "Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Achieving sexual and reproductive health relies on realising sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected.
- freely define their own sexuality, including sexual orientation and gender identity and expression.
- decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences.
- decide whether, when and whom to marry.
- decide whether, when and by what means to have a child or children, and how many children to have.
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence."

Source: (Guttmacher-Lancet Commission, 2018[2]), *Accelerate Progress: Sexual and Reproductive Health and Rights for All — Executive Summary*; (WHO, 2017[9]), *Sexual health and its linkages to reproductive health: an operational approach*; (UNFPA, 1994[4]), International Conference on Population and Development (ICPD); (United Nations, 1968[10]), International Conference on Human Rights 22 April-13 May 1968, Teheran.

Adolescence – the time to set the right course for sexual and reproductive health and rights

Adolescence represents a critical age window where young people shape their own attitudes and beliefs and learn to make independent decisions. Focusing on adolescents' SRHR is crucial as that age is a decisive moment in life, with implications at the individual, community and societal levels. However, failures to enable adolescents to access comprehensive sexual and reproductive healthcare affect their life trajectories in a myriad of interdependent ways. When access to relevant information and services, including contraception, is limited or unavailable, adolescents can face an increased risk of STIs, early

and/or unintended pregnancies, complications in childbirth, and unsafe abortions with undisputable consequences on their health, education, employment opportunities, and overall well-being and socio-economic situation (Munakampe, Zulu and Michelo, 2018[11]). Boys' and girls' SRHR are thus not only a question of individual health, rights and well-being but also of sustainable development – particularly in countries where adolescents make up large parts of the population.

Differences in population growth rates affect adolescents' SRHR outcomes. To date, there are 1.3 billion adolescents in the world – more than ever before – accounting for 16% of the world's population (UNICEF, 2023[12]). The proportion of adolescents among the population is highest in Asia and the Pacific but is expected to experience the sharpest decline over the coming years, whereas the share of adolescents will continue to increase in Africa. Such population trends can put pressure on healthcare systems, increasing the risk of unmet demands for SRHR services – disproportionately affecting adolescents in countries where they represent a significant part of the population. Moreover, population growth can outpace declining rates, e.g. in girl child marriage, thus leading to a larger total number of girls being deprived of their rights (see Chapter 2) (Liang et al., 2019[13]; UNICEF, 2018[14]). Legal frameworks that effectively prohibit such harmful practices and guarantee SRHR can play a key role in mitigating such reversing trends.

Legislation can support or restrain SRHR for adolescence and beyond

Age of consent laws can restrain adolescents' access to sexual and reproductive rights. When the law requires parental consent and/or does not provide for consent-free counselling – as recommended by the United Nations (UN) Committee on the Rights of the Child (CRC)[3] – adolescents may be reluctant or unable to solicit SRHR services and advice (United Nations, 2016[15]; United Nations, 2009[16]). In more than 75% of countries (110 out of 144),[4] adolescents under the age of 18 cannot get tested for HIV without parental consent and in half of countries (44 out of 90),[5] parental consent is needed to access contraceptives, including condoms (UNAIDS, 2021[17]). The CRC further recognises the importance of setting an acceptable minimum legal age for sexual consent and recommends not to criminalise consensual sex among adolescents[6] (United Nations, 2016[15]). Internationally, no consensus on a minimum legal age for sexual consent has been reached, proving the difficulty of balancing the right to protection and the recognition of the autonomy of adolescents. In some countries, the age of consent varies between girls and boys, which can reinforce persisting gender inequalities and leave adolescents, especially girls, unprotected from sexual abuse and violence. In other countries, adolescents' consensual sexual activity is prohibited by the law (Kangaude and Skelton, 2018[18]; Government of Kenya, 2006[19]; Government of Ethiopia, 2004[20]). This can lead to or reinforce the stigmatisation of young people's sexual development, limit access to information, prevent or delay the use of contraception, lead to unsafe sexual behaviour and negatively affect adolescents' help-seeking in case of STIs and unintended pregnancies (UNFPA, 2017[21]).

Weak legal frameworks and informal laws leave children and adolescents insufficiently protected from child marriage and FGM/C (see Box 3.1). In 17% of countries (30 out of 178), the minimum legal age of marriage for women is below 18 years, whereas for men this is the case in 8% of countries (15 out of 178), highlighting the gendered dimensions of child marriage (see Chapter 2) (OECD Development Centre/OECD, 2023[22]). While child marriage deprives mostly girls of their right to choose when to marry, it also has implications on additional SRHR outcomes. Child marriage is often accompanied by adolescent pregnancies, which entails high risks of maternal mortality, morbidity and infant mortality and may lead to greater social isolation and increased risks of intimate-partner violence (Izugbara, 2018[23]; Lee-Rife et al., 2012[24]). While FGM/C affects women's entire lives, it particularly undermines young girls' rights to bodily autonomy, integrity and security. Survivors of FGM/C often experience immediate and long-lasting health consequences that can cause severe bleeding, infections, complications in childbirth and also, inter alia, undermine their right to have pleasurable sexual experiences. Most countries (80%) where FGM/C is a

local custom have enacted laws that specifically prohibit the practice. Nevertheless, weak law enforcement and informal laws allow for FGM/C to persist (see Chapter 2) (OECD Development Centre/OECD, 2023[22]).

When laws on gender-based violence do not extend to the school context, adolescents' SRHR are at risk. School-related gender-based violence (SRGBV) can entail severe consequences on learners' physical and mental health, increase their risk of contracting STIs or becoming pregnant, and negatively affect their educational attainment and outcomes. Among 196 countries, 32% do not provide legal protection from any form of violence in educational institutions (UNESCO, 2022[25]). Data from the fifth edition of the SIGI further reveal that the legal framework on sexual harassment – a common form of SRGBV – often fails to comprehensively protect students from this form of violence. In fact, the law in most countries (138 out of 178) specifies that sexual harassment is prohibited at the workplace but in just about half of the countries (96 out of 178) does the law specifically cover the school environment. No specific mention of the school environment can constitute a legal loophole and weaken the protection of children and adolescents. Among the 82 countries where sexual harassment is not prohibited in schools, 33% of countries are in Africa and 39% in Asia (OECD Development Centre/OECD, 2023[22]).

Beyond SRGBV, laws that prohibit pregnant girls from attending school and/or re-integrate the school system after having given birth limit girls' educational opportunities. Globally, it is estimated that the law in 8% of countries restricts pregnant and parenting girls' right to education and only 27% of countries explicitly enshrine this right in legislation (UNESCO, 2022[25]). For instance, the law in Tanzania prohibited pregnant students and adolescent mothers from continuing their education in public schools until 2021 when the "pregnancy ban" was finally abolished (Human Rights Watch, 2022[26]).

Adolescents reproduce discriminatory norms with gendered impacts on their SRHR

Adolescents are likely to reproduce dominant social norms which in turn underpin their sexual and reproductive health behaviour, decision making, and ability to exercise their rights and health outcomes now and in the future (Liang et al., 2019[13]; Pulerwitz et al., 2019[27]). Gender norms have a different effect on boys' and girls' access to and realisation of SRHR. Trying to comply with the social expectations and existing norms of what it means to be a man or woman and how one should act accordingly, adolescents may reinforce ideals of male strength and control and female vulnerability and need for protection. For instance, evidence from South Africa and Uganda shows that whereas boys who have multiple sexual partners achieved popularity, girls were more likely to be socially excluded (Khumalo et al., 2020[28]; Muhanguzi, 2011[29]). Norms of masculinities, such as taking sexual risks, having multiple partners or avoiding healthcare can affect boys' SRHR with consequences on their partners' health and rights (Buller and Schulte, 2018[30]). Moreover, such attitudes can lead to violations of bodily integrity in practice – particularly of their female partners. For instance, recent data from France reveal that almost one-quarter (23%) of men aged 25 to 34 years believe that one must be violent sometimes to be respected (Government of France, 2023[31]).

Even when adolescents seek sexual and reproductive health services, they often face discrimination and stigma. For example, in settings where it is not socially acceptable for unmarried girls or women to be sexually active, service providers may be reluctant to share relevant information and/or access to contraceptives as well as sexual and reproductive health checks and interventions including abortions (Save the Children, 2019[32]). Sexual orientation and gender identity can further heighten the risk of discrimination. In countries where same-sex relationships are criminalised and/or where recognition of gender identity is not possible, young LGBTI+ persons' right to bodily and mental integrity is violated from the onset and they are likely to face stigmatisation with undisputable consequences for their access to and realisation of SRHR (WHO, 2023[33]). Given adolescents' limited socio-economic independence, their SRH choices and realisation of rights can be restricted by families or communities (Pulerwitz et al., 2019[27]).

Is digitalisation a curse or a blessing for adolescents' SRHR?

With the digital transformation, norms and behaviours are no longer only shaped offline. Digital media and online resources represent a useful tool for adolescents to develop their sexuality, inform themselves about sexual and reproductive health topics and seek advice. For instance, the cost-free mobile application "Hello Ado" aims at providing young people in Central and West Africa with SRHR information, e.g. via a list of service providers who can answer their questions or by offering direct exchanges via a chatbot (Institut de Recherche pour le Développement, 2020[34]). Social media further allow boys and girls to explore and challenge norms, values and identities, particularly in conservative settings where open discussions around SRHR are restricted.

However, the use of social media and exposure to digital content also entail several risks. Adolescents are at risk of predatory behaviour from individuals they contact online. Anonymity may create gaps between socially tolerated behaviour and communication online and offline. Emerging forms of gender-based violence (GBV) including stalking and cyber harassment can have lasting real-life consequences on young people's health, well-being and rights (see Chapter 2). Moreover, exposure to harmful or discriminatory content can shape adolescents' choices, behaviour and attitudes towards sexuality and reproductive health (UNFPA, 2021[35]; Liang et al., 2019[13]). For instance, evidence reveals that when youth consume media that sexualise girls and women, there is a greater acceptance and replication of such discriminatory notions on gender and sexual roles (Coyne et al., 2019[36]).

There are disparities between girls' and boys' use of online resources, with diverging effects on their SRHR. Evidence shows that, on average, men start consuming online content at an earlier age than women and for longer time periods. This may increase boys' and men's exposure to pornography, which often promotes patriarchal gender roles and does not respect essential elements such as consensual and safe sexual relations (UNFPA, 2021[35]; OECD, 2020[37]). Comprehensive sexuality education (CSE) can enable children and adolescents to learn about relevant information, resources and skills to realise their SRHR, both online and offline.

The C in CSE (comprehensive sexuality education) is key

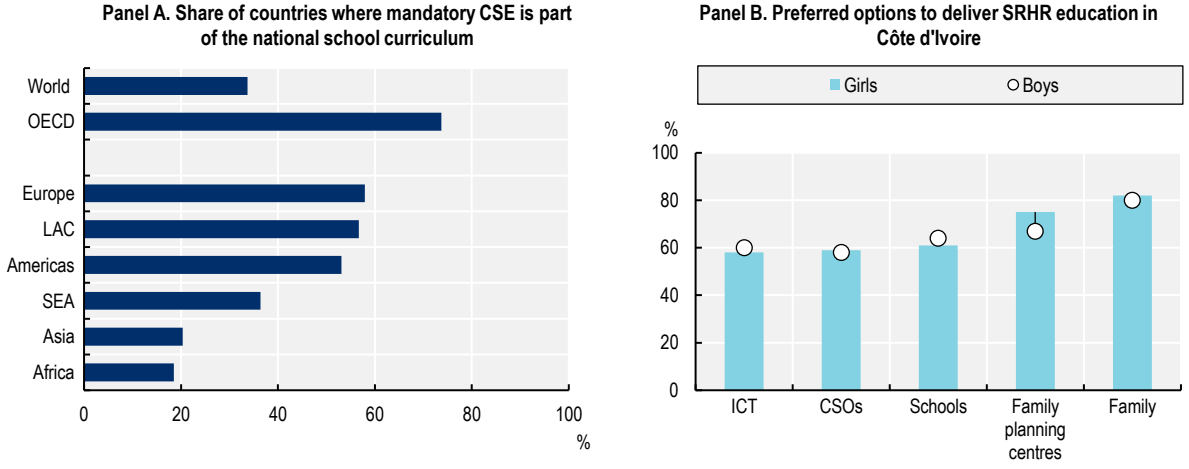
While adolescents across the world face different realities and challenges, sexuality education is indispensable for everyone. CEDAW, the CRC and the Committee on Economic, Social, and Cultural Rights Committee highlight the need for evidence-based and age appropriate comprehensive sexuality education (CSE) in order to promote access to sexual and reproductive health services within wider gender equality efforts. Specifically, CSE programmes that account for gender and power dynamics, social contexts as well as children's and adolescents' rights are found to be more likely to promote respectful and pleasurable relationships, safe sexual behaviour and egalitarian attitudes to sexuality and reproduction (UNESCO et al., 2018[38]). Evidence further shows that discussions about power and values can encourage learners to reflect on and question restrictive norms of masculinities (Greene et al., 2019[39]). Equipping children and adolescents with the relevant knowledge, information and skills for their age empowers them to detect when their rights are violated, which is particularly relevant for GBV, child marriage and FGM/C.

Access to CSE, however, remains limited across all regions. While the concept and importance of CSE is emphasised in recommendations by international committees, achieving global consensus on access to CSE is not a globally agreed-upon target. In fact, most countries report that sexuality education is integrated into their national school curricula in some form, but there are many differences regarding the topics covered and age groups targeted (UNESCO et al., 2021[40]). Although the trend is towards a more comprehensive curriculum, the extent to which "non-traditional" or controversial aspects such as sexual orientation, gender identity, gender power dynamics, the importance of consent and pleasure, or access to safe abortion services are included varies (OECD, 2020[37]). The SIGI finds that only one-third of countries (60 out of 178) are mandating CSE globally (Figure 3.1, Panel A). It further highlights important regional disparities. The share of African and Asian countries where CSE is mandatorily taught in schools

is much lower than in Europe or the Americas, although it is in those regions where the world's youth is predominantly living (OECD Development Centre/OECD, 2023[22]).

Figure 3.1. Access to CSE is uneven across regions, and schools may not always be the preferred place to deliver education on SRHR

Share of countries where mandatory CSE is part of the national curriculum (Panel A) and share of the population in Côte d'Ivoire in favour of the different settings presented to deliver education on SRHR (Panel B)



Note: In Panel A, LAC refers to Latin America and the Caribbean, and SEA refers to Southeast Asia. In Panel B, ICT refers to information and communications technology, and CSO refers to civil society organisations. Panel B presents the percentage of the Ivorian population who think that girls or boys should receive sexual and reproductive education for each of the possible options.
Source: (OECD, 2022[41]), SIGI Côte d'Ivoire Database, https://stats.oecd.org and (OECD Development Centre/OECD, 2023[22]), "Gender, Institutions and Development (Edition 2023)", *OECD International Development Statistics* (database), https://doi.org/10.1787/7b0af638-en.

StatLink https://stat.link/c63uka

To reach all children and adolescents, CSE cannot only be taught in schools. Globally, in 2020, school enrolment rates stand at 91% for primary schools but only at 67% for upper secondary schools (UNESCO, 2020[42]). Particularly at the secondary education level, school enrolment is far from universal in many developing countries and gender disparities persist. While schools are central places for children's and adolescents' learning and socialisation, the role schools and teachers can and should play in delivering CSE can be controversial. This is especially the case when moral and political views are not aligned with the educational content or the perceived need for sexual education. Civil society organisations have raised concerns that conservative lawmakers and politicians can exert pressure at all administrative levels to exclude certain key concepts from the nationally mandated (comprehensive) sexuality education content. For instance, during Bolsonaro's presidency in Brazil (2019-22), teachers reported being hesitant to educate their students on gender and sexual orientation as they were fearing consequences by elected officials or community members (Human Rights Watch, 2022[43]). Moreover, teachers may often lack insufficient training and guidance to deliver CSE which in turn can undermine their 'suitability' to do so. For instance, in Côte d'Ivoire, the adult population considers that girls and boys should receive SRHR education but preferably within the family (Figure 3.1, Panel B). Accounting for country context, CSE must be provided in various settings to reach all boys and girls, and those delivering it should receive adequate training.

Policy recommendations to improve adolescents' sexual and reproductive health and rights

Adolescence is an age full of opportunities but also risks – particularly when prevailing laws and norms threaten adolescents' rights and health outcomes. Policy makers, development partners and civil society should concert their efforts to convert current barriers into levers, minimise risks and amplify opportunities.

Enact or update laws to ensure adolescents' sexual and reproductive rights are upheld

In line with international or regional legal frameworks, governments in consultation with human and women's rights organisations and youth leaders should reform discriminatory laws that prevent adolescents' SRHR:

- Clearly define an age of consent for medical services and guarantee that adolescents have access to counselling and advice without parental consent in line with the CRC. Consider setting a specific minimum age of consent for HIV testing and contraception.
- Set an appropriate minimum age of consent for sexual activity that balances adolescents' need for protection and development, without gender differences, and decriminalise consensual sexual relations among adolescents in line with the CRC.
- Set 18 as the minimum age for marriage without any exceptions as recommended by the CRC and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and work with community and traditional leaders to ensure law enforcement.
- Criminalise the practice of FGM/C and establish penalties for all perpetrators, including parents and medical practitioners. Add an extraterritorial jurisdiction clause extending penalties to citizens who commit the crime outside of the country.
- Remove bans prohibiting pregnant and parenting adolescent girls from attending and/or returning to school and sitting exams.
- Strengthen laws on GBV, ensuring they extend to the school environment.

Tackle discriminatory social norms that undermine adolescents' access to and realisation of SRHR

Respective ministries in collaboration with development partners, civil society and the private sector should develop and implement evidence-based programmes focusing on changing transformative norms:

- Leverage edutainment – a combination of education and entertainment – to promote gender-equitable attitudes and practices regarding decision making, including over contraception use, and to tackle harmful practices including child marriage and FGM/C, etc.

  > *Sex Ki Adalat is a web series accessible on YouTube that was developed by Population Foundation of India dealing with taboo topics related to sexual and reproductive health. A project evaluation has shown that the series enhanced evidence-based knowledge on SRHR and provoked a questioning of regressive social norms (Population Foundation of India, 2023[44]).*

- Engage with local influencers and role models to organise (media) campaigns centred on masculinities, gender equality and SRHR.

  > *In Mozambique, the civil society network HOPEM (Homens pela Mudança) works to shift restrictive attitudes, norms and values around gender by conducting trainings on masculinities, launching media-based campaigns or organising a Men's march for gender equality. The activities have resulted in more*

> *men recognising gender related vulnerabilities and numerous celebrities breaking the silence around gender-based violence (MenEngage Africa, 2023[45]).*

- Develop and/or support existing local initiatives such as gender school clubs to engage children and adolescents in discussions and workshops on gender, values and power hierarchies to help them form gender-equitable attitudes and norms.
- Develop and implement training programmes for healthcare providers to ensure adolescents receive adequate and discrimination-free SRHR advice and services.

Deliver CSE to all children and adolescents – in and out of school

- Civil society and development partners should pursue advocacy efforts and closely work with governments to highlight the long-term benefits of CSE to prevent and respond to health challenges, promote gender equality and ensure children's and adolescents' rights. This includes advocating for an expansion of the content to cover all aspects of SRHR and to include modules on gender norms and power dynamics.
- Policy makers in consultation with education, health and gender experts should adopt or update national curricula or strategies to mandate CSE delivery for children and adolescents with evidence-based and appropriate content for each age group. Involving parents, religious leaders and youth in the design and implementation of CSE can strengthen effective delivery and pave the way to expand the content taught.
- Ministries and other government bodies in charge of national education, together with civil society and development partners, should consider integrating CSE in wider education and health efforts and develop strategic plans on how CSE can be delivered to all children and adolescents, regardless of schooling status and in both formal and informal settings.
- Design and set up budgetary tracking mechanisms to monitor governments' financial commitments and efforts to achieve CSE targets as stated in national action plans or policies, including budget allocation to develop and provide training for CSE implementers.

Maternal and newborn health – understanding what slows down progress

Maternal and newborn health has significantly improved over the years, but conflict and crises slow down such progress

The importance of reducing maternal and newborn mortality is enshrined in the 2030 Agenda. SDG 3 (Good Health and Well-being) has set the objective to reduce the global maternal mortality rate (MMR) to less than 70 maternal deaths per 100 000 live births and to end preventable deaths of newborns and children under the age of five by 2030[7] (United Nations, 2015[46]). Beyond ensuring human rights to life and health, improving the well-being of mothers and children is a crucial public health challenge, as it determines the health of the next generation with spillover effects on future children's well-being, education and socio-economic inclusion (WHO and International Center for Equity in Health, 2015[47]).

Newborn health has made substantial progress in child survival since 1990. Globally, the number of neonatal deaths declined from 5 million in 1990 to 2.4 million in 2020, but there are still approximately 6 700 newborn deaths every day, amounting to 47% of all child deaths under the age of 5 years (WHO, 2022[48]). Seventy-five per cent of neonatal deaths occur during the first week of life, mainly caused by preterm birth, childbirth-related complications and infections. The chances of survival strongly depend on the child's birthplace. Sub-Saharan Africa had the highest neonatal mortality rate in 2020, with 27 deaths per 1 000 live births, followed by Central and Southern Asia with 23 deaths per 1 000 live births. A child

born in sub-Saharan Africa is ten times more likely to die in the first month than a child born in a high-income country (Figure 3.2, Panel A).

Figure 3.2. Maternal and newborn mortality has been decreasing globally but unevenly

Panel A shows trends in the neonatal mortality rate over time and by region. Panel B shows trends in the maternal mortality rate over time and by region.

Note: In Panel A, the newborn mortality rate corresponds to the number of newborn deaths per 1 000 live births. In Panel B, the maternal mortality rate corresponds to the number of maternal deaths per 100 000 live births. In both panels, Australia and New Zealand are not included, but they exhibited the lowest newborn mortality rates and maternal mortality rates globally in 2021 (2.4 newborn deaths per 1 000 live births and 4 maternal deaths per 100 000 live births). In both panels, the regions displayed correspond to the official regions used for SDG data reporting.
Source: (UNICEF, 2022[49]), Neonatal mortality, UNICEF Data, https://data.unicef.org/topic/child-survival/neonatal-mortality/ and (WHO, 2023[50]), Maternal and reproductive health, Global Health Observatory (GHO), https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/maternal-and-reproductive-health.

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Despite significant progress in reducing maternal mortality over the past ten years, 287 000 women globally died from pregnancy or childbirth-related complications in 2020 – and the vast majority of them in Africa (WHO et al., 2023[51]). From 2000 to 2020, the global MMR declined on average 2.1% every year (Figure 3.2, Panel B). This was achieved thanks to improvements in healthcare, nutrition and hygiene levels. Nonetheless, the majority (75%) of maternal deaths occur because of preventable causes including severe bleeding, high blood pressure, infections and complications from unsafe abortions (WHO et al., 2023[51]). Sub-Saharan Africa alone accounted for approximately 70% of global maternal deaths in 2020. Among the countries, Nigeria has the highest estimated number of maternal deaths, accounting for over one-quarter of all estimated global maternal deaths in 2020, followed by India, the Democratic Republic of the Congo and Ethiopia (WHO et al., 2023[51]).

Contrary to the positive trend in reducing maternal mortality over the 2000-15 period, MMRs stagnated or worsened in most regions between 2016 and 2020 (Figure 3.2, Panel B). In Europe, Latin America and the Caribbean, and Northern America, there were increases in the MMR between 2016 and 2020 (Figure 3.2, Panel B) (WHO et al., 2023[51]). In particular, the countries with the most significant percentage increases in the MMR between 2000 and 2020 are, in descending order, Venezuela, Cyprus, Greece, the United States, Mauritius, Puerto Rico, Belize and the Dominican Republic (WHO et al., 2023[51]), with increases ranging from 183% in Venezuela to 36% in the Dominican Republic. For instance, Venezuela's deep economic, political and social crisis has affected women's access to antenatal care and hospital delivery, which they seek across the border in Brazil and Colombia (John Hopkins Center for Humanitarian Health, 2022[52]).

Conflict and crises particularly put maternal and newborn health at risk. Within humanitarian settings, and especially in the context of armed conflicts, insecurity coupled with forced displacement produces an instability that leads to a higher risk of maternal and newborn mortality (WHO et al., 2023[51]; Jawad et al., 2021[53]). In 2020, according to the OECD States of Fragility Index, thirteen countries were classified as "extremely fragile"[8] (OECD, 2020[54]).. The average MMR in these countries was over double the world average in 2020 (507 maternal deaths compared to 223 per 100 000 live births) (UNICEF, 2020[55]), and the newborn mortality rate was substantially higher than the world average in 2020 (27 newborn deaths compared to 18 per 1 000 live births) (UNICEF, 2022[49]). Crises other than armed conflict also compromise maternal and newborn health. A study on the impact of the COVID-19 crisis shows that the disruptions in health services during the pandemic led, on average, to an increase of 3.6% in child mortality and 1.5% in maternal mortality in 18 low- and middle-income countries[9] (Ahmed et al., 2022[56]). Moreover, climate change directly and indirectly affects maternal and newborn health. For instance, extreme weather events can demolish health infrastructure, disrupt service provisions or lead to forced displacement of people with implications for their access to necessary healthcare (Women Deliver, 2021[6]).

Barriers – both structural and social – hinder maternal and newborn health

High-quality healthcare systems are key to improving and guaranteeing maternal and newborn health. Yet, resource constraints can compromise countries' capacity to establish a high-quality care system – particularly in remote and rural areas (WHO, 2010[57]). Health systems' (partial) failure to ensure maternal and newborn health can translate into delays in seeking and receiving care after reaching the healthcare facility, shortages of essential medical supplies and poor accountability of the system itself (Roozbeh, Nahidi and Hajiyan, 2016[58]). A study conducted in Nigeria revealed that women choose not to give birth in healthcare facilities because prior experiences of mistreatment and healthcare facilities' poor reputations have eroded their trust in the health system (Bohren et al., 2017[59]).

The distance to healthcare facilities can hamper women's access to services, with implications for their own and their (future) children's health. For instance, cattle camp residents and pastoralists from Ethiopia, Mali and South Sudan, reported distance as a crucial challenge to accessing healthcare facilities (Dahab and Sakellariou, 2020[60]; Kohi et al., 2018[61]). Farming and raising livestock are common activities in these countries, where farmers and pastoralists often live in continuous movement (Ag Ahmed, Hamelin-Brabant and Gagnon, 2018[62]; Medhanyie et al., 2018[63]; Wilunda et al., 2017[64]). Weather events can further hinder access to hospitals and health centres. For instance, rainy seasons in Mozambique, South Sudan and Togo can cause roads to flood, preventing women from seeking facility-based maternal care (Arnold et al., 2016[65]; Munguambe et al., 2016[66]; Wilunda et al., 2017[64]). During weather-related hazards – which are likely to increase due to climate change (see Chapter 4) – in some countries, such as Togo, walking is the only available means to reach a healthcare facility, due to the condition of the roads (Arnold et al., 2016[65]).

Beyond such structural barriers, patriarchal norms result in low prioritisation of girls' and women's rights, including their right to safe, quality and affordable SRH services (Crear-Perry et al., 2021[67]).

Discriminatory gender norms can reduce women's ability to obtain healthcare, influence how health providers treat them and exclude women's involvement from family planning choices (Roozbeh, Nahidi and Hajiyan, 2016[58]). For instance, a study in Tanzania shows that a woman's decision to give birth in a healthcare facility is dependent upon the husband's approval. This often depends either on the men's conviction that childbirth is a natural duty or on their desire to avoid their wives from being exposed to male healthcare providers (Kohi et al., 2018[61]). In settings where women's mobility is conditioned by the presence of a man and/or where men are the healthcare decision makers, women may be precluded from seeking pre-natal healthcare or from reaching healthcare facilities on time. A study from Mali reported that it was not acceptable for women to go alone to healthcare facilities, and they had to be accompanied by their husbands for their security, for cultural acceptance and for covering the financial expenses (Dahab and Sakellariou, 2020[60]). Women's economic dependence on men can thus further limit access to and decision making over essential healthcare services.

Traditions and customs can lead to misconceptions about the importance of using maternal healthcare services. For example, women from pastoralist communities in Ethiopia reported preferring home delivery to order to participate in commonly observed religious practices after childbirth (Medhanyie et al., 2018[63]). In South Sudan, women declared they could give birth to their babies anywhere naturally, without the need for prior preparations. They perceived the use of maternal healthcare facilities to be restricted to complicated pregnancies, as did women from a study in Mozambique (Wilunda et al., 2017[64]; Munguambe et al., 2016[66]).

While many women are affected by the above-mentioned barriers to a certain degree, some are more discriminated against than others. A geography of inequality can be identified between countries but also within countries. Poverty is a crucial factor which can act as a multiplier of the different obstacles that hinder women's access to SRH services. For instance, lower-caste women in India face greater hardships in access to essential reproductive healthcare services compared to higher-caste women due to the financial burden required (Mishra, Veerapandian and Choudhary, 2021[68]). Discrimination linked to race and sexual orientation is also a crucial factor that affects women's treatment in healthcare facilities. For instance, Romani women, the largest minority group in Europe, have strong difficulties accessing maternal healthcare due to internalised racism of health providers, problems of poor communication and a lack of sexual education (Janevic et al., 2011[69]). Moreover, a study from the United States reports that more than half (51%) of LGBTQIA+ birthing people reported that the quality of their experience with pregnancy, birth and postpartum care was impacted by bias or discrimination (Alvarado et al., 2022[70]).

Contraception and family planning – questions of reproductive justice and autonomy

Increased access to contraception has profoundly affected the lives of many. Contraception use means greater control over family planning decisions, reduces the possibility of contracting STIs (depending on contraception method), allows for sexual freedom and can help, in some cases, to manage medical conditions (Cadena, Chaudhri and Scott, 2022[71]). However, unequal power structures have created inequalities in a person's ability to choose, voice and act on contraception and family planning preferences (Moreau et al., 2020[72]). Social and/or theoretical concepts such as reproductive justice and reproductive autonomy highlight stakeholders' call for a more nuanced and intersectional examination when looking at contraception use and family planning (Grace and Anderson, 2016[73]; Luna and Luker, 2013[5]).

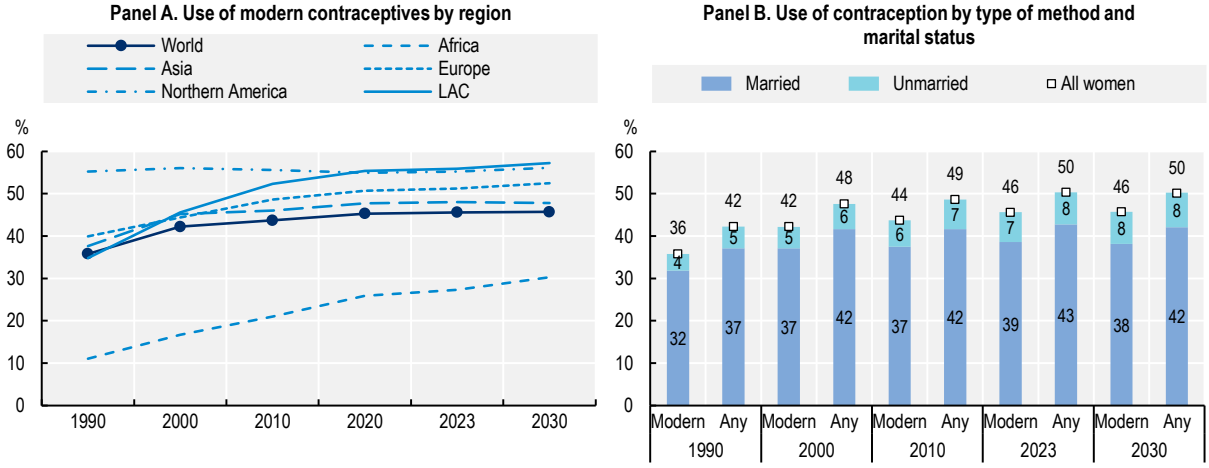
Modern contraception as a mean to control family planning decisions has been enshrined in the development agenda. The SDG Indicator 3.7.1. monitors "the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods of contraception" (United Nations, 2022[74]). The 2017 Family Planning Summit states that "family planning is a best-buy in global development. When women and girls have access to family planning, they are able to

complete their education, create or seize better economic opportunities, and fulfil their full potential – in short, entire families, communities and nations benefit" (Family Planning 2020, 2017[75]). Worldwide, it is estimated that 13% of all women (and 17% of married or in-union women) of reproductive age have an unmet need for family planning. In other words, 13% of women of reproductive age who want to stop or delay childbearing do not use modern contraception. Regional discrepancies persist, and estimated unmet needs are highest in Africa, standing at 18% for all women and 24% for married or in-union women (United Nations, 2022[76]). Unmet needs for family planning are, on average, significantly lower in the Americas, Asia and Europe with some country variation (United Nations, 2022[76]; OECD Development Centre/OECD, 2023[22]).

Unmet needs for family planning persist despite the increased use of modern contraceptive methods. In 2023, worldwide, half of all women are estimated to use any method of contraception, and most use a modern method. Among those, the majority are married or in union (Figure 3.3, Panel B). While Africa remains the region where the use of modern contraception remains the lowest worldwide, it is also the region where usage rates have increased the most (Figure 3.3, Panel A). The reasons for not using contraception can be the results of commodity supply issues or personal preferences but can also be the product of social and legal barriers that restrain disproportionately (young) women's ability to access and decide over contraception use with implications for family planning. For instance, only 57% of women[10] make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare (United Nations, 2022[77]).

Figure 3.3. Contraception use has increased substantially since 1990, but gaps persist

Share of women aged 15-49 years using contraception by regions (Panel A) and by marital status (Panel B)



Note: LAC refers to Latin America and the Caribbean. Panel A shows the estimated median share of women (regardless of marital status) aged 15-49 years using a modern contraception method from 1990 to 2030, by region. Panel B shows the estimated median share of women aged 15-49 years using a modern or any contraception method from 1990 to 2030, by marital status. Modern contraceptives include female and male sterilisation, intra-uterine devices, implants, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method, emergency contraception, and other modern methods not reported separately (e.g. the contraceptive patch or vaginal ring). Any methods of contraception include both modern and traditional methods, the latter including rhythm (e.g. fertility awareness-based methods, periodic abstinence), withdrawal and other traditional methods.
Source: (United Nations, 2022[76]), Family Planning Indicators, https://www.un.org/development/desa/pd/data/family-planning-indicators.

StatLink https://stat.link/pdye4w

Structural factors and discriminatory social institutions limit access to and decision-making power over contraception use and family planning

Restrictive laws hinder access to and use of contraception. Age restrictions and parental notification laws on contraception use can limit adolescents' access to family planning services (see above). Moreover, third-party consent laws can prevent girls and women from accessing contraceptives. Under these types of legal provisions, a third party – often a spouse or another relative – must provide their consent before one can receive a contraception method. Despite a declaration from the Human Rights Committee deeming such legal provisions a violation of privacy, this is still the reality in some countries (OHCHR, 2020[78]). In some parts of Kenya, for example, providers are required to have permission from a third party before providing certain types of contraception (Solo and Festin, 2019[79]). In addition, laws according to which a woman must obey her husband could deter them from using contraceptives. This can be the case when the man is opposed to contraception use but also when he does not allow his wife to go by herself to a service provider. The SIGI data show that in 19 countries where the law requires women to obey their husbands, the average unmet need for family planning is 28% compared to 21% in 151 countries without such a law (OECD Development Centre/OECD, 2023[22]).[11] This finding highlights the need for eradicating gender-based discrimination in social institutions, including laws, in order to enhance gender equality goals.

Healthcare and transportation infrastructure are also decisive in ensuring access to family planning services. A general lack of healthcare facilities and/or concentration of service centres in urban areas can be a burden on women's and men's ability to access services, particularly in rural areas. Infrastructure challenges also arise regarding the supply of medical resources and contraceptives. Commodity supply chain shortages can translate into a lack of choice in family planning methods available – especially in already underserved areas that are difficult to reach and where it is difficult to ensure supply continuity. This can thus result in decreasing contraception use (Mukasa et al., 2017[80]).

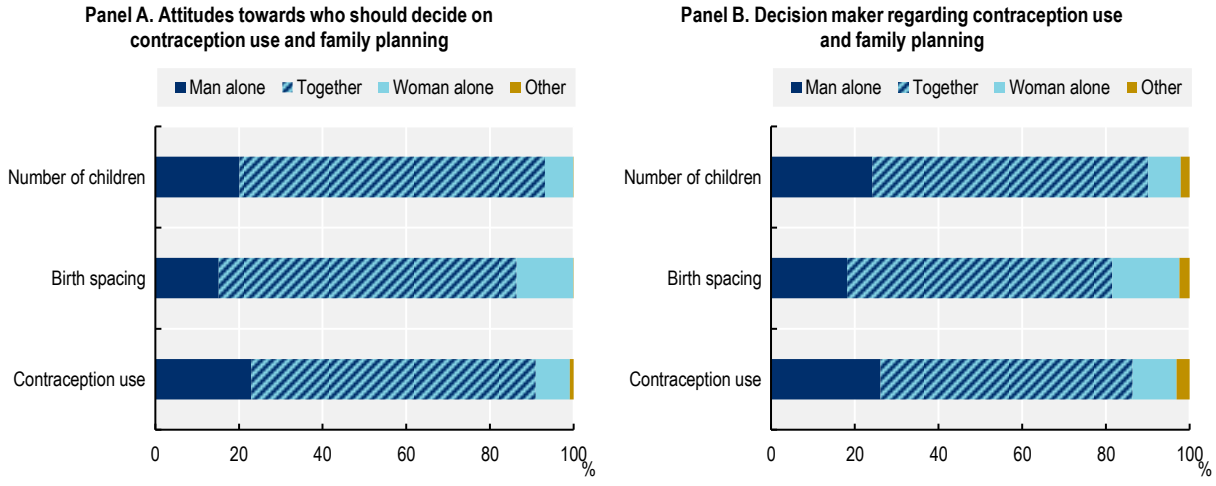
Provider bias can limit access to contraceptives. Even when a person can reach family planning centres, pharmacies or other relevant structures, stigmatisation and bias against specific population groups can prevent them from accessing contraception. For instance, a study from Malawi found that more than 40% of providers stated not being comfortable with providing family planning services to young, unmarried women without children (Solo and Festin, 2019[79]). In urban Kenya, 41% of providers reported that they would not offer one or more methods of contraception to women without any children (Tumlinson, Okigbo and Speizer, 2015[81]). In Nigeria, many health providers have discouraged the use of contraceptives among newly-married women due to their belief that couples should have children soon after their marriage, that people with small families should have bigger ones or that women should obtain the consent of their husbands to receive contraception (Oduenyi et al., 2021[82]).

Poverty and economic dependence are important barriers to contraception. Financial resources (or the lack of) determine whether a person can cover the costs related to transportation to reach a healthcare facility or provider of contraceptives, can pay for service fees and the price of the chosen method. Women's and adolescents' economic dependence on men can limit independent decision making over healthcare spending. For instance, SIGI data from Côte d'Ivoire and Tanzania reveal that in 52% and 24% of all families respectively, the father alone decides on healthcare spending for children (OECD, 2022[83]). This comes at a cost as women's limited ability to make investment decisions for their own or their children's health is associated with poorer (sexual and reproductive) health outcomes (Government of the United Kingdom, 2004[84]). To counteract women's financial dependence and ensure that everyone, regardless of their economic situation, has access to contraception, policies mandating free-of-charge or subsided service provision are essential. In fact, the SIGI data show that more than 40% of countries worldwide (74 out of 178) have a national strategy to provide contraception free of charge or to subsidise it – with a similar share of countries in each region[12] (OECD Development Centre/OECD, 2023[22]).

Attitudes according to which men should be the decision makers on contraception use and reproductive choices can undermine women's decision-making power in practice. For instance, recent SIGI data from Côte d'Ivoire show that more than one-fifth of the population thinks that the man alone should decide on contraception use within the couple, which corresponds to the decision-making pattern in practice. The same pattern also holds true for attitudes on who should and who actually decides the number of children the family should have, and birth spacing (Figure 3.4) (OECD, 2022[83]). Evidence from Palestine, Lebanon, Uganda and Tanzania further shows that more than one-third of men who agree that it is a woman's responsibility to avoid getting pregnant think that contraception use should be the man's decision. This underlies an important paradox. While men view pregnancy (and its avoidance) as a "woman's issue", they are not willing to grant women the final say over their bodily autonomy (Equimundo, 2022[85]). In that sense, both men's opposition or non-involvement in family planning decisions can restrict women's uptake and continued use of contraceptives (Thummalachetty et al., 2017[86]; Kabagenyi et al., 2014[87]).

Figure 3.4. In Côte d'Ivoire, decision making over contraception use and family planning is largely in the hands of men

Share of the population of Côte d'Ivoire who thinks men and/or women should take important family planning decisions (Panel A) and those who take these decisions in practice (Panel B)



Source: (OECD, 2022[41]), SIGI Côte d'Ivoire Database, https://stats.oecd.org.

StatLink https://stat.link/trsd28

Married women's ability to access contraception can be hindered by social norms that link marriage with motherhood. In contexts where women's identity and status strongly rely on their roles as wives and mothers, married women may face social pressure to have children and may suffer adverse consequences in case of infertility (Box 3.2). Married women who do not conform to the status quo – i.e. those who do not want to have children or want to delay a pregnancy – may be reluctant to (openly) use contraception as they fear judgement, spousal retaliation or even intimate-partner violence. When unequal power dynamics are questioned, a person's bodily autonomy can thus be violated. This is the case for any relationship regardless of a person's marital status, gender identity or sexual orientation. For instance, 23% of women in 64 countries report not being able to refuse sex and 8% are unable to make decisions specifically about contraception (UNFPA, 2022[88]). In Tanzania, 40% of women but only 11% of men who currently have a partner and use a contraception method do so without the knowledge of their partner (OECD, 2022[89]).

The modern contraception paradigm – does a one-size-fits-all approach work?

Globally, women's contraceptive autonomy is undermined by providers and research bias in the reproductive health industry. Evidence has revealed instances where family planning providers have given women certain contraception methods as a matter of routine and often without their consent. For instance, women in three African countries reported that providers refused to remove long-acting reversible contraceptives upon their request (Hardee et al., 2014[90]) (Britton et al., 2021[91]; Yirgu et al., 2020[92]; Callahan et al., 2020[93]). Even when service providers respect women's preferences, women may feel trapped to use a certain contraception method because there are no effective and reversible options available for men. Research and development of hormonal contraceptives for men has been underway for almost as long as for women, but they have never made it beyond clinical trials (Reynolds-Wright, Cameron and Anderson, 2021[94]). Clinical trials have been suspended, as male participants experienced adverse events such as changes in libido, headaches, weight gain, changing moods, etc. The fact that the same adverse effects are considered manageable for women reveals a gendered notion of what is acceptable for men and who is ultimately responsible for managing pregnancy – with undisputable implications for women's bodily autonomy and well-being (Abbe and Roxby, 2020[95]).

Since the 1994 International Conference on Population and Development, the family planning discourse has shifted away from population control. Yet, the majority of family planning programmes focus on fertility reduction targets and contraception uptake rather than adopting a person-centred approach that focuses on people's needs and enables them to make autonomous decisions on family planning (Cahill et al., 2018[96]; Ouedraogo et al., 2021[97]; Senderowicz et al., 2023[98]). The success or impact of family planning programmes is often tied to numeric targets such as the share of the population using a modern contraception method. These indicators fall short in measuring whether programmes are person-centred and effectively promote people's autonomous choice and use of contraception methods. Moreover, quantitative goals of contraception uptake can in certain circumstances reduce the provision of care and undermine individuals' reproductive rights. To promote high quality and person-centred provision of SRH services, novel indicators that go beyond numeric goals and measures, and thus reflect individuals' and communities' priorities are needed. Increasingly, researchers are working to develop frameworks and indicators which would eventually allow to measure reproductive autonomy and quality of care (Senderowicz et al., 2023[98]).

Community involvement and sensitivity to local preferences and needs have been proven to be decisive for the success of family planning programmes. National governments in co-operation with development partners have been implementing family planning programmes for several decades, but not all have been successful. While the "intensity" of structural, social and legal barriers may partly explain regional differences in contraception use, modern contraception methods can be perceived as imported Western products that may not be trusted or are insensitive to local values and preferences (Cadena, Chaudhri and Scott, 2022[71]; Gautier et al., 2020[99]). Recent studies mention the collective memory of development partners promoting "the pill" in developing countries, as well as of medicinal experiments that were run in African countries during the colonial period, as a partial explanation of aversion towards certain contraception methods (Gautier et al., 2020[99]; Coulibaly, 2017[100]). In contrast, evidence reveals that family planning programmes that are integrated into existing health services, that are community-managed and sensitive to populations' needs, and transform discriminatory social norms in a cultural and local accepted way have been most effective while "imported" programmes failed to achieve their goals (Skinner et al., 2021[101]; Mwaikambo et al., 2011[102]). For instance, the Tupange programme in Kenya has been associated with a significant increase in modern contraception use. Family planning services were scaled up by integrating them into existing health services and working with national health staff and community groups. The programme further focused on improving the availability of services and commodities and enhancing the choice of methods (Keyonzo et al., 2015[103]).

Box 3.2. Infertility: An overlooked and underfunded area of sexual and reproductive health and rights

According to 2022 estimates, one in six persons has experienced infertility at some point in their life. The prevalence of lifetime infertility in high-income countries is similar to that in low- and middle-income countries, standing at 17.8% and 16.5% respectively. Some regional discrepancies persist. Lifetime infertility prevalence is estimated to be highest in the Western Pacific Region (23%) and lowest in the Eastern Mediterranean Region (11%) (WHO, 2023[104]). Although the share of women and men seeking fertility care is similar in developing and developed countries, only a small, privileged part of the concerned world population has access to the most technologically advanced treatments.

In contexts where women's identity and status are closely linked to motherhood and marriage, the negative consequences of infertility tend to be more severe. In developing countries, the central role children continue to play for a family's economic survival alongside traditional gender roles particularly exacerbates women's experience with infertility. Women who cannot have children risk being stigmatised and isolated by family and/or local communities, which can result in negative consequences on their physical integrity, mental health, marital relationship and socio-economic situation. For instance, a study from Gambia revealed persistent social pressure on women to have children. When unable to conform to the traditional gender roles, women have faced social stigma but also emotional and physical violence from their partner (Dierickx et al., 2018[105]; Greil, McQuillan and Slauson-Blevins, 2011[106]).

Patriarchal norms according to which infertility is a threat to masculinity can nurture the misconception that infertility is a woman's issue. Therefore, men may simply assume that there is "nothing wrong with them", thus not seeing the need to get tested or refusing to do so. While women may be blamed, stigmatised and held responsible for the situation, men's solution to infertility may be divorce or remarriage – or polygamy in settings where this is socially and legally tolerated (Mumtaz, Shahid and Levay, 2013[107]; Greil, McQuillan and Slauson-Blevins, 2011[106]).

Resource constraints, laws and intersectional discrimination create inequalities in access to infertility care within and between countries. Developed countries dispose of more resources to offer subsidised or free-of-charge fertility care, whereas developing countries may have to balance budget constraints and health priorities (Ombelet, 2011[108]). Differences in laws regulating assisted reproductive technology (ART) and third-party reproduction further create inequalities in access across and within countries. Single women's and female-female, trans and intersex couples' access to ART is disproportionately prohibited by the law. For instance, Norway only legalised single women's access to ART in 2020 and France in 2021 (Norwegian Health Care Service, 2023[109]; Government of France, 2022[110]).

Intersectional discrimination on the basis of, for example, gender, race, socio-economic status or education level creates inequalities in access to treatment – in terms of one's own capacity to afford it but also in terms of bias and discrimination from service providers. Data from the United Kingdom and the United States reveal that while service providers advise "[w]hite and affluent couples [to take up treatment], poorer women, non-native English speakers, and women of colour often find many barriers to receiving an official diagnosis of infertility – let alone treatment" (Royal College of Obstetricians and Gynaecologists, 2020[111]; Luna and Luker, 2013[5]). Overall, data at the country level reveal that higher levels of gender inequality[13] are associated with lower utilisation of ART such as in vitro fertilisation (Dyer et al., 2020[112]).

Access to safe and legal abortion – a fragile right?

Women's[14] right to safe and legal abortion is – beyond being a question of human rights – a question of life and death. Estimates show that every year more than 45% of abortions are unsafe (UNFPA, 2022[88]). This entails severe consequences for women's health and well-being especially in developing countries, where the quasi-totality of all unsafe abortions occurs (WHO, 2021[113]). It is estimated that unsafe abortions lead to 39 000 deaths per year, among which 60% are concentrated in Africa and 30% in Asia (WHO, 2022[114]). In fact, unsafe abortions are a leading but evitable cause of maternal mortality and morbidity (see above), and every year millions of girls and women are hospitalised following complications of unsafe abortion procedures. Unsafe abortions can further threaten girls' and women's mental health and socio-economic situation with negative spillover effects on communities and societies as a whole (WHO, 2021[113]; Bearak et al., 2020[115]).

Globally, 189 countries have signed the CEDAW which enshrines in Articles 12 and 16 (e) women's right to health, including their right to bodily autonomy and reproductive freedom (United Nations, 1979[116]). More specifically, CEDAW calls on countries to legalise abortion at least in cases of rape, incest, threats to the life or health of the pregnant woman and severe foetal impairment (CEDAW, 2022[117]). This is also reflected by regional frameworks such as the Maputo Protocol which protects African women's right to safe abortion "in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus" (African Union, 2003[118]). The 2022 guidelines of the World Health Organization (WHO) on the quality of abortion emphasise that "abortion care must be safe, timely, affordable, non-discriminatory and respectful", calling for the removal of restrictive policies and laws (WHO, 2022[119]).

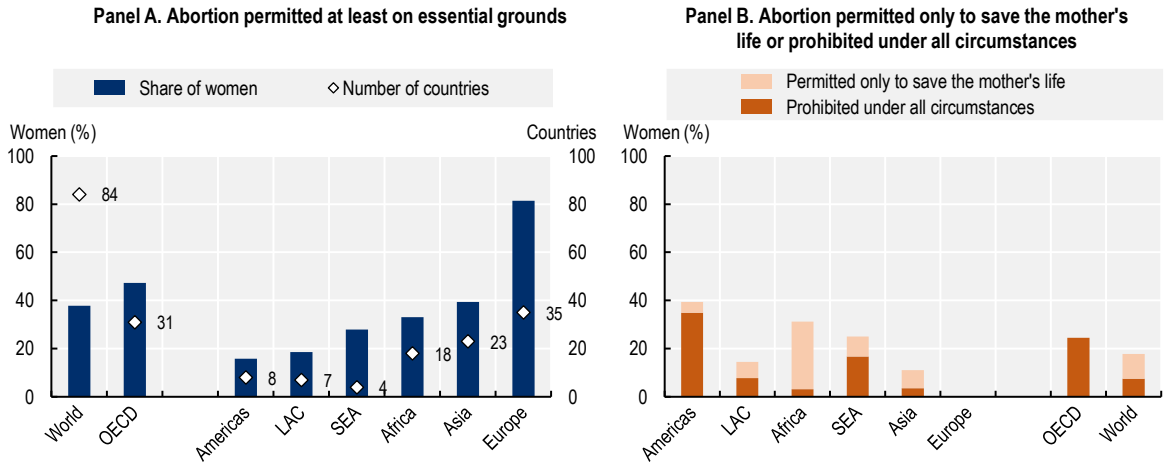
Restrictive laws are at the heart of unsafe abortions

The share of unsafe abortions is higher in countries with restrictive abortion laws. Data reveal that the share of unintended pregnancies resulting in induced abortion is similar across countries irrespective of the legal status of abortion (Bearak et al., 2020[115]). However, the share of unsafe abortions is significantly higher in countries with restrictive laws. According to the Guttmacher Institute, in countries with the least restrictive abortion laws, less than 1% of abortions are unsafe, contrasting sharply with 31% in countries with the most restrictive laws (Singh et al., 2018[120]). When carried out using a method appropriate to the pregnancy duration and assisted by an informed and skilled person, abortions are a safe healthcare intervention (WHO, 2022[114]). Yet, legal but also socio-economic and structural barriers unevenly restrict girls' and women's access to abortion care.

Access to safe and legal abortion is uneven across the world. Out of 178 countries covered by the fifth edition of the SIGI, 15 countries fully prohibit abortion without any exceptions, and 25 countries only permit abortion when it is necessary to save a woman's life.[15] This means that, worldwide, 142 million women of reproductive age do not have access to abortion under any circumstance and 193 million women of reproductive age only have access to abortion when their life is in danger (OECD Development Centre/OECD, 2023[22]). In contrast, in 47% of countries (84 out of 178) representing more than 710 million women of reproductive age, the law permits abortion at least on all essential grounds[16] or upon the woman's request[17] (Figure 3.5, Panel A). The data reveal regional discrepancies. While more than 80% of European women of reproductive age can legally and safely interrupt a pregnancy on essential grounds, this is the case for less than 40% of Asian women, for 33% of African women and only 16% of women living in the Americas.[18] This trend is reflected in the share of women living in countries that only permit abortion when essential to save the mother's life (Figure 3.5, Panel B).

Figure 3.5. Access to safe and legal abortion is out of reach for many women in Africa and the Americas

Share of women living in countries where abortion is permitted at least on essential grounds (Panel A) and where abortion is prohibited under all circumstances or permitted only to save the mother's life (Panel B)



Note: In Panel A, essential grounds include saving the woman's life, preserving the physical or mental health of the mother, if the pregnancy is the result of rape, statutory rape or incest, and the case of foetal impairment. In Panels A and B, LAC refers to Latin America and the Caribbean, and SEA refers to Southeast Asia.
Source: (OECD Development Centre/OECD, 2023[22]), "Gender, Institutions and Development (Edition 2023)", *OECD International Development Statistics* (database), https://doi.org/10.1787/33beb96e-en.

StatLink https://stat.link/jqevpi

Laws in many countries fall short of recognising the need to grant women the right to abortion for reasons other than those directly affecting the mother's (or foetus') life and health. According to SIGI data, in 83 countries worldwide and thus affecting more than 60% of women of reproductive age, abortion is not legally permitted in case of rape, statutory rape or incest. At a regional level, this translates into more than 80% of women living in the Americas, and about 60% of women living in Africa and Asia not having access to safe and legal abortion under these circumstances (OECD Development Centre/OECD, 2023[22]).[19] In some countries where the law is silent on rape and/or incest but where abortion is permitted to preserve the mother's physical and mental health, interrupting a pregnancy following rape or incest may thus be possible if justified for health reasons. However, this will always depend on a third party's opinion and interpretation of the law. As recommended by CEDAW, legally enshrining women's right to safe abortion following rape or incest is essential given the detrimental consequences such pregnancies can have, including, but not only, on their mental health and socio-economic situation (CEDAW, 2022[117]). Furthermore, legal thresholds such as penetration tests can create obstacles for survivors to seek justice and exercise their rights (see Chapter 2).

Third-party consent laws represent legal barriers regarding girls' and women's right to access safe abortion care. In most countries (65%, or 106 out of 163 countries) where abortion is legal, a medical practitioner must approve the procedure (OECD Development Centre/OECD, 2023[22]). For instance, in Thailand, a medical practitioner other than the professional who will perform the abortion must certify that the mental health of the pregnant woman is at risk if she seeks an abortion based on this reason (Government of Thailand, 1956[121]). In addition, third-party consent laws may require that the father provides his consent, which constitutes a high barrier in cases where the pregnancy is the result of non-consensual sex, but generally undermine women's agency and reproductive rights. Moreover, adolescents face barriers unique

to their age group, such as the need to have parental consent or the fact that parents have to be notified (Center for Reproductive Rights, 2022[122]). The WHO recognises that third-party authorisation requirements can create undue delays in accessing abortion services and exacerbate physical and mental health conditions for pregnant women who are seeking abortion services (WHO, 2012[123]).

Abortion rights are not set in stone. The 2022 United States Supreme Court's decision to overturn Roe v. Wade showed that women's reproductive rights can be restricted at any time (Center for Reproductive Rights, 2022[124]). Such legal rollbacks – which can come in many forms – not only affect women's access to safe abortion but can also include legal consequences for service providers. Despite the global attention paid to Roe v. Wade, more countries have recently curbed women's access to legal and safe abortion. Several countries have undertaken law reforms that expand women's access to abortion – often following year-long advocacy and activism led by civil society organisations. While some countries decriminalised abortion, others have expanded the circumstances based on which a woman can legally have an abortion or are taken measures to enshrine abortions rights in their constitution (see Box 3.3).

Box 3.3. Recent developments in reproductive rights

Across the world, several countries have undertaken law reforms to enhance women's access to safe and legal abortion. In contrast, a growing number of countries is curbing women's reproductive rights. For instance:

Law reforms restricting women's and girls' access to safe and legal abortion

- Honduras: In 2020, Honduras amended its Constitution to prohibit abortion outright, sending a strong signal as the law already prohibited abortion under any circumstances (Government of Honduras, 2020[125]).
- Hungary: While abortion has been legal since 1953,[20] Hungarian women are now subject to a mandatory ultrasound where they must listen to the foetus' heartbeat before they can have an abortion (Government of Hungary, 2022[126]).
- Poland: In 2020, Poland's Constitutional Tribunal ruled that abortions in cases of foetal impairment are unconstitutional, which translates into a near-total ban, as most abortions prior to the ruling were performed due to foetal abnormalities (Government of Poland, 2020[127]).
- United States: In 2022, the Supreme Court overturned the landmark ruling Roe v. Wade which constitutionally granted women's right to abortion. Since then, several states have reformed their laws to prohibit abortion or to restrict access to abortion, for instance by limiting the gestational limit (Government of the United States of America, 2021[128]).

Law reforms enhancing access to safe and legal abortion

- Argentina: The Voluntary Interruption of Pregnancy Bill was passed by the National Congress in December 2020 which liberalises and protects women's rights to access a safe and legal abortion until the fourteenth week of pregnancy. Prior to 2020, abortion was banned and criminalised unless it was to save the woman's life or the result of rape or incest (Government of Argentina, 2020[129]).
- Benin: The Law on Sexual and Reproductive Health was amended in 2021, granting women access to safe and legal abortion on all essential and socio-economic grounds until the twelfth week of pregnancy (Government of Benin, 2020[130]).
- Colombia: The recent ruling of the Constitutional Court of Colombia in 2022 decriminalised abortion in all cases up to 24 weeks of pregnancy. Beyond the gestational limit, abortion remains

legal when the pregnancy represents a risk to the health or life of the woman or is the result of rape (Government of Colombia, 2022[131]).

- France: In 2023, the Senate voted in favour to include women's right to voluntary termination of pregnancy in the Constitution, after the National Assembly had adopted the bill in 2022 (Government of France, 2023[132]).
- Gabon: Before 2021, abortion was illegal and criminalised. An amendment to the Penal Code of Gabon introduced for women the possibility of having an abortion when the mother's life is in danger, if the pregnancy is the result of rape or incest, or in the case of foetal impairment (Government of Gabon, 2020[133]).
- India: In 2021, the Indian Supreme Court ruled that different gestational limits based on marital status were unlawful. Previously, under the Medical Termination of Pregnancies Act (1971), married women could have abortions up to 24 weeks into their pregnancies, but single women were limited to 20 weeks (Government of India, 2022[134]).
- Kenya: In 2022, the High Court of Kenya ruled that "abortion care is a fundamental right under the Constitution and that arbitrary arrests and prosecution of patients and healthcare providers seeking or offering such services is illegal" (Government of Kenya, 2022[135]).
- Korea: In April 2019, South Korea's Constitutional Court ruled that the ban on abortion was unconstitutional and mandated the National Assembly to revise the law by 31 December 2020. In the absence of a legal revision, abortion in South Korea was decriminalised on 1 January 2021 (Government of Korea, 2019[136]).
- Mexico: In 2021, the Mexican Supreme Court ruled that penalising abortion is unconstitutional. Since then, several states have amended their laws to decriminalise and legalise abortion up to 12 weeks of pregnancy (Government of Mexico, 2021[137]).

A complex web of structural and social barriers limits women's access to safe abortion

Insufficient numbers of service providers and financial constraints restrict access to safe abortion care – particularly for rural and poor women. In 2019, Northern Ireland decriminalised abortion, but the provision of abortion services remained limited. To address this, the government amended the law in 2022, which now obliges the Northern Ireland Department of Health to commission and fund abortion services (Rough, 2023[138]; Government of the United Kingdom, 2022[139]). In Zambia, where abortion is legal on all grounds, an unknown number of women each year resort to unsafe procedures, as abortion care remains inaccessible. As the law stipulates that only a registered medical practitioner and not a nurse or midwife can perform an abortion, safe access is rendered out of reach for many and especially those living in rural areas where the doctor-per-person ratio[21] is lower than in urban settings (Ngoma, Masumo and Sianchapa, 2017[140]). Moreover, girls and women who are financially dependent or lack financial resources may not be able to access safe abortion services when these are expensive and/or not covered or subsidised by the public healthcare system.

Women's access to safe abortion can be restricted when service providers limit access to information or treatment based on personal beliefs. Conscientious objection refers to healthcare workers or service providers refusing to provide information on or carry out an abortion based on personal beliefs which may be often anchored in culture, religion or the fear of social stigma. In Italy, for example, where abortion is legal and free during the first 90 days of pregnancy, many women face difficulties in accessing abortion services, as medical staff refuse to carry them out. According to the Italian government, the phenomenon of conscientious objection concerned 65% of gynaecologists, 45% of anaesthesiologists and 36% of non-medical personnel in 2020 (Government of Italy, 2022[141]).

Social stigma can limit access to quality information. When relevant information is not easily accessible, misconceptions about the risks and safety of abortion procedures can prevail, disproportionately affecting

illiterate, rural and indigenous women and women with disabilities, among others and depending on context (National Partnership for Women & Families and Autistic Self Advocacy Network, 2021[142]). Moreover, many women tend to rely on informal sources of information based on anecdotal experiences of other women and community members. Resorting to informal but trusted sources can be fuelled by abortion stigma, which refers to "a shared understanding that abortion is morally wrong and/or socially unacceptable" (Makleff et al., 2019[143]). Evidence from India and Kenya (countries where abortion is legal on all essential grounds) reveals that many women considering abortion expect to be judged not only by community members but also by medical professionals (Makleff et al., 2019[143]).

Restrictive gender norms and social tolerance of GBV impede women's reproductive rights. In contexts where men are the socially designated decision makers, women may be reluctant to disclose an unintended pregnancy out of fear of their partner's reaction, interference or even abandonment – which can increase the number of unsafe abortions conducted in secrecy. For example, evidence from Tanzania and Côte d'Ivoire reveals that 19% and 33% of women respectively who had an abortion did so without the knowledge of their partner or spouse (OECD, 2022[83]; OECD, 2022[89]). A woman may also experience a violation of her rights when her partner or family forces her to have an abortion (Lo Forte, 2018[144]).

Conclusion and ways forward

Ensuring everyone's SRHR is a necessity from a health, human rights and gender equality perspective. Yet, numerous barriers prevent particularly adolescents' and women's ability to make choices about their own lives and optimal health outcomes. This in turn, undermines their ability to realise their sexual and reproductive rights. While some barriers such as the lack of quality healthcare infrastructure can be contingent on a country's resources, discriminatory social institutions undermine SRHR worldwide. Transforming restrictive laws, discriminatory attitudes and behaviours is thus crucial but takes time and is not necessarily a linear process. Key stakeholders should concert their efforts and work in close co-ordination to optimise the use of resources and create synergies across interlinked sectors such as health and education.

To counteract backlash movements on certain reproductive and sexual rights, development partners and philanthropic actors are in a powerful position to centre SRHR as a policy priority and support stakeholders promoting increased access to services and rights on the ground (OECD, 2022[145]). Precisely, policy makers at all administrative levels, in close co-operation with civil society and development partners should work to update or reform discriminatory laws, transform social norms and provide well-functioning healthcare systems that cater particularly to adolescents' and women's SRHR needs. The design and implementation of laws, policies or programmes should follow three guiding principles: (i) systematically adopt an intersectional approach; (ii) collect and use gender-disaggregated data to design targeted and evidence-based policies and programmes; (iii) engage boys and men by developing targeted interventions that permit them to reflect upon restrictive masculine norms and equip them with the tools and knowledge to reconstruct such rigid norms.

Policy recommendations to enhance sexual and reproductive health and rights

Enact or reform laws and policies

In line with international and regional legal frameworks, policy makers – in consultation with women's rights and civil society organisations focusing on SRHR – should reform laws and enact policies that legally enshrine the right and access to sexual and reproductive health.

- Bar legal provisions that mandate third-party consent to access contraceptives and that require women to obey their husbands.
- Stipulate free (or subsidised) access to all contraception methods in national action plans or relevant legal frameworks to ensure access and choice.
- Enact or reform laws that grant women access to safe and legal abortions in line with CEDAW.

Address discriminatory social norms

National ministries in charge of health and gender – in collaboration with development partners including bilateral agencies and multilateral organisations, foundations, national and international non-governmental organisations and grassroots organisations – should design and implement transformative social norms interventions. The following elements should be factored in:

- Closely work with traditional, religious and community leaders to co-create and implement interventions on gender-equitable decision making for family planning decisions.
- Leverage edutainment campaigns and national role models to promote gender-equitable masculinities and to engage men as allies for women's rights.
- Integrate modules on gender equality, power structures, and rights across all health and women empowerment programmes.
- Throughout interventions, systematically include activities and safe spaces for boys and men where they can reflect both alone and together with girls and women on prevailing gender norms and learn how to adopt more equitable attitudes and behaviours.
- Allocate budget for monitoring and evaluation to track if interventions are achieving their objectives. Prioritise interventions with concrete plans to achieve change that can be sustained over the long term, as transforming norms takes time and may not be linear.

Strengthen healthcare systems and service provision

National governments in charge of finance, development and health, in co-operation with development partners, should allocate sufficient budget to ensure everyone's access to high-quality healthcare within reach.

- Invest in health infrastructure to increase the number of healthcare facilities in remote and underserved areas and to improve the quality of existing facilities.
- Leverage innovative and alternative ways such as telemedicine to increase access to SRHR services. To account for inequities in access to technology, hybrid models where telemedicine is integrated with community accompaniment can help bridge such gaps and ensure consistent access to services as shown during the COVID-19 pandemic (UNFPA, 2021[146]).

- Allocate budget for capacity building and training of healthcare personnel, midwives and nurses to ensure high-quality services provision including prenatal care, child delivery, and family planning advice free of bias.
- In collaboration with grassroots organisations, raise awareness of the risks of unsafe abortions, and provide accurate information on abortion care providers (where legal).

Notes

[1] In accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (UNFPA, 2014[1]; UN Women, 1995[150]).

[2] In 2019, the International Conference on Population and Development renewed its commitments, focusing on achieving zero unmet needs for family planning information and services, zero preventable maternal deaths, and zero sexual and gender-based violence and other harmful practices (e.g. FGM/C, exploitation, trafficking) against women and girls (Nairobi Summit, 2019[147]).

[3] Paragraph 101, General Comment No. 12; and Paragraph 39, General Comment No. 20.

[4] Data are available for 144 countries (2019). In 34 countries, the law does not require parental consent for adolescents to access HIV testing. In 50 countries, parental consent is required for adolescents younger than 18 years; in 29 countries it is required for adolescents younger than 16 years and in 31 countries it is required for adolescents younger than 14 years.

[5] Data are available for 90 countries (2019). In 46 countries, the law does not require parental consent for adolescents to access contraceptives. In 26 countries, parental consent is required for adolescents younger than 18 years; in 6 countries, parental consent is required for adolescents younger than 16 years; in 9 countries, parental consent is required for adolescents younger than 14 years and in 9 countries parental consent is required for adolescents younger than 12 years.

[6] Paragraph 40, General Comment No. 20.

[7] SDG Target 3.2 on neonatal and child mortality states: “By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality to at least as low as 25 per 1 000 live births.”

[8] Afghanistan, Burundi, Central Africa Republic, Chad, Congo, Democratic Republic of the Congo, Haiti, Iraq, Somalia, South Sudan, Sudan, Syrian Arab Republic and Yemen.

[9] Afghanistan, Bangladesh, Cameroon, the Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Haiti, Kenya, Liberia, Madagascar, Malawi, Mali, Nigeria, Senegal, Sierra Leone, Somalia and Uganda.

[10] SDG indicator 5.6.1 “Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care”. Data is available for 64 countries, spanning the years 2007-21.

[11] SIGI data reveal that in 21 out of 178 countries, the law requires women to obey their husband. For 19 out of these 21 countries, data on unmet needs for family planning is available (2023 estimates, married or in-union women, modern methods of contraception only). Among the 157 countries where the law does not require women to obey their husband, data on unmet needs for family planning is available for 151 countries, resulting in a sample of 170 countries. The countries where women are required to obey their husband are the following (ordered by the increasing share of women with unmet needs): Egypt, Islamic Republic of Iran, Qatar, Mali, West Bank and Gaza Strip, Djibouti, Pakistan, Lebanon, Syrian Arab Republic, Iraq, Jordan, Saudi Arabia, Malaysia, Bahrain, Mauritania, Somalia, Equatorial Guinea, Yemen and Oman. The difference in average value of unmet family planning needs between countries where the law obliges women to obey their husbands versus those where this is not the case is statistically significant (p-value of 0.002).

[12] In Africa, 19 out of 54 countries with available data mandate for free or subsidised contraceptives in their national action plans. In the Americas, it is 14 out of 32 countries; in Asia it is 24 out of 55 countries and in Europe it is 17 out of 38 countries with available data.

[13] Levels of gender inequality are measured with the help of the UN Development Programme's Gender Inequality Index (GII), which "is a composite metric of gender inequality using three dimensions: reproductive health, empowerment and the labour market. A low GII value indicates low inequality between women and men, and vice-versa".

[14] While this chapter focuses on girls' and women's abortion rights, individuals who may not identify as women also need access to safe and legal abortion and related healthcare services.

[15] In the absence of a federal law on abortion, the SIGI Methodology relies on the most restrictive law that applies in any federal state.

[16] Essential grounds include that abortion is permitted (i) to save a woman's life, (ii) to preserve her mental and physical health, in the case of rape, statutory rape or incest, and (iii) in the case of foetal impairment.

[17] Abortion available at women's request means that women can have an abortion for any reason prior to the gestational limit defined by their country. While the most common gestational limit is 12 weeks, it varies across or sometimes even within countries (Center for Reproductive Rights, 2023[148]).

[18] The presented data refer to the share of women of reproductive age in each region. In Africa, abortion on essential grounds (all circumstances except for socioeconomic reasons) is legal in 17 out of 54 countries; in the Americas it is legal in 8 out of 32 countries; in Asia it is legal in 23 out of 55 countries and in Europe it is the case for 35 out of 38 countries (OECD Development Centre/OECD, 2023[22]).

[19] The SIGI 2023 legal database covers 178 countries. In 83 out of 178 countries abortion is not legally permitted in case of rape or incest. In Africa, this is the case for 28 out of 54 countries; in the Americas this is the case for 24 out of 32 countries; in Asia this is the case for 29 out of 55 countries and in Europe it is the case for 2 out of 38 countries.

[20] Abortion is legal upon request until 12 weeks of pregnancy and also beyond the gestational limit when interrupting the pregnancy is necessary to save the women's life or preserve her health.

[21] In 2021, Zambia had three practicing medical doctors per 10 000 inhabitants (WHO, 2021[149]).

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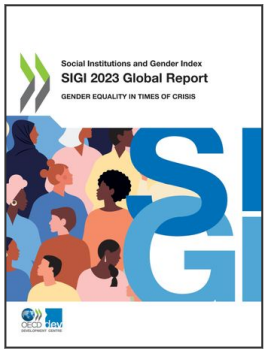

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