

OECD *publishing*

TRANSFORMING LAWS AND NORMS TO ACHIEVE UNIVERSAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

OECD DEVELOPMENT
POLICY PAPERS

February 2025 No. 58



OECD Development Policy Papers
February 2025 – No. 58

Transforming laws and norms to achieve universal sexual and reproductive health and rights

This work is published under the responsibility of the Secretary-General of the OECD. The opinions expressed and the arguments employed herein do not necessarily reflect the official views of the Member countries of the OECD or its Development Centre.

This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

This document was authorised for publication by Ragnheiður Elín Árnadóttir, Director of the OECD Development Centre.

Keywords: gender equality, reproductive health, social norms, legal frameworks, SDG5, SDG3.

JEL classification: I14, I15, K38.

© OECD 2025



Attribution 4.0 International (CC BY 4.0)

This work is made available under the Creative Commons Attribution 4.0 International licence. By using this work, you accept to be bound by the terms of this licence (<https://creativecommons.org/licenses/by/4.0/>).

Attribution – you must cite the work.

Translations – you must cite the original work, identify changes to the original and add the following text: *In the event of any discrepancy between the original work and the translation, only the text of original work should be considered valid.*

Adaptations – you must cite the original work and add the following text: *This is an adaptation of an original work by the OECD. The opinions expressed and arguments employed in this adaptation should not be reported as representing the official views of the OECD or of its Member countries.*

Third-party material – the licence does not apply to third-party material in the work. If using such material, you are responsible for obtaining permission from the third party and for any claims of infringement.

You must not use the OECD logo, visual identity or cover image without express permission or suggest the OECD endorses your use of the work.

Any dispute arising under this licence shall be settled by arbitration in accordance with the Permanent Court of Arbitration (PCA) Arbitration Rules 2012. The seat of arbitration shall be Paris (France). The number of arbitrators shall be one.

Abstract

Sexual and reproductive health and rights (SRHR) are essential for achieving gender equality, empowering women and fostering sustainable development. Despite global progress in reducing maternal mortality, adolescent fertility, unmet contraception needs and HIV/AIDS prevalence, discriminatory laws and harmful social norms continue to limit access to quality SRHR services. Drawing on the OECD Development Centre's Social Institutions and Gender Index (SIGI), this paper explores the legal and social barriers to SRHR. It highlights the need for comprehensive metrics to capture its multi-dimensional nature and offers actionable recommendations, including legal reforms, transformative social norm interventions and enhanced measurement tools. Examples of good practices illustrate effective implementation of these recommendations.

Acknowledgements

This report was prepared by the OECD Development Centre under the leadership of Ragnheiður Elín Árnadóttir, Director of the OECD Development Centre, and Bathylle Missika, Head of the Networks, Partnerships and Gender Division. It was authored by Carolin Beck and Gaëlle Ferrant, with contributions from Sofia da Silva Urech and Alannah Johnson, all part of the Gender team, under the guidance of Hyeshin Park, Gender Programme Coordinator.

The report builds on insights from the *SIGI 2023 Global Report: Gender Equality in Times of Crisis*, and the Expert Workshop “Exploring the role of data in promoting contextualised and people-centred approaches for better sexual and reproductive health”, held on 12 September 2024. The workshop explored alternative approaches to measuring reproductive autonomy and brought together researchers, programme implementers and data providers to discuss the limitations of existing family planning indicators, challenges in developing new measures, and potential solutions.

The Gender team extends its gratitude to workshop participants, whose expertise enriched this report: Boniface Ushie (Beshi King Development Services), Claire Rothschild (Population Services International), Dana Loll (Johns Hopkins Center for Communication Programs), Emebet Wuhib-Mutungji (Plan International), Emilie Filmer-Wilson (UNFPA), Isha Bhatnagar (Equimundo), Joseph Molitoris (United Nations), Leigh Senderowicz (University of Wisconsin-Madison), Mengjia Liang (UNFPA), Sarah Compton (University of Michigan), and Vladimira Kantorova (UNSD).

We also acknowledge the support of members of the SIGI Working Group and the Development Centre Governing Board who provided valuable feedback and comments throughout the drafting process.

Special thanks go to Henri-Bernard Solignac-Lecomte, Delphine Grandrieux, Elizabeth Nash and Aida Buendia in the Communications team for design and editorial contributions.

Finally, the OECD Development Centre expresses its gratitude for the generous support of the Waterloo Foundation. Their contribution was instrumental in advancing its work on SRHR.

Table of contents

Abstract	3
Acknowledgements	4
Executive summary	6
Abbreviations and acronyms	8
1 Introduction	9
2 How laws and social norms affect women’s SRHR	11
2.1. From constraints to empowerment: Harnessing the impact of legal frameworks on SRHR	12
2.2. Transforming gender norms: Leveraging social and cultural values to advance SRHR	16
3 Harnessing data and rethinking metrics to advance women’s SRHR	21
3.1. Extending the scope of SRHR indicators	22
3.2. Strengthening SRHR data systems: Insights from the OECD Expert Workshop	23
4 Policy recommendations and conclusion	26
4.1. Strengthen healthcare systems and service delivery	26
4.2. Enact and reform laws and policies	26
4.3. Transforming discriminatory social norms	27
4.4. Deliver comprehensive sexuality education (CSE)	27
4.5. Enhancing data and measurement	27
Notes	29
References	30
Annex A. Legal developments in reproductive rights	35
FIGURES	
Figure 1. Access to safe and legal abortion is out of reach for many women in Africa and the Americas	14
Figure 2. In Côte d'Ivoire, decision making over contraception use and family planning is largely in the hands of men	16

Executive summary

Sexual and reproductive health and rights (SRHR) are essential for achieving gender equality, empowering women and fostering sustainable development. Significant progress has been made in recent decades, evidenced by reductions in maternal mortality, increases in access to modern contraceptives, and improvements in skilled birth attendance. For instance, maternal mortality declined from 339 deaths per 100 000 live births in 2000 to 223 in 2020, while the use of modern contraceptives nearly doubled between 1990 and 2020. However, over 200 million women worldwide still lack access to modern contraceptives, and unsafe abortions account for nearly 39 000 preventable deaths annually. Fully realised SRHR not only improve women's health but also enhance economic empowerment and broader human rights, contributing to inclusive and sustainable growth for society as a whole.

Structural challenges remain a significant obstacle to achieving universal SRHR. Insufficient healthcare infrastructure, especially in underserved areas, financial constraints, and inequitable service distribution disproportionately affect rural and marginalised populations. Women and girls in these settings face a lack of trained providers, essential supplies and affordable services, compounded by geographic and systemic inefficiencies. Crises such as pandemics, conflicts and climate-related shocks further disrupt service delivery, amplifying vulnerabilities. For instance, during the COVID-19 pandemic, interruptions in family planning services resulted in an estimated 1.4 million unintended pregnancies globally, highlighting the fragility of progress.

Legal frameworks present deeply entrenched barriers to SRHR. Restrictive laws, such as those requiring spousal or parental consent for contraception or abortion, severely undermine women's autonomy. In many countries, abortion is either heavily restricted or entirely prohibited, leading to unsafe procedures that endanger women's health and lives. Laws barring pregnant adolescents from attending school perpetuate gender inequities, denying young mothers opportunities for education and economic advancement. Furthermore, inadequate legal protections against gender-based violence and harmful practices, such as child marriage and female genital mutilation/cutting (FGM/C), leave many women and girls without recourse to justice or support. Even where progressive laws exist, weak enforcement often limits their impact. In addition, legal rollbacks in some countries, such as restrictions on abortion rights, underscore the precariousness of progress and the need for sustained advocacy to safeguard reproductive rights. Reforming legal frameworks to align with international human rights standards, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Maputo Protocol, is critical for safeguarding women's agency and health.

Social and cultural norms exacerbate these legal and structural challenges. Patriarchal values and restrictive gender norms often deny women and girls the ability to make autonomous decisions about their health. Norms of masculinity that designate men as final decision makers, coupled with economic dependency, further limit women's SRHR choices. Social stigma and provider bias around contraception, abortion, and adolescent sexuality deter women and girls from seeking essential care. Gender-based violence, including intimate partner violence and sexual coercion, directly undermines access to SRHR services and perpetuates cycles of harm. Programmes that engage communities, including men and boys,

alongside comprehensive sexuality education, have proven successful in shifting harmful beliefs and fostering supportive environments for SRHR.

Accurate and comprehensive data are crucial for identifying barriers and designing effective interventions. Yet traditional SRHR indicators often fail to capture the nuanced dynamics of reproductive autonomy, quality of care, and the influence of discriminatory norms. Innovative metrics, such as those measuring decision-making autonomy and social attitudes, are essential for advancing evidence-based policies and programmes. Additionally, improving data systems to ensure greater disaggregation by age, gender and other intersecting factors is critical for uncovering disparities and targeting interventions effectively.

This paper underscores the urgent need for collective action among governments, development partners, civil society and local communities to dismantle barriers and accelerate progress on SRHR. Drawing on insights from the OECD Development Centre's Social Institutions and Gender Index (SIGI) and an expert workshop on alternative SRHR measures organised by the OECD in 2024, it provides actionable recommendations supported by examples of good practices:

- Strengthen healthcare systems and service delivery by expanding infrastructure in underserved areas, adopting innovative solutions like telemedicine, and training providers to deliver adolescent-friendly and bias-free care.
- Reform legal frameworks to eliminate discriminatory laws, ensure safe and legal access to abortion, decriminalise consensual adolescent relationships, and guarantee education for pregnant girls and adolescent mothers.
- Transform social norms by engaging men and boys, reducing stigma, and promoting gender-equitable decision making through community programmes and school-based initiatives.
- Deliver comprehensive sexuality education (CSE) through age-appropriate, inclusive curricula co-designed with parents, youth and community leaders.
- Enhance data systems with comprehensive metrics and greater disaggregation to better capture the multi-dimensional aspects of SRHR and guide effective interventions.

By addressing structural, legal and social barriers, and improving data systems, stakeholders can transform challenges into opportunities for advancing SRHR. These efforts are essential for empowering women, achieving gender equality, and fostering sustainable development for society as a whole.

Abbreviations and acronyms

AIDS	Acquired immunodeficiency syndrome
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CSE	Comprehensive sexuality education
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-based violence
GID-DB	Gender, Institutions and Development Database
HIV	Human immunodeficiency virus
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
SIGI	Social Institutions and Gender Index
STI	Sexually transmitted infection
VAWG	Violence Against Women and Girls
WHO	World Health Organization

1 Introduction

Sexual and reproductive health and rights (SRHR) are fundamental to achieving gender equality, empowering women, and fostering sustainable development worldwide (Box 1). Women’s ability to make autonomous decisions about their bodies, access quality healthcare, and live free from discrimination and violence is central to their well-being and societal progress. Realising SRHR leads to better health outcomes, greater economic empowerment, and the broader fulfilment of human rights. The United Nations Population Fund (UNFPA) estimates that every dollar invested in SRH services yields a return of USD 120 through reduced healthcare costs and increased productivity (UNFPA, 2022^[1]).

Box 1. Defining sexual and reproductive health and rights (SRHR)

In 1968, at the International Conference on Human Rights in Teheran, reproductive rights were first formally linked to human rights, affirming that “parents have a basic human right to determine freely and responsibly the number and spacing of their children.”

Since then, the understanding of SRHR has evolved significantly, reflecting a growing recognition of their centrality to human rights, gender equality, and sustainable development. While there is no universally agreed-upon definition of SRHR, the Guttmacher-Lancet Commission (2018) provides the most comprehensive one, framing SRHR as a state of physical, emotional, mental, and social well-being concerning all aspects of sexuality and reproduction. Thus, achieving SRHR depends on

- the realisation of rights such as respect for bodily integrity, privacy, and personal autonomy.
- freedom to define one’s sexuality, including orientation and gender identity.
- the right to decide when and with whom to marry, have children, or engage in sexual activity.
- access to necessary information, resources, and services across a lifetime, free from discrimination, coercion, or violence.

Source: (Guttmacher-Lancet Commission, 2018^[2]) (UNFPA, 1994^[3]), (United Nations, 1968^[4]) and (WHO, 2017^[5]).

Global frameworks have driven substantial progress in advancing SRHR. The Sustainable Development Goals (SDG) provide a significant milestone by including SRHR targets within both health (SDG 3) and gender equality (SDG 5):

- Target 3.7 under SDG 3 calls for universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- Target 5.6 under SDG 5 emphasises universal access to SRHR, aligning with the Beijing Platform for Action and the outcomes of their review conferences.

Additionally, the SDGs address maternal mortality (SDG 3.1), preventable newborn deaths (SDG 3.2) and the AIDS epidemic (SDG 3.3), challenges disproportionately affecting women and girls. Progress over last the decades is evident: maternal mortality fell from 339 deaths per 100 000 live births in 2000 to 223 in

2020, and adolescent fertility rates declined from 64.4 to 42.7 births per 1 000 women aged 15-19. Access to reproductive health services has improved significantly, with the percentage of births attended by skilled health staff rising from 62.3% in 2000 to 83.3% in 2020, and users of modern contraceptives nearly doubling from 467 million in 1990 to 874 million in 2020 (UNDESA, 2022^[6]; World Bank, n.d.^[7]).

Despite important progress, access to and realisation of SRHR remains inequitable due to structural, economic and cultural barriers that disproportionately affect vulnerable groups such as rural women, adolescent girls, and marginalised communities. In many underserved regions, insufficient healthcare infrastructure and shortages of trained professional continue to undermine access to quality care. For example, women in rural Cambodia face significantly higher unmet needs for family planning (13%) compared to urban areas (9.8%) in 2021-22 (National Institute of Statistics, Ministry of Health and ICF, 2023^[8]). Even where services are available, a lack of essential supplies and distant facilities limit their effectiveness.

Economic constraints further exacerbate inequalities, as women and girls in low-income settings often cannot afford SRHR services or expenses such as transportation. For instance, while sub-Saharan Africa has seen the fastest increase in modern contraceptive use over the past two decades, only 56% of women of reproductive age have their need for family planning satisfied, compared to 77% globally (UNDESA, 2022^[6]). These disparities perpetuate cycles of poverty and poor health outcomes, particularly for adolescent girls, who are most vulnerable to unintended pregnancies and restricted access to education and healthcare.

At the core of these structural challenges lie discriminatory social institutions, encompassing restrictive laws, norms and practices that limit women's autonomy and perpetuate power imbalances (Box 2). Legal provisions requiring third-party consent for contraception, restrictions on safe and legal abortion, and laws mandating women to obey their husbands in health-related decisions reflect these systemic barriers. In addition, deeply ingrained gender norms reinforce male dominance in SRHR decision making, limiting women's agency. Cultural and religious stigmas surrounding contraception or abortion further amplify these challenges, leaving many women without access to vital information, services, and support (OECD, 2023^[9]).

These challenges are further compounded during crises – such as pandemics, conflicts, and climate-related shocks – which disrupt essential healthcare services and heighten risks for women and marginalised populations. For example, the COVID-19 pandemic led to significant interruptions in family planning services, resulting in an estimated 1.4 million unintended pregnancies (UNFPA, 2020^[10]). Additionally, growing pushback against women's reproductive rights in various contexts, reflected in recent legal rollbacks, highlights the fragility of progress and the need for sustained advocacy to protect women's reproductive autonomy (OECD, 2023^[9]).

International organisations, governments, statistical institutes and researchers should increase efforts to produce comprehensive and unbiased data to identify barriers and gaps in SRHR access in order to overcome existing challenges. Accurate measurement is essential for designing effective policies and programmes that respond to individuals' needs, particularly marginalised groups. Beyond addressing data scarcity, experts emphasise the need for measures that capture the multi-dimensional aspects of SRHR, focusing on individuals' agency and decision-making power regarding their health and rights. Moving forward, data-driven approaches must also prioritise person-centred care that respects autonomy, dignity, and the rights of all individuals, regardless of their identity or circumstances. This paper explores the legal and social determinants of SRHR, highlights actionable recommendations, and showcases good practices aimed at transforming entrenched barriers into opportunities for positive change. By advancing innovative policies, fostering collaboration, and addressing systemic inequalities, SRHR progress can be both equitable and sustainable.

2 How laws and social norms affect women's SRHR

Barriers to SRHR are multifaceted and deeply entrenched. A lack of quality, affordable healthcare services and infrastructure is a critical barrier, particularly in low-resource settings where women and girls face significant challenges in accessing timely and adequate sexual and reproductive health care. These barriers are further compounded by inadequate healthcare funding, workforce shortages, and disparities in rural and urban service provision. Moreover, the intersection of poverty, geographical constraints, and systemic inefficiencies creates a reality where SRHR services remain out of reach for many. Reports such as the Guttmacher-Lancet Commission on SRHR and the UNFPA's State of the World Population Report (2024) comprehensively document these barriers, highlighting issues like inequitable service distribution, lack of trained providers, and high out-of-pocket costs for essential SRHR services lives (Guttmacher-Lancet Commission, 2018^[2]; Guttmacher-Lancet Commission, 2018^[2]; UNFPA, 2024^[11]). This literature provides a robust foundation for understanding the structural obstacles that undermine SRHR outcomes globally.

Box 2. What is the Social Institutions and Gender Index?

The SIGI provides a comprehensive measure of gender equality gaps in social institutions in 179 countries. The SIGI is one of the official data sources for SDG Indicator 5.1.1. on legal frameworks, but also provides data for almost all targets included in SDG 5, providing a comprehensive vision of national progress on gender equality.

The SIGI looks at the gaps that legislation, attitudes and practices create between women and men in terms of rights, justice and empowerment opportunities. The composite index is composed by 4 dimensions, 16 indicators and 25 underlying variables:

- The “Discrimination in the family” dimension captures these power dynamics within the household and evaluates the extent to which girls and women are undervalued.
- The “Restricted physical integrity” dimension captures social institutions that make women and girls vulnerable in these areas and limit their control over their bodies and reproductive autonomy.
- The “Restricted access to productive and financial resources” dimension captures women’s restricted access to and control over such critical productive and economic resources and assets.
- The “Restricted civil liberties” dimension captures social institutions that restrict women’s access to and participation and voice in the public and social spheres.

Source: (OECD, 2023^[9]).

Building on the SIGI framework (Box 2), this section focuses on less documented but equally impactful factors that influence SRHR: legal and social barriers and enablers. These include discriminatory laws, norms, and customs that directly shape women's and girls' ability to access knowledge, make decisions, and utilise services related to their SRHR. By examining the interplay between legal frameworks and social norms, this section aims to shed light on how these factors can either exacerbate inequalities or serve as pivotal enablers of gender equality and improved SRHR outcomes.

2.1. From constraints to empowerment: Harnessing the impact of legal frameworks on SRHR

Legal and policy frameworks play a crucial role in promoting and safeguarding women's and girls' SRHR. Yet, discriminatory provisions persist. These range from restrictive policies on accessing SRHR services to laws that institutionalise gender-based discrimination. Such constraints erode women's contraceptive and sexual autonomy from adolescence onwards. The ripple effects of these barriers extend beyond individual well-being, perpetuating gender disparities and hindering equitable health and development outcomes for women and men.

Legal reforms can empower women and promote reproductive autonomy by establishing rights-based protections. When governments enact and enforce such reforms, they embed gender equality into the legal and policy landscape, inspiring confidence among stakeholders and driving investment in gender-responsive policies (OECD, 2023^[9]). These reforms not only address structural barriers but also create an enabling environment for women's empowerment.

This section highlights the importance of updating discriminatory laws, such as those limiting school attendance for pregnant girls, restricting access to safe abortion, and requiring third-party consent for SRHR services. Addressing these provisions is a vital first step towards achieving gender equality and advancing reproductive autonomy.

2.1.1. Ensuring educational continuity for pregnant girls

Early pregnancy remains widespread with negative implications for adolescent girls' health, social inclusion and economic opportunities. In 2022, more than 12 million adolescent girls between ages 15 and 19 gave birth. While important progress has been observed in South Asia, adolescent fertility rates remain high in sub-Saharan Africa and Latin America and Caribbean, reaching 99 and 52 births per 1 000 women aged 15 to 19 in 2022. Besides the health risks pregnant girls face, this comes at a high socioeconomic cost as it often results in school-dropouts. For instance, estimates reveal that 36% of school dropout cases in Latin America and the Caribbean can be attributed to teen pregnancy or motherhood over the last decade (UNFPA, UNICEF and PAHO/WHO, 2018^[12]).

Legal and policy frameworks are crucial to keep pregnant girls in school and facilitate their re-entry after childbirth. However, in some countries, laws prohibit pregnant girls from accessing education, violating their rights and limiting future opportunities. Moreover, in parts of the MENA region, "morality laws" enable authorities to prosecute girls who have had sexual relations outside marriage, making it nearly impossible for pregnant girls or young mothers to stay in school (Human Rights Watch, 2018^[13]). Such measures or laws rarely extend to the boys or men involved, thus reinforcing gender disparities (UNICEF, 2020^[14]).

Encouragingly, more countries are adopting policies to safeguard the educational rights of pregnant adolescents and young mothers (Box 3). For instance, 26 African countries¹ have adopted "continuation" or "re-entry" policies, including six with legal protections allowing girls to resume their education post-childbirth (Human Rights Watch, 2018^[13]). Implementation and adherence to the laws and policies remain challenging and there are differences in the acceptable length of school absence, processes for withdrawal and re-entry, as well as the availability of support systems to help young mothers stay in school persist.

Box 3. Good practice: Example from Sierra Leone | Keeping Pregnant Girls in School

For decades, pregnant schoolgirls in Sierra Leone faced systemic exclusion from education, reflecting broader issues of gender inequality and social stigma. With the intent of discouraging teenage pregnancies, the Ministry of Education introduced an informal ban for pregnant girls in 2010 which was formalised in 2015. The policy faced widespread criticism for its discriminatory nature and failure to address the root causes of teenage pregnancy.

In December 2019, the ECOWAS Court ruled Sierra Leone's ban discriminatory violating both domestic and international law, which led to its reversal in 2020. The 2021 National Policy on Radical Inclusion in Schools explicitly prioritises the inclusion of marginalised groups, including pregnant girls and parent learners, ensuring they can access and remain in education until completion. In addition, increased government investment in education underscores a commitment to inclusive education, ensuring no girl should be left behind.

Source: (Daka, 2020^[15]; Amnesty International, 2020^[16]; Equality Now, 2023^[17]).

2.1.2. Ensuring safe and legal abortion access

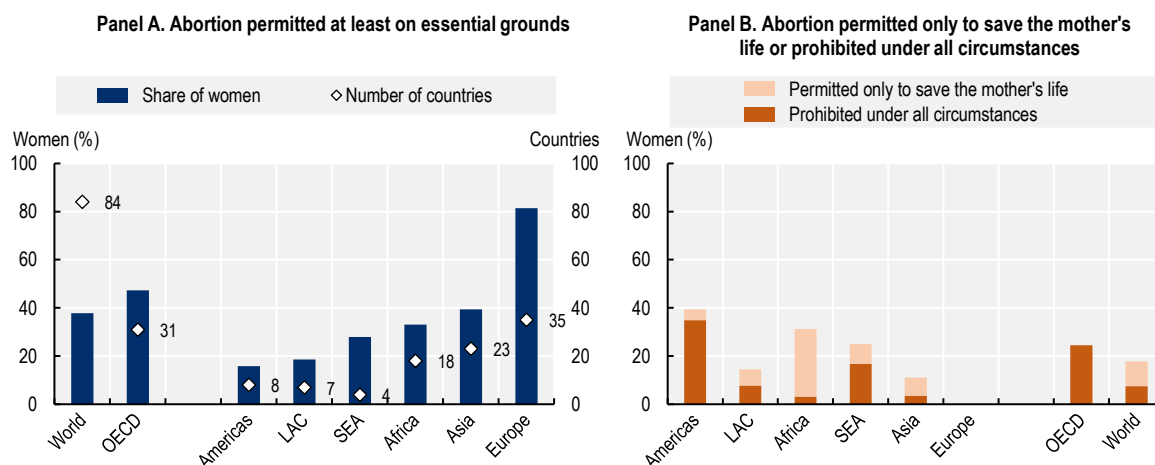
Women's right to safe and legal abortion is not only a matter of human rights but also a critical issue of health and safety. Estimates show that every year more than 45% of abortions are unsafe (UNFPA, 2022^[18]) and entail severe consequences for women's health and well-being, including infection, haemorrhage, and long-term complications. It is further estimated that unsafe abortions lead to 39 000 deaths per year, among which 60% are concentrated in Africa and 30% in Asia (WHO, 2022^[19]).

Restrictive laws are at the heart of unsafe abortions. Data reveal that the share of unintended pregnancies resulting in induced abortion is similar across countries irrespective of the legal status of abortion (Bearak et al., 2020^[20]). However, the share of unsafe abortions is significantly higher in countries with restrictive laws. SIGI data reveal that 15 countries fully prohibit abortion without any exceptions, and 25 countries only permit abortion when it is necessary to save a woman's life, accounting together for 335 million women. In contrast, 84 out of 178 countries, representing over 710 million women, permit abortion on essential grounds or at the woman's request (Figure 1).

International and regional frameworks and treaties enshrine women's right to reproductive autonomy. For instance, CEDAW or the Maputo Protocol, which applies to African women, establish the right to safe and legal abortion in cases of rape, incest, threats to the life or health of the pregnant woman and severe foetal impairment (OECD, 2023^[9]). Laws in many countries fall short of recognising the need to grant women the right to abortion under these essential circumstances, and countries where abortion rights are well established remain vulnerable to legal and political rollbacks.

Figure 1. Access to safe and legal abortion is out of reach for many women in Africa and the Americas

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



Note: In Panel A, essential grounds include saving the woman's life, preserving the physical or mental health of the mother, if the pregnancy is the result of rape, statutory rape or incest, and the case of foetal impairment. In Panels A and B, LAC refers to Latin America and the Caribbean, and SEA refers to Southeast Asia.

Source: (OECD Development Centre/OECD, 2023^[21]), "Gender, Institutions and Development (Edition 2023)", *OECD International Development Statistics* (database), <https://doi.org/10.1787/33beb96e-en>.

Abortion rights are not set in stone. Several countries have undertaken law reforms that expand women's access to abortion – often following years of advocacy and activism led by civil society organisations. Reforms range from decriminalising abortion to broadening the circumstances under which abortion is legally permitted and enshrining abortion rights in constitutions. Conversely, legal rollbacks in some countries have recently restricted women's access to safe abortion (see Annex A). Such trends may have global implications, emboldening anti-abortion movements and potentially influencing policy reversals in other regions.

Box 4. Good practice: Example from Benin | Reforming laws on abortion

In October 2021, Benin amended its Sexual Health and Reproduction Law of 2003. The reform expands women's access to safe abortion not only in cases of rape, incest, or severe foetal impairment but also when the pregnancy causes material, educational, professional, or moral distress incompatible with the well-being of the woman or the unborn child.

The amendment aimed to address Benin's high maternal mortality rate, with unsafe abortions causing 200 deaths annually – 20% of all maternal deaths. Years of evidence-based advocacy and behind-the-scenes lobbying drove the liberalisation of the law. Yet, continued efforts are needed to align social norms with legal frameworks. In Benin, significant barriers remain due to cultural resistance, lack of awareness as many women remain unaware of their rights and the taboo surrounding sex education.

Source: (Gänsler, 2021^[22]; Peltier, 2022^[23]; Johnson, 2023^[24]; WHO, 2024^[25]).

2.1.3. Empowering women and adolescents through consent-free SRHR services

Third-party consent laws represent legal barriers regarding girls' and women's SRHR. In some countries, women are required to obtain their husband's approval to access contraception or other reproductive health services (OHCHR, 2020^[26]). In parts of Kenya, for example, healthcare providers demand spousal consent before administering contraception (Solo and Festin, 2019^[27]). Moreover, medical practitioner approval requirements exist in many countries. For instance, in 65% of countries where abortion is legal, women must obtain approval from a medical practitioner, with some countries also requiring additional consent from their partner. These requirements create delays, increase emotional distress, and disproportionately affect marginalised groups, including adolescents and survivors of sexual violence (OECD, 2023^[9]).

Parental consent laws similarly impede adolescents' access to essential SRHR services, including contraception and STI testing. While these laws aim to involve parents in adolescents' health decisions, they can erode trust in healthcare systems, particularly when confidentiality is compromised. Adolescents fearing judgment or punishment from their families may avoid seeking necessary services altogether, increasing their vulnerability to early pregnancies, sexually transmitted infections, and unsafe abortions (UNFPA, UNICEF and PAHO/WHO, 2018^[12]). International guidelines, such as the Convention on the Rights of the Child, stress the importance of balancing adolescents' rights to confidential care with parental roles in supporting their well-being (United Nations, 1989^[28]).

Age of consent laws for sexual activity and SRHR services add further complexity. With no international consensus on a minimum legal age for sexual consent (United Nations, 2016^[29]), many countries adopt laws that criminalise consensual adolescent relationships while limiting access to SRHR information and care. Such restrictions reflect societal discomfort with adolescent sexuality rather than prioritising their health and rights. Promising practices from around the world demonstrate how reforms can recognise and support adolescents' reproductive autonomy whilst protecting simultaneously protecting them (Box 5).

Box 5. Good practice: Example from Kazakhstan | Advancing adolescents' access to SRHR

Kazakhstan has taken significant steps to improve adolescents' SRHR through legal and policy reforms with the aim to address high rates of unintended pregnancies among teenagers, low contraceptive use, and the rising spread of HIV and other sexually transmitted infections (STIs) among young people.

In Kazakhstan, youth health centres were established in 2006 but faced several challenges, including underfunding, poor regulation, and the lack of family planning services. Adolescents also faced barriers to care as parental consent was required to access SRHR services.

In 2020, a new National Health Code introduced significant reforms:

- Reduced parental consent requirements for most SRHR services from 18 to 16 years of age, except for surgical procedures and medical abortion.
- Guaranteed free access to family planning and contraception counselling, as well as STI/HIV testing, under the national health insurance plan.
- Enhanced accessibility of SRHR services by integrating them into existing youth-friendly health centres.

To operationalise these changes, a regulatory framework was enacted in 2021. This framework governs the operation of youth-friendly health centres, ensuring the delivery of comprehensive SRHR services aligned with the new law.

Source: (Center for Reproductive Rights, 2023^[30]; UNFPA Kazakhstan, n.d.^[31])

2.2. Transforming gender norms: Leveraging social and cultural values to advance SRHR

Social norms, customs, and practices shape the environments in which individuals seek to realise their SRHR. Rooted in patriarchal systems, discriminatory gender norms, attitudes and behaviours often limit who can access information and services, make independent decisions, and lead healthy lives.

However, social norms – when transformed or leveraged effectively – can support access to and the realisation of SRHR. Community-level norms that promote gender equity, respect for women’s autonomy, and the value of women’s education and health create environments where girls and women are more likely to access services and exercise their rights.

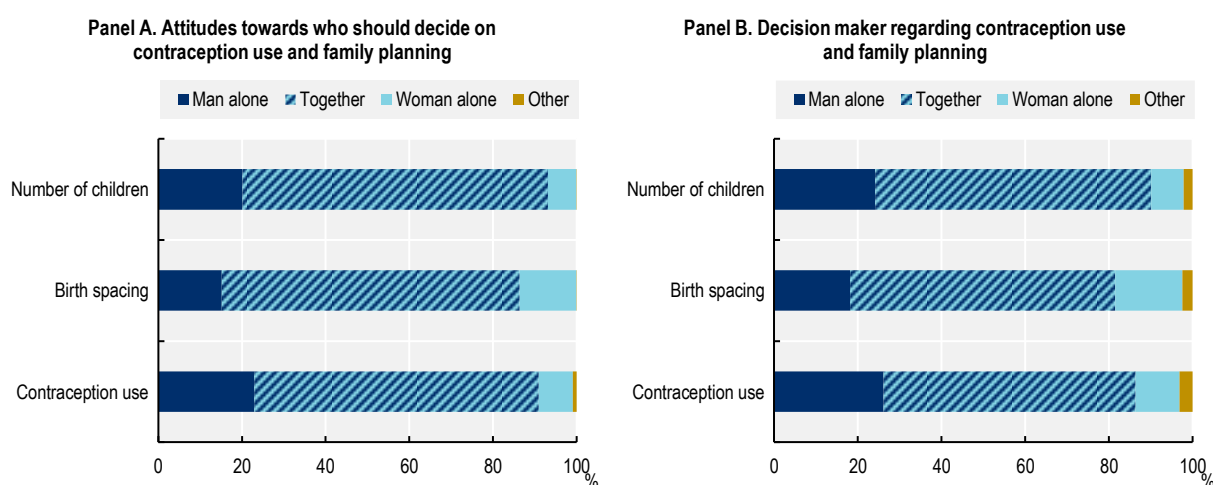
2.2.1. Shifting gender norms and unequal power dynamics

Gender norms and stereotypes affect girls’ and boys’, women’s and men’s SRHR in distinct and multiple ways. Patriarchal values that have inherently shaped the institutions that govern everyday life in most societies, perpetuate unequal power systems that promote male dominance and decision-making including sexual and reproductive choices. Conversely, women are expected to exhibit submissive behaviours, limiting their ability to negotiate safe sex or make independent decisions about contraception and childbirth (Svanemyr et al., 2015^[32]).

Data from SIGI Côte d’Ivoire shows that beliefs on who should take family planning decision within the couple translate into actual decision-making patterns (Figure 2). Moreover, a study in Tanzania revealed social barriers to women’s ability to give birth in a healthcare facility as they needed their husband’s approval along with widespread beliefs that giving birth is a natural duty, or men not wanting their wives to be treated by male healthcare providers (Kohi et al., 2018^[33]). Globally, only 57% of women make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare (United Nations, 2022^[34]).

Figure 2. In Côte d’Ivoire, decision making over contraception use and family planning is largely in the hands of men

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



Source: (OECD, 2022^[35]), SIGI Côte d’Ivoire Database, <https://stats.oecd.org/>.

Traditional gender roles further uphold systems of economic dependency where men are expected to be breadwinners and in control of household finances. For instance, in Cuba, power imbalances within relationships often compel young women to engage in unprotected sex, driven by fear of losing their partner or because of economic dependency on older men (Guerrero Borrego, 2015^[36]). When women are involved in financial decision making and able to access healthcare services independently, they report higher satisfaction with care better maternal health outcomes and increase use of contraceptives (Ahmed et al., 2010^[37]; Jejeebhoy and Sathar, 2001^[38]; Thummalachetty et al., 2017^[39]; Kabagenyi et al., 2014^[40]).

In contexts where women's status is closely linked to motherhood, social norms can exert pressure on the timing of childbearing but also perpetuate the gendered division of reproductive responsibilities within a family (Härkönen, 2014^[41]). In some contexts, early pregnancies are celebrated or normalised, with repercussions on young women's educational and economic opportunities. Finally, women who cannot have children risk being stigmatised and isolated by family and/or local communities, whereas men may resort to divorce and re-marriage – assuming that “nothing is wrong with them”. In fact, infertility is often perceived as a threat to masculinity and patriarchal norms nurture the misconception that it is a woman's issue (OECD, 2023^[9]).

Restrictive norms of masculinities directly affect men's health and bear indirect consequences for women. In conformity with dominant norms, individuals may reinforce ideals of male strength and control and female vulnerability and need for protection. This can create an environment where men may avoid healthcare services, take sexual risks, and prioritise their needs over those of their partners. For example, research in the Caribbean highlights how norms link masculinity with sexual activity, prestige through multiple partners, and even acceptance of violence, creating barriers to equitable and safe sexual health practices (PAHO, 2013^[42]). These dynamics place women and girls at greater risk of sexually transmitted infections (STIs), unintended pregnancies, and gender-based violence.

Box 6. Good practice: Example from Promundo | Engaging men in shifting social norms and promoting women's SRHR

Since 1997, Promundo (now Equimundo) has been at the forefront of efforts to engage men and boys in promoting gender equality and improving women's SRHR. Their innovative approach focuses on transforming harmful gender norms and fostering positive masculinities, recognising that men's attitudes and behaviours are critical in shaping SRHR outcomes for women and girls. This includes:

- The Program P targets fathers and partners to encourage their active involvement in caregiving, maternal health, and family planning. Implemented across diverse settings, including Brazil, Rwanda, and India, the programme uses group education sessions, community campaigns, and media to challenge traditional notions of masculinity that prioritise dominance and distance from reproductive health. It has demonstrated significant results: increased use of contraception, improved maternal health outcomes, and more equitable decision making within households.
- The Program H aims at engaging young men in conversations and reflection about rigid gender norms, promote SRHR and prevent violence against women and girls. The program can be adapted to country priorities, and typically relies on group-based activities such as role-play or discussions, and youth-led campaigns. An impact evaluation of Program H implementation in 14 countries reveals positive changes in young men's knowledge and behaviour regarding SRHR, and gender attitudes.

Source: (Equimundo, n.d.^[43]; Doyle and Kato-Wallace, 2021^[44]).

Social norms transformation can foster positive behaviours and equitable dynamics. Engaging men and boys in initiatives that question restrictive masculinities and promote shared responsibility in reproductive health and childcare are associated with improved SRHR outcomes for women (Box 6). Moreover, programmes that actively engage communities and promote shared decision making among couples further drive progress on SRHR (Box 7). Initiatives that facilitate discussions between spouses about family planning have led to increased contraceptive uptake and fostered more supportive attitudes toward women's reproductive choices (Doyle and Kato-Wallace, 2021^[44]). In the same vein, community-based interventions that reduce stigma and raise awareness about women's rights have demonstrated significant effectiveness in reshaping gender power dynamics.

Box 7. Good practice: Example from Uganda | Empowering women

SASA! (Start, Awareness, Support, Action) is a community-based initiative designed to address the root causes of gender inequality and its impacts on SRHR. The programme focuses on shifting power dynamics in relationships and communities to prevent violence against women and improve SRHR outcomes. It is rolled out through several phases to gradually empower women:

- **Start Phase:** Community activists are recruited and trained to build awareness about power dynamics and their effects on relationships and SRHR. This approach ensures cultural relevance and trust, establishing strong local buy-in from the outset.
- **Awareness Phase:** Through dialogues, drama, and interactive sessions, the programme raises awareness on gender inequality, intimate partner violence and reproductive health. These activities engage key stakeholders, including religious leaders, healthcare providers and local influencers to challenge entrenched norms and foster broad-based support.
- **Support Phase:** Activists and key community members such as healthcare providers and religious leaders work closely with individuals to promote shared decision making in family planning and encourage collective action.
- **Action Phase:** Community members take collective action to address systemic barriers, embedding changes in local structures for long-term impact.

Subject to a randomised control trial, SASA! has been found to increase couples' joint decision making regarding contraception and reproductive health, reduced male dominance and mobilised community members, including religious leaders and healthcare providers, to advocate for gender equality and women's SRHR. Religious leaders played a vital role in addressing sensitive topics through culturally and faith-aligned messaging, while healthcare providers ensured that services were delivered in a supportive and nonjudgmental manner.

Source: (Abramsky, Devries and Kiss, 2012^[45]).

2.2.2. Challenging stigma and biases

Social stigma remains one of the most pervasive barriers to adolescents' and women's access to SRHR services. Stigma manifests in various forms across societal, cultural and institutional levels and extends an environment of silence and shame around topics such as contraception, sexuality or abortion. Adolescents and women who access certain SRHR services risk being labelled as promiscuous or morally deviant by their communities. In faith-based communities, contraception or abortion can be framed as sinful. Increasingly, social networks are also found to affect access to services notably when influencers voice disapproval (Taiwo, Oyekenu and Hussaini, 2023^[46]). Fear of judgment, ostracism, or even violence from family and community members often compels women to pursue unsafe procedures or forgo abortion

altogether. These pressures are exacerbated by economic dependency on male partners and inadequate knowledge about SRHR options (Lo Forte, 2018^[47]).

Provider bias can limit access to reproductive services and care. Evidence shows that healthcare providers can be influenced by personal biases, cultural norms, or institutional policies in their professional practice. So-called provider bias can manifest as judgmental behaviour, refusal to provide services, or the imposition of unnecessary barriers such as mandatory counselling or waiting periods. For instance, a study from Malawi found that more than 40% of providers stated not being comfortable with providing family planning services to young, unmarried women without children (Solo and Festin, 2019^[27]). Moreover, evidence from Kenya and South Asia showed that women seeking abortion services often encounter providers who stigmatise them for their decision, leading to delays in care or reliance on unregulated providers, which increases the risk of complications (Sedgh, Singh and Hussain, 2016^[48]).

On the other hand, healthcare providers who actively challenge these stigmas play a transformative role. By creating a nonjudgmental and supportive environment, providers can encourage women and adolescents to seek relevant counselling and care. Training programmes that address stigma and promote evidence-based practices have shown positive outcomes, improving both the quality of care and women's trust in healthcare systems (Box 9).

Box 8. Good practice: Example from SheDecides Movement | Changing Social Stigma Around Abortion and Access to Contraception

Launched in 2017, the SheDecides movement promotes the rights of women and girls to decide freely and responsibly about their bodies, including access to contraception and safe abortion services. Its initiatives address stigma and restrictive norms through:

- **Youth Engagement:** The SheDecides “25x25 Initiative” empowers young leaders under 25 to challenge stigma and advocate for bodily autonomy within their communities. In Nepal, for example, SheDecides partnered with local youth groups to launch the "Abortion is Health Care" campaign, which used storytelling and advocacy to reduce abortion-related stigma, resulting in an increased demand for safe abortion services, especially among adolescent girls.
- **Provider outreach:** In Kenya and Uganda, the SheDecides partners with local NGOs to train community health workers and peer educators who work directly with communities to counter misinformation about contraception and abortion, emphasising their health and social benefits.
- **Advocacy with Religious Leaders:** Recognising the influence of faith-based organisations, SheDecides engages with progressive religious leaders to promote sexual and reproductive rights. In Senegal, for example, religious leaders have openly advocated for family planning, helping to shift community attitudes toward contraception use.

Source: (SheDecides, 2022^[49]).

2.2.3. Leveraging sexual and reproductive health education to empower adolescents and women

While adolescents across the world face different realities and challenges, sexuality education is indispensable for everyone. International conventions and committees highlight the need for evidence-based and age-appropriate comprehensive sexuality education (CSE) in order to promote access to sexual and reproductive health services within wider gender equality efforts. However, access to CSE remains limited across all regions. While most countries report that sexuality education is integrated into their national school

curricula in some form, only one-third of countries (60 out of 178) are mandating comprehensive sexuality education (OECD Development Centre/OECD, 2023^[21]; UNESCO et al., 2021^[50]). In the broader context of the rollback on reproductive rights, conservative civil society organisations, law makers or politicians may exert pressure at various public and administrative levels to exclude certain concepts, such as sexual orientation or gender identity, from the CSE curricula (OECD, 2023^[9]).

Social and gender norms significantly restrict access to sexual education and information on SRHR. In many contexts, discussing sexual health remains taboo as it is associated with immorality or improper behaviour. Moreover, teachers may not be well trained to deliver CSE which can contribute towards misinformation around SRHR. Limited knowledge about SRHR contributes to poorer health outcomes and violation of individuals rights. Accounting for country context, CSE must be provided in various settings to reach all boys and girls, including marginalised groups such as out-of-school children or LGBTQ+ individuals.

Evidence attests to the positive impact of CSE not only on SRHR but gender equality more broadly (Box 9). CSE programmes that account for gender and power dynamics, social contexts as well as children's and adolescents' rights are found to be more likely to promote respectful and pleasurable relationships, safe sexual behaviour and egalitarian attitudes to sexuality and reproduction (UNESCO et al., 2018^[51]). Evidence further shows that discussions about power and values can encourage learners to reflect on and question restrictive norms of masculinities (Greene et al., 2019^[52]).

Box 9. Good practice: Example from Right Here Right Now 2 | Advancing SRHR information

Right Here Right Now 2 is a global partnership initiative coordinated by Rutgers International, and implemented by country coalitions in Bangladesh, Benin, Burundi, Ethiopia, Indonesia, Kenya, Morocco, Nepal, Tunisia, and Uganda. The initiative runs from 2021 to 2025, and aims to empower young people to make informed decisions about their SRHR while promoting gender-just societies, through four pathways:

- Empowering young people with SRHR information and CSE: Efforts include online and offline education tailored to diverse audiences, including young people with disabilities. Young individuals are trained to lead discussions and share accurate information with their peers in schools and communities.
- Mobilising public support through campaigns and influencers: Influencers, including faith leaders, celebrities and social media personalities, deliver impactful messages to challenge taboos and stigmas, building public support and reinforcing positive norms on SRHR.
- Advocating for policy change: Activities like policy briefs, public campaigns and evidence-generation target national and international decision makers to adopt human rights-based policies. Governments are urged to enforce laws that uphold young people's SRHR and promote gender justice at all levels.
- Strengthening civil society and youth leadership: promoting inclusivity and local ownership ensures programmes are sustainable, contextually relevant, and responsive to community needs.

Source: (Rutgers International, 2021^[53]; Rutgers International, 2024^[54]).

3 Harnessing data and rethinking metrics to advance women's SRHR

Data is foundational for advancing SRHR. Accurate, comprehensive, and disaggregated data equips policymakers, practitioners, and advocates to identify barriers, design targeted interventions, and monitor progress effectively. It provides insights into critical issues such as reproductive autonomy and service access while offering a nuanced understanding of the legal and social determinants that shape women's agency over their bodies. By leveraging robust data, stakeholders can drive evidence-based decision making, close critical gaps, and accelerate progress toward universal access to SRHR, empowering individuals and fostering gender equality.

However, persistent challenges in data and measurement hinder policymakers' ability to address the structural and societal barriers to progress. Standard indicators often fail to capture the complexity of SRHR, overlooking issues such as relational dynamics, social norms, and quality of care. The need for alternative, people-centred measures is increasingly recognised, but significant obstacles remain in their development and adoption.

Building on insights from an expert workshop organised by the OECD Development Centre on "Alternative Measures for Reproductive Autonomy" (Box 10), this section explores the limitations of existing SRHR indicators and highlights promising practices for developing comprehensive and nuanced metrics. It concludes with recommendations for advancing data systems that reflect the multi-dimensional nature of SRHR, enabling stakeholders to drive transformative change.

Box 10. OECD expert workshop: Alternative measures for reproductive autonomy

The OECD Development Centre's expert workshop "Exploring the role of data in promoting contextualised and people-centred approaches for better sexual and reproductive health" (September 2024) brought together a diverse group of researchers, programme implementers, and data providers to reflect on potential limitations of existing family planning indicators, and the need for alternative measures. Participants had the opportunity to discuss the challenges they face in developing more comprehensive measures and to collaboratively explore potential solutions and future directions.

To date, there is no consensus on what an "ideal" indicator of SRHR would be. However, experts provided key elements that should be captured, reflecting the multi-dimensional nature of SRHR while being actionable for policy and programme design. These include:

- **Supportive frameworks.** Existence of laws and policies that promote SRHR, including access to contraception, safe abortion, and information on SRHR.
- **Availability of quality and affordable services.** Whether quality SRHR services (e.g. contraception, safe abortion, maternal healthcare, STI prevention and treatment) are accessible geographically, operationally and financially.

- **Access to information.** This includes awareness of SRHR rights and available services; access to accurate, comprehensive, and unbiased information about SRHR services including different family planning options and information about potential side effects; and age-appropriate, gender-sensitive, and comprehensive sexuality education.
- **Sexual and reproductive autonomy.** The ability to make informed, voluntary decisions about sexual and reproductive health without coercion or external pressure. This includes the need for contextually relevant measures focused on individual agency and personal preferences.
- **Couples' dynamics, social norms and attitudes.** Household dynamics, partner influence, and community norms impact reproductive choices, as well as stigma and service provider bias.
- **Adolescents' needs.** Existing indicators often overlook adolescents and young people leaving a gap in understanding their needs.

Note: Participants include Boniface Ushie, Principal Consultant, Beshi King Development Services; Claire Rothschild, Senior Research Advisor for Sexual Reproductive Health (SRH) Strategic Evidence and Learning, Population Services International; Dana Loll, Research & Evaluation Officer, Johns Hopkins Center for Communication Programs; Emebet Wuhib-Mutungu, Global SRHR Hub and Practice Lead, Plan International; Emilie Filmer-Wilson, Human Rights Adviser, UNFPA; Isha Bhatnagar, Senior Research Officer, Equimundo; Joseph Molitoris, Associate Population Affairs Officer, United Nations; Leigh Senderowicz, Assistant Professor of Gender & Women's Studies, and Obstetrics & Gynecology; Mengjia Liang, Technical Specialist, SDG Data and Research, UNFPA; Sarah Compton, Research Associate Professor, Institute for Healthcare Policy and Innovation, University of Michigan; Vladimira Kantorova, Population Affairs Officer, UNSD.

Source: Authors' notes.

3.1. Extending the scope of SRHR indicators

Extending the scope of SRHR indicators is essential to fully understand the barriers and enablers shaping women's and adolescents' SRHR. Traditional metrics, such as maternal mortality ratios and contraceptive prevalence, provide valuable benchmarks but fail to fully reflect relational dynamics, the quality of care, and the influence of discriminatory social norms. Without addressing these gaps, data systems risk misalignment with global SRHR commitments.

3.1.1. Focusing on reproductive autonomy and agency

Since the 1994 International Conference on Population and Development, the family planning discourse has shifted away from population control towards modern goals of sexual and reproductive autonomy. Yet, fertility reduction and contraceptive uptake remain priorities in policy and programme design, often to the detriment of individuals' preferences and needs. Alternative metrics, such as contraceptive autonomy (Senderowicz, 2020^[55]), centre on informed, full and free choice.

- **Informed choice:** Ensures individuals receive accurate information about contraceptive methods, side effects, and alternatives, enabling decisions aligned with personal needs.
- **Full Choice:** Evaluates whether individuals can exercise their contraceptive autonomy in practice, easily accessing affordable and comprehensive options despite supply- and demand-side challenges such as affordability or social norms and stigma.
- **Free Choice:** Measures whether contraceptive decisions are voluntary and free from coercion, aligning with ethical standards and reproductive justice goals.

These dimensions align with the World Health Organisation's principle of person-centred care, emphasising individuals' expertise in navigating their circumstances and decisions.

3.1.2. Addressing both access and quality issues

Qualitative dimensions of SRHR, such as user satisfaction and quality of care, remain under-measured, limiting policymakers' ability to enhance service delivery and tackle user-centred barriers. For instance, while the maternal mortality ratio provides essential benchmarks for maternal health, it fails to capture the quality of care women receive. Similarly, metrics on family planning primarily focuses on access to services but neglect critical factors. For instance, in 2012, the WHO reported that 33% of women using contraception reported dissatisfaction due to limited choices or adverse side effects (World Health Organization, 2012^[56]). Concurrently, measures such as contraceptive prevalence or the unmet need for family planning often fail to account for user satisfaction, side effects, availability of diverse contraceptive options, decision-making autonomy, or even coercion (Upadhyay et al., 2014^[57]).

Indicators like adolescent fertility rates provide insights into early pregnancy trends but fail to reflect whether adolescents have access to comprehensive sexuality education (CSE) or the ability to make informed decisions. They overlook adolescents' needs and preferences, as well as underlying gender norms and the availability of services such as safe abortion.

Health surveys should include both qualitative and quantitative data collection components to assess the quality of SRHR services and access to unbiased, accurate information. Measures like informed choice and service satisfaction provide a deeper understanding of user-centred barriers, enabling policymakers to refine service delivery and tailor interventions to meet individuals' needs effectively. By addressing both access and quality, data systems can better support equitable, rights-based approaches to SRHR.

3.1.3. Incorporating social norms and gender power dynamics

Social norms and power dynamics affect reproductive decision making. Family planning and reproductive health decisions frequently occur within relationships where gender dynamics, communication patterns, and power imbalances play a significant role. For example, studies in sub-Saharan Africa show that partner disapproval is a leading reason for unmet contraceptive needs, yet such relational dimensions are rarely captured in existing data systems (OECD, 2023^[9]). Such behaviour is embedded in social norms that reflect restrictive gender roles that naturally grant men decision-making power which can further impact their partner's mobility, financial independence and access to information and services.

Social norms and stigma also affect reproductive autonomy outside a relationship. Peers, communities and healthcare providers are not immune to the dominant norms which can constraining individuals' ability to exercise their SRHR. For instance, surveys conducted in low- and middle-income countries showed that up to 25% of women face barriers related to stigma, spousal disapproval, or inadequate health worker training when seeking contraception (Focus 2030, 2024^[58]).

To address these gaps, data collection tools should include metrics that reflect couples' decision-making processes and household power dynamics, as well as individuals' attitudes and behaviour towards SRHR. Integrating these relational aspects can help policymakers design more targeted interventions that consider the influence of partners, family structures and community norms on reproductive choices. Collecting data on attitudes, stigma, and enabling environments will allow for more targeted interventions that address the root causes of inequality and improve SRHR outcomes.

3.2. Strengthening SRHR data systems: Insights from the OECD Expert Workshop

The OECD Development Centre's expert workshop on "Alternative Measures for Reproductive Autonomy" offered critical insights into the limitations of current SRHR indicators and proposed actionable pathways for improvement. Discussions highlighted the need for data systems that reflect the multi-dimensional

nature of SRHR, moving beyond traditional metrics to capture autonomy, quality, and the influence of relational and social dynamics.

3.2.1. Promoting the inclusion of alternative measures in global databases and national systems

Collective efforts among researchers, policy and programme implementers and data providers to rethink how sexual and reproductive autonomy can be measured more effectively are increasingly underway (see Box 11). However, more work and exchanges are needed to gain consensus on the sub-topics of SRHR that should be measured more predominantly, how they can be measured and integrated in global frameworks beyond the 2030 Agenda and SDGs.

Alternative measures exist but their complexity bears challenges for data collection. Workshop participants stressed the difficulty in increasing data coverage as relevant questions used to compute innovative SRHR metrics are not yet standard questions in relevant demographic and health surveys. Specifically, measuring complex concepts requires asking multiple questions in a survey. More efforts are thus needed to develop and test survey tools that allow data collection for novel indicators in a time- and cost-efficient manner. Only then will it be possible to mainstream the inclusion of alternative measures in global data bases and national systems.

Box 11. Good practice: Example from alternative measures for reproductive autonomy

Several innovative approaches provide valuable lessons for addressing SRHR data and measurement challenges:

- **SDG 5.6.1.** It measures the proportion of women aged 15–49 who make their own decisions regarding sexual relations, contraceptive use, and reproductive health. This indicator highlights autonomy and decision-making power, aligning with a rights-based approach to SRHR. Currently, SDG 5.6.1 covers 69 countries.
- **SDG 5.6.2.** It measures the number of countries with laws and regulations that guarantee full and equal access to sexual and reproductive healthcare, information and education. This indicator takes into account third party consent requirements and parallel legal systems that may contradict the national laws. Currently, SDG 5.6.2 covers 153 countries.
- **Contraceptive Autonomy Measure.** It addresses limitations of standard indicators by focusing on three pillars: informed, full, and free choice. This approach tailors criteria to individuals' contraceptive status (e.g. users vs. non-users) and considers both supply- and demand-side factors. The measure has been tested in 2018 in Burkina Faso.
- **The reproductive autonomy scale.** It measures women's ability to decide if and when to become pregnant. This tool includes dimensions of control, coercion, and external influence, providing a nuanced understanding of reproductive empowerment.

Source: (United Nations, 2023^[59]; Senderowicz et al., 2023^[60]; Upadhyay et al., 2014^[57]).

3.2.2. Improving data disaggregation

Disaggregated data is essential for uncovering disparities within and across populations, yet significant gaps persist. National averages often obscure the challenges faced by vulnerable groups such as adolescents, displaced women, and individuals with disabilities. Participants of the expert workshop highlighted the importance of adopting an intersectional approach to data collection by increasing the availability of disaggregated data. According to UNFPA, for instance, only 20% of countries disaggregate SRHR data by age, marital status, or disability, despite evidence that these factors significantly influence SRHR outcomes (United Nations, 2022^[61]). Such granularity is critical for designing inclusive programmes that address the unique challenges of underserved populations. For example, data on adolescents' access to comprehensive sexuality education can reveal gaps in service delivery that perpetuate early pregnancies and poor health outcomes. Including displaced women and other marginalised groups in surveys ensures that their SRHR needs are not overlooked in policy and programme design.

Investments in national statistical systems are crucial to strengthening disaggregated data collection. This includes technical assistance, capacity building, and funding support to ensure consistent and high-quality data reporting across regions. Enhanced collaboration between countries and international organisations can also harmonise data systems, enabling more effective cross-country comparisons and progress tracking.

3.2.3. Reflecting social norms and sensitivities in data collection

The deeply personal and culturally sensitive nature of SRHR topics poses challenges for accurate data collection. Issues such as abortion and adolescents' SRHR are often underreported due to stigma and social desirability bias. For example, individuals may avoid disclosing their contraceptive use or experiences with abortion for fear of judgment or backlash. This underreporting skews data and limits the ability to design interventions that address these sensitive issues effectively.

Workshop discussions emphasised the importance of participatory research methods and culturally appropriate data collection tools. Engaging communities directly in the research process can build trust and ensure that data reflects lived realities. Leveraging digital technologies, such as anonymous surveys and real-time data collection platforms, can also mitigate stigma-related barriers and enhance accuracy. Furthermore, training researchers and data providers on culturally sensitive methodologies ensures that data collection is respectful, reliable, and aligned with local contexts.

4 Policy recommendations and conclusion

Achieving universal access to SRHR is a necessity from a health, human rights and gender equality perspective, but requires tackling a wide range of systemic, legal, social and practical barriers. It is not always a problem of resources: while the lack of quality healthcare infrastructure does mostly affect the poorer countries, discriminatory social institutions undermine SRHR worldwide. This section outlines policy recommendations to transform restrictive laws, discriminatory attitudes and behaviours, so as to accelerate progress towards universal access to SRHR.

4.1. Strengthen healthcare systems and service delivery

While not the primary focus of this paper, strengthening healthcare systems is a critical part of the holistic approach needed. Policymakers, in collaboration with development partners, and where relevant the private sector, civil society and philanthropic actors, should:

- Invest in high-quality healthcare services, especially in underserved areas and integrate SRHR service provision in universal health coverage plans.
- Leverage innovative solutions such as telemedicine to reach underserved populations while addressing inequities in access to technology.
- Develop training programmes for healthcare providers, midwives and nurses to deliver gender sensitive, adolescent-friendly and bias-free SRHR advice and services. Development partners and philanthropies should support these efforts.

4.2. Enact and reform laws and policies

In line with international and regional frameworks such as CEDAW or the Maputo protocol and recommendations by the United Nations Committee on the Rights of the Child, policymakers should enact legal reforms to ensure the protection and advancement of universal SRHR and establish effective mechanisms for law enforcement. In consultation with legal and women's rights experts, policymakers should focus on:

- Eliminating legal requirements for third-party consent to access contraceptives and other SRHR services, ensuring that women and adolescents can make autonomous decisions.
- Setting clear and equitable legal standards regarding the appropriate age of consent for medical services, including contraception and HIV testing, without gender biases.
- Combatting harmful practices by establishing 18 as the minimum legal age for marriage, without exceptions and criminalising FGM/C with strict penalties for perpetrators, including provisions for extraterritorial jurisdiction.

- Decriminalising consensual sexual relations among adolescents while balancing protection and autonomy in line with the International Convention on the Rights of the Child.
- Removing educational bans for pregnant and parenting adolescents and strengthen gender-based violence protections within the education system.
- Guaranteeing free or subsidised access to all forms of contraception and update laws to ensure safe and legal abortion services under all essential circumstances as recommended by CEDAW.

4.3. Transforming discriminatory social norms

Transforming harmful social norms is essential to advancing SRHR. Governments, in collaboration with development partners, civil society, philanthropic and private sector actors should:

- Leverage educational entertainment and mobilise local influencers to address attitudes and social norms that perpetuate stigma around reproductive health and sexuality, uphold unequal power dynamics, and tolerate harmful practices such as FGM/C and child marriage.
- Engage men and boys as allies by implementing programmes to address restrictive norms of masculinity, promote gender-equitable decision making and raise awareness about GBV. These programmes should also provide safe spaces for boys and men to reflect and learn how to adopt more equitable attitudes and behaviours.
- Collaborate with gatekeepers such as community and religious leaders but also parents and support local initiatives such as gender school clubs to engage adolescents in discussions on power hierarchies, gender values, and equitable attitudes.
- Allocate dedicated budgets to monitor the success of social norms interventions and ensure sustainable, long-term changes.

4.4. Deliver comprehensive sexuality education (CSE)

The delivery of comprehensive CSE provides children and adolescents with the knowledge and skills they need to protect their health and exercise their rights.

- Civil society and development partners should promote CSE as a long-term approach to effectively address health challenges, promote gender equality, and ensure the rights of children and adolescents.
- Policymakers should adopt evidence-based, age- and culturally appropriate CSE curricula, inclusive of topics such as gender norms and power dynamics. To improve acceptance and impact, parents, youth and religious leaders should be involved in the design and delivery of CSE.
- Policymakers should work with civil society organisations and philanthropies to ensure CSE is available in both formal and informal settings and reaches out-of-school children.
- Key stakeholders should design budgetary tracking mechanisms to monitor investments in CSE, including training programmes for educators and community facilitators.

4.5. Enhancing data and measurement

Accurate, comprehensive and disaggregated data is essential to identify persisting barriers, monitor trends and underpin gender-transformative policymaking. Longstanding SRHR indicators must be complemented by more comprehensive measures that embrace concepts such as quality of care, personal preferences and reproductive agency. Policy makers, researchers and development partners should prioritise

developing and implementing multi-dimensional SRHR measures that reflect both structural and societal factors and collaborate with national statistical offices and other data providers, including health care facilities and civil society organisations, to collect this data. Key actions include:

- Expand and refine SRHR indicators: Move beyond traditional metrics focused solely on health outcomes by incorporating measures that reflect reproductive autonomy, decision-making power, and the influence of social norms. This includes capturing relational and social dimensions such as household dynamics, couples' decision making and community attitudes.
- Address gaps in data disaggregation: Ensure SRHR data is disaggregated by age, gender, marital status, disability and geographic location to uncover disparities and better target interventions.
- Invest in data collection and dissemination: Strengthen national capacities to collect reliable data, adopt participatory approaches and leverage technology for real-time data collection. Ensure that data is widely disseminated and integrated into global databases for evidence-based policymaking.

Notes

¹ Benin, Democratic Republic of the Congo, Lesotho, Mauritania, Nigeria and South Sudan have national laws related to pregnant girls' and mothers' right to education. Cabo Verde, Côte d'Ivoire, Gabon and Rwanda have policies or strategies that provide "continuation". Botswana, Burundi, Cameroon, Gambia, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Senegal, South Africa, Swaziland, Zambia and Zimbabwe have "re-entry" policies that set out conditions for adolescent mothers.

References

- Abramsky, T., K. Devries and L. Kiss (2012), “Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda.”, *BMC Med* 12, 122, <https://doi.org/10.1186/s12916-014-0122-5>. [45]
- Ahmed, S. et al. (2010), *Economic status, education, and empowerment: Implications for maternal health service utilization in developing countries*. [37]
- Amnesty International (2020), *Sierra Leone: Discriminatory ban on pregnant girls attending school is lifted*, <https://www.amnesty.org/en/latest/news/2020/03/sierra-leone-discriminatory-ban-on-pregnant-girls/>. [16]
- Bearak, J. et al. (2020), “Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019”, *The Lancet Global Health*, Vol. 8/9, pp. 1152-1161, [https://doi.org/10.1016/s2214-109x\(20\)30315-6](https://doi.org/10.1016/s2214-109x(20)30315-6). [20]
- Center for Reproductive Rights (2023), *Pathways to Change - Building stronger legal guarantees for SRHR*, https://reproductiverights.org/wp-content/uploads/2024/02/Pathways-to-Change_English_6-3-24.pdf. [30]
- Daka, M. (2020), “ECOWAS Court affirms that pregnant girls in Sierra Leone have a right to equal education”, Oxford Human Rights Hub. [15]
- Doyle, K. and J. Kato-Wallace (2021), *Program H: A review of the evidence: Nearly two decades of engaging young men and boys in gender equality*, Equimundo, <https://www.equimundo.org/wp-content/uploads/2021/11/Program-H-Eva.-Report-2.-September-2021.pdf>. [44]
- Equality Now (2023), *Let girls learn: what happened after Sierra Leone lifted the ban on pregnant girls attending school?*, https://equalitynow.org/news_and_insights/let-girls-learn-what-happened-after-sierra-leone-lifted-the-ban-on-pregnant-girls-attending-school/. [17]
- Equimundo (n.d.), *Program P*, <https://www.equimundo.org/programs/program-p/> (accessed on 14 February 2025). [43]
- Focus 2030 (2024), *The access to contraception around the world*, https://focus2030.org/The-access-to-contraception-around-the-world-situational-analysis-and-current?utm_source=chatgpt.com (accessed on 5 December 2024). [58]
- Gänsler, K. (2021), “Benin liberalizes abortion law”, <https://www.dw.com/en/benin-liberalizes-abortion-law/a-59778601>. [22]

- Greene, M. et al. (2019), *Getting to Equal: Men, Gender Equality, and Sexual and Reproductive Health and Rights*, Promundo-US, Washington, DC, <https://www.equimundo.org/resources/getting-to-equal-men-gender-equality-and-sexual-and-reproductive-health-and-rights/> (accessed on 27 March 2023). [52]
- Guerrero Borrego, N. (2015), *Youth subjectivities and STI HIV/AIDS prevention policies*, CENESEX, Havana. [36]
- Guttmacher-Lancet Commission (2018), *Accelerate Progress: Sexual and Reproductive Health and Rights for All — Executive Summary*, <https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary> (accessed on 14 April 2023). [2]
- Härkönen, H. (2014), *Kinship, love, and life cycle in contemporary Havana, Cuba: to not die alone*, Palgrave Macmillan. [41]
- Human Rights Watch (2018), *Leave No Girl Behind in Africa. Discrimination in Education against Pregnant Girls and Adolescent Mothers*. [13]
- Jejeebhoy, S. and Z. Sathar (2001), “Women’s autonomy in India and Pakistan: The influence of religion and region”, *Population and Development Review*. [38]
- Johnson, S. (2023), “Benin passed one of Africa’s most liberal abortion laws. Why are women still dying?”, *The Guardian*, <https://www.theguardian.com/global-development/2023/feb/28/benin-africa-liberal-abortion-laws-women-still-dying>. [24]
- Kabagenyi, A. et al. (2014), “Barriers to male involvement in contraceptive uptake and reproductive health services: A qualitative study of men and women’s perceptions in two rural districts in Uganda”, *Reproductive Health*, Vol. 11/1, pp. 1-9, <https://doi.org/10.1186/1742-4755-11-21/PEER-REVIEW>. [40]
- Kohi, T. et al. (2018), “When, where and who? Accessing health facility delivery care from the perspective of women and men in Tanzania: A qualitative study”, *BMC Health Services Research*, Vol. 18/1, pp. 1-9, <https://doi.org/10.1186/S12913-018-3357-6/TABLES/1>. [33]
- Lo Forte, C. (2018), *Safe abortion and social norms: an annotated bibliography*, Overseas Development Institute. [47]
- National Institute of Statistics, Ministry of Health and ICF (2023), *Cambodia Demographic and Health Survey 2021–22 Final Report*, NIS, MoH and ICF, Phnom Penh, Cambodia, and Rockville, Maryland, USA. [8]
- OECD (2023), *SIGI 2023 Global Report: Gender Equality in Times of Crisis*, Social Institutions and Gender Index, OECD Publishing, Paris, <https://doi.org/10.1787/4607b7c7-en>. [9]
- OECD (2022), *SIGI Côte d’Ivoire Database*, <https://stats.oecd.org>. [35]
- OECD Development Centre/OECD (2023), “Gender, Institutions and Development (Edition 2023)”, *OECD International Development Statistics* (database), <https://doi.org/10.1787/7b0af638-en> (accessed on 1 June 2023). [21]
- OHCHR (2020), *Information Series: Sexual and Reproductive Health and Rights*, Office of the United Nations High Commissioner for Human Rights, <https://www.ohchr.org/en/women/information-series-sexual-and-reproductive-health-and-rights> (accessed on 1 June 2023). [26]

- PAHO (2013), *Reaching poor adolescents in situations of vulnerability with sexual and reproductive health*, PAHO, Washington, DC, <http://iris.paho.org/xmlui/handle/123456789/34306>. [42]
- Peltier, E. (2022), *While Abortion Rights Shrink in U.S., This Small Country Expanded Access*, <https://www.nytimes.com/2022/11/13/world/africa/benin-abortion.html#:~:text=benin%2Dabortions.html-,While%20Abortion%20Rights%20Shrink%20in%20U.S.%2C%20This%20Small%20Country%20Expanded,women%20dying%20from%20illegal%20abortions>. [23]
- Rutgers International (2024), *Right Here Right Now - Key achievements in 2023*, https://rutgers.international/wp-content/uploads/2024/07/RHRN-2024-Twopager_EN_V1b.pdf. [54]
- Rutgers International (2021), *Right Here Right Now 2 - Consolidated baseline report*, <https://rutgers.international/wp-content/uploads/2021/12/1.-Baseline-Report-Right-Here-Right-Now-2.pdf>. [53]
- Sedgh, G., S. Singh and R. Hussain (2016), "Intended and unintended pregnancies worldwide in 2012 and recent trends", *Studies in Family Planning*, Vol. 45/3, pp. 301-314. [48]
- Senderowicz, L. (2020), "Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator", *Studies in Family Planning*, Vol. 51/2, pp. 161-176, <https://doi.org/10.1111/sifp.12114>. [55]
- Senderowicz, L. et al. (2023), "Measuring Contraceptive Autonomy at Two Sites in Burkina Faso: A First Attempt to Measure a Novel Family Planning Indicator", *Studies in Family Planning*, Vol. 54/1, pp. 201-230, <https://doi.org/10.1111/sifp.12224>. [60]
- SheDecides (2022), *SheDecides Annual Report 2022*. [49]
- Solo, J. and M. Festin (2019), "Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations", *Global Health: Science and Practice*, Vol. 7/3, pp. 371-385, <https://doi.org/10.9745/GHSP-D-19-00130>. [27]
- Svanemyr, J. et al. (2015), "Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches", *Journal of Adolescent Health*, Vol. 56/1, pp. S7-S14, <https://doi.org/10.1016/j.jadohealth.2014.09.011>. [32]
- Taiwo, M., O. Oyekenu and R. Hussaini (2023), "Understanding how social norms influence access to and utilization of adolescent sexual and reproductive health services in Northern Nigeria", *Sec. Gender, Sex and Sexualities*, <https://doi.org/10.3389/fsoc.2023.865499>. [46]
- Thummalachetty, N. et al. (2017), "Contraceptive knowledge, perceptions, and concerns among men in Uganda", *BMC Public Health*, Vol. 17/1, pp. 1-9, <https://doi.org/10.1186/S12889-017-4815-5/TABLES/2>. [39]
- UNDESA (2022), *World Family Planning 2022: Meeting the changing needs for family planning: Contraceptive use by age and method*, UN DESA/POP/2022/TR/NO. 4. [6]
- UNESCO et al. (2021), *The journey towards comprehensive sexuality education: Global status report*, UNESCO, Paris, <https://unesdoc.unesco.org/ark:/48223/pf0000379607>. [50]
- UNESCO et al. (2018), *International technical guidance on sexuality education: An evidence-informed approach*, UNESCO, Paris, <https://unesdoc.unesco.org/ark:/48223/pf0000260770>. [51]

- UNFPA (2024), *State of World Population 2024: Ending inequalities in sexual and reproductive health and rights*, UNFPA, Geneva, <https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf> (accessed on 1 June 2023). [11]
- UNFPA (2022), *Investing in three transformative results: Realizing powerful returns*, New York. [1]
- UNFPA (2022), *State of World Population 2022: Seeing the Unseen - The Case for Action in the Neglected Crisis of Unintended Pregnancy*, UNFPA, Geneva, <https://doi.org/10.18356/9789210015004> (accessed on 1 June 2023). [18]
- UNFPA (2020), *Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage*, https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf. [10]
- UNFPA (1994), *International Conference on Population and Development (ICPD)*, <https://www.unfpa.org/events/international-conference-population-and-development-icpd> (accessed on 14 April 2023). [3]
- UNFPA Kazakhstan (n.d.), *Kazakhstan - Advancing adolescent health through policy and legislation*, https://kazakhstan.unfpa.org/sites/default/files/pub-pdf/kazakhstan_-_advancing_adolescent_health_through_policy_and_legislation_d1.pdf. [31]
- UNFPA, UNICEF and PAHO/WHO (2018), *Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean. Report of a technical consultation.*, UNICEF, New York. [12]
- UNICEF (2020), *Global education monitoring report 2020: gender report, A new generation: 25 years of efforts for gender equality in education*. [14]
- United Nations (2023), *SDG Indicators: Metadata repository*, United Nations, <https://unstats.un.org/sdgs/metadata/?Text=&Goal=5&Target=5.3> (accessed on 1 June 2023). [59]
- United Nations (2022), “Estimates and Projections of Family Planning Indicators 2022”, *United Nations Department of Economic and Social Affairs, Population Division* (database), <https://www.un.org/development/desa/pd/data/family-planning-indicators> (accessed on 1 June 2023). [61]
- United Nations (2022), *The Sustainable Development Goals Report 2022*, United Nations, New York, <https://unstats.un.org/sdgs/report/2022/The-Sustainable-Development-Goals-Report-2022.pdf> (accessed on 1 June 2023). [34]
- United Nations (2016), *General comment no. 20 (2016) on the implementation of the rights of the child during adolescence*, Committee on the Rights of the Child, United Nations, Geneva, <https://digitallibrary.un.org/record/855544>. [29]
- United Nations (1989), *Convention on the rights of the child*. [28]
- United Nations (1968), *International Conference on Human Rights 22 April-13 May 1968, Teheran*. [4]
- Upadhyay, U. et al. (2014), “Development and Validation of a Reproductive Autonomy Scale”, *Studies in Family Planning*, Vol. 45/1, pp. 19-41, <https://doi.org/10.1111/j.1728-4465.2014.00374.x>. [57]

- WHO (2024), *Contraceptive prevalence (% of women ages 15-49)*, [25]
<https://genderdata.worldbank.org/en/indicator/sp-dyn-zs> (accessed on 7 October 2024).
- WHO (2022), “WHO issues new guidelines on abortion to help countries deliver lifesaving care”, [19]
<https://www.who.int/news/item/09-03-2022-access-to-safe-abortion-critical-for-health-of-women-and-girls> (accessed on 1 June 2023).
- WHO (2017), *Sexual health and its linkages to reproductive health: an operational approach*. [5]
- World Bank (n.d.), *World Bank Open Data*, <https://data.worldbank.org/> (accessed on [7]
7 January 2022).
- World Health Organization (2012), *Causes and consequences of contraceptive discontinuation*. [56]

Annex A. Legal developments in reproductive rights

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

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

- Honduras: In 2020, Honduras amended its Constitution to prohibit abortion outright, sending a strong signal as the law already prohibited abortion under any circumstances.
- Hungary: While abortion has been legal since 1953 (upon request until 12 weeks of pregnancy and also beyond the gestational limit when interrupting the pregnancy is necessary to save the woman's life or preserve her health). Hungarian women are now subject to a mandatory ultrasound where they must listen to the foetus' heartbeat before they can have an abortion.
- Poland: In 2020, Poland's Constitutional Tribunal ruled that abortions in cases of foetal impairment are unconstitutional, which translates into a near-total ban, as most abortions prior to the ruling were performed due to foetal abnormalities.
- United States: In 2022, the Supreme Court overturned the landmark ruling *Roe v. Wade* which constitutionally granted women's right to abortion. Since then, several states have reformed their laws to prohibit abortion or to restrict access to abortion, for instance by limiting the gestational limit.

Law reforms enhancing access to safe and legal abortion

- Argentina: The Voluntary Interruption of Pregnancy Bill was passed by the National Congress in December 2020 which liberalises and protects women's rights to access a safe and legal abortion until the fourteenth week of pregnancy. Prior to 2020, abortion was banned and criminalised unless it was to save the woman's life or the result of rape or incest.
- Benin: The Law on Sexual and Reproductive Health was amended in 2021, granting women access to safe and legal abortion on all essential and socio-economic grounds until the twelfth week of pregnancy.
- Colombia: The recent ruling of the Constitutional Court of Colombia in 2022 decriminalised abortion in all cases up to 24 weeks of pregnancy. Beyond the gestational limit, abortion remains legal when the pregnancy represents a risk to the health or life of the woman or is the result of rape.
- France: In 2023, the Senate voted in favour to include women's right to voluntary termination of pregnancy in the Constitution, after the National Assembly had adopted the bill in 2022.
- Gabon: Before 2021, abortion was illegal and criminalised. An amendment to the Penal Code of Gabon introduced for women the possibility of having an abortion when the mother's life is in danger, if the pregnancy is the result of rape or incest, or in the case of foetal impairment.

- India: In 2021, the Indian Supreme Court ruled that different gestational limits based on marital status were unlawful. Previously, under the Medical Termination of Pregnancies Act (1971), married women could have abortions up to 24 weeks into their pregnancies, but single women were limited to 20 weeks.
- Kenya: In 2022, the High Court of Kenya ruled that “abortion care is a fundamental right under the Constitution and that arbitrary arrests and prosecution of patients and healthcare providers seeking or offering such services is illegal”.
- Korea: In April 2019, South Korea’s Constitutional Court ruled that the ban on abortion was unconstitutional and mandated the National Assembly to revise the law by 31 December 2020. In the absence of a legal revision, abortion in South Korea was decriminalised on 1 January 2021
- Mexico: In 2021, the Mexican Supreme Court ruled that penalising abortion is unconstitutional. Since then, several states have amended their laws to decriminalise and legalise abortion up to 12 weeks of pregnancy.