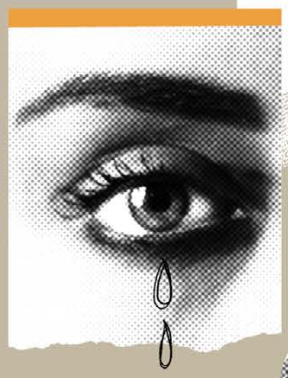
No Exceptions, No Exclusions

REALIZING SEXUAL AND REPRODUCTIVE HEALTH, RIGHTS AND JUSTICE FOR ALL



2021 Report of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up

ICPD25
The Nairobi Summit
Accelerating the Promise of ICPD

Report available at https://www.nairobisummiticpd.org/content/second-anniversary-nairobi-summit-icpd25

November 2021

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Acknowledgements

The Co-Chairs of the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up convey sincere gratitude to all Commissioners. Your contributions are invaluable, and we look forward to continuing this noble journey with you. We thank the Commission's Secretariat, under the leadership of Ms. Saskia Schellekens, Global Coordinator, ICPD25 Follow-up, and the author of the report, Ms. Gretchen Luchsinger, who prepared the text with the inputs of the Commissioners and in close coordination with the Secretariat. We extend appreciation as well to Avenir Health for developing the Global Commitments Monitoring Framework to track progress against key indicators for the global Nairobi commitments.

Finally, we make special mention of all those local, national, regional and global stakeholders who are hard at work implementing the Nairobi commitments, at times against very difficult odds. Many of your good practices and successes have been shared with us, even if only a few can be presented in this concise report. We firmly believe that every action contributes to making the ICPD Programme of Action a reality in people's lives. We thank you for all you have done and will continue to do.

Table of contents

Foreword

In late 2019, the *Nairobi Summit on ICPD25: Accelerating the Promise* reignited global commitment to sexual and reproductive health and rights. People from around the world affirmed that we must finish realizing the promises of the landmark 1994 International Conference on Population and Development. We can no longer wait to make rights and choices a reality for *all*.

At the Summit, more than 8,300 participants from 170 countries and territories made over 1,300 commitments to mobilize action. The Nairobi Statement captured the moment with 12 global overarching commitments to complete the ICPD agenda.

The High-Level Commission on the Nairobi Summit on ICPD25 Follow-up subsequently emerged to track progress. A fully independent advisory body, it links accomplished individuals from different backgrounds, experiences and perspectives, from all over the world. The commission reports annually on steps forward and back, making recommendations to spur continued momentum.

As the Co-Chairs of the Commission, we are honoured by the profound responsibility entrusted to us. When we began our work in late 2020, Dr. Natalia Kanem, the Executive Director of UNFPA, the United Nations Population Fund, stressed, "The High-Level Commission is needed now more than ever – to keep forging ahead, to make sure that promises made are promises kept."

These are words that we take deeply to heart. In its first year, the Commission has met four times. It also established three working groups around issues central to the commitments: achieving zero preventable maternal deaths, zero unmet need for family planning and zero gender-based violence and harmful practices. Ongoing, honest and deeply enriching conversations have touched on all elements of advancing sexual and reproductive health and rights for all, culminating in this report.

After careful consideration of events over the past year, this report makes a case for sexual and reproductive justice built on deliberate, comprehensive actions to achieve human rights and development for everyone. Too many gaps remain in the ICPD goals, with dire consequences for individuals and families, for human rights and for human development. The Commission finds that the COVID-19 pandemic illuminated many existing and deeply disturbing disparities in sexual and reproductive health and rights. The crisis also made many inequalities worse, a process driven by deep-rooted discrimination and regressive forces that used the pandemic to roll back rights protections that are fundamental to bodily autonomy.

The news is not all bad. We can also point to new and promising ways of providing services, leaps forward in legislation and stepped-up accountability for realizing the Nairobi commitments both internationally and in individual countries. Most promising, all over the world, people, especially the members of the next generation, are taking up the call for rights, justice and development that is fair and sustainable. Joining all those who have made and now are acting on the Nairobi commitments, they know we are connected by our common humanity and life on a shared planet. Issues of sexual and reproductive health and rights are central to our ability to survive, thrive and remain resilient to risks.

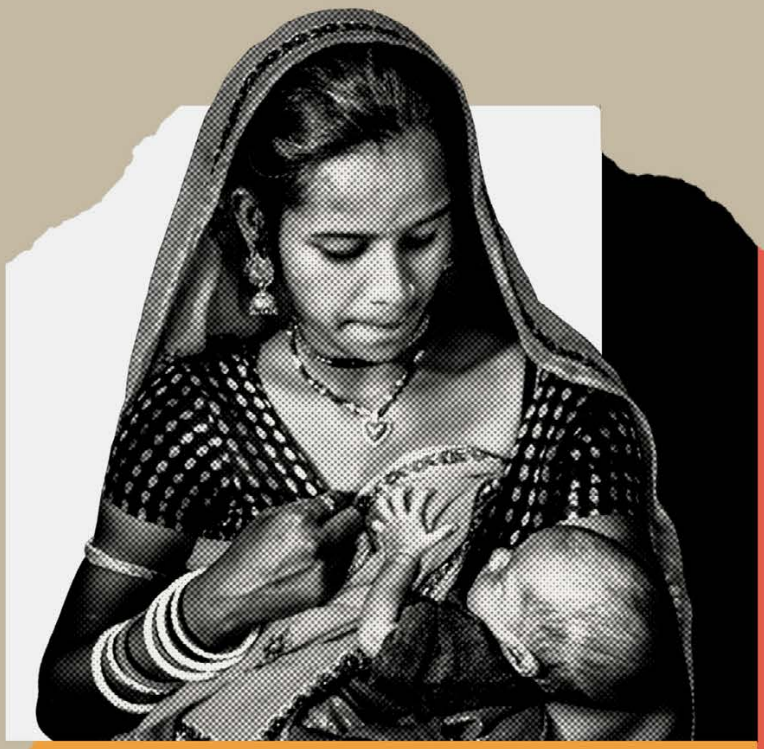
We present this report with the belief that it is bold, fresh and forward-looking. It speaks to diverse settings in the Global South and North, to countries small and large, to nations that are developing and to people caught in humanitarian crises. We hope it provokes thought and action. And that it reminds everyone of how many of us are pulling together to carry and share the torch of Nairobi, on the march to a future where rights and choices are no longer denied.

Jakaya Mrisho Kikwete

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

Michaëlle Jean

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



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Executive Summary

Executive summary

In late 2019, over 8,300 people from 172 countries and territories gathered at the Nairobi Summit on ICPD25. Together, they celebrated the twenty-fifth anniversary of the landmark Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo. Participants from governments, civil society, businesses and more presented over 1,300 commitments to action. These were accompanied by widespread endorsement of the Nairobi Statement, which defines 12 overarching global commitments to achieve the ICPD goals for everyone, everywhere.

To guide and propel meaningful follow-up on the commitments, the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up was formed. Each year, it will submit a public report on gains and gaps to the United Nations Population Fund, UNFPA.

This report is the Commission's first. It stresses that progress has been made on some Nairobi commitments, even amid the devastating fallout from the COVID-19 pandemic over the past two years. But on balance, governments and the international community have fallen short. Moral and political failure has been evident in eroding services, lost financing and diminishing political accountability for sexual and reproductive health and rights.

The Commission emphasizes that if the realization of sexual and reproductive rights is incomplete, people will not gain the agency to make their own empowered decisions about their bodies and the rest of their lives. This in turn will impede the development of societies overall. Amid continued evidence of the denial of sexual and reproductive rights, the Commission calls for a global agenda for sexual and reproductive justice that requires deliberately overcoming all barriers to realizing rights and achieving bodily autonomy. The Commission emphasizes that this depends on specific, tailored and prioritized interventions for individuals and groups facing multiple, intersecting forms of discrimination.

The profound inequality of the current world underscores the urgency of sexual and reproductive justice and accelerated achievement of the Nairobi commitments. The Commission finds that patterns of injustice undercut human resilience and well-being for everyone, and that the COVID-19 pandemic has exacerbated disparities based on gender, race, age, disability and other parameters. The redirection of services and funding from humanitarian settings is a grave concern, diminishing already insufficient support for sexual and reproductive health and rights and gender equality.

The Commission also sees the COVID-19 pandemic as revealing the consequences of the failure to strengthen health systems, make them resilient and universally accessible, and treat comprehensive sexual and reproductive health and rights as essential elements, in line with the Nairobi commitments. At the same time, the pandemic has ushered in new

ways of delivering care that can improve quality and access. A new era of sexual and reproductive health programmes should build on the self-expressed needs and wants of distinct population groups, operating under a framework of delivering rights and justice for all.

Full recovery from the pandemic depends on domestic and international financing that sets health systems on the path to universal health coverage in line with the Nairobi commitments. The Commission is concerned that while countries have made recent commitments to expanding the reach of essential health-care services, no substantial change is apparent in allocations of additional funds. With some international donors making radical and unjustifiable cuts, the Commission strongly warns against such reversals and calls for safeguards against choices rooted in gender discriminatory agendas.

Above all, the Commission underlines that the world cannot wait for sexual and reproductive justice. It welcomes people's movements demanding justice and human rights and believes they should be encouraged and supported as drivers of action and accountability. This is particularly needed at a moment of continued and even intensifying backlash by regressive ideologies. The Commission appreciates

Make sexual and reproductive justice the goal

Conduct all work on sexual and reproductive health and rights under a justice framework. This must consider human rights and fundamental freedoms as universal, indivisible, interdependent and interrelated. It includes establishing and using mechanisms for accountability, investing in people's movements to claim sexual and reproductive justice, and strengthening and forging new alliances. Closer engagement with parliamentarians should advance laws and budget choices in line with achieving sexual and reproductive justice and gender equality.

Put rights and development at the core

Develop universal health coverage with comprehensive sexual and reproductive health and rights as essential services. The COVID-19 recovery should be used to jumpstart universal health coverage, including through scaled-up support for midwives as a proven investment. Listening to health-care users will help uphold their rights and improve the quality of care.

Think differently

Pursue recent innovations in health-care service delivery to accelerate sexual and reproductive justice and support people's agency and bodily autonomy. One starting point is to develop the potential of self-managed care, which can be particularly helpful in reaching some marginalized groups. Another is to pursue digital innovations while tackling the digital divide.

those countries that are marshalling political will and establishing national mechanisms to steer progress on the Nairobi commitments.

It is also encouraged by increasing use of the commitments in global accountability mechanisms, such as the Universal Periodic Review of the Human Rights Council. This accords with the spirit of the Nairobi Summit, which demonstrated the immense value of global solidarity and set in motion a more rigorous architecture for accountability, built on many allies working together to push sexual and reproductive justice forward.

The Commission sees agency and bodily autonomy as what most people want and what all people deserve. Everyone being able to exercise these, freely and on their own terms, will determine the resilience, development and even survival of individuals and nations. Accordingly, the Commission makes several recommendations to further the Nairobi commitments and set the stage for realizing sexual and reproductive justice.

In sum, the Commission maintains that closing inequalities and gender gaps, sustaining resilience in the face of crisis, and making successful links between development and demographics will depend on realizing agency and bodily autonomy for all. The surest route forward is through sexual and reproductive justice.

Reach further

Prioritize groups facing the worst disparities in sexual and reproductive justice. Closing gaps in humanitarian action is one urgent priority, coupled with more emphasis on reducing risks to sexual and reproductive health and rights in forward-looking disaster risk reduction and management plans. More outreach to youth, particularly adolescents and stigmatized young people with diverse sexual orientations and gender identities, upholds their right to be meaningfully involved in public policymaking that influences their health and well-being.

Show the money

Increase domestic and international finance for sexual and reproductive health and rights at levels sufficient to achieve sexual and reproductive justice. Expenditure must be visible and measurable in national health budgets and accounting for donor contributions. No-cost comprehensive services for sexual and reproductive health and rights should be introduced. Other priorities are to explore new avenues for finance and alliances with new partners beyond the health sector.

Tell a new story

Create new narratives around sexual and reproductive justice that are accurate and powerful enough to counter ongoing opposition. This calls for developing more robust systems to collect and use data on critical aspects of sexual and reproductive health and rights, gender equality and intersectionality. Towards galvanizing broader support, making sexual and reproductive justice a rallying cry will instil new energy and inspire action.


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Introduction

In late 2019, over 8,300 people from 172 countries and territories gathered at the Nairobi Summit.[1] Together, they celebrated the twenty-fifth anniversary of the landmark Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo. Energized by the exchange and inspired by a common purpose, they committed to accelerating the realization of historic promises to put people at the centre of sustainable development. They vowed to uphold rights and choices for all.

Before the Summit, national, regional and global assessments considered gains and gaps since the ICPD and galvanized momentum. At the Summit, participants from governments, civil society, businesses and more presented over 1,300 commitments to action. These were accompanied by widespread endorsement of the Nairobi Statement, which defines 12 core global commitments to achieve the ICPD goals for everyone, everywhere.

The Nairobi Statement calls for a periodic review of progress. Towards that end, an independent advisory body was formed, linking the diverse constituencies who attended the Summit. Known as the High-Level Commission on the Nairobi Summit on ICPD25 Follow-up, it is charged with submitting a public report each year to the United Nations Population Fund, UNFPA, and providing guidance and political backing to propel meaningful follow-up. The 27-member Commission includes government leaders, academics and researchers, civil society and women's rights activists, human rights advocates, businesspeople, foundation representatives, parliamentarians and youth leaders from around the world.

This report is the Commission's first. In it, members have agreed that progress has been made on some Nairobi commitments.[2] But on balance, governments and the international community have fallen short. Moral and political failure has been evident in eroding services, lost financing and diminishing political accountability for sexual and reproductive health and rights.

These tendencies were all in play before the COVID-19 pandemic. But the global crisis worsened them and deepened inequalities and disparities in rights. The consequences have been profound. Unplanned pregnancies have increased. So have child marriages and deaths in childbirth. Gender-based violence became known as the "shadow" pandemic.

The Commission intends this report to be a fearless call to return to meaningful follow-up on the Nairobi commitments – immediately. It urges ambitious action to end shortfalls

in sexual and reproductive health and rights that cost lives, destroy health and slow development around the world. It reminds everyone that there are no excuses for delaying advances on norms and standards that have been internationally agreed and broadly accepted.

For the Commission, sexual and reproductive health and rights are integral to an agenda for justice and development that is universal in its reach. This agenda must be reflected in how people think and act, with political and community leaders setting examples and remaining accountable for progress. The agenda should be centrally embedded in health systems that achieve universal coverage and are resilient to crises now and looking forward. It must be upheld in laws, and advocated for and financed as integral to realizing the 2030 Agenda for Sustainable Development as well as longstanding legal guarantees of human rights, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

What's in this report

In 2021, the Commission met at several points to take stock of the 12 global Nairobi commitments. It settled on five key issues explored in five chapters of this report. Commission members discussed and fully endorsed these before presenting the report to the Executive Director of UNFPA, the United Nations Population Fund, as the global custodian of the ICPD Programme of Action and its follow-up.

Chapter 1 highlights sexual and reproductive rights as a basic prerequisite for achieving the commitments. The Commission points to the fragility of rights, which remain far out of reach for many people, and argues for a comprehensive agenda for sexual and reproductive justice. This must be grounded in actively realizing rights and removing the many barriers to them – in health systems, families and societies more broadly. Progress in claiming rights depends fundamentally on people having the agency to make choices about their bodies and enjoy bodily autonomy.

Chapter 2 dives into inequalities exacerbated by COVID-19, including those that stem from discrimination based on gender, race, ethnicity, age, disability or other factors, and those that are linked to displacement and humanitarian crises. If the world is serious about leaving no one behind, in the spirit of the 2030 Agenda for Sustainable Development and the Nairobi Statement, the Commission urges tackling these inequalities without further delay.

In **Chapter 3**, the Commission considers constraints on quality, accessible sexual and reproductive health care due to the pandemic that have undermined or delayed progress on the 12 commitments. At the same time, it highlights innovations born out of necessity that have kept services going and even offered new models that can be more widely replicated.

In **Chapter 4**, the Commission takes up the financing of the ICPD agenda and the financial commitments, both domestic and international, reflected in the Nairobi Statement. It calls attention to concerning and, at times, politically motivated choices to defund sexual and reproductive health and rights.

Building on earlier chapters, **Chapter** 5 looks at forces propelling and pushing back against

Countries gear up to meet their commitments

Action to achieve and ensure accountability for the Nairobi commitments is ramping up in international forums such as the Universal Periodic Review of the Human Rights Council, through the establishment of regional and subregional tracking mechanisms, and in individual countries. In 2020, among the developing countries tracked by UNFPA, at least 34 created national action plans to implement their national Nairobi commitments, integrated commitments into national or sector policies and/or developed systems to monitor progress.

These countries include Angola, Argentina, Burkina Faso, Cameroon, Colombia, Congo, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Dominican Republic, Ecuador, Egypt, Ghana, Haiti, Iraq, Kazakhstan, Kenya, Madagascar, Mauritania, Mexico, Nigeria, Pakistan, Paraguay, Philippines, Rwanda, Senegal, South Africa, South Sudan, Tunisia, Turkey, Turkmenistan, Uganda, United Republic of Tanzania and Viet Nam.

advances on the Nairobi commitments, and the levels of accountability that will keep progress on track towards sexual and reproductive justice.

A final chapter sketches the Commission's Call for Action for all relevant partners, including governments, civil society, the private sector, academia, the United Nations and other international bodies. By joining forces, they can accelerate action and ensure accountability for sexual and reproductive health and rights, for justice and development, in line with the Nairobi Statement, the ICPD Programme of Action and the 2030 Agenda for Sustainable Development.

Annex A summarizes key global indicators for the global commitments in the Nairobi Statement and presents their current status, globally and regionally, using the most recent available data. The framework presented will offer an opportunity to assess progress against the identified indicators in the coming years as the Commission advances its work.

The Nairobi Statement: 12 Global Commitments

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

In that context, we will:

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

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

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

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

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

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

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

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

6 NAIROBI GLOBAL COMMITMENT

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

7 NAIROBI GLOBAL COMMITMENT

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

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

8 NAIROBI GLOBAL COMMITMENT

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

9 NAIROBI GLOBAL COMMITMENT

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

10 NAIROBI GLOBAL COMMITMENT

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

11 NAIROBI GLOBAL COMMITMENT

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

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

12 NAIROBI GLOBAL COMMITMENT

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


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1 RIGHTS, BODILY AUTONOMY AND THE POWER OF AGENCY

Human well-being depends, fundamentally, on upholding sexual and reproductive rights. This applies to everyone, without exception. Yet the link, while often made, remains contested. The impetus persists to subtract rights from the equation altogether – or leave sexual rights behind.

The Commission contends that if sexual and reproductive rights are incomplete, people will not gain the agency to make their own empowered decisions about their bodies and the rest of their lives. Countries will fall short on the three "zeros" endorsed in the Nairobi Statement and at the heart of its 12 commitments, namely: zero unmet need for family planning, zero preventable maternal deaths, and zero sexual and gender-based violence and harmful practices. The 2030 Agenda for Sustainable Development will remain unfinished.

Upholding or denying sexual and reproductive rights determines whether a pregnant woman lives or dies giving birth, whether a teenager avoids an unwanted pregnancy that derails her education, or whether people with diverse gender identities can find safe, respectful and affirmative health

KEY MESSAGES

- If the realization of sexual and reproductive rights is incomplete, people will not gain the agency to make their own empowered decisions about their bodies and the rest of their lives.
- In line with the Nairobi Statement, a strong, consistent commitment to sexual and reproductive rights must be clearly embedded in laws, across practices in health systems and more broadly in social norms.
- Amid continued evidence of the denial of sexual and reproductive rights, the Commission calls for a global agenda for sexual and reproductive justice, premised on justice as integral to achieving development.
- Sexual and reproductive justice requires deliberately overcoming all barriers that people face in realizing their rights and achieving bodily autonomy. It calls for specific, tailored and prioritized interventions for individuals and groups facing multiple, intersecting forms of discrimination, shaped by what they define as their needs and choices.

care. People who realize these rights enjoy greater well-being and improve their chances of becoming productive members of their communities. They are in a stronger position to exercise choices and claim rights in all areas of life, from workplaces to political arenas and beyond. They become part of stronger, more inclusive and just societies that distribute development gains equitably across all places and groups of people.

The Commission decries upfront how the COVID-19 pandemic has affirmed, once again, that it remains easy to set aside sexual and reproductive health and rights in favour of other priorities. Similar issues are perpetually at work in humanitarian crises, in poor communities, for excluded people around the world, and on issues such as abortion and services for adolescents. During the pandemic, sexual and reproductive health and rights were often sacrificed as health systems struggled to keep up with the virus. Even more concerning was that political opposition from diverse sources, including movements, parties and governments with natalist and gender discriminatory ideologies, successfully sought openings to further disrupt comprehensive sexual and reproductive health services.

Sexual and reproductive health and rights should be a priority in pandemic recovery and beyond, in line with the 12 Nairobi commitments.

While there is no question that fallout from the pandemic has been profound, imposing severe pressures on health systems and entire societies and economies, the Commission does not accept this as a rationale for diminishing guarantees of sexual and reproductive health and rights. These rights should in fact be a priority in recovery and beyond, in line with the 12 Nairobi commitments.

Rights remain fragile

The Commission finds that challenges to sexual and reproductive health and rights operate persistently at multiple levels, in clinical care, in health systems and in social determinants of health, such as education and patterns of racism and discrimination. A single statistic tells the story of how far the world still must go in realizing these rights. Based on data from 57 countries, only 55 per cent of women make their own decisions on three issues central to sexual and reproductive rights and bodily autonomy: sexual intercourse, contraceptive use and access to health care.[3]

The denial of bodily autonomy and sexual and reproductive rights was evident from the start of the pandemic. One account found traumatic incidents in 45 countries that defied World Health Organization (WHO) guidelines, such as Caesarean sections performed without consent to speed up labour. Pregnant women died where COVID-19 restrictions prevented or delayed access to emergency services.[4]

Shortfalls in upholding rights are often blatant. Around 21 per cent of countries where laws protect access to contraceptive services still require third-party authorization for contraceptive use, for instance.[5] The quality of services may be dramatically lower in poor rural areas where more women die

Sobering indications of slow progress

The global commitments monitoring framework in Annex A shows that the world is still far from achieving the ICPD Programme of Action and the Nairobi commitments. Global commitment 1 is a composite of indicators under all other commitments. Strikingly, no region has advanced ICPD implementation enough to score a passing grade, or green light, in the framework's traffic light system. While Europe and North America, and Eastern and South-Eastern Asia are most advanced, scoring at least a yellow traffic light, Central and South Asia, Latin America and the Caribbean, and Northern Africa and Western Asia, as their orange scores reflect, remain behind. Sub-Saharan Africa has the lowest (red-light) scores overall, even though it is the region with the most urgent needs.

giving birth. Health services may be obligated to provide care to transgender people but in practice deny it, with impunity. Other insidious markers of imbalances in power and rights arise when women must justify choices about their body with "acceptable" health-related reasons rather than those based solely on their own preferences. This keeps control over women's bodies in the medical or legal realm.

When the What Women Want campaign on reproductive and maternal health care surveyed 1.2 million women and girls in 114 countries, it found that the top request was for more respectful and dignified care,[6] a finding indicating that care generally is not in line with autonomy and rights.[7] Evidence suggests the prevalence of care that is either "too little, too late" or "too much, too soon" in pregnancy and birth, for example.[8] Some practices may be packaged as "life-saving", but in reality fail to fully consider women's wishes and right to bodily autonomy.

In line with the Nairobi Statement, the Commission stresses that a strong, consistent commitment to sexual and reproductive rights must be clearly embedded in laws, across practices in health systems and more broadly in social norms. Otherwise, bodily autonomy, choices and rights are perpetually at risk. Coercive measures such as those used for population control, despite copious evidence that they are ineffective, become more palatable and justifiable. Systemic biases and histories of coercion, including those linked to race and gender identity, become easier to sustain.

Setting a new framework: Sexual and reproductive justice

Given many longstanding shortfalls in sexual and reproductive health and rights, and towards achieving the 12 Nairobi commitments, the Commission believes that now is the time for a global agenda for sexual and reproductive justice. Such an agenda is premised on justice as integral to achieving development. It recognizes that development itself is both a right and a manifestation of justice.

Putting health and rights under a justice framework goes beyond describing rights to

Defending the defenders

Human rights are under threat and so are the people who defend them, often in ways that cut along the lines of gender. In 2019, Fátima Mimbire, a woman human rights defender in Mozambique, received death threats and other intimidating messages on social media, including a Facebook message from a Member of Parliament calling for her to be raped by 10 strong and energetic men to teach her a lesson.

The same year, during a hearing on human rights in connection with the Universal Periodic Review of the Human Rights Council, Lilit Martirosyan – a transgender woman human rights defender and president of the human rights organization Right Side – addressed the Parliament of Armenia. After she highlighted attacks against lesbian, gay, bisexual, transgender and intersex persons, a Member of Parliament called for her to be burned alive.

Such cases underscore the powerful pushback against gender equality and sexual and reproductive rights. In 2021, the Special Rapporteur on the situation of human rights defenders, Mary Lawlor, reiterated that all States have an obligation to ensure that no human rights defenders are killed for their work. She said States should pass and enforce laws and develop gender-sensitive protection mechanisms for human rights defenders. She placed specific emphasis on defenders from vulnerable groups, including women and transgender human rights defenders, and defenders advocating for lesbian, gay, bisexual, transgender and intersex rights.

Source: Human Rights Council, 2021a.

actively achieving them, including through systematically monitoring and correcting disparities. It requires deliberately overcoming systemic barriers people face in realizing rights and achieving bodily autonomy, over their lifetimes. These barriers may include a lack of health services, but also gender, sexual and racial discrimination, inequalities that trap people in poverty, and social and political marginalization.

Sexual and reproductive justice acknowledges that different forms of discrimination may intersect and compound each other. As a result, cumulative injustices may be greater for some individuals and groups; solutions to these can require specific, tailored and prioritized interventions aligned with human rights. The Commission feels strongly that such measures should be shaped by what people themselves define as their needs and choices. They should be grounded in the recognition that individuals have the right to make decisions amid conditions conducive to implementing them.[9]

Towards autonomy and justice: norms, universal care and voice

The Commission agrees that achieving sexual and reproductive justice hinges on challenging and eliminating discriminatory social norms that constrain bodily autonomy, agency and rights. Such norms define stigmas about what kind of person seeks contraception or an abortion, for example, or whether domestic violence is prevented or tolerated. Norms are filtered through laws and political choices and reflected in health-care institutions and practices.

An agenda for sexual and reproductive justice can make a more forceful case for abolishing discriminatory norms, wherever they arise and however they manifest. It can reframe issues and the policy decisions that emerge from them. Where abortion is legal and safe, for instance, maternal deaths tend to drop remarkably, with no increase in abortions. Conversely, where abortion is criminalized, it goes underground with more lethal consequences. Reducing maternal mortality is therefore not just about better delivery of services but also about upholding women's bodily autonomy and decision-making. At the Nairobi Summit, Argentina, Bolivia, Eritrea, Mexico, Nepal and the Republic of North Macedonia committed to eradicating maternal mortality caused by unsafe abortion, which the Commission sees as a positive step that other countries should follow.

Under an agenda for sexual and reproductive justice, the Commission calls attention to how an explicit focus on bodily autonomy can directly advance gender equality, in line with the rights of women and girls and as an underpinning of sustainable development.

What do we mean by rights and bodily autonomy?

Realizing sexual and reproductive rights is grounded in the human rights of all individuals to have their bodily integrity, privacy and personal autonomy respected. They must be able to freely define their sexuality, including sexual orientation and gender expression and identity; to decide when and if to have sex and with whom; to have safe and pleasurable sexual experiences; and to make their own choices about marriage and children. These rights depend on access to and choices in high-quality services and information, tailored to different stages of life, and free from discrimination, coercion and violence.[10]

Bodily autonomy means having the power and agency to make choices over one's body and future, without violence or coercion. It implies having the resources needed to carry out these choices. Bodily autonomy is upheld when individuals can decide whether to have sex, with whom and when, and whether or with whom to become pregnant. It encompasses the freedom to choose to go to a doctor or other health-care provider.

Sources: UNFPA, 2021g; Positive Women's Network, n.d.

A call to redefine sexuality in public policy

In 2021, the Special Rapporteur on the right of everyone to the enjoyment of the highest available standard of physical and mental health, Tlaleng Mofokeng, called on the Human Rights Council to recommend that public policy reflect a notion of sexuality beyond the ability to reproduce. She stressed that achieving sexual health and well-being depends on comprehensive, good-quality information about sex and sexuality; knowledge about the risks the concerned individuals may face and their vulnerability to adverse consequences of unprotected sexual activity; ability to access sexual health care; and living in an environment that affirms and promotes sexual health. Only if these elements are in place can countries and the world ensure that no one is left behind.

Source: Human Rights Council, 2021b.

This focus can also support an expanded recognition of rights violations that persist, often invisibly, among the most marginalized groups. Highlighting commonalities between female genital mutilation and genital mutilation conducted on intersex people, for example, could build on the former, a more widely understood and addressed assault on bodily autonomy, to galvanize action on the latter. Achieving bodily autonomy would require broadening sexual and reproductive health care to encompass facets such as access to contraception and pregnancy services for transgender people.

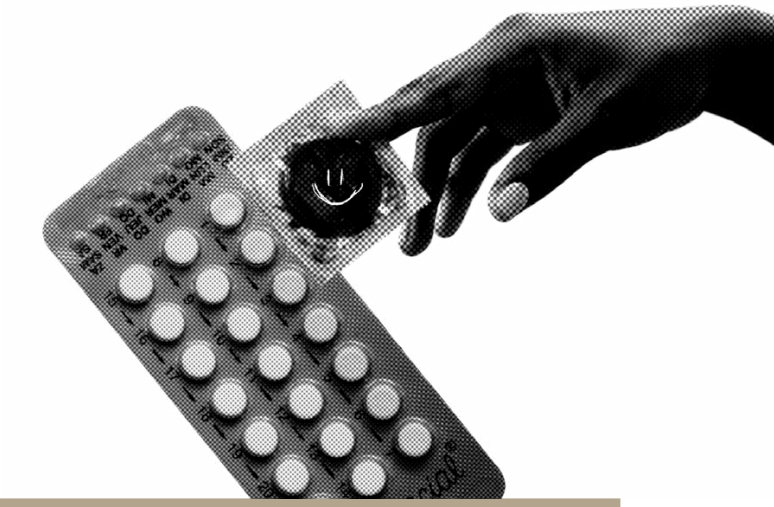
If sexual and reproductive rights are incomplete, people will not gain the agency to make their own empowered decisions about their bodies and the rest of their lives.

The Commission explicitly links sexual and reproductive justice to universal health coverage, a promise made in the 12 commitments as well as the Sustainable Development Goals. Universal health coverage is vital to human well-being and inclusive development more broadly. But its promise can only be achieved by integrating sexual and reproductive health and rights across health systems, as agreed in the 2019 UN high-level meeting on universal health coverage.[11]

Finally, the Commission uses its voice to call for listening to other voices, in all their diversity. Sexual and reproductive justice

depends on hearing women, adolescents and youth, people with diverse gender and other identities, and all those who remain furthest from realizing their rights. They must have clearer and more influential inputs into how health care can meet their needs and uphold their rights, and what sexual and reproductive justice looks like. At the Nairobi Summit, young delegates pressed for "nothing about us, without us." The 12 commitments affirm that decisions on all issues related to young people's health and well-being require their meaningful involvement and participation.

One current arena for greater voice could be COVID-19 task forces set up by countries to recover from the pandemic. The Commission maintains that equal participation of men and women, women's leadership and a clear gender mainstreaming mandate would make recovery efforts more inclusive and effective. Yet a review of 137 of these bodies found that only 8 have gender parity in their membership; 26 have no women at all.[12]



Argentina achieves a landmark law, but not without contradictions in fulfilling rights

In December 2020, after years of protests and campaigning by women's rights groups, Argentina became the largest Latin American country to legalize abortion without restriction in the first trimester. Earlier, in 2010, it was the first country in its region to approve same-sex marriage, a step followed in 2012 by the adoption of one of the world's most progressive gender identity laws. The abortion law was largely attributed to a massive feminist movement working with a critical mass of women who now sit in Parliament, in the wake of a law requiring gender parity among legislators.

Yet in a sign of how sexual and reproductive justice, while moving forward, remains incomplete, a 2006 law still allows doctors to sterilize women who are declared legally incompetent, based on the request of a family member or legal guardian. This is a blatant violation of bodily autonomy. It contradicts Argentina's signature of the United Nations Convention on the Rights of Persons with Disabilities, which specifies that the will of a person with disabilities cannot be taken away.

Sources: Politi and Londoño, 2021; Pellettieri, 2021.

2 COVID-19 REVEALED AND SHARPENED INEQUALITIES

The Commission argues that the profound inequality of the current world underscores the urgency of its call for sexual and reproductive justice and accelerated achievement of the Nairobi commitments. The three zeros explicitly depend on rights and justice in all circumstances for everyone. The Nairobi commitments also call for building peaceful, just and inclusive societies that leave no one behind.

This vision is achievable but requires a sharp U-turn in current patterns of development, which are not just, not sustainable and not inclusive. More than 70 per cent of the world's people now live amid rising income and wealth inequality.[13] The wealth of billionaires skyrocketed by over $3.9 trillion between March and December 2020, yet 4 billion people went with no safety net, lacking any form of basic social protection.[14] On health indicators, the global preventable maternal mortality rate remains stubbornly high, at more than 10 times the global target;[15] 94 per cent of deaths occur among poor women in low-income countries.[16]

KEY MESSAGES

- The profound inequality of the current world underscores the urgency of sexual and reproductive justice and accelerated achievement of the Nairobi commitments.
- Patterns of injustice undercut human resilience and well-being for everyone. Reversing such practices and restoring greater cooperation and trust will be the only way to successfully respond to the even more difficult global crises on the horizon.
- COVID-19 has exacerbated disparities based on gender, race, age, disability and other parameters. For many groups, different forms of discrimination intersect, amplifying abuses against them.
- The redirection of services and funding from humanitarian settings as attention shifted to the pandemic is a grave concern, diminishing already insufficient support for sexual and reproductive health and rights and gender equality.

For many people, digital technology became a way to cope with lockdowns and restrictions during the pandemic, but the digital divide remains unbridgeable for many more, consigning them to lost opportunities for livelihoods and education. Globally, 3.7 billion people are not online; the majority are women and girls.[17] Only 15 per cent of women in the least developed countries used the Internet in 2019, compared to 86 per cent of women in the more developed world.[18]

The Commission expresses its strong moral concern about COVID-19 vaccine hoarding and gross imbalances in access as a disturbing indicator of patterns of injustice that undercut human resilience and well-being for everyone. Reversing such practices and restoring greater cooperation and trust will be the only way to successfully respond to the even more profound global crises on the horizon.

An often gender-blind response

The Commission sees COVID-19 as exacerbating already deep gender discrimination. This undercuts all Nairobi commitments and is cause for great concern. It points to lessons learned in earlier crises but unfortunately not taken to heart: that gender must be a primary consideration, from the beginning, and that gender differences must be fully integrated in all elements of crisis response.

More broadly, since gender inequalities remain apparent in every area of life, measures to transform disparities must consistently be at the centre of every public policy and fiscal process, backed by supportive legislation and institutional mandates. The Commission stresses that an agenda for sexual and reproductive justice also requires an inclusive definition of gender, embracing diverse orientations and identities.

During the first six months of the pandemic, with lockdowns trapping some women and girls in violent situations in homes, UNFPA estimated that 31 million new incidents of gender-based violence may have occurred. This blatant violation of rights was driven by a toxic mix of confined living conditions, economic stress and fear of the virus.[19] It came on top of the distressing calculation that one third of women globally experience gender-based violence at some point in their lives.

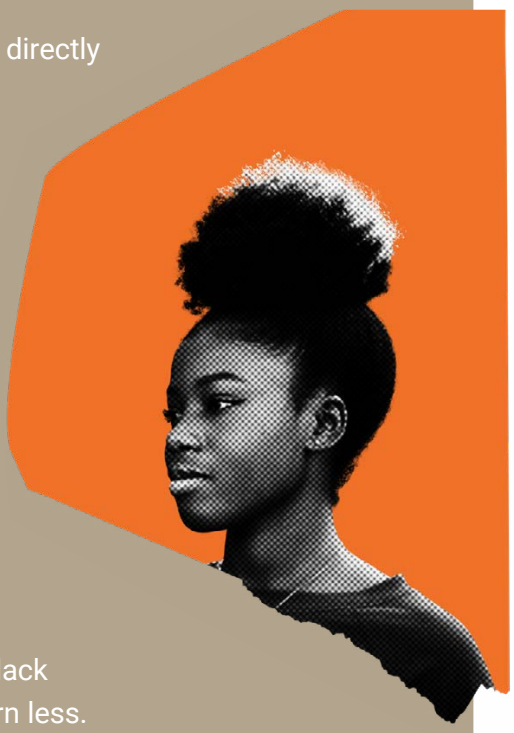
Women lost jobs at higher rates than men, with many starting the pandemic already disadvantaged by gaps in earnings and assets. Intensified burdens from unpaid household care work added to women's disproportionate share before the pandemic began. Rising rates of hunger concentrated among women and girls[20] are likely pushing some into child marriages, transactional sex or human trafficking. All risks associated with being female were compounded for women associated with other categories of vulnerability, including race and disability, poverty, and status as a migrant or refugee.

Other indications of gender discrimination came from the African Queer Youth Initiative. It surveyed queer youth in 10 African countries on the impact of COVID-19, finding that 8 out of every 10 experienced financial difficulties. Only about 2 in10 could access health services. About a quarter experienced homelessness, yet when they lived together, they felt vulnerable to targeting by law enforcement under the guise of "curtailing" the coronavirus. Some were forced to live

with homophobic family members, leading to an increase in domestic violence.[21]

While many gender impacts of the pandemic have been well documented, including in the media, the Commission finds a gender-blind response evident among governments and international organizations. One review of over 70 reports on COVID-19 by the United Nations and the World Bank found almost half failed to mention the specific needs of women and girls.[22] Assessments of stimulus and social protection measures have found gender gaps in support for agriculture, industry and the unemployed. Programmes targeting larger formal businesses and employment, for instance, miss the large share of women clustered in smaller enterprises and the informal sector.[23]

Justice for Black women means more than choice



An abundance of evidence demonstrates that racism leads directly to higher rates of death and illness, including during the pandemic. Racism also intersects with gender, sexual orientation, level of education, and economic, disability or other status, to deter access to health care. Unwinding systemic racism in health care requires a comprehensive approach, like an agenda for sexual and reproductive justice, which recognizes these intersections.

Women of African descent in many countries, for instance, may find it more difficult to obtain modern contraception as well as adequate prenatal and pregnancy care, for reasons that include affordability and distance to services along with the attitudes of providers. Compared with White women, more Black women die from preventable maternal mortality and lack access to domestic violence assistance. They may also earn less.

In such cases, simply having the ability to make a choice, of a contraceptive, for instance, is essential but not sufficient. Bodily autonomy and realizing the right to make decisions about pregnancy depend as well on women earning a decent income, living in safe housing with clean water and air, and knowing that they can provide their children with sufficient physical, mental, spiritual, moral and social development.

Source: Human Rights Council, 2021b.

Adolescents and youth pay a heavy price

Multiple Nairobi commitments promise to improve the health and well-being of youth and adolescents, yet the Commission fears that the next generation, already facing many challenges before the pandemic, is now slipping even further behind. Among the 30 million people in Africa falling into extreme poverty during the first 12 months of the pandemic, the vast majority were under age 18.[24] Disparities between young people and adults were evident in employment declines, with youth employment falling by 8.7 per cent in 2020 compared with 3.7 per cent for older adults.[25]

School closures disrupted education, including comprehensive sexuality education, even as they also stranded some children and young people in violent homes.[26] A year after the pandemic began, half of the world's students were still affected by school closures, contributing in part to rising rates of child labour. Large disparities in online access left already disadvantaged children even further behind.[27] Vocal and intensifying resistance to comprehensive sexuality education in many countries has hampered sexual and reproductive health and rights and gender equality.

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The Commission found much disturbing evidence of how gender discrimination has intersected with age to impose additional risks. Girls were at higher risk of missing out on school, despite ample evident that keeping girls in school is one of the most important strategies to advance the achievement of the Nairobi commitments and the ICPD agenda.

Child marriage and adolescent pregnancies are more common among girls who are poor and less educated. Due to the pandemic, 2020 saw the largest surge in girls becoming brides in 25 years, and additional 10 million girls (above pre-COVID estimates) are likely to enter into child marriage by 2030.[28] Teenage pregnancies are projected to increase as well. Even before the pandemic, in 2019, 43 per cent of sexually active adolescent girls aged 15 to 19 who wanted to avoid pregnancy were not using modern contraception, resulting in 10 million unintended pregnancies and 5.7 million abortions. Of 12 million adolescents who give birth each year, nearly 4 million do not deliver in a health facility. [29]

The pandemic has imposed enormous burdens on mental health, especially for the 20 per cent of the world's children and adolescents who already have a mental health condition, and given that suicide is a leading cause of death among those aged 15 to 29.[30] A poll of adolescents and young people in Latin America and the Caribbean suggested significant deterioration in mental health. Almost half of respondents were less motivated to do activities they normally

enjoy and 15 per cent had experienced depression within the previous week.[31] The South African Government responded to such concerns in 2020 by launching the Higher Health 24-hour crisis hotline to help young people cope with COVID-19.

The Commission is deeply concerned that the disparities faced by adolescents and young people today will set them off track as they move into adulthood, translating into a struggle to keep up with less education and fewer skills. The strong possibility that

Gender dynamics and poor health options drive displacement in Venezuela

Venezuela's longstanding political and economic crisis has spilled into a broader regional refugee and migrant crisis. In this, gender dynamics have posed extra risks to the health of women, girls and LGBTIQ+ people, both in Venezuela and in countries hosting people who flee. Many Venezuelan women and girls are highly vulnerable to sexual exploitation and abuse; at the same time, they are afraid to seek services and help from authorities. In general, for people on the move, increased health risks most frequently affect reproductive health, mental health and nutritional status.

Access to sexual and reproductive health services is limited both in Venezuela and in countries that host refugees and migrants. HIV infections in Venezuela have increased, and it is one of the few countries where access to antiretroviral treatment has contracted. Extreme shortages in contraceptive methods make surgical sterilization the only option for many women. Where contraceptives are available, costs have skyrocketed 25 times since the pandemic began. Most pregnancies are not planned, and adolescent pregnancy has climbed by 65 per cent since 2015.

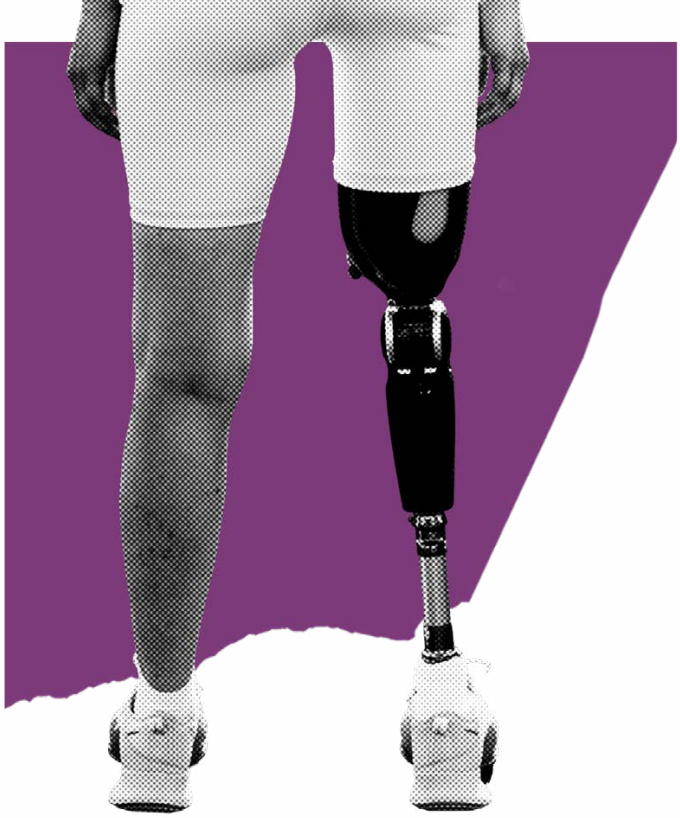
For some Venezuelan women, the lack of health care has been a primary driver behind choices to migrate. Some regularly cross the border with Colombia to obtain essentials such as antenatal care. But the tremendous scale of needs, scarce resources and poor coordination have driven up birth rates and maternal morbidity among Venezuelans who have resettled in Cucuta, Colombia. In Peru, a survey found that only around a quarter of Venezuelans had received a service for sexual and reproductive health over the previous year.

Source: CARE, 2020.

existing inequalities will become even worse, with implications for human rights as well as the development of entire societies, underscores the urgency of making services and support for adolescents and young people integral to recovery.

Raising already high barriers for people with disabilities

The Commission lauds the increasingly outspoken and powerful movements of people with disabilities. They are struggling around the world against often enormous obstacles to realize justice and claim their rights, inspiring the Nairobi commitment to ensure that people with disabilities feel valued and able to shape their destinies.



Some of the sharpest disparities in rights and bodily autonomy affect people with disabilities. They are three times more likely to experience violence than people without disabilities, for instance.[32] Some are still legally subjected to forced sterilization, one end of a spectrum of discrimination that includes people with disabilities who cannot access contraception and thus lack choice in planning a family.[33] Pandemic lockdowns and service shortfalls made obstacles to accessing information and services much worse. Caregivers could not provide assistance. Pharmacies in some cases were closed or farther away and harder to reach. New barriers emerged such as difficulties for deaf people in reading the lips of masked health-care providers.[34]

Confirming how different forms of discrimination magnify each other, a global survey of women, non-binary and trans persons with disabilities concluded that COVID-19 had amplified abuses against them. Respondents feared that health-care shortages coupled with discrimination would deprive them of care. They reported struggling to meet basic needs and feeling more concerned about personal safety.[35]

Compounding humanitarian crises

The Commission draws attention to the Nairobi commitment on upholding rights and services in humanitarian and fragile settings, observing that action to realize it is far behind and long overdue. Some of the worst inequalities and injustices occur in humanitarian crises of all kinds.[36] Crises increase vulnerabilities to HIV infection, unwanted pregnancy, sexual and gender-based violence, and child marriage. It is within crisis situations that more than half of maternal deaths occur.[37]

And the need to step up, quickly, is only growing more urgent. In 2020, even with COVID-19 restrictions, a record 82.4 million

people fled from persecution, conflict, violence or human rights violations, up by 2.9 million people over the previous year.[38]

The Commission is gravely concerned about the redirection of services and funding in humanitarian settings as attention shifted to the pandemic. This may have diminished already insufficient support for sexual and reproductive health and rights and gender equality. A look at 15 humanitarian crises in Africa bluntly concluded that the COVID-19 response failed to protect the rights of women and girls, with 73 per cent of women interviewed saying that they had experienced intimate partner violence and 51 per cent reporting sexual violence in the first 10 months of the pandemic. A third indicated that child marriage had increased.[39]

Significant political and media attention to violence against women and girls during the pandemic may have shrouded the fact that very little was being done about it in practice, particularly in humanitarian contexts. People managing crisis-related programmes to respond to gender-based violence reported that funding had been withdrawn or redirected to infection prevention. In the 2020 Global Humanitarian Response Plan, funding for work on gender-based violence made up only a scant 0.48 per cent of the total appeal. [40]

The review of indicators of the Nairobi commitments in Annex A shows that, in 2020, funding for humanitarian action to address the specific needs of women, girls and young people, in terms of sexual and reproductive health and rights and gender-based violence, was sufficient only in Eastern and South-Eastern Asia and Oceania. All other regions fell short.

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Despite many challenges, the Commission appreciates how some organizations found ways to extend service lifelines to people in crisis during the pandemic. Building off commitments at the Nairobi Summit, for example, the International Rescue Committee made sexual and reproductive health and rights and gender equality central components of its main corporate plan, Strategy 100. As a result, in 2020 it scaled up services in 24 countries, helping to avert an estimated 159,500 unintended pregnancies through contraception, support around 180,000 safe deliveries and provide around 5,800 clinical services for survivors of sexual assault.

Midwives extend the reach of care even as they struggle with their own marginalization

Increasing the number of midwives is a proven way to reach groups that have been socially or economically marginalized – and to improve the quality of care. Midwives can provide 90 per cent of the care needed for sexual and reproductive health and rights, working as an integral part of health-care teams. Increasing the supply of midwives in low- and middle-income countries who are trained to the standards of the International Confederation of Midwives, towards universal coverage by 2035, could avert 41 per cent of maternal deaths.

Situating midwives close to where women live, including marginalized communities, can improve access to high-quality health care, easing barriers such as those that often arise around transportation to more distant health facilities. Since most midwives are women, investing in midwifery also reduces gender and other inequities by boosting women's employment. Recruiting diverse individuals is an opportunity to build representation of the populations they serve, which is critical for positive experiences of care, especially among marginalized groups. With more latitude to work with local institutions outside the health system, such as schools, midwives could be influential voices in steering new social norms and behaviours that help diminish gender discrimination and support bodily autonomy.

Some progress has been made in greater recognition of the essential roles of midwives in sexual and reproductive health, backed by increased training and investment. Yet the pandemic saw midwives shunted aside. Deaths of midwives early on compelled the International Confederation of Midwives to call on governments to ensure they were included in the distribution of personal protective equipment (PPE), given evidence of preferential provision to other health-care professionals in some cases.

A survey by the Confederation found that over half of 143 midwifery associations in 124 countries had not received any information on COVID-19 from national health authorities. The study also pointed to the resilience and perseverance of midwives. Many kept providing care despite limited resources and a lack of pay, quickly adopting innovative approaches to keep themselves and their clients safe.

Sources: Nove, Friberg, de Bernis and others, 2020; ICM, 2020; ICM, 2021.

A turning point to close the gaps

As the pandemic has deepened inequalities, it has also raised awareness of them. The Black Lives Matter movement in countries around the world, extreme disparities in vaccine access and the tragic developments in Afghanistan, among other events, have all inspired concern and quests for justice. A turning point could be at hand, one that relooks at models of development that have fallen so far short of justice for so many people.

While this is a turbulent moment, the Commission is encouraged by the growing number of governments and political leaders acknowledging that investing in health is vital for recovery, including specific efforts to reach groups facing discrimination and inequality.[41] The Commission underscores that political will could be a powerful accelerator of progress that is already unfolding, driven by the demands of people's movements for an end to inequalities and injustice, and building on decades of knowledge and proven solutions in closing the gaps.

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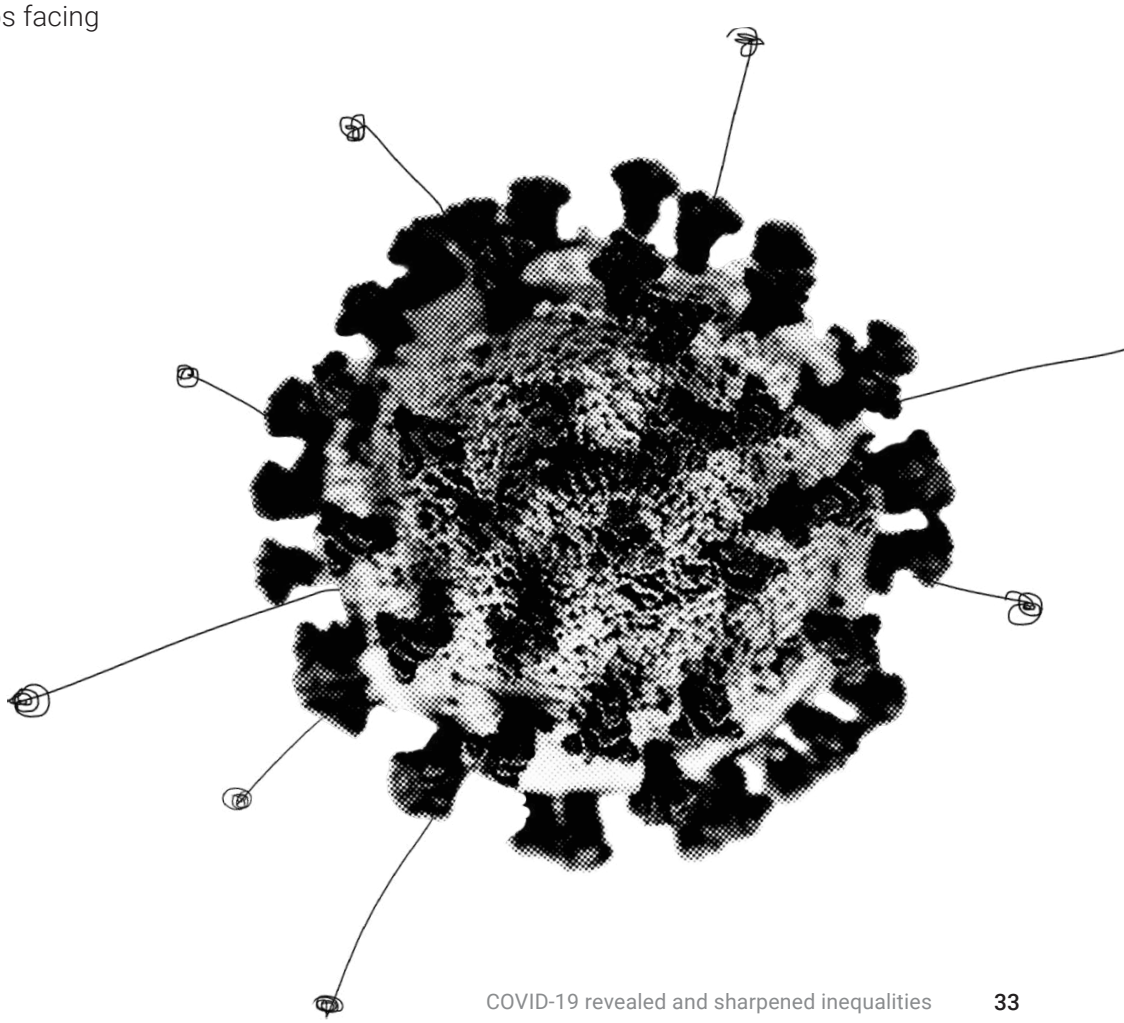

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3 HEALTH CARE: AN OLD CRISIS FEATURED IN A NEW ONE

The Commission views COVID-19 as a stress test for health systems that many countries failed. A rapid assessment by the WHO found that, by early 2021, 90 per cent of countries had experienced disruptions in essential services.[42] This occurred in the wake of longstanding underinvestment in health systems by many national governments and international donors.

Shallow political and financial commitments to sexual and reproductive health and rights as well as the deep roots of gender equality manifested in choices to pause or defund essential sexual, reproductive, maternal, newborn and child health care. In South Asia, mirroring a pattern at work in many parts of the world, these services declined 50 per cent in the second quarter of 2020.[43]

KEY MESSAGES

- COVID-19 revealed the consequences of the failure to strengthen health systems, make them resilient and universally accessible, and treat comprehensive sexual and reproductive health and rights as essential elements, in line with the Nairobi commitments.
- At the same time, it is apparent that more people than ever before understand the value of strong and comprehensive health care, and are willing to demand it, opening scope for accelerating the ICPD agenda.
- The pandemic resulted in disturbing gaps in sexual and reproductive health care, but also ushered in new ways of delivering care that can improve quality and access. There was ample demonstration of the potential for more community and self-care and the use of digital technologies.
- A new era of sexual and reproductive health programmes should build on the self-expressed needs and wants of distinct population groups, and specifically respond to intersecting vulnerabilities by operating under a framework of delivering rights and justice for all.

For the first time, this story played out on a global scale. But it was not a new story. Similar issues have arisen in earlier epidemics and pandemics and other forms of crisis. Such concerns routinely feature in development deficits that are not resolved even as they restrict rights and choices for billions of vulnerable people. The Commission finds this indicates a consistent lack of decisions to strengthen high-quality health systems, make them resilient and universally accessible, and treat comprehensive sexual and reproductive health and rights as essential elements, in line with the Nairobi commitments.

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One result has been a step back from sexual and reproductive justice and an erosion of bodily autonomy. While this is discouraging and must be quickly reversed, it is also apparent that more people than ever before understand the value of strong and comprehensive health care, are willing to demand that it be provided, and see it as integral to movements for racial, gender, development and other forms of justice. The Commission maintains that the pandemic has opened scope for rethinking health care and even prospects for accelerating the ICPD agenda and achieving universal health coverage.

Shortfalls in care became worse

The pandemic may have put the world on pause, but that was not the case for sexual and reproductive health and rights, which are often sensitive to time. The Commission underlines how shutdowns in sexual and reproductive health services in many countries produced immediate consequences: more maternal deaths, unwanted pregnancies, unsafe abortions, gender-based violence and violations of people's rights.

As a result of the pandemic, an estimated 12 million women may have been unable to access family planning services. The disruption of supplies and services lasted an average of 3.6 months, leading to as many as 1.4 million unintended pregnancies.[44] Longer-term consequences include diminished mental and physical health, education and workforce participation – losses that will be felt by families, communities and societies at large.[45]

Sweden, where the quality of care is generally high, saw drop-offs in gynaecological pap smears, restrictions on contraceptive counselling and HIV prevention work put on hold.[46] In the Gaza Strip, all three major providers of care – the Ministry of Health, the United Nations Relief and Works Agency and NGOs – scaled down sexual and reproductive health services and family planning by as much as 90 per cent in some places.[47] In the Syrian Arab Republic, the pandemic response quickly exhausted the national health budget and disrupted immunization programmes and antenatal care. Women in Sierra Leone, concerned about being caught if they tried to access regular services during lockdowns, turned to unsafe abortions as a coping strategy.[48]

Despite many commitments to address sexual and gender-based violence made at the Nairobi Summit by individual governments, and in keeping with core global commitments, services for survivors of gender-based violence worldwide were forced to close shelters. Many struggled to sustain funding even for barebones support such as telephone hotlines. Police stations and courts were shut, depriving survivors of essential protections such as restraining orders. With programmes to avert female genital mutilation ceasing operations, 2 million additional cases are expected over the next decade.[49]

By 2021, two thirds of countries continued to report disruptions related to the health workforce, while a third faced lingering interruptions in supply chains for essential medicines, diagnostics and PPE. Forty-three per cent of countries cited financial challenges to service provision. Among the most affected services were those for family planning and contraception.[50] By the end of 2020, a survey of International Planned Parenthood Federation (IPPF) member associations in six regions found significant improvements in the number of service delivery points for sexual and reproductive health that had restarted operations. But differences among services were evident, with contraceptive services the most likely to be restored or even scaled up. Abortion services were the least likely to be operating at pre-pandemic levels.[51]

The Commission is encouraged to see that more countries have now defined core services that must be maintained in crises.[52] Further, half of IPPF member associations have reported that national governments have now included sexual and reproductive health in essential health services packages,[53] although the goal must be 100 per cent. By September 2020, 52 countries had integrated the prevention and response to violence against women and girls into COVID-19 response plans, and 121 countries had adopted measures to strengthen services for women survivors.[54] While broad commitments to care are an important step, the Commission also cautions that they need a strong focus on sexual and reproductive justice to avoid service gaps and the risk of perpetuating existing disparities.

New avenues for care emerged

The pandemic has been a progression of dark and discouraging moments, but the Commission finds that it has also ushered in new ways of delivering health care that can improve quality and access. Countries have stepped up health communications efforts and developed systems to identify and better meet the most urgent patient needs. More than half of countries have recruited additional health staff and switched to alternative methods to deliver care, such as home-based services, multi-month prescriptions and telemedicine.[55]

The Commission affirms ample demonstration of the potential for more community and self-care. Self-managed abortion through telemedicine emerged, for example, in Nepal, where civil society organizations successfully advocated for the Government to allow home use of medical abortion drugs in line with WHO recommendations. In Australia, the Government expanded telehealth services

and allowed them to be billed to the public health system. Telehealth consultations for early medical abortion increased by 25 per cent, demonstrating how this approach can improve access where distance and cost might be barriers along with fears of infection from entering a health facility.[56]

Albania enabled telemedicine for prenatal care,[57] while Uruguay established criteria for obstetric care at home and instituted "optimized" health-centre visits with multiple services performed during one visit. It eased access to contraceptives by reducing requirements for new prescriptions. Interruptions in antiretroviral drugs for HIV were avoided through combined delivery methods at home, by mail or through prior arrangement with pharmacies.

A practical response to the pandemic upholds bodily autonomy

In March 2020, the United Kingdom amended legislation so women could temporarily access early medical abortions at home. This cut waiting times and increased care at earlier stages of pregnancy. Eighty per cent of women reported that they now prefer telemedicine and would choose it in the future. This response demonstrates how telemedicine and self-care became not only a practical response to the pandemic but a way to respect women's bodily autonomy and trust them with decisions about their sexual and reproductive health.

Source: FSRH, 2021.

Other pandemic-driven innovations have delivered remote comprehensive sexuality education, provided in-home testing for the human papillomavirus (HPV), and used WhatsApp channels to create virtual support groups for young people living with HIV.[58] Botswana, with continued concerns about its high rate of maternal mortality, used drones to deliver maternal health supplies and commodities – including essential obstetric care drugs, blood, blood products and laboratory specimens – to hard-to-reach communities.[59]

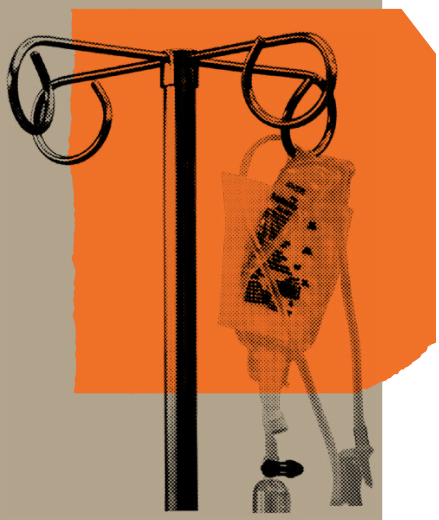
The Commission also recognizes the value of non-digital care services that gained ground. These include mobile clinic outreach for family planning services, patient call centres and task shifting to expand service provision.[60] They remain vital to reaching many marginalized groups. In the Congo, UNFPA developed a novel solution by positioning health teams in pairs that included a midwife and a psychologist. They offered integrated services on sexual and reproductive health, mental health and gender-based violence to complement the efforts of government teams deployed to humanitarian zones affected by conflict, floods and COVID-19.

Making sexual and reproductive health and rights integral to health systems

As the world recovers from the pandemic, the Commission underlines that stronger health systems will depend on the full integration of sexual and reproductive health and rights. It calls for top political will to set a direction of systematically financing and embedding changes across all levels, as some countries are already doing as frontrunners in acting on the Nairobi commitments.

Realizing a commitment to keeping up services

At the Nairobi Summit, MSI Reproductive Choices made a commitment to no unsafe abortions and universal access to contraception by 2030. Despite dire projections at the beginning of the COVID-19 pandemic that up to 80 per cent of MSI services could be disrupted, it reached nearly as many women with high-quality sexual and reproductive health care in 2020 as in 2019, a total of 12.8 million clients across 34,000 sites. Every day, it provided 35,000 people with contraception, safe abortion and post-abortion care services, in line with local legal frameworks. One in every six clients were under 20, an age group still facing significant barriers to access around the world.



Keeping up services required creative means. In Uganda, in partnership with UNFPA, MSI delivered contraception using a ride-hailing app similar to Uber. It obtained government permits in Madagascar to deliver services by bus and transport women safely to their local health facility. New quality assurance methods deployed audio and video streaming for clinical audits, saving time and money, and reducing the organization's carbon footprint. Chat platforms launched in 10 countries, including the Democratic Republic of the Congo, Nepal and Yemen, enabled MSI agents to seamlessly manage WhatsApp and Facebook messaging and provide advice and information during lockdowns.

Such efforts have paid off. In 2020, MSI helped avert 13.4 million unintended pregnancies, 5.6 million unsafe abortions and 35,000 maternal deaths.

Sources: MSI Reproductive Choices, see the website: www.msichoices.org.

The Commission equally urges a new era of sexual and reproductive health programmes that build on the self-expressed needs and wants of distinct population groups, and that specifically respond to intersecting vulnerabilities by operating under a framework of delivering rights and justice for all. Measures should be in place to ensure that care is consistently non-discriminatory, upholds individual dignity, and fully respects rights and choices. [61]

One emerging lesson is that health systems need to be intentional in integrating digital health technologies.[62] This includes explicit recognition of potential barriers related to poverty, lack of access and limited digital literacy. Embedding digital equity in health policies would ensure fair access and affordability and align with sexual and reproductive justice.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4 FINANCING FOR RECOVERY, RESILIENCE AND RIGHTS

The Nairobi Summit committed to increased domestic and international financing to ensure the full, effective and accelerated implementation of the ICPD Programme of Action. The Commission realizes that, at the current moment, finding the money will not be easy, given economic slowdowns and disruptions in employment, business and revenue sources. Public debt burdens have escalated in already vulnerable countries, raising the risk of austerity.

Yet the Commission stresses that now is not the time to disinvest in sexual and reproductive health. Continued and increased investment is a matter of rights, justice and development overall, and is backed by longstanding evidence of high returns on these investments. Through expanded investment in preventive sexual and reproductive health care, overall health-care costs decline. Economic productivity and household income rise. Gender equality advances.[63] Demographic prospects improve for countries with both higher and lower fertility rates.

KEY MESSAGES

- Full recovery from the pandemic depends on domestic and international financing that sets health systems on the path to universal health coverage in line with the Nairobi commitments.
- The Commission is concerned that while countries have made recent commitments to expanding the reach of essential health-care services, no substantial change is apparent in allocations of additional funds.
- Some international donors have made radical and unjustifiable cuts in support for sexual and reproductive health and rights. The Commission strongly warns against such reversals and calls for safeguards against choices rooted in gender discriminatory agendas.
- Health-care financing to meet the ambition of the Nairobi commitments must be considered in light of complementarities with other investments that advance or deter rights and bodily autonomy, such as education for girls and women's economic empowerment.

In short, full recovery from the pandemic depends on financing that sets health systems on the path to universal health coverage in line with the Nairobi commitments. Instead of retreating into budget cuts and downsizing, the Commission calls for being ambitious and farsighted, and going to scale. It does so underscoring immediate benefits to human well-being as well as returns from greater resilience to future pandemics and the intensifying risks of climate change.

Now is not the time to disinvest in sexual and reproductive health. Continued and increased investment is a matter of rights, justice and development overall, and is backed by longstanding evidence of high returns on these investments.

Funding patterns are mixed

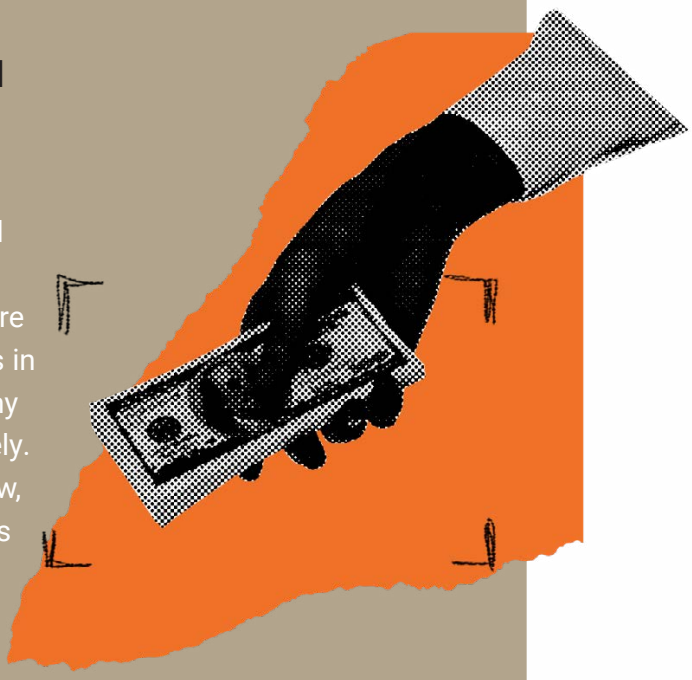
Both national governments and international donors have roles in providing finance to realize Nairobi commitments and accelerate the ICPD agenda. In general, services for sexual and reproductive health and rights are among the most cost-effective health interventions and are affordable by all but the poorest countries. Meeting all women's needs for contraceptive, maternal and newborn care in low- and middle-income countries, for instance, would average $9 per person per year, a fraction of spending on health care overall.[64]

Yet the Commission is concerned that while countries have made recent commitments to expanding the reach of essential health-care services, no substantial change is apparent in allocations of additional funds.[65] Very few data are available on funds spent on sexual and reproductive rights and services within national health budgets. But one study of a small but diverse group of countries – including Colombia, Kenya, Nigeria, South Africa, Uganda and the United States – found that the pandemic led to deprioritizing services related to gender-based violence and sexual and reproductive health. It concluded that services were grossly underfunded in all countries and failed to reach the most vulnerable, including adolescents, migrants and refugees, sex workers, LGBTQI, Afro-descendant people and Indigenous people.[66]

High out-of-pocket health-care spending has become another trend that the Commission warns must be curtailed to avoid further penalizing people who are already poor and excluded.[67] Positive examples of change include Ethiopia's definition of care for obstetric fistula as an essential sexual and reproductive health service exempt from out-of-pocket payments.[68]

The Commission highlights substantial differences in how foreign aid budgets have responded to the pandemic. Some international donors, like the United Kingdom, have made radical and deeply concerning cuts[69] expected to significantly reduce sexual and reproductive health services and supplies.[70] Other donors have increased spending. At the Nairobi Summit, 12 European donor governments and the European Union affirmed political and financial support to complete the ICPD agenda. In 2019-2020, 8 out of 12 European donors increased or maintained

A quick infusion of funds helped sustain support for survivors of gender-based violence



Civil society groups working on gender-based violence were among the first to warn that cases were spiking and becoming more severe during pandemic lockdowns. Calls to hotlines in some cases rose by nearly 800 per cent. Many organizations responded quickly and creatively. But it was soon clear that, even as needs grew, funding was harder to find, and new expenses had emerged in adapting to different working methods.

The UN Trust Fund to End Violence against Women is a key multilateral resource for civil society groups providing essential services to prevent and respond to violence. In 2020, it assisted 150 projects in 71 countries and territories with nearly $73 million in grants. As the impacts of the pandemic escalated, the Trust Fund convened civil society, donor and government representatives to define challenges and strategies to respond and worked directly with grantees to reallocate funds and adapt programmes.

The UN Trust Fund also facilitated a timely $9 million infusion of additional resources for 44 civil society and women's rights organizations in sub-Saharan Africa, working through the European Union/United Nations Spotlight Initiative. Current and former grantees could apply for up to 43 per cent of their original grant. They used the funds to strengthen organizational resilience, manage risks and support recovery.

Source: UN Trust Fund to End Violence Against Women, 2021.

their level of funding to sexual and reproductive health and rights. European governments also reinstated the importance of sexual and reproductive health, including family planning, in official responses to the COVID-19 pandemic and in humanitarian aid.[71]

Another encouraging sign came from the United States, where the Federal Government lifted restrictions on the so-called "global gag rule" preventing US global health assistance from going to organizations that provide or even offer information on abortions.

With governments under pressure to restore national economies, however, the temptation to cut foreign aid may grow. The Commission strongly warns against such reversals and calls for safeguards against choices rooted in gender discriminatory agendas. It also draws attention to how existing allocations are headed in the wrong direction and do not yet fairly align with needs across all facets of sexual and reproductive health and rights.

With governments under pressure to restore national economies, the temptation to cut foreign aid may grow. The Commission strongly warns against such reversals and calls for safeguards against choices rooted in gender discriminatory agendas.

From 2017 to 2018, based on the latest available data, total official and private aid disbursements for sexual and reproductive health fell from $7.19 to $6.57 per woman of reproductive age in developing countries. The largest share of aid disbursements for sexual and reproductive health, at 68 per cent of the total, went to one area: combating HIV and other sexually transmitted infections.[72]

One source of deep alarm for the Commission is that even as health clinics in poor countries struggle to put adequate supplies and choices of contraception, for instance, on clinic shelves, "anti-gender" funding is pouring into movements opposing feminism, bodily autonomy, and access to sexual and reproductive rights. A 2021 report by the European Parliamentary Forum documented how 54 organizations generated $707.2 million for such activities from 2009 to 2018. Most are in the Russian Federation, United States and Europe.[73]

Some philanthropies and businesses have made and met commitments to finance sexual and reproductive health and rights, a development strongly appreciated by the Commission. At the Nairobi Summit, the Ford Foundation committed to support women's rights organizations, feminist movements and girl-led organizations working to prevent and respond to gender-based violence. Beyond planned investments in evidence-based programmes to prevent violence and reduce impunity, the foundation provided an additional $50 million to sustain women's rights movements during COVID-19. It has also worked with donor governments and the Equality Fund to leverage further funding for feminist and girl-led organizations in the Global South.

The Bayer Corporation committed to boosting production of long-acting reversible contraception at the Nairobi Summit and realized this objective in 2020 with a 31 per cent increase over 2019. Along with the Bill & Melinda Gates Foundation, the company contributed to The Challenge Initiative

of Johns Hopkins Bloomberg School of Public Health, aimed at "business unusual" approaches to financing and scaling up family planning for the urban poor. Bayer joined the German Red Cross to further support family planning activities in humanitarian crises.

Financing stronger health systems

COVID-19 shed light on longstanding deficits in health systems management, coordination, data and finance. The Commission is troubled by all the evidence of how these have spilled into health, social and economic impacts, at the cost of many lives. It welcomes vocal calls for more integrated and resilient health systems aimed at universal coverage, health security and equity, with the understanding that these must build on comprehensive services for sexual and reproductive health and rights. Such systems protect and empower people and are a pillar of human security.

The WHO has suggested that health system investments have "multiplier" effects across the rest of the economy that are greater than investments in other sectors and should be a priority for recovery.[74] Early signs of commitment to financing stronger health systems are not encouraging, however. By early 2021, for instance, the bulk of contributions to the WHO Access to COVID-19 Tools Accelerator had gone to vaccines, with just 6 per cent earmarked for health-care systems despite their centrality to pandemic preparedness and response. [75]

In late October 2020, modelling by the WHO, the Global Fund AIDS, Tuberculosis and Malaria, and the World Bank projected that helping health systems in the poorest countries to manage the pandemic would cost $9.7 billion, including for the protection of front-line health workers, clinical care, in-country supply chains and data monitoring. Beyond improving the COVID-19 response, this would lay foundations to establish stronger health systems as countries emerge from the crisis.[76]

Costing three core Nairobi commitments

An estimated $264 billion is required to achieve the Nairobi commitments to the three zeros by 2030. Globally, ending preventable maternal deaths will cost $115.5 billion, meeting unmet need for family planning will cost $68.5 billion, and eliminating gender-based violence and all harmful practices will cost $79.4 billion.

The total cost is high at $264 billion. And the current gap in investment, whether from foreign donors, domestic public budgets or private concerns, is $222 billion over the coming 10 years. Without closing this gap, however, the costs will be incalculably greater, in financial terms, lives lost or thwarted by illness, and generations whose potential will go unfulfilled.

Source: UNFPA, 2020b.

Experience suggests that progress largely depends on publicly financed universal coverage.[77] The Commission underscores how progressive tax reforms and more efficient tax collection may improve revenue generation.[78] Other sources of revenue include sustainable development bonds or innovative debt swap mechanisms linked to achieving health objectives. The Global Fund for AIDS, Tuberculosis and Malaria has a Debt2Health programme that converts debt repayments into lifesaving investments in health. By late 2020, Australia, Germany and Spain had cancelled debts to 10 developing countries that in turn invested nearly $180 million in domestic health programmes.[79]

The case for investment in small island developing States

An investment case for five small island developing States in the Pacific – Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu – demonstrates the high return on investment for achieving 95 per cent coverage of maternal health services and realizing 0 per cent unmet need for family planning. It offered a comparison to existing coverage, which declined in 2020 and 2021 due to the pandemic. With an additional $13.4 million in total between 2020 and 2030, all five countries could achieve both targets. This would avert 38 per cent more unintended pregnancies, 28 per cent more stillbirths and 29 per cent more maternal deaths. It could bring an estimated 11-fold economic benefit of $149.7 million.

In four Caribbean countries – Barbados, Guyana, Jamaica and Saint Lucia – an additional $18.8 million in total would achieve the targets and avert 23 per cent more unintended pregnancies, 23 per cent more stillbirths and 25 per cent more maternal deaths. The 20-fold economic benefit is estimated to total $375.4 million.

Source: UNFPA, 2021c.

A broader take on investment

The Commission maintains that for health-care financing to meet the ambition of the Nairobi commitments and uphold sexual and reproductive justice, it must be considered in light of complementarities with investments in other arenas that advance or deter the realization of rights and bodily autonomy. Seeing a broader system of concerns helps to understand and capitalize on how different issues build on each other, while avoiding contradictions.

Investing in adequate water and sanitation services improves hygiene and menstrual health, for instance, and increases the chance that girls will remain in school. Renewable modern energy services can protect women from the backbreaking collection of wood and similar fuels and indoor air pollution that is harmful to health, including during pregnancy. Financing education systems should focus on reversing losses in girls' education and introducing universal, high-quality and comprehensive sexuality education that emphasizes agency and empowerment. Developing such capacities will help girls claim their bodily autonomy throughout their lives, become confident, productive citizens, and break intergenerational cycles of poverty.

Women's economic empowerment supports their ability to realize bodily autonomy and vice versa. Yet they have not only lost more jobs than men during the pandemic but have had a harder time getting back to work. Care services, targeted employment policies and gender-responsive social protection programmes at the heart of stimulus and recovery packages are among the measures that sustain and increase women's agency,[80] and from there the ability to plan their futures and make their own choices.


KEEP PROGRESS ON TRACK

5 ACCOUNTABILITY FOR SEXUAL AND REPRODUCTIVE JUSTICE

The Nairobi Summit showed the rich diversity of people who stand behind sexual and reproductive health and rights and are willing to amplify the call for justice on a global scale. Embodied by the Nairobi commitments, their vision is a powerful one. The Commission believes that it will overcome the forces still set against it.

That said, the Commission finds change happening too slowly, too sporadically and for too few people, a reality on display in late 2021. Even as Mexico's Supreme Court decriminalized abortion, the bordering state of Texas in the United States banned the procedure at six weeks, well before many women even know they are pregnant. Melissa

KEY MESSAGES

- The world cannot wait for sexual and reproductive justice. People's movements are demanding justice and human rights and should be encouraged as drivers of action and accountability. At the same time, the Commission is concerned about intensifying backlash and the use of the pandemic to further regressive agendas.
- Some countries are marshalling political will and establishing national mechanisms to steer progress on the Nairobi commitments, setting examples for other nations to follow. Increasing use of the commitments in the Universal Periodic Review is also encouraging.
- The Nairobi Summit demonstrated the immense value of global solidarity and set in motion a more rigorous architecture for accountability, built on many allies working together to push sexual and reproductive justice forward.
- The Commission sees agency and bodily autonomy as what most people want and what all people deserve. Everyone being able to exercise these, freely and on their own terms, will determine the resilience, development and even survival of individuals and nations.

Upreti, who chairs the United Nations working group on discrimination against women and girls, called the Texas law "structural sex and gender-based discrimination at its worst".[81]

The Commission stresses that we cannot wait for sexual and reproductive justice. We must bring the full weight of national and global solidarity behind rights and commitments and insist on accountability, so they move off paper and beyond conference rooms. The Nairobi vision must be one that people can claim throughout their lives.

The Nairobi vision must be one that people can claim throughout their LIVES.

People's movements and pushback

The Commission finds optimism in the passion of people's movements around the world that are demanding justice and human rights. Such movements should be encouraged and supported as drivers of action and social accountability that extends from the local to the global level. Many of these movements are driven by younger people who do not see a future for themselves in unjust and exclusionary politics and patterns of development.

Activists flooded the streets for months in 2020 to support Black Lives Matter in the United States and other countries, for example. Ireland, the Maldives and Turkey[82] all saw protests for action on gender-based violence. After a video of men sexually assaulting a woman went viral in Bangladesh, protests erupted over "empty promises" and the failure to address an alarming rise in sexual violence.[83] Groups in Poland defied COVID-19 restrictions to protest a near total ban on abortion in mid-2021.[84]

Following years of pressure by women's movements, Chile made history in early 2021 by becoming the first country where equal numbers of women and men began drafting a new Constitution. It is expected to put a central emphasis on the rights of women and minority groups, including Indigenous peoples, and to walk back current limitations that restrict bodily autonomy, including on abortion and equality in marriage.[85]

Despite these welcome developments, the Commission also sees continued and, in some cases, intensifying backlash. The current moment of political polarization fosters regressive social ideologies, and the

Commission finds evidence of such forces exploiting the pandemic to further their agendas. This was the case in Romania with a decision not to include abortion on a list of essential services, resulting in a dramatic decline in access.[86] In Namibia, South Africa and Zambia, opposition to comprehensive sexuality education took off. In Ghana, a surge in stigma and discrimination against LGBTQ+ people came after faith leaders blamed them for causing the pandemic. Orthodox leaders in Georgia called COVID-19 God's punishment for same-gender marriage and abortion.[87]

The Commission decries how civil society space has shrunk through the deliberate use of lockdown measures to deter activities and free speech. Other pressures have entailed funding cuts. Difficulties in sustaining advocacy in virtual forums led civil society organizations to join some UN Member States in 2021 to launch the #UNmuteCivilSociety campaign.

Mechanisms to keep countries on track

The current moment, while a difficult one, has seen some countries marshalling political will and establishing national mechanisms to steer progress on the Nairobi commitments. The Commission finds this strongly encouraging and highlights these examples for other nations to follow. Rwanda, for instance, has established a national action plan to fast track commitments to universal access to sexual and reproductive health and rights by 2030. The plan prioritizes achieving the three zeros and is fully aligned to a broader Health Sector Strategy defining the roles and responsibilities of various actors as well as required resources.

Mauritania's Ministry of Economic Affairs is devising a monitoring plan to track the integration of the Nairobi commitments into sectoral policies and development programmes. Nigeria's Health Ministry has formally agreed to honour a yearly commitment of $4 million for family planning. Angola integrated the Nairobi commitments in its Health Ministry's workplans, including on youth-friendly municipal health services.

Kazakhstan has made good on its Summit commitment to reduce the age for receiving health services without parental consent. A new regulation gives adolescents the right to such services without parental consent starting from age 16. The Dominican Republic has prepared new national plans on preventing teenage pregnancy and preventing and responding to violence against women. Viet Nam has brought commitments into several policy documents, including on improved family planning, adolescent sexual and reproductive health, a national HPV vaccination roadmap, and a national action plan on maternal and neonatal health.

The Commission emphasizes the value of bringing more diverse voices into national decisions on the Nairobi commitments. Young people and marginalized groups have been part of efforts in Cambodia, Djibouti,

The Commission finds change happening too slowly, too sporadically and for too few people.

Ecuador, Iraq, Madagascar, Malawi, Mali, Mexico, the Philippines, the Republic of North Macedonia, Sudan, Thailand and Zimbabwe. Sudan has set up a summit coordination group connecting technical specialists in ministries, civil society, the media, academia and activist groups, and developed a roadmap and priorities for a comprehensive ICPD implementation plan.

Regional and subregional systems to track the Nairobi commitments have also emerged and have been adopted by UN regional economic commissions in Asia and the Pacific and Europe and Central Asia. The Commission considers these important in building broader momentum and providing support across borders. They could provide a forum for developing countries to cooperate and share

Some countries are hewing to a "feminist" recovery

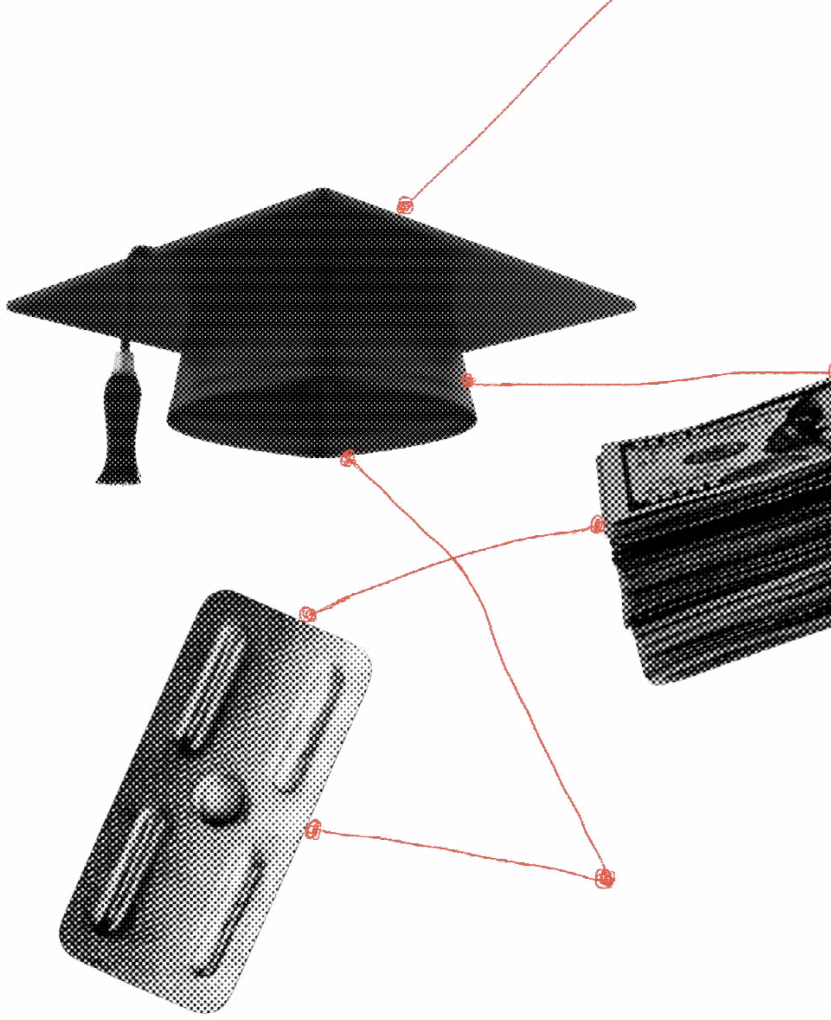
While gender responsiveness has not been the norm in the pandemic recovery, some countries have made great strides, in part through women's leadership. Chrystia Freeland, Canada's first female finance minister, set up an all-women task force so the 2021 budget would be geared towards a "feminist and intersectional recovery". Mercedes D'Alessandro, Argentina's first director of economy, equality and gender, has pushed government recovery efforts to expand care infrastructure, move more women into male-dominated industries and vice versa, and increase options for parents to work remotely.

Colombia's Congress has promoted a gender-sensitive approach through the Women's Equality Commission, which requested that violence prevention and response measures be considered essential services during the crisis, and launched a public sensitization campaign, #MujeresSinVirusdeViolencia. Colombia also launched a fund devoted to women entrepreneurs and created a digital platform to help 30,000 women develop online businesses. Morocco has helped women's farming collectives sell products online, while Egypt, Georgia and Guatemala are prioritizing women-led businesses in efforts to stimulate their economies.

In Mexico, a working group headed by the speaker of the chamber of deputies has female deputies representing all parliamentary groups and committees, including the gender equity and justice committees. During the pandemic response, it steered budget decisions that, for example, included requiring public development banks to achieve gender parity on boards of directors, and develop products and services that meet women's specific needs for savings, credit and investment.

Source: Nugent, 2021; IPU, 2020.

experiences, potentially through links with Partners in Population and Development, an intergovernmental organization of 27 developing countries that promotes cooperation on reproductive health.



Parliamentarians set and oversee new standards

The Commission considers parliaments to be seats of accountability. Their legislative, oversight and budgetary roles can potentially shift the needle on gender equality and sexual and reproductive justice. Parliamentarians have in recent years passed an unprecedented amount of legislation on ending violence against women and shepherded improvements in the quality of legislation. In 2020, for instance, the Parliament of Djibouti adopted legislation that strengthened comprehensive care for survivors of violence against women and girls.

The Commission also acknowledges that parliaments can be sources of opposition to rights and justice where fundamentalist groups exert a strong influence. In some cases, this results in harassment and abuse against parliamentarians who support gender equality and sexual and reproductive justice issues. While recognizing parliaments as places for the exchange of different views, the Commission states that zero tolerance is the only appropriate response to violence.

Parliamentarians should, in the Commission's view, take a leading role in mobilizing political will and accountability for old and new gaps in sexual and reproductive justice. In recent decades, 50 countries have liberalized abortion laws, for instance, with a mix of incremental and transformative reforms. But 700 million women of reproductive age still cannot access a safe and legal abortion,[88] a gross contradiction of their right to bodily autonomy. Emerging issues include the online flood of misogynistic and violent content used to silence and violate women and girls, which often serves as a tool for political persecution. Such practices remain mostly uncontrolled and unregulated. Progressive parliamentary caucuses on gender equality and human rights must lead the stand against them, including through cross-country cooperation given the global reach of the web.

The Commission calls for closer engagement between parliaments and civil society advocates for sexual and reproductive justice to give the Nairobi commitments a clearer focus in legislative processes. The commitments should frame

Online violence is increasingly virulent – and mostly unchecked

Around the world, pervasive online violence is used to harm and silence women and girls. A study on women in European parliaments found 58 per cent had been targeted by online sexist attacks. Threats included death, rape and beatings. Women fighting against gender inequality and violence against women were prime targets for organized online attacks by ultraconservative or anti-feminist groups. Another poll of women journalists in 125 countries found that 73 per cent faced online violence; 11 per cent withdrew from online communities due to harassment.

Online violence remains mostly unregulated. Stopping it requires regulations on issues such as transparency on algorithmic decision-making. A new digital social contract should require companies in information and communication technologies to have the same duty of care, accountability and transparency as other industries. They must erect guardrails to protect users online and provide avenues to report and respond to cyber abuse. More public education on gendered patterns of online abuse is needed so people can protect themselves.

Sources: Recommendations from the "We Have Your Back" virtual side event at the UN Commission on the Status of Women, 24 March 2021 (for more, see the website: https://haveyourback.org/); IPU, 2018; Posetti, Aboulez, Bontcheva and others, 2021.

legislative and budgetary reviews assessing alignment with the commitments and reforms as warranted, with a priority being the removal of all discriminatory provisions. Public hearings should inform this process and put a deliberate emphasis on the voices of grass-roots activists, service users and providers, survivors of gender-based violence and harmful practices, and groups facing single or multiple forms of discrimination.

There are now many examples of women parliamentarians rallying behind gender equality objectives across party lines. But the Commission also points to male political leaders as allies and agents of change. Men make up most members of Sierra Leone's first parliamentary caucus on female genital mutilation, for example, strengthening public discussion and policies around abandoning this harmful practice.

Evolving international accountability

The Commission notes that international human rights mechanisms remain among the most important expressions of global solidarity. As such, they should be more systematically involved in advancing sexual and reproductive justice so that it reaches every country and community. The Commission is already encouraged by the increasing use of the Nairobi commitments in the Universal Periodic Reviews of the UN Human Rights Council. Since the Nairobi Summit, the majority of countries undergoing these reviews have received specific recommendations on the commitments.

Costa Rica, for instance, called on the United States to implement its commitment to increase financing for preventing female genital mutilation and child and forced marriages. Iceland urged Sao Tome and Príncipe to realize its promise to respond to the needs of young people and reduce the early pregnancy rate through comprehensive sexuality education in all secondary schools and youth-friendly sexual and reproductive health services in all health facilities. Panama emphasized that Paraguay could strengthen maternal morbidity and mortality surveillance systems and death registries, and boost investment in areas with high mortality rates.

Most countries receiving these recommendations have committed to implementation, which the Commission sees as promising. Furthermore, linking the Nairobi commitments with the Universal Periodic Review offers scope for regular monitoring and accountability as part of ongoing follow-up under the latter.

The Commission looks to the CEDAW Committee's recent *Guidance Note on COVID-19* as an important benchmark to assess and hold countries accountable for achieving sexual and reproductive justice. Among other provisions, the Note requests State Parties to CEDAW to ensure that women have full access to health care and that those committing gender-based violence are held accountable. Continued engagement with the Committee can insert sexual and reproductive justice in dialogues with State Parties and lead to revisions of national laws accordingly.

Linking the Nairobi commitments with the Universal Periodic Review offers scope for regular monitoring and accountability as part of ongoing follow-up under the latter.

A welcome development has been the integration of the ICPD agenda in global political conversations not explicitly focused on health, including at the UN Security Council. While political opposition to sexual and reproductive rights has flared in the past at the Council, in 2021 it convened an open debate on sexual violence in conflict. This provided scope for Nobel Peace Prize Laureate Dr. Denis Mukwege to appeal for responding to sexual violence with greater resources and accountability. The Special

Representative on sexual violence in conflict underlined how the COVID-19 pandemic has exacerbated violence faced by LGBTQI individuals, but that it remains underreported due to stigma, fear of further violence and a lack of services.[89]

In 2021, the global Generation Equality Forum marked the 25th anniversary of the Beijing Declaration and Platform for Action. It spotlighted how the platform complements the ICPD Programme of Action in achieving rights, justice and sustainable development. The Forum was a chance to mobilize around continued progress on the Nairobi commitments, including through the global Action Coalition on Bodily Autonomy and Sexual and Reproductive Health and Rights. Some countries reinforced their Nairobi Summit commitments through new pledges of financial resources.

A new era for global solidarity

In closing, the Commission considers the Nairobi Summit a moment that celebrated 25 years of progress towards the landmark ICPD agenda. But it also embodied a new era, demonstrating the immense value of global solidarity and setting in motion a more rigorous architecture for accountability.

Both are grounded not in single institutions or structures of power, but in people from all walks of life in every part of the world who stand up every day to fight for sexual and reproductive justice. Their experience and advocacy became the Nairobi commitments, which despite slow and imperfect progress are starting to become a reality. New and newly active national and international mechanisms to reinforce their efforts, including the Commission, offer additional room for optimism.

Many allies working together will push sexual and reproductive justice forward. They are making a case that is increasingly impossible to deny. The Commission sees agency and bodily autonomy as what most people want and what all people deserve. Everyone being able to exercise these, freely and on their own terms, will determine the resilience, development and even survival of individuals and nations.

» A CALL FOR ACTION

The Commission appreciates the progress made by some countries, since the end of 2019, in meeting the Nairobi commitments, despite arduous circumstances. At the same time, it is concerned about the diversion of attention and resources away from sexual and reproductive health and rights, which has exacerbated already severe disparities. Some gaps have been deliberately widened by regressive politics and gender discrimination, requiring a forceful and immediate response.

The Commission strongly believes that accelerating the achievement of the commitments depends on advancing a unifying framework for sexual and reproductive justice. This requires taking all measures required for all people to fully claim their sexual and reproductive health and rights. Towards that end, the Commission makes several recommendations.

1 Make sexual and reproductive justice the goal. Conduct all work on sexual and reproductive health and rights under a justice framework. This must consider human rights and fundamental freedoms as universal, indivisible, interdependent and interrelated.[90]

Establish and use mechanisms for accountability. All countries should establish national mechanisms dedicated to Nairobi follow-up. These should serve to shine a spotlight on progress towards national and global Nairobi commitments. In countries with a UN presence, the 12 global commitments should be integrated into UN sustainable development cooperation frameworks. All countries should bring the commitments into voluntary national reviews to report on the SDGs. Continued and broadened use of international human rights instruments such as the Universal Periodic Review and CEDAW should help extend sexual and reproductive justice across countries and communities.

Invest in people's movements to claim sexual and reproductive justice. Scaled-up investment should prioritize movement-building and grass-roots leadership. Gender equality and other advocates standing up for the rights of diverse communities should have meaningful roles in national mechanisms monitoring the Nairobi commitments as well as decision-making for health-care institutions more broadly. Younger advocates should be encouraged as experienced and successful leaders of new forms of online and offline activism, and for their skills in linking diverse movements for justice.

Strengthen and forge new alliances with parliamentarians. The Commission calls on advocates of sexual and reproductive justice, movements for gender equality, technical experts and international organizations to explore closer ties with progressive parliamentarians and parliamentary caucuses, including those committed to gender equality. It also urges parliamentarians to step up and actively advance laws and budget choices that will achieve sexual and reproductive justice and gender equality.

2 Put rights and development at the core. Develop universal health coverage with comprehensive sexual and reproductive health and rights as essential services.

Use the COVID-19 recovery to jumpstart universal health coverage. In the wake of the greatest global health crisis in generations, recovery provides an historic opportunity to develop universal coverage built on strong health systems, quality care, and comprehensive services for sexual and reproductive health and rights tailored to diverse groups of people. Important support and accountability for progress could come from including experts on sexual and reproductive rights and health and gender equality in pandemic recovery plans and mechanisms.

Scale up support for midwives as a proven investment. This should increase the number of midwives and provide an environment enabling their work. It should better integrate midwives within health-care teams, including through supportive regulations, so that they work in an atmosphere of trust and respect as essential health-care workers.

Listen to health-care users to uphold their rights and improve the quality of care. Regular surveys, including simple forms through text messages, should capture patient perspectives after care. Training for health-care providers should emphasize bodily autonomy and principles of respectful communication attuned to diverse user demands and experiences.

3 Think differently. Pursue recent innovations in health-care service delivery to accelerate sexual and reproductive justice and support people's agency and bodily autonomy.

Develop the potential of self-managed care. Some of the most successful innovations during the pandemic involved self-managed care at home. The Commission recommends studying

the cost-effectiveness and potential of this modality for better meeting rights and needs, particularly among excluded groups. Findings could be used for a systematic review of health systems to understand where self-managed care is feasible and desirable, towards adapting care practices accordingly.

Pursue digital innovations while tackling the digital divide. Wider use of digital health technologies in health systems should include support for self-managed care and access to information. For digital innovations to remain aligned with sexual and reproductive justice, health systems need deliberate strategies to close the digital divide.

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

Close gaps in humanitarian action and plan ahead: The limited inclusion of sexual and reproductive health and rights in humanitarian programmes, plans and budgets results in devastating shortfalls in terms of bodily autonomy and gender equality. Every crisis response must include the Minimum Initial Service Package for Sexual and Reproductive Health as a floor and not a ceiling. More systematic strategies to reduce risks to sexual and reproductive health and rights during crises should be embedded in forward-looking disaster risk reduction and management plans.

Reach youth on their terms: Youth have the right to be meaningfully involved in all areas of public policymaking that influence their health and well-being. The Commission particularly emphasizes engaging with younger adolescents, who remain shut off from services and information in many parts of the world for reasons that include political opposition as well as poverty and social marginalization. Similar issues apply and must be addressed for young people with diverse sexual orientations and gender identities who may face severe stigmas at a highly vulnerable point in their lives.

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

Make expenditure visible and measurable: In tandem with more resources, the Commission urges greater transparency and accountability around expenditure. Sexual and reproductive health and rights must have specific, trackable lines in national health budgets and accounting for donor contributions.

Introduce no-cost comprehensive services for sexual and reproductive health and rights: Given the high returns on sexual and reproductive health and its relatively low cost, a comprehensive package of services should be free of charge as part of universal health coverage. The Commission sees this step as among the clearest expressions of political commitment to the ICPD agenda and gender equality, one deserving international recognition and support.

Explore new avenues for finance: At a moment of profound fiscal pressures, governments should use innovative means to raise revenues for sexual and reproductive health and rights, such as debt swaps that provide new finance and reduce debt burdens. Since such instruments are technically complex, the international community should source expertise to support national governments in structuring them.

Forge alliances with new partners: Sufficient finance for sexual and reproductive health and rights requires new public and private alliances beyond the health sector. Ministries of finance and the economy and businesses and their associations should be engaged as advocates of investment in sexual and reproductive justice, given its substantial contribution to development.

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

Develop more robust systems to collect and use data. Critical aspects of sexual and reproductive health and rights, gender equality and intersectionality are still not measured. The Commission urges national governments and international donors to take a more systematic approach to investing in statistical systems, one that includes capacity development and the transfer of technologies. This process should prioritize country-specific data that underpin persuasive advocacy and policy choices aligned with human rights.

Inspire broad support and action. The Commission recalls the spirit of the Nairobi Summit, which demonstrated just how much support there is globally for sexual and reproductive justice. Knowing this is the will of most people, it calls for a more assertive push against persistent minority opposition. This should use sexual and reproductive justice as a rallying cry that will inspire many and instil new energy. It should foster new alliances, including with faith-based leaders and organizations that sustain often unique and trusted links to communities.

Closing inequalities and gender gaps, sustaining resilience in the face of crisis, and making successful links between development and demographics will all depend on realizing agency and bodily autonomy for all. The surest route forward is through sexual and reproductive justice.

ANNEX A

NAIROBI GLOBAL COMMITMENTS MONITORING FRAMEWORK

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

Complementing the narrative report by the High-Level Commission, this annex presents the Global Commitments Monitoring Framework. It uses a four-colour traffic light system to indicate progress globally and regionally on key global indicators under each of the 12 global commitments and as an overall score for every commitment.[1] The colours run from green as the most positive, to yellow, then orange and finally red as the lowest score. A grey colour, means there isn't sufficient data for that indicator for the respective region. The methodological note in Annex B documents the development of the framework.

This initial version of the framework presents a baseline for selected indicators and overall regional scores for each commitment, against the benchmarks and level of ambition included in the Nairobi Statement commitments. The Commission will explore the possibility of continuing to reflect on these indicators in future reports to distinguish trends and hopefully mark progress.

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Commitment 2	●	●	●	●	●	●	●
Commitment 3	●	●	●	●	●	●	●
Commitment 4	●	●	●	●	●	●	●
Commitment 5	●	●	●	●	●	●	●
Commitment 8	●	●	●	●	●	●	●
Commitment 9	●	●	●	●	●	●	●
Commitment 10	●	●	●	●	●	●	●
Commitment 11	●	●	●	●	●	●	●
Commitment 12	●	●	●	●	●	●	●
Overall score	●	●	●	●	●	●	●

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

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Adolescent birth rate	🟡	🟢	🟢	🔴	🟠	🟢	🔴
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - contraceptive and family planning)	🟠	🟡	🟢	🟠	🟠	🟢	🟡
Unmet need for modern methods, total (all women)	🟡	🟡	🟡	🟡	🟠	🟡	🟠
Overall score	🟠	🟡	🟡	🟠	🟠	🟡	🟠

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Universal Health Coverage Index (SDG 3.8.1)	🔴	🟡	🟢	🟡	🟠	🟢	🔴
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - maternity care)	🟠	🟠	🟡	🟠	🟠	🟡	🟠
Proportion of births attended by skilled health personnel (SDG 3.1.2)	🔴	🟡	🟢	🟡	🔴	🟡	🔴
Maternal mortality ratio (SDG 3.1.1)	🔴	🟢	🟢	🟢	🟡	🟢	🔴
World Abortion Laws	🟡	🟡	🟢	🟠	🟡	🟡	🟠
Overall score	🟠	🟡	🟢	🟡	🟠	🟡	🔴

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Percentage of young women age 20-24 who gave birth by age 15	🟡	🟡	🟡	🟡	🟡	⚪	🟠
Percentage of young women age 20-24 who gave birth by age 18	🔴	🔴	🟠	🔴	🔴	⚪	🔴
Demand for family planning satisfied by modern methods (all women age 15-24)	🔴	🟠	🟠	🟠	🔴	⚪	🔴
Number of new HIV infections per 1,000 uninfected population (15-24 years) (SDG 3.3.1)	🟢	🟡	🟢	🟡	🟢	🟢	🔴
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2- sexuality education)	🔴	🟡	🟢	🔴	🔴	🔴	🔴
Overall score	🔴	🟡	🟡	🟠	🔴	⚪	🔴

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Violence against women from an intimate partner (SDG 5.2.1)	🟠	🟡	🟡	🟡	🟡	🟡	🟠
Proportion of women aged 20–24 years who were married or in a union before age 15 (SDG 5.3.1 - under age 15)	🟡	🟡	🟡	🟡	🟡	🟡	🟠
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - violence against women)	🟡	🟠	🟡	🟡	🔴	🟢	🟠
Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment (SDG 5.c.1)	🟡	🟡	🟢	🟡	🟡	🟢	🟡
Consensual same sex sexual acts between adults legal	🔴	🟠	🟢	🟠	🔴	🔴	🔴
Overall score	🟠	🟡	🟡	🟡	🟠	🟡	🟠

8 NAIROBI GLOBAL COMMITMENT

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Secondary school net attendance ratio	🔴	🟠	🟢	🟡	🔴	🟢	🔴
Proportion of youth (aged 15–24 years) not in education, employment or training (SDG 8.6.1)	🔴	🔴	🟡	🔴	🔴	🟡	🔴
Proportion of women aged 20-24 years who were married or in a union before age 18 (SDG 5.3.1 - under age 18)	🔴	🟠	🟡	🔴	🟠	🟠	🔴
Overall score	🔴	🟠	🟡	🔴	🔴	🟡	🔴

9 NAIROBI GLOBAL COMMITMENT

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Representation in public institutions (ratio of female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	🔴	🔴	🟠	🔴	🔴	🟠	🔴
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	🔴	🔴	🟠	🟡	🔴	🔴	🔴
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1. - employment and economic benefits)	🔴	🟠	🟢	🟡	🟠	🟡	🟠
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - overarching legal frameworks and public life)	🟠	🟠	🟡	🟠	🔴	🟠	🟠
Existence of independent national human rights institutions in compliance with the Paris Principles (SDG 16.A.1 - A status)	🔴	🔴	🟠	🟠	🔴	🔴	🔴
Protection against hate crimes (ILGA)	🔴	🔴	🔴	🔴	🔴	🔴	🔴
Protection against incitement (ILGA)	🔴	🔴	🟠	🔴	🔴	🔴	🔴
Overall score	🔴	🔴	🟠	🟠	🔴	🔴	🔴

10 NAIROBI GLOBAL COMMITMENT

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Open Data Watch Index - overall score (coverage and openness of official statistics)							
Completeness of birth registration (SDG 17.19.2)							
Completeness of census (SDG 17.19.2)							
Completeness of death registration (SDG 17.19.2)							
Common operational data set							
Overall score							

11 NAIROBI GLOBAL COMMITMENT

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Economic empowerment							
Education							
Youth policy and political participation							
Safety and security							
Overall score							

12 NAIROBI GLOBAL COMMITMENT

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

	Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Proportion of funds "received" compared with "requested" for humanitarian action to address the specific needs, in particular, sexual and reproductive health and rights and gender-based violence, of women, girls and young people							
Overall score							

ANNEX B

METHODOLOGICAL NOTE

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

The framework was developed at the request of and fully endorsed by the High-Level Commission. Avenir Health lead the process in collaboration with the ICPD25 Follow-up Secretariat, the Commission and technical experts at UNFPA and its partners. The work built off on the initial draft framework that was prepared by a UNFPA Task Team during 2020.

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

Indicator selection

For each global commitment,[1] indicators were selected based on several criteria, namely that they:

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

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

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

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

Missing data

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

1 Except for commitments 1, 6 and 7.

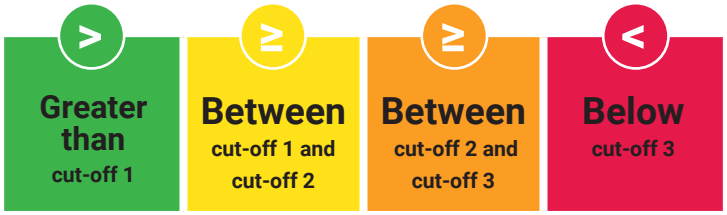
Scaling indicators

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

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

Traffic light cut-off thresholds

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



Indicator weights

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

Regional classification

The results for each indicator of each commitment are presented by geographic regions based on the country groupings defined by the UN Statistics Division in presenting the SDG indicators. Table 20 shows the number of countries represented in each region.

Global Commitments Monitoring Framework summary

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

Table 1. Commitment index value and colour by region

	1	2	3	4	5	8	9	10	11	12
Central and Southern Asia	0.629	0.725	0.770	0.677	0.642	0.585	0.302	0.684	0.553	0.593
Eastern and South-Eastern Asia	0.769	0.844	0.846	0.878	0.830	0.758	0.400	0.768	0.574	0.913
Europe and Northern America	0.838	0.843	0.942	0.893	0.929	0.894	0.722	0.769	0.672	0.775
Latin America and the Caribbean	0.701	0.700	0.821	0.758	0.832	0.719	0.607	0.740	0.621	0.388
Northern Africa and Western Asia	0.653	0.696	0.805	0.683	0.681	0.650	0.383	0.684	0.542	0.641
Oceania	no data	0.855	0.886	no data	0.841	0.838	0.497	0.641	0.698	1.000
Sub-Saharan Africa	0.531	0.548	0.556	0.607	0.598	0.500	0.418	0.515	0.536	0.450

Commitment details

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

Global commitment 1: Intensify our efforts for the full, effective and accelerated implementation and funding of the ICPD Programme of Action, Key Actions for the Further Implementation of the Programme of Action of the ICPD, the outcomes of its reviews, and Agenda 2030 for Sustainable Development.

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

Global commitment 2: Zero unmet need for family planning information and services, and universal availability of quality, accessible, affordable and safe modern contraceptives.

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

Table 2. Global commitment 2 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Adolescent birth rate (SDG 3.7.2)	Adolescent birth rate per 1,000 women aged 15-19 years.	*World Population Prospects 2019*
Sexual and reproductive health-care laws and regulations: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2, Section 2, contraceptive and family planning)	Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (Section 2, contraceptive and family planning).	SDG Global Database
Unmet need for modern methods of contraception, total (all women)	Percentage of all women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with an unmet need are those who want to stop or delay childbearing but are not using any modern method of contraception.	*World Contraceptive Use 2020*

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

INDICATOR	POPULATION	WEIGHT	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Adolescent birth rate (SDG 3.7.2)*	Women aged 15-19 years	0.4	25	37.5	50
Sexual and reproductive health-care laws and regulations: Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2, Section 2, contraceptive and family planning)	Men and women aged 15 and over	0.2	90	75	60
Unmet need for modern methods of contraception, total (all women)*	Women aged 15-49 years	0.4	0	15	30

Global commitment 3: Zero preventable maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national UHC strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.

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

Table 4. Global commitment 3 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Universal Health Coverage Index (SDG 3.8.1)	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 (worst) to 100 (best), which is computed as the geometric mean of 14 tracer indicators of health service coverage.	SDG Global Database
Sexual and reproductive health-care laws and regulations: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2, Section 1, maternity care)	Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (Section 1, maternity care).	SDG Global Database

INDICATOR	DEFINITION	SOURCE
Proportion of births attended by skilled health personnel (SDG 3.1.2)	Proportion of births attended by skilled health personnel (generally doctors, nurses or midwives but can refer to other health professionals providing childbirth care).	SDG Global Database
Maternal mortality ratio (SDG 3.1.1)	Number of maternal deaths during a given period per 100,000 live births during the same period. It depicts the risk of maternal death relative to the number of live births and essentially captures the risk of death in a single pregnancy or of a single live birth.	SDG Global Database
World Abortion Laws	The Center for Reproductive Rights tracks the legal status of abortion in countries across the globe. Countries are classified by several categories (e.g., prohibited altogether, to save the woman's life, to preserve health, etc.). For the framework, each category is assigned a numeric level: "prohibited altogether" = 0; "to save the woman's life" = 0.25; "to preserve health" = 0.5; "broad social or economic grounds" = 0.75; "on request (gestational limits vary)" = 1.	Center for Reproductive Rights

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

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

Global commitment 4: Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality and timely services to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood.

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

Table 6. Global commitment 4 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Young women aged 20–24 giving birth by age 15	Percentage of young women aged 20–24 who gave birth by age 15.	Demographic and Health Survey, Multiple Indicator Cluster Survey
Young women aged 20–24 giving birth by age 18	Percentage of young women aged 20–24 who gave birth by age 18.	Demographic and Health Survey, Multiple Indicator Cluster Survey
Demand for family planning satisfied by modern methods of contraception, all women aged 15–24 years	The number of women aged 15–24 years using modern methods of family planning divided by the number of currently married women with demand for family planning (either with unmet need or currently using any family planning).	Demographic and Health Survey, Multiple Indicator Cluster Survey
Number of new HIV infections per 1,000 uninfected population aged 15–24 years (SDG 3.3.1)	Number of new cases of HIV per year per uninfected adolescents per 1,000 people aged 15–24 years.	UNAIDS
Sexual and reproductive health-care laws and regulations: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2, Section 3, sexuality education)	Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (Section 3, sexuality education).	SDG Global Database

Table 7. Global commitment 4 indicator weights, scales and threshold cut-offs

INDICATOR	POPULATION	WEIGHT	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Young women aged 20–24 giving birth by age 15*	Women aged 20–24 years	0.125	0	2.5	5
Young women aged 20–24 giving birth by age 18*	Women aged 20–24 years	0.125	0	2.5	5
Demand for family planning satisfied by modern methods of contraception, all women aged 15–24	Women aged 15–24 years	0.25	90	75	60

INDICATOR	POPULATION	WEIGHT	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Number of new HIV infections per 1,000 uninfected population aged 15–24 years (SDG 3.3.1)*	Men and women aged 15–24 years	0.25	0.2	0.6	1
Sexual and reproductive health-care laws and regulations: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2, Section 3, sexuality education)	Men and women 15 years and older	0.25	90	75	60

Global commitment 5: Zero sexual and gender-based violence and harmful practices, including zero child, early and forced marriage, as well as zero female genital mutilation; and elimination of all forms of discrimination against all women and girls, to realize all individuals' full socioeconomic potential.

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

Table 8. Global commitment 5 indicators and definitions

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

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

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

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

Global Commitment 6: Using national budget processes, including gender budgeting and auditing, increasing domestic financing and exploring new, participatory and innovative financing instruments and structures to ensure full, effective and accelerated implementation of the ICPD Programme of Action.

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

Global commitment 7: Increasing international financing for the full, effective and accelerated implementation of the ICPD Programme of Action, to complement and catalyse domestic financing, in particular of sexual and reproductive health programmes, and other supportive measures and interventions that promote gender equality and girls' and women's empowerment.

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

Global commitment 8: Investing in the education, employment opportunities, health, including family planning and sexual and reproductive health services, of adolescents and youth, especially girls, to fully harness the promises of the demographic dividend.

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

Table 10. Global commitment 8 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Total net enrolment rate, secondary school	Total number of students of secondary-school age who are enrolled in secondary education, expressed as a percentage of the corresponding population in that age group.	World Bank

INDICATOR	DEFINITION	SOURCE
Young people not in education, employment or training (SDG 8.6.1)	This indicator presents the share of young people who are not in employment, education or training as a percentage of the total number of young people in the corresponding age group, by gender.	SDG Global Database
Women married before age 18 (SDG 5.3.1)	Proportion of women aged 20–24 years who were married or in a union before age 18	SDG Global Database

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

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

Global Commitment 9: Building peaceful, just and inclusive societies, where no one is left behind, where all, irrespective of race, colour, religion, sex, age, disability, language, ethnic origin, sexual orientation and gender identity or expression, feel valued and are able to shape their own destiny and contribute to the prosperity of their societies

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

Table 12. Global commitment 9 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Representation in public institutions (ratio for female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Proportions of positions in national and local institutions, including (a) the legislature, (b) the public services and (c) the judiciary, compared to national distributions (ratio of the proportion of women in parliament in the proportion of women in the national population with the age of eligibility as a lower-bound boundary).	SDG Global Database
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Proportions of positions in national and local institutions, including (a) the legislature, (b) the public services and (c) the judiciary, compared to national distributions (ratio of the proportion of young Members of Parliament in the proportion of the national population with the age of eligibility as a lower-bound boundary).	SDG Global Database

INDICATOR	DEFINITION	SOURCE
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 3, employment and economic benefits)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (Area 3, employment and economic benefits).	SDG Global Database
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 1, overarching legal frameworks and public life)	Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (Area 1, overarching legal frameworks and public life).	SDG Global Database
National human rights institutions – A: Status (SDG 16.A.1)	Existence of independent national human rights institutions in compliance with the Paris Principles (A: Status).	SDG Global Database
Protection against hate crimes	The *State-Sponsored Homophobia: Global Legislation Overview Update 2020* report states that hate crime protection is composed of "different legal vehicles to address the violence motivated by a victim's sexual orientation". For the framework, countries are defined as: 1 = "yes protection exists", 0 = "no protection exists" or 0.25 (for a limited number of countries) = "protection is not available nationwide or does not meet the threshold for the category".	International Lesbian, Gay, Bisexual, Trans and Intersex Association
Protection against Incitement	The *State-Sponsored Homophobia: Global Legislation Overview Update 2020* report states that protection against incitement entails laws that "recognize the paramount importance of securing the safety and protection of marginalized communities". For the framework, countries are defined as: 1 = "yes protection exists", 0 = "no protection exists" or 0.25 (for a limited number of countries) = "protection is not available nationwide or does not meet the threshold for the category".	International Lesbian, Gay, Bisexual, Trans and Intersex Association

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

INDICATOR	POPULATION	WEIGHT	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Representation in public institutions (ratio for female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Women aged 18 years and older	0.125	0.9	0.75	0.6
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Men and women aged 18-44 years	0.125	0.9	0.75	0.6
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 3, employment and economic benefits)	Entire population	0.125	90	75	60

INDICATOR	POPULATION	WEIGHT	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Legal frameworks that promote, enforce and monitor gender equality (SDG 5.1.1, Area 1, overarching legal frameworks and public life)	Entire population	0.125	90	75	60
National human rights institutions – A: Status (SDG 16.A.1)	Entire population	0.25	0.9	0.75	0.6
Protection against hate crimes	Entire population	0.125	0.9	0.75	0.6
Protection against incitement	Entire population	0.125	0.9	0.75	0.6

Global commitment 10: Providing quality, timely and disaggregated data that ensure privacy of citizens and are also inclusive of younger adolescents, investing in digital health innovations, including in big data systems, and improvement of data systems to inform policies aimed at achieving sustainable development.

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

Table 14. Global commitment 10 indicators and definitions

INDICATOR	DEFINITION	SOURCE
Open Data Watch Inventory – overall score	The inventory assesses the coverage and openness of official statistics to monitor the progress of open data relevant to the economic, social and environmental development of a country. The overall score is an indicator of how complete and open a national statistical office's data offerings are. It comprises a coverage subscore (how complete the country's data offerings are) and an openness subscore (how well the data meet standards recommended by the Open Definition and Open Data Charter).	Open Data Watch ODIN
Completeness of birth registration (SDG 17.19.2)	Proportion of countries that have achieved 100 per cent birth registration.	*State of the World's Children,* UNICEF
Completeness of census (SDG 17.19.2)	Proportion of countries that have conducted at least one population and housing census in the last 10 years.	SDG Global Database
Completeness of death registration (SDG 17.19.2)	Proportion of countries that have achieved 80 per cent death registration.	The United Nations Statistics Division's *Population and Vital Statistics Report* and the United Nations Population Division's *World Population Prospects*.

INDICATOR	DEFINITION	SOURCE
Common operational data set – population statistics	Common operational data sets are authoritative reference data sets to support operations and decision-making for all actors in a humanitarian response. "Up-to-date" population statistics in the data sets have reference years within three years of the current year.	OCHA common operational data sets

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

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

Global commitment 11: Committing to the notion that nothing about young people's health and well-being can be discussed and decided upon without their meaningful involvement and participation ("nothing about us, without us").

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

Table 16. Global commitment 11 domains and definitions

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

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

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

Global Commitment 12: Ensuring that the basic humanitarian needs and rights of affected populations, especially those of girls and women, are addressed as critical components of responses to humanitarian and environmental crises, as well as fragile and post-crisis reconstruction contexts, through the provision of access to comprehensive sexual and reproductive health information, education and services, including access to safe abortion services to the full extent of the law, and post-abortion care, to significantly reduce maternal mortality and morbidity, sexual and gender-based violence and unplanned pregnancies under these conditions.

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

Table 18. Global commitment 12 indicator and definition

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

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

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

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

Table 20. Scaled cut-off thresholds by global commitment

	CUT-OFF 1	CUT-OFF 2	CUT-OFF 3
Commitment 1	0.900	0.753	0.607
Commitment 2	0.930	0.725	0.520
Commitment 3	0.898	0.816	0.733
Commitment 4	0.945	0.839	0.733
Commitment 5	0.965	0.724	0.483
Commitment 8	0.911	0.822	0.733
Commitment 9	0.900	0.750	0.600
Commitment 10	0.900	0.750	0.600
Commitment 11	0.700	0.600	0.500
Commitment 12	0.900	0.750	0.600

Table 21. Scaled threshold cut-offs for indicators by commitment

	SCALED CUT-OFF 1	SCALED CUT-OFF 2	SCALED CUT-OFF 3
Commitment 2			
Adolescent birth rate	0.875	0.8125	0.75
Sexual and reproductive health care laws and regulations (SDG 5.6.2 - contraceptive and family planning)	0.9	0.75	0.6
Unmet need for modern contraception, all women	1	0.625	0.25
Commitment 3			

	SCALED CUT-OFF 1	SCALED CUT-OFF 2	SCALED CUT-OFF 3
Universal Health Coverage Index	0.8	0.7	0.6
Sexual and reproductive health-care laws and regulations (SDG 5.6.2, Section 1, maternity care)	0.9	0.75	0.6
Skilled birth attendance (SDG 3.1.2)	0.98	0.94	0.9
Maternal mortality rate (SDG 3.1.1)	0.93913	0.908696	0.878261
World Abortion Laws	0.75	0.5	0.25
Commitment 4			
Women aged 20–24 who gave birth before age 15	1	0.875	0.75
Women aged 20–24 who gave birth before age 18	1	0.958333	0.916667
Family planning demand satisfied by modern contraception, aged 15–24	0.9	0.75	0.6
New HIV infections (SDG 3.3.1)	0.98	0.94	0.9
Sexual and reproductive health care laws and regulations (5.6.2, Section 3, sexuality education)	0.9	0.75	0.6
Commitment 5			
Intimate partner violence (SDG 5.2.1)	1	0.625	0.25
Women aged 20–24 years who married before age 15 (SDG 5.3.1)	1	0.666667	0.333333
Legal framework (SDG 5.1.1, Area 2, violence against women)	0.9	0.75	0.6
Countries tracking gender equality (SDG 5.c.1)	0.9	0.75	0.6
Same sex sexual acts legal	1	0.9	0.8
Commitment 8			
Secondary-school net attendance ratio	0.9	0.8	0.7
Youth not in education, employment or training	0.833333	0.791667	0.75
Women aged 20–24 years who married before age 18 (SDG 5.3.1)	1	0.875	0.75
Commitment 9			
Female Members of Parliament (SDG 16.7.1)	0.9	0.75	0.6
Young Members of Parliament (SDG 16.7.1)	0.9	0.75	0.6
Employment and economic benefits (SDG 5.1.1, Area 3, employment and economic benefits)	0.9	0.75	0.6
Overarching legal frameworks and public life (SDG 5.1.1 Area 1, overarching legal frameworks and public life)	0.9	0.75	0.6
Independent human rights institutions (SDG 16.A.1, A: status)	0.9	0.75	0.6
Protection against hate crimes	0.9	0.75	0.6
Protection against incitement	0.9	0.75	0.6
Commitment 10			
Open Data Watch Index	0.9	0.75	0.6
Birth registration (SDG 17.19.2)	0.9	0.75	0.6
Census (SDG 17.19.2)	0.9	0.75	0.6

	SCALED CUT-OFF 1	SCALED CUT-OFF 2	SCALED CUT-OFF 3
Death registration (SDG 17.19.2)	0.9	0.75	0.6
Common operational data set	0.9	0.75	0.6
Commitment 11			
Economic empowerment	0.7	0.6	0.5
Education	0.7	0.6	0.5
Youth policy and political participation	0.7	0.6	0.5
Safety and security	0.7	0.6	0.5
Commitment 12			
Humanitarian “ask” versus “give”	0.9	0.75	0.6

Global Commitments Monitoring Framework results

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

Table 22. Regional groupings used in the framework

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

Table 23. Global commitment 1 results by region

REGION	COMPOSITE INDEX VALUE
Central and Southern Asia	0.629
Eastern and South-Eastern Asia	0.769
Europe and Northern America	0.838
Latin America and the Caribbean	0.701
Northern Africa and Western Asia	0.653
Oceania	*no data*
Sub-Saharan Africa	0.531

Table 24. Global commitment 2 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Adolescent birth rate	Index value	0.872	0.895	0.930	0.685	0.780	0.914	0.475
	# countries	13	14	26	25	17	9	48
	% population	100%	100%	100%	100%	100%	100%	100%
Nr of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - contraceptive and family planning)	Index value	0.608	0.878	0.944	0.679	0.739	0.965	0.772
	# countries	10	9	14	12	9	2	33
	% population	76.9%	64.3%	53.8%	46.2%	52.9%	20.0%	68.8%
Unmet need for modern methods, total (all women)	Index value	0.637	0.775	0.707	0.725	0.589	0.740	0.510
	# countries	13	14	24	25	17	8	47
	% population	100.0%	100.0%	99.9%	100.0%	100.0%	99.5%	100.0%

Table 25. Global commitment 3 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Universal Health Coverage Index (SDG 3.8.1)	Index value	0.536	0.745	0.818	0.760	0.659	0.844	0.441
	# countries	13	14	26	25	16	9	48
	% population	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%
Nr of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - maternity care)	Index value	0.659	0.668	0.844	0.677	0.663	0.810	0.705
	# countries	7	8	12	9	9	1	24
	% population	53.8%	57.1%	46.2%	34.6%	52.9%	10.0%	50.0%
Proportion of births attended by skilled health personnel (SDG 3.1.2)	Index value	0.781	0.960	0.991	0.956	0.883	0.975	0.625
	# countries	13	14	22	25	16	9	48
	% population	100%	100%	87%	100%	98.40%	100%	100%
Maternal mortality ratio (SDG 3.1.1)	Index value	0.869	0.947	0.990	0.941	0.933	0.990	0.553
	# countries	13	14	26	25	17	9	48
	% population	100%	100%	100%	100%	100%	100%	100%
World Abortion Laws	Index value	0.712	0.607	0.923	0.413	0.500	0.500	0.464
	# countries	13	14	26	25	17	9	48
	% population	100%	100%	100%	100%	100%	90%	100%

Table 26. Global commitment 4 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Percentage of young women age 20–24 who gave birth by age 15	Index value	0.929	0.982	0.999	0.904	0.966	*no data*	0.759
	# countries	12	7	3	13	8		40
	% population	100%	34.00%	5%	81.80%	61.50%		96.90%
Percentage of young women age 20–24 who gave birth by age 18	Index value	0.812	0.879	0.945	0.706	0.875	*no data*	0.546
	# countries	12	7	3	13	8		40
	% population	100%	34.00%	5%	81.80%	61.50%		96.90%
Demand for family planning satisfied by modern methods (all women aged 15–24)	Index value	0.438	0.719	0.657	0.671	0.497	*no data*	0.456
	# countries	8	5	3	10	5		39
	% population	75.2%	27.2%	4.9%	56.7%	34.8%	0.0%	95.5%
Number of new HIV infections per 1,000 uninfected population (aged 15–24) (SDG 3.3.1)	Index value	0.989	0.970	0.988	0.979	0.995	0.998	0.833
	# countries	8	9	9	19	10	3	44
	% population	20.20%	21.20%	19.70%	44.60%	65.90%	93.20%	97.70%
Number of countries with laws and regulations that guarantee equal access to sexual and reproductive health care (SDG 5.6.2 - sexuality education)	Index value	0.410	0.891	0.955	0.578	0.320	0.500	0.487
	# countries	9	8	11	12	9	2	32
	% population	69.2%	57.1%	42.3%	46.2%	52.9%	20.0%	66.7%

Table 27. Global commitment 5 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Violence against women from an intimate partner (SDG 5.2.1)	Index value	0.538	0.805	0.871	0.795	0.675	0.879	0.496
	# countries	11	12	25	23	11	9	39
	% population	97.9%	97.3%	91.3%	99.9%	69.0%	100%	94.4%
Proportion of women aged 20–24 years who were married or in a union before age 15 (SDG 5.3.1 - under age 15)	Index value	0.775	0.934	0.988	0.835	0.871	0.883	0.642
	# countries	13	10	6	20	15	5	45
	% population	100%	36.0%	7.1%	86.4%	97.9%	6.0%	99.7%
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - violence against women)	Index value	0.833	0.736	0.830	0.852	0.595	0.917	0.656
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%
Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment (SDG 5.c.1)	Index value	0.750	0.833	1.000	0.857	0.857	1.000	0.808
	# countries	4	6	3	7	7	5	26
	% population	30.8%	42.9%	11.5%	26.9%	41.2%	50.0%	54.2%
Consensual same sex sexual acts between adults legal	Index value	0.385	0.857	1.000	0.846	0.412	0.500	0.458
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%

Table 28. Global commitment 8 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Secondary school net attendance ratio	Index value	0.599	0.745	0.929	0.800	0.686	0.918	0.339
	# countries	11	8	25	23	13	6	35
	% population	99.7%	33.0%	99.8%	97.5%	78.4%	95.5%	58.4%
Proportion of youth (aged 15–24 years) not in education, employment or training (SDG 8.6.1)	Index value	0.504	0.725	0.801	0.654	0.495	0.824	0.603
	# countries	10	11	26	21	13	9	37
	% population	98.2%	40.4%	100.0%	98.6%	86.2%	100.0%	92.9%
Proportion of women aged 20–24 years who were married or in a union before age 18 (SDG 5.3.1 - under age 18)	Index value	0.654	0.805	0.951	0.702	0.769	0.772	0.558
	# countries	13	10	8	20	15	5	45
	% population	100.0%	36.0%	15.6%	86.4%	97.9%	6.0%	99.7%

Table 29. Global commitment 9 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Representation in public institutions (ratio of female Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Index value	0.335	0.459	0.612	0.549	0.410	0.642	0.460
	# countries	13	14	26	24	14	9	47
	% population	100.0%	100.0%	100.0%	98.4%	87.2%	100.0%	99.7%
Representation in public institutions (ratio of young Members of Parliament, lower chamber or unicameral) (SDG 16.7.1)	Index value	0.364	0.311	0.706	0.761	0.470	0.561	0.478
	# countries	10	8	25	15	9	5	21
	% population	97.7%	92.3%	95.5%	56.7%	42.0%	97.8%	67.0%
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1. - employment and economic benefits)	Index value	0.417	0.683	0.905	0.778	0.600	0.900	0.663
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%
Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex (SDG 5.1.1 - overarching legal frameworks and public life)	Index value	0.683	0.606	0.814	0.726	0.570	0.700	0.655
	# countries	6	6	22	18	7	3	16
	% population	46.2%	42.9%	84.6%	69.2%	41.2%	30.0%	33.3%
Existence of independent national human rights institutions in compliance with the Paris Principles (SDG 16.A.1 - A status)	Index value	0.308	0.500	0.731	0.615	0.471	0.400	0.479
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Protection against hate crimes (ILGA)	Index value	0.000	0.143	0.548	0.462	0.059	0.225	0.083
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Protection against incitement (ILGA)	Index value	0.000	0.000	0.731	0.346	0.015	0.150	0.047
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%

Table 30. Global commitment 10 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Open Data Watch Index - overall score (coverage and openness of official statistics)	Index value	0.439	0.538	0.691	0.457	0.510	0.461	0.395
	# countries	13	13	26	23	16	7	45
	% population	100%	92.9%	100%	88.5%	94.1%	70.0%	93.8%
Completeness of birth registration (SDG 17.19.2)	Index value	0.556	0.625	1.000	0.600	0.813	0.571	0.222
	# countries	9	8	26	24	16	6	27
	% population	69.2%	57.1%	100%	96.2%	94.1%	70.0%	56.3%
Completeness of census (SDG 17.19.2)	Index value	0.692	1.000	0.923	0.885	0.588	1.000	0.688
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%
Completeness of death registration (SDG 17.19.2)	Index value	0.889	0.750	1.000	0.760	0.625	0.571	0.273
	# countries	9	8	26	24	16	6	22
	% population	69.2%	57.1%	100%	96.2%	94.1%	70.0%	45.8%
Common operational data set	Index value	0.846	0.929	0.231	1.000	0.882	0.600	1.000
	# countries	13	14	26	26	17	10	48
	% population	100%	100%	100%	100%	100%	100%	100%

Table 31. Global commitment 11 results by region

		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Economic empowerment	Index value	0.622	0.666	0.706	0.641	0.569	0.709	0.629
Education	Index value	0.501	0.670	0.803	0.772	0.674	0.785	0.472
Youth policy and political participation	Index value	0.462	0.272	0.443	0.525	0.350	0.485	0.476
Safety and security	Index value	0.626	0.688	0.735	0.548	0.574	0.815	0.568

Table 32. Global commitment 12 results by region

Indicators/Region		Central and Southern Asia	Eastern and South-eastern Asia	Europe and Northern America	Latin America and the Caribbean	Northern Africa and Western Asia	Oceania	Sub-Saharan Africa
Proportion of funds "received" compared with "requested" for humanitarian action to address the specific needs, in particular, sexual and reproductive health and rights and gender-based violence, of women, girls and young people	Index value	0.593	0.913	0.775	0.388	0.641	1.000	0.450
	# countries	6	4	2	10	10	1	29
	% population	46.2%	28.6%	7.7%	38.5%	58.8%	10.0%	60.4%

ANNEX C

HIGH-LEVEL COMMISSION MEMBERS

Co-Chairs

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

Members

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

ANNEX D

HIGH-LEVEL COMMISSION SECRETARIAT AND SUPPORT TEAMS

Secretariat

- Saskia Schellekens, Global Coordinator, ICPD25 Follow-up & Lead HLC Secretariat
- De-Jane Gibbons, Coordination Specialist, ICPD25 Follow-up
- Gabriela Ullauri, Communications and Outreach Consultant, ICPD25 Follow-up
- Lisha Du, Junior Technical Consultant, ICPD25 Follow-up
- Lily Tong, Executive Associate, ICPD25 Follow-up

Sherpas and Support Teams

- Co-Chair H.E. President Kikwete: Togolani Mavura (until mid-2021) and Adam Issara, Private Secretaries
- Co-Chair H.E. Michaëlle Jean: Paul Cormier, Special Adviser

ENDNOTES

1 See UNFPA, 2020a.

2 For additional analysis, see IPPF, 2020b.

3 UNFPA, 2020d.

4 Archer and Provost, 2020.

5 UNFPA, 2020d.

6 The White Ribbon Alliance, n.d.

7 Filby, McConville and Portela, 2016; Renfrew, McFadden, Bastos and others, 2014.

8 Miller, Abalos, Chamillard and others, 2016; Renfrew, Ateva, Dennis-Antwi and others, 2019.

9 Acria, n.d.

10 Adapted based on Starrs, Ezeh, Barker and others, 2018.

11 Countdown 2030 Europe, 2021.

12 UN Women and United Nations Department of Economic and Social Affairs, 2021.

13 United Nations Secretary-General, 2020.

14 Ibid.

15 WHO and UNFPA, n.d.

16 WHO, 2019b.

17 ITU, 2021.

18 Ibid.

19 UNFPA, 2020c.

20 UNOCHA, 2021.

21 African Queer Youth Initiative, n.d.

22 Shenoy, 2020.

23 UN Women Europe and Central Asia, 2021.

24 Malick Fall and Holmes à Court, 2021.

25 United Nations, 2021.

26 Chakraborty and Samuels, 2021.

27 United Nations, 2021.

28 UNICEF, 2021.

29 Sadinsky, Jarandilla Nuñez, Nabulega and others, 2020.

30 WHO, n.d.

31 UNICEF Latin America and the Caribbean, 2020.

32 UNFPA, n.d.

33 UNFPA, 2021a.

34 Women Enabled International, 2020.

35 Ibid.

36 WHO, 2019a.

37 UNFPA, 2021b.

38 USA for UNHCR, n.d.

39 IRC, 2020.

40 Ibid.

41 Fisseha, Sen, Ghebreyesus and others, 2021.

42 WHO, 2021.

43 UNICEF Regional Office for South Asia, 2021.

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55 WHO, 2021.

56 Cousins, 2020.

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58 Sadinsky and Ahmed, 2021.

59 UNFPA, 2021f.

60 Sadinsky and Ahmed, 2021.

61 Samuels and Daigle, 2021.

62 Chattu, Abreu Lopes, Javed and others, 2021.

63 Starrs, Ezeh, Barker and others, 2018.

64 Ibid.

65 WHO, 2021.

66 Columbia University Mailman School of Public Health, 2020.

67 Christian Aid, 2021.

68 UNFPA, 2021d.

69 Worley, 2021.

70 IPPF, n.d.

71 Countdown 2030 Europe, 2021.

72 Commission on Population and Development, 2021.

73 European Parliamentary Forum for Sexual and Reproductive Rights, 2021.

74 UNFPA, ICM and WHO, 2021.

75 Lal, Erondu, Heymann and others, 2021.

76 Ibid.

77 Ibid.

78 Sadinsky and Ahmed, 2021.

79 The Global Fund, n.d.

80 Esquivel, 2020.

81 Pilkington, 2021; Sheridan and Chaoul, 2021.

82 Rasheed, 2021; Lally, 2021; Al Jazeera, 2021

83 Human Rights Watch, 2020.

84 BBC News, 2021.

85 McGowan, 2021.

86 NPR, 2021.

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88 Center for Reproductive Rights, n.d.

89 Peace Women, 2021.

90 Human Rights Council, 2018.

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