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Connecting the Dots

Sexual and reproductive health
and rights as prerequisites for global
gender equality and empowerment



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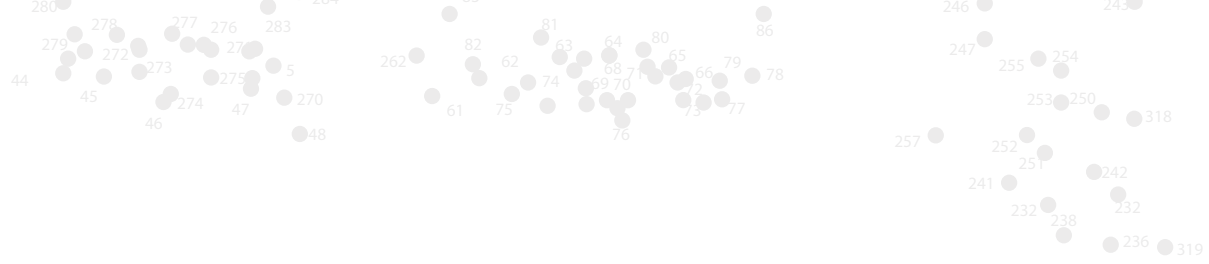
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List of Abbreviations

Acquired immunodeficiency syndrome	AIDS	The Joint United Nations Programme on HIV and AIDS	UNAIDS
The anti-prostitution loyalty oath	APLO	Low- and middle-income countries	LMICs
Centers for Disease Control and Prevention	CDC	Maternal and child health	MCH
Child, early, and forced marriage	CEFM	Maternal mortality ratio	MMR
Coronavirus disease	COVID-19	Menstrual health and hygiene	MHH
Comprehensive sexuality education	CSE	Millennium Development Goals	MDGs
<i>Equal Access to Abortion Coverage Act</i>	EACH Act	Non-governmental organizations	NGOs
Family planning and reproductive health	FP/RH	Official Development Assistance	ODA
Female genital mutilation/cutting	FGM/C	President's Emergency Plan for AIDS Relief	PEPFAR
Fiscal Year	FY	Population Institute	PI
Gender-based violence	GBV	Sexual and reproductive health	SRH
Gender Equity and Equality Action Fund	GEEA Fund	Sexual and reproductive health and rights	SRHR
Global gag rule	GGR	Sexually transmitted infections	STIs
<i>Global Health, Empowerment and Rights Act</i>	Global HER Act	Sustainable Development Goals	SDGs
<i>Greater Leadership Overseas for the Benefit of Equality Act</i>	GLOBE Act	U.S. Agency for International Development	USAID
Gross domestic product	GDP	United Kingdom	U.K.
Gross national income	GNI	United Nations	U.N.
Gross national product	GNP	United Nations International Children's Emergency Fund	UNICEF
Human immunodeficiency virus	HIV	United Nations Population Fund	UNFPA
Human papillomavirus	HPV	United States	U.S.
In vitro fertilization	IVF	<i>Universal Declaration of Human Rights</i>	UDHR
International Conference on Population and Development	ICPD	Women, Peace, and Security	WPS
<i>International Violence Against Women Act</i>	I-VAWA	World Health Organization	WHO

Forward

Women and girls across the globe continue to experience deep and persistent gender inequality, leaving many with fewer educational opportunities, lower income, less autonomy, and less political power compared to their male counterparts. U.S. foreign assistance and policy priorities play an important role in advancing efforts aimed at achieving universally agreed goals related to gender equality and empowerment.

However, policymakers who determine U.S. foreign assistance priorities often fail to recognize the ways in which bipartisan gender equality and empowerment policy objectives are directly impacted by the availability and accessibility of comprehensive sexual and reproductive health services. This report makes these connections clear.

For example, we know that girls' education and sexual and reproductive health services have a mutually reinforcing relationship, with unintended pregnancy being both a cause and a consequence of girls' absence from school. We know that having autonomy over one's own body creates greater agency for economic and political engagement, as women having the ability to choose the number, timing, and spacing of births is inextricably linked to their participation in the formal economy and civil society. We know that reproductive health is a critical element to making space for women to meaningfully contribute to peace and security efforts, not only because they are affected by these outcomes, but also because they are more often able to come to lasting solutions. We must connect these dots—which are straightforward, yet too often overlooked—to ensure that full gender equality and empowerment can be achieved.

To do so will require both fiscal and political commitment from our policymakers. The U.S. will need to provide its “fair share” of support needed for sexual and reproductive health services in the Global South. It will also need to address some of its foreign policies that restrict sexual and reproductive health service delivery, impeding progress in advancing gender equality and empowerment worldwide.

As this report illustrates, this is a crucial time for the U.S. to increase its investment in the SRHR agenda. The world's population recently surpassed 8 billion people, reminding us that the scale of human needs will only continue to grow. Unfortunately, bilateral funding for family planning and reproductive health programming has remained flat for the past decade; and yet, today, we have the largest generation of youth in history, with a majority living in the Global South. It is imperative that the U.S. reestablish itself as a leader in SRHR on the global stage by investing in the SRHR agenda to meet the needs of this generation.

If we fail to make the connection, our progress on global gender equality and empowerment will be incomplete.



Kathleen Mogelgaard
President and CEO, Population Institute



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Connecting the Dots: Sexual and reproductive health and rights as prerequisites for global gender equality and empowerment



Global gender equality and empowerment are universally agreed upon goals and are widely considered critical across political affiliations in the United States (U.S.). Achieving these goals requires dedicated commitment to women's and girls' health; freedom from violence; and equal participation in education, the workforce, and politics. Additionally, as these issues are all directly impacted by the availability and accessibility of comprehensive sexual and reproductive health services, investment in the global sexual and reproductive health and rights (SRHR) agenda is critical to the advancement of gender equality and empowerment.

Without robust support for comprehensive SRHR policy and programs, the U.S. government cannot properly address its own priority policy goals related to girls' education; women's economic empowerment; women's political involvement; and women, peace, and security efforts. Progress in the SRHR agenda requires the U.S. to address the barriers that are entrenched in funding allocations, foreign policies, and social norms and values that all work to prevent people around the world from achieving optimal personal health and well-being. By financially and politically investing in the global SRHR agenda, the U.S. can reengage as a global leader in helping to advance equality and empowerment for women and girls worldwide.

The SRHR Agenda

The SRHR index, supported by many reproductive rights advocates, examines the U.S. government's foreign policies related to SRHR and holds it accountable to its work on SRHR in U.S. global health assistance. The index details the following core components of SRHR:

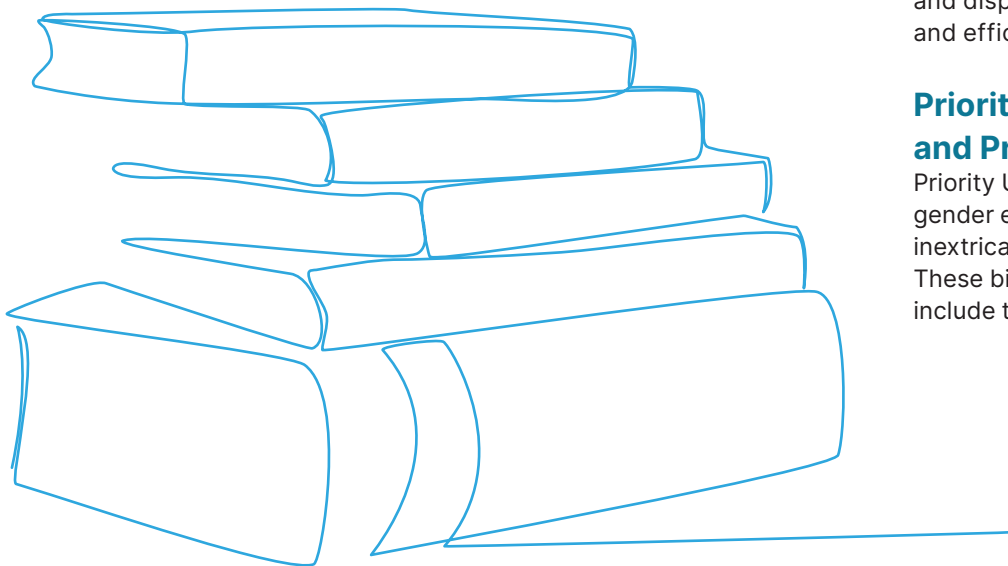
- **Comprehensive family planning and contraceptive services, including emergency contraception;**
- **Maternal health, including prenatal care, skilled attendance at birth, antenatal care, emergency obstetric care, and respectful maternity care;**
- **Prevention and treatment of infertility;**
- **Safe abortion and postabortion care;**

- **Prevention, care, and treatment of STIs, HIV, and AIDS; reproductive tract infections; and reproductive cancers; and**
- **Prevention and treatment of gender-based violence (GBV), including screening, counseling, and referral, as well as the elimination of harmful practices, such as female genital cutting/mutilation and child, early, and forced marriage.¹**

The components of this index offer a comprehensive agenda of care and services that are needed to enable people to achieve SRHR. Recognizing the interconnectedness of these services as parts of a greater system and designating funding streams that support the full agenda can enable the U.S. to tackle global challenges and disparities with greater efficiency and efficacy.

Priority U.S. Policy Goals and Programming

Priority U.S. policy goals focused on gender equality and empowerment are inextricably intertwined with SRHR. These bipartisan policy objectives include the following items:





Girls' Education

Access to quality education is a necessary element of gender equality for girls and a basic human right. Girls' education and SRHR have a mutually reinforcing relationship. Early marriage and unintended pregnancy can both be a cause of and a reason as to why girls are out of school. Research has found that increasing girls' education is one of the best ways to avoid child marriage and delay first births.² Of the 261 million adolescent girls aged 15–19 living in low- and middle-income countries (LMICs), an estimated 32 million are sexually active and do not want a child in the next two years; and yet, 14 million of those adolescent girls have an unmet need for modern contraception and are thus at elevated risk of unintended pregnancy.³ Adolescents in LMICs have an estimated 21 million pregnancies each year, 50 percent of which are unintended.⁴ A lack of access to SRHR services drives high rates of unintended adolescent pregnancy, putting global commitments to girls' education at risk.

Women's Economic Empowerment

Having control over one's own reproductive life creates more agency for engagement in economic activities. Research shows that women's empowerment to choose where and when to work is inextricably linked to their freedom and ability to choose the timing, spacing, and number of their births.⁵

As an unmet need for contraception is one of the leading causes for women's constrained labor force participation, especially in Global South, improved access to SRH services is intrinsically linked with higher labor force participation for women.^{6,7}

Women's Political Involvement

Strengthening women's political engagement and their participation in government is both an imperative to improving SRHR conditions worldwide and reinforced by funding SRHR programs. When women are engaged in policymaking processes, they are better able to influence decisions that affect them, their families, and their communities. Women's political participation often hinges on their ability to exercise autonomy over their own bodies and reproduction. Women Deliver, a leading global advocate championing gender equality, has identified the following among the key investment areas needed to strengthen women's political participation and decision-making power: meet the demand for modern contraception and reproductive health; dramatically reduce GBV and harmful practices; and respect, protect, and fulfill sexual health and rights.⁸

Women, Peace, and Security Efforts

Matters of peace and security are of the utmost importance to women and girls globally, especially in the Global South. Armed conflict

and crises inhibit women's access to basic services, including SRH services, and heighten ongoing threats of GBV, sometimes subjecting women and children to wide-scale sexual violence.⁹ And yet, women are rarely included in the spaces where decision-making around peace and security efforts occur. It is important that women have a presence in these spaces, not only because they will be affected by the outcomes, but also because they are more often able to come to peaceful solutions. When women occupy positions of authority, they are more likely than their male counterparts to resolve national crises without violence, advocate for social issues that benefit all, and allocate budgets to health and education.¹⁰ It is imperative that women have an equal share of the seats at the peace and security efforts table. Access to SRH services can enable women's ability to participate in paths to peace. Bridging the gaps in SRHR is crucial for enforcing women's bodily autonomy and including women in peace-building efforts for lasting and inclusive development before situations arise, as well as during post-conflict reconstruction efforts.¹¹

Channeling funding to efforts to improve gender equality and women's empowerment without connecting the dots between women's access to SRHR and their subsequent ability to participate in education, the workforce, and political decision-making will inevitably weaken these efforts.

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Current U.S. Funding for SRHR

U.S. support for various components of the SRHR agenda flows through multiple budget and appropriations line items, such as bilateral Family Planning/Reproductive Health (FP/RH), Maternal and Child Health, the U.S. President’s Emergency

Plan for AIDS Relief, contributions to the United Nations Population Fund (UNFPA) and other multilateral funding avenues. Since SRHR is interwoven in many development priorities that are funded by U.S. foreign assistance, it is difficult to pinpoint the exact current U.S. expenditure on SRHR programming.

The following table provides an overview of current funding levels for FP/RH programming, one of the main funding streams for SRHR activities, as well as a calculation of what can be seen as the U.S. “fair share” of support needed for these services in the Global South.

Current and Fair Share Funding for FP/RH Programming

	FY 2022 Funding Amount	U.S.’s Fair Share	Difference
FP/RH Bilateral Programming	\$575 million	\$1.62 billion	\$1.045 billion
UNFPA Core Contribution	\$32.5 million	\$116 million	\$83.5 million
Total	\$607.5 million	\$1.736 billion	\$1.1285 billion

The Concept of “Fair Share”

In 1994, the International Conference on Population and Development Programme of Action recommended that two-thirds of the costs of reproductive health care in low and middle income countries be provided by the countries themselves, and one-third of the needed funds come from external sources, such as bilateral funders like the U.S. and other donor countries.¹² A recommendation espoused by PAI and other SRHR advocacy organizations is that each donor’s share of total funds should be based on the wealth of the donor country as measured by their gross national income.¹³ According to this formula, the U.S. should provide 41.34 percent of the support for reproductive health care from donor countries.¹⁴

The Guttmacher Institute estimates that it would take \$12.6 billion to ensure the reproductive health needs of all women of reproductive age in LMICs.¹⁵ Of that number, the one-third share from donor countries would equal \$4.2 billion. The U.S.’s fair share calculation of 41.34 percent of the donor countries’ contribution totals \$1.736 billion. This means that, in order to be in accordance with the estimated fair share, the U.S. would need to raise its support for FP/RH programming to \$1.736 billion annually.¹⁶

What It Takes

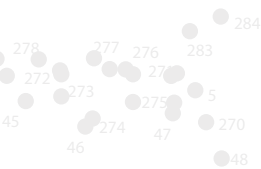
Full gender equality and empowerment cannot be achieved without SRHR. Policymakers must shift their mindsets from seeing SRHR as a siloed and contentious public health issue and instead shape their understanding of SRHR as a prerequisite for bipartisan policy goals related to gender equality and empowerment. It is imperative that

the U.S. increase its support for FP/RH programming to its estimated fair share of \$1.736 billion annually, including \$116 million for UNFPA. However, it is also important for policymakers to understand that current FP/RH programming and other sources of SRHR funding are not inclusive of the entire SRHR agenda, namely abortion care and infertility treatment and care, and

further U.S. funding is needed to ensure all SRHR components are fully realized.

When it comes to the core components of SRHR, there cannot be any exceptions or exclusions; the U.S. should expand its SRHR programming to include all core components of the SRHR agenda. This will require a change in U.S.





foreign policy—notably to enable more supportive SRHR funding and programming, such as passage of the *Global HER Act*, permanently repealing the global gag rule; passage of the *Abortion is Health Care Everywhere Act*, repealing the Helms Amendment; and modifications to the Kemp-Kasten Amendment, ensuring U.S. funds are not wrongfully withheld from UNFPA.

A Committed Focus

In addition to a need for full funding and advancement of progressive policies, it is essential that there is a committed focus ensuring that systemically excluded groups, including ethnic minorities, forcibly displaced peoples, indigenous peoples, sex workers, young people, unmarried people, people in a forced union, people with disabilities, rural and urban poor individuals, and the LGBTQI+ community, are intentionally centered in U.S. funding and programming for SRHR. Inequalities related to SRHR exist for a range of reasons that include

income inequality; insufficient health facilities, providers, and supplies; legal barriers; inadequate education; and cultural norms.¹⁷

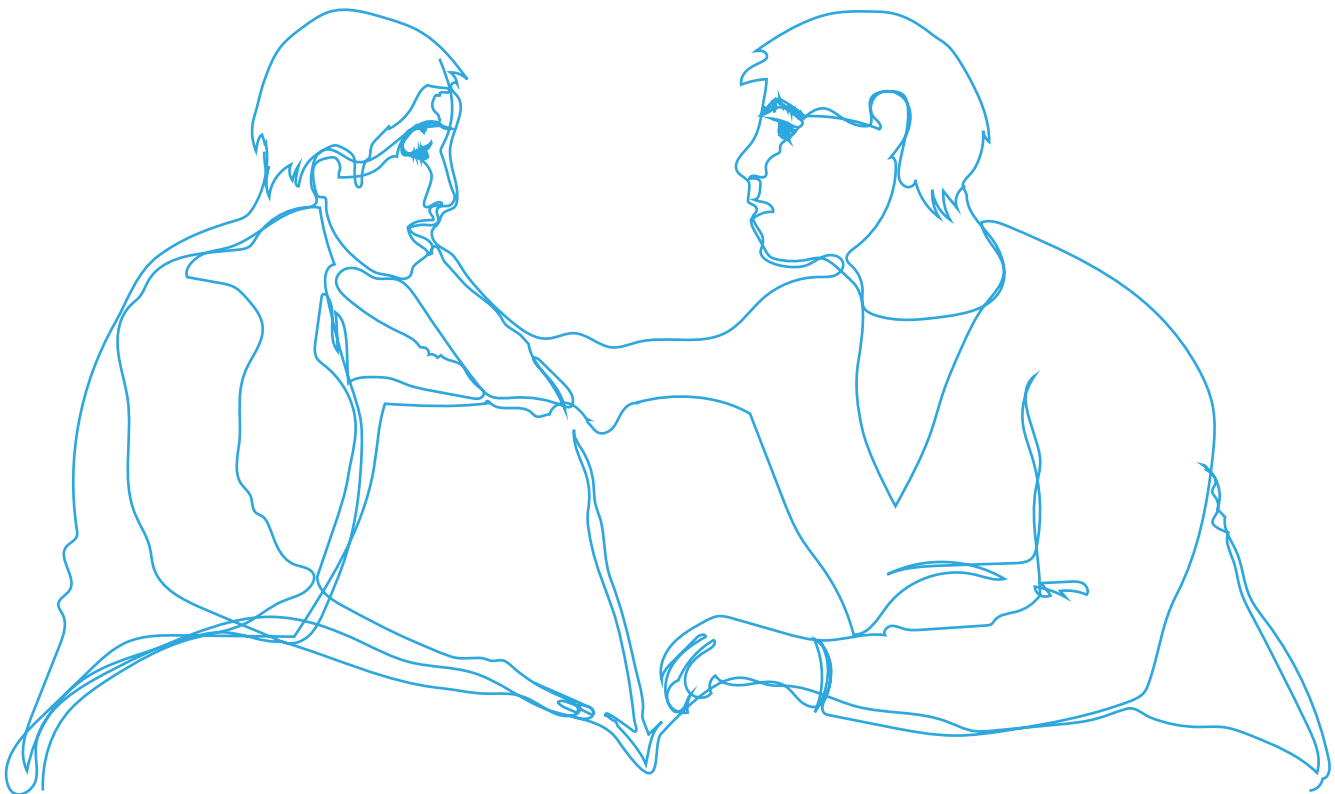
At This Moment

Now is an opportune time to invest. As the world population grows, so too does the need for SRHR funding to fulfill every individual’s right to access SRH services. Today, there are 1.8 billion people between the ages of 10–24—the largest generation of youth in history. Close to 90 percent of this generation lives in LMICs, and the numbers of individuals of reproductive age are projected to grow by 2030.¹⁸ These figures highlight just how critically important it is to increase U.S. funding for global SRHR in order to ensure efforts do not fail to keep pace with the SRH needs of this generation. But it will take a commitment from the U.S. to reestablish its leadership on global SRHR through robust investment—both financially and politically. Achieving these crucial elements can pave the way for real progress in gender equality and empowerment.

The Use of Women and Girls in Data Points

Population Institute intentionally uses the terms “women” or “girls” when describing data that did not include nonbinary people or trans men in the research. Otherwise, Population Institute is committed to using gender-inclusive language to represent all individuals who deserve full access to SRHR services.

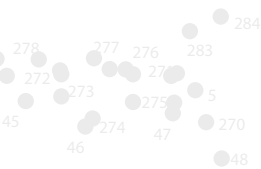
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Chapter 1

Gender Equality, Empowerment, and Reproductive Rights





Gender equality and empowerment are universally agreed upon goals and are widely considered critical across political affiliations in the United States (U.S.). Achieving these goals requires dedicated attention to women’s and girls’ health, freedom from violence, and equal participation in education, the workforce, and politics. Additionally, since these issues are all directly impacted by the availability and accessibility of comprehensive sexual and reproductive health and rights (SRHR), robust investment in the global SRHR agenda is critical to the advancement of gender equality and empowerment.

Good sexual and reproductive health (SRH) is a state of complete physical, mental, and social well-being in all matters relating to sexuality and the reproductive system.¹⁹ All individuals have a right to bodily autonomy and access to information and services that support that right.²⁰ SRHR, therefore, is a fundamental human right that promotes the health and

well-being of people around the world. Access to SRH services and information is essential to achieving gender equality and empowerment, as well as foundational to the social and economic development of communities and nations.²¹

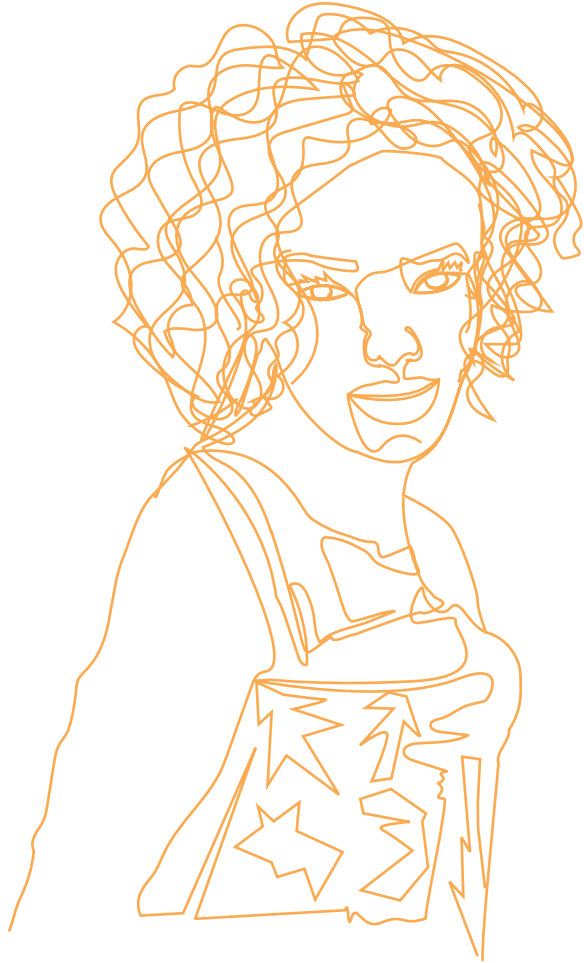
Despite governments around the world investing in SRHR, progress has fallen short due to weak political commitment, insufficient resources, continued gender discrimination, and an unwillingness to comprehensively address all aspects of SRHR.²² Progress in the SRHR agenda involves addressing the barriers that are entrenched in U.S. funding allocations, foreign policies, and social norms and values that all work to prevent people around the world from achieving optimal personal health and well-being. Without full support for comprehensive SRHR policy and programs, the U.S. government cannot properly address its own priority policy goals and programming such as girls’ education; women’s economic empowerment; women’s political involvement; and women, peace, and security (WPS) efforts. By financially and politically investing in the global SRHR agenda, the U.S. can reengage as a global leader in helping to advance gender equality and empowerment for women and girls worldwide.

Fundamental Human Rights

Reproductive rights have roots in the 1948 *Universal Declaration of Human Rights* (UDHR) and have been recognized in several instruments of international human rights law, such as the 1979 *Convention on the Elimination of All Forms of Discrimination Against Women* and the 1989 *Convention on the Rights of the Child*.²³ These international human rights treaties were the basis for the rights recognized in the 1994 International Conference on Population and Development (ICPD).

Held in Cairo, Egypt, the ICPD marked global acceptance in addressing reproductive rights. The U.S. joined approximately 180 countries in support of an agenda to advance global reproductive health and rights.²⁴ For the first time, there was a clear, international focus on the reproductive needs of individuals and the importance of gender equality, shifting the primary focus away from reducing fertility and curbing population growth.²⁵

Aspects of SRHR have since been central to international development goals, first within the Millennium Development Goals (MDGs) and currently within the 2030 Agenda for Sustainable Development, commonly known as the Sustainable



Development Goals (SDGs).^{26,27} The presence of “sexual and reproductive health and reproductive rights” in the SDGs represents an international commitment to these issues, as it includes targets not only on service provision, but also on addressing the barriers and human rights dimensions.²⁸

Roots in the Universal Declaration of Human Rights

In 1948, governments around the world proclaimed the UDHR as a common standard of civil, political, economic, social, and cultural rights for all peoples in all nations. Most relevant to SRH, the UDHR recognized:

- (a) The right to nondiscrimination;
- (b) The right to life, liberty, and security of person;
- (c) The right to social security;
- (d) The right to a standard of living adequate for health and well-being; and
- (e) That “motherhood and childhood are entitled to special care and assistance.”

The UDHR reaffirmed the dignity and worth of the human person, the equal rights of women and men, and the determination to promote social progress and better standards of life in larger freedom. Human rights related to sexuality, gender, gender diversity, and SRH have been recognized in the treaties that were derived from the UDHR, and in the decades since, SRHR have received extensive legal recognition at both regional and national levels.²⁹

U.S. Government Support for Global SRHR

The U.S. government has supported global family planning and reproductive health (FP/RH) efforts for more than 50 years as a part of a bipartisan U.S. foreign assistance agenda. It is the largest global donor of FP/RH assistance, supporting programs in 40 countries.³⁰ While some U.S. international family planning activities originated before, Congress first authorized research on family planning issues through the enactment of the *Foreign Assistance Act* of 1961, and in 1965, the U.S. Agency for International Development (USAID) launched its first contraceptive distribution programs.³¹ USAID administers the majority of FP/RH funding, which Congress appropriates primarily through the Global Health Programs account in its annual State, Foreign Operations, and Related Programs appropriations. These programs have evolved to also include other areas of reproductive health, such as female genital mutilation/cutting (FGM/C) and obstetric fistula prevention and care.³² The Centers for Disease Control and Prevention (CDC) (research, surveillance, technical assistance, and a designated World Health Organization Collaborating Center for Reproductive Health); the Department of State (diplomatic and humanitarian efforts); the National Institutes of Health (research); and the Peace Corps (volunteer activities) are all involved in carrying out FP/RH efforts, as well.³³

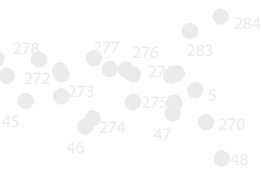
The role of the U.S. government in global FP/RH has changed over time, often influenced by political and ideological views. Historically, the debates that arise from these views have centered around the amount of U.S. funding provided, as well as

how that funding is used, primarily as it relates to abortion services.³⁴ U.S. funding for international FP/RH rose steadily in its first two decades but has plateaued in recent years. Currently, annual funding totals \$607.5 million for international FP/RH, including funding for the United Nations Population Fund (UNFPA).³⁵ The U.S.’s maternal and child health (MCH) efforts are also closely linked with FP/RH, as are coordinated efforts with global human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) programs through the President’s Emergency Plan for AIDS Relief (PEPFAR), although Congress directs funding to these programs separately.³⁶ Current U.S. funding for MCH is \$1.1 billion and U.S. funding for HIV/AIDS efforts is \$7.4 billion (see Chapter 4).³⁷

A Comprehensive and Integrated Definition of SRHR

The ICPD first outlined four categories of reproductive health and set funding goals for low-income countries that called for one-third of the required funds to come from development assistance donors. The four categories of needed funding include:

- **Family Planning;**
- **Basic Reproductive Health—safe delivery and other maternal health care, education on sexuality and reproductive health, prevention, and appropriate treatment of sexually transmitted infections (STIs) and infertility, safe abortion where not against the law;**
- **HIV/AIDS prevention; and**
- **Basic Research, Data, and Policy Analysis—censuses and other demographic data.**³⁸



The ICPD funding targets for each of these categories were lacking due to the unavailability of cost data for a full range of SRHR activities. For example, the funding target for HIV/AIDS did not include an estimate of funds needed for treatment and care. However, cost estimates continue to be constrained due to a notable lack of cost data available for the full range of SRHR services.

Since the Cairo conference, there has been a substantial increase in the scope of activities considered essential for full SRHR. The evolution of goals for SRHR is exemplified by targets set by the World Health Organization (WHO), as well as those set by the SDGs in 2015 in relation to health (Goal 3), education (Goal 4), and gender-equality (Goal 5).^{39,40} And yet the SRHR agenda remains fragmented.

To address the unfinished SRHR agenda, the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights built upon existing international norms and proposed a new, comprehensive definition of SRHR in 2018. For the purpose of this report, Population Institute (PI) uses this integrated definition to cover a wide range of important elements that helps realize a broader vision of SRHR and supports the U.S. government adoption of the full definition and agenda.

The Guttmacher-*Lancet* Commission integrated definition of SRHR states: *Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease,*

dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- **Have their bodily integrity, privacy, and personal autonomy respected;**
- **Freely define their own sexuality, including sexual orientation and gender identity and expression;**
- **Decide whether and when to be sexually active;**
- **Choose their sexual partners;**
- **Have safe and pleasurable sexual experiences;**
- **Decide whether, when, and whom to marry;**
- **Decide whether, when, and by what means to have a child or children, and how many children to have; and**
- **Have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.⁴¹**

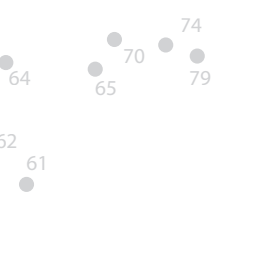
The Guttmacher-*Lancet* Commission further defines what should be included in SRH services to enable all individuals to make informed decisions about their reproductive health:

Essential SRH services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health. The services should include:

- **Accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;**
- **Information, counselling, and care related to sexual function and satisfaction;**
- **Prevention, detection, and management of sexual and gender-based violence (GBV) and coercion;**
- **A choice of safe and effective contraceptive methods;**
- **Safe and effective antenatal, childbirth, and postnatal care;**
- **Safe and effective abortion services and care;**
- **Prevention, management, and treatment of infertility;**
- **Prevention, detection, and treatment of STIs, including HIV, and of reproductive tract infections; and**
- **Prevention, detection, and treatment of reproductive cancers.⁴²**

Core Components of SRHR

Taking the comprehensive approach to what SRH services should entail from the Guttmacher-*Lancet* Commission, CHANGE—now a part of Fós Femenista—led to the creation of the SRHR Index. The SRHR Index uses standardized indicators to assess and score government policies,



investments, and programs on how well U.S. global health assistance promotes SRHR with a letter grade. This allows users to understand how the government is doing within a particular domain of SRHR [family planning, MCH, and HIV/AIDS], as well as across SRHR as a whole.⁴³

Informed by the Guttmacher-*Lancet* definition of SRH services, the core components of the SRHR Index include:

- **Comprehensive family planning and contraceptive services, including emergency contraception;**
- **Maternal health, including prenatal care, skilled attendance at birth, antenatal care, emergency obstetric care, and respectful maternity care;**
- **Prevention and treatment of infertility;**
- **Safe abortion and postabortion care;**
- **Prevention, care, and treatment of STIs, HIV, and AIDS; reproductive tract infections; and reproductive cancers; and**
- **Prevention and treatment of GBV, including screening, counseling, and referral, as well as the elimination of harmful practices, such as female genital cutting/mutilation (FGC/M) and child, early, and forced marriage.⁴⁴**

As the global status of SRHR and U.S. government funding are examined, it is critical to include all components of the SRHR Index under the broader umbrella of the global

SRHR agenda. While many of the individual components and health services that make up SRHR are researched, analyzed, and funded in silos, they have direct impacts on one another. For example, funding maternal health care without funding abortion care can limit accomplishing the end goal, as unsafe abortions are a leading cause of maternal mortality worldwide.⁴⁵ By acknowledging the importance of viewing these services as interconnected parts of a greater system and funding them as such, the U.S. can tackle global health challenges and disparities with greater efficiency and efficacy.

Across the globe, women and girls still experience gender inequality, leaving them with fewer opportunities, lower income, less autonomy, less political power, and increased risk of gender-based violence. For women of reproductive age, poor access to SRHR makes up one-third of the total global burden of disease.⁴⁶ The realization of SRHR is crucial in elevating women's and girls' health; freedom from violence and persecution; and equal participation in education, politics, and the workforce.

This report will examine the global status of these core components of SRHR, as well as explore how SRHR is a prerequisite for achieving other priority goals, such as girls' education; women's economic empowerment; political involvement; and WPS efforts. Furthermore, this report will demonstrate the "fair share" of funding and political will needed from the U.S. government to fully achieve the global SRHR agenda.

The Integration of Menstrual Health and Hygiene in SRHR

There is a growing understanding of the importance menstrual health and hygiene (MHH) has on issues related to girls' education, gender equality, and women's empowerment.⁴⁷ Though an entry point to women's and girls' reproductive health lives, researchers, donors, and advocates have often overlooked the value of menstruation within the context of SRHR. While it has historically been relegated to interventions promoted and funded by the Water, Sanitation, and Hygiene sector, more advocates are suggesting that MHH should be viewed within the broader frame of SRHR.^{48,49} Regrettably, MHH is not included as a core component of SRHR within this report, and the important links between MHH and SRH warrant further exploration.

A Committed Focus

In addition to a need for full funding and advancement of progressive policies, it is essential that there is a committed focus to ensuring that systemically excluded groups are intentionally centered in U.S. funding and programming for SRHR. The fundamental promise of the SDGs to "leave no one behind" represents the commitment of all United Nations (U.N.) member states



to eradicate poverty in all its forms, end discrimination and exclusion, and reduce the inequalities that exist.⁵⁰

Centering Systemically Marginalized Groups and People

SRHR inequalities exist for a range of reasons that include income inequality; insufficient health facilities, providers, and supplies; legal barriers; inadequate education; and cultural norms.⁵¹ Systemically marginalized groups with lower levels of access to SRHR globally include, but are not limited to:

- **Ethnic minorities;**
- **Forcibly displaced peoples;**
- **Indigenous peoples;**
- **Sex workers;**
- **Young people;**
- **Unmarried people;**
- **People with disabilities;**
- **The rural and urban poor; and**
- **The LGBTQI+ community.**⁵²

While reaching these long-excluded groups can be difficult and expensive, it should be a central priority of U.S. funding efforts.

These figures highlight just how critically important it is to increase U.S. funding for global SRHR in order to ensure efforts do not fail to keep pace with the SRH needs of this generation.

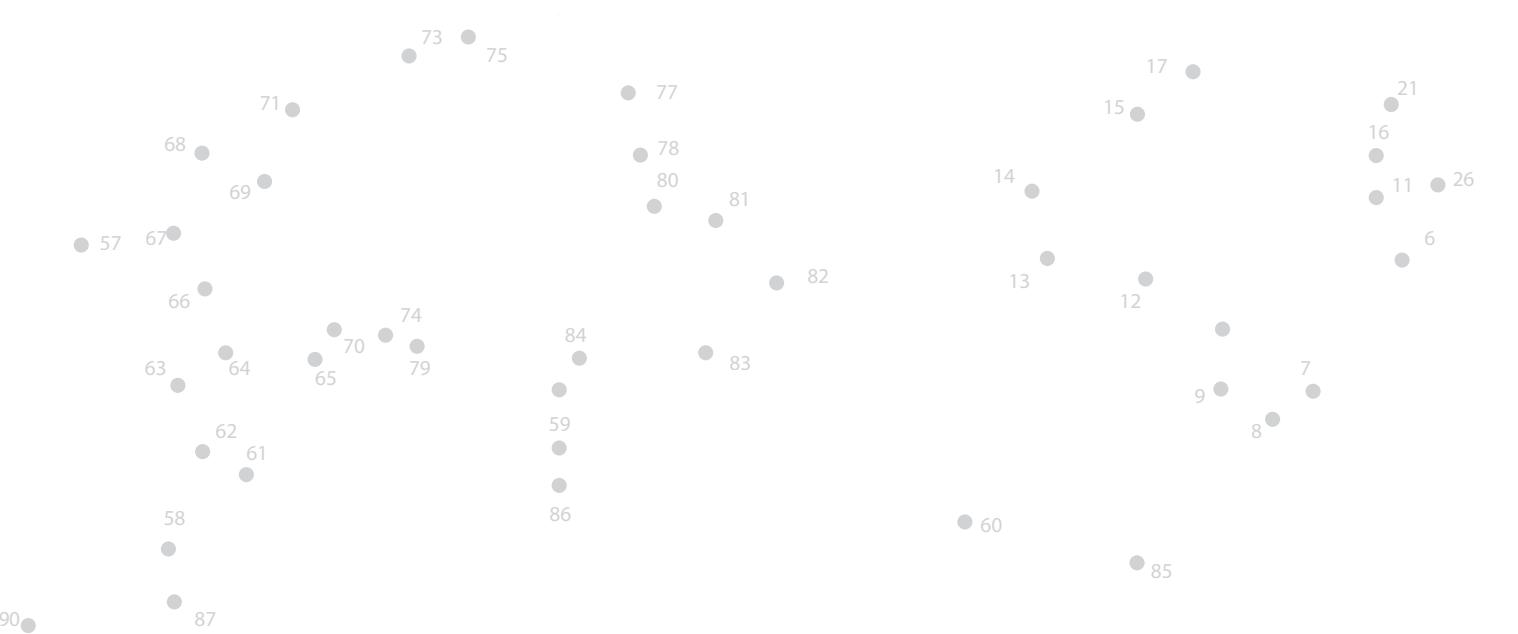
An Opportune Time

As the world population grows, so too does the need for SRHR funding to fulfill every individual's right to access SRH services. Today, there are 1.8 billion people between the ages of 10–24—the largest generation of youth in history. Close to 90 percent of this generation lives in low- and middle-income countries (LMICs) and the numbers of individuals of reproductive age are projected to grow, with 1.9 billion young people projected to turn 15 years old between 2015 and 2030.⁵³

These figures highlight just how critically important it is to increase U.S. funding for global SRHR in order to ensure efforts do not fail to keep pace with the SRH needs of this generation.

But it will take a commitment from the U.S. to reestablish its leadership on global SRHR.

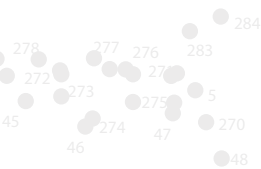
Funding cuts and regressive policies stemming from the Trump administration have had a devastating impact on SRHR globally. The expansion of the global gag rule (GGR) alone (see Chapter 4) caused extreme damage to the progress made in global SRHR.⁵⁴ After four years of the Trump administration's dismantling of global SRHR efforts, it is now more important than ever that the U.S. reengages in efforts to improve the status of SRHR worldwide and reestablishes itself as a leader on the world stage. To do so, robust funding, progressive policies, and a committed focus are required.



Chapter 2

The Current Status of Global Sexual and Reproductive Health and Rights





Since the 1994 ICPD in Cairo, Egypt, many governments and advocates have promoted universal SRHR through a human rights framework.⁵⁵ However, much of the SRHR agenda remains unfinished. Even prior to the Coronavirus disease (COVID-19) pandemic, the state of SRHR globally needed attention and meaningful investment. Today, the pandemic has made already vulnerable health care systems even more unstable and exposed cracks in seemingly robust health care systems. The unmet need for comprehensive SRHR experienced by adolescents, rural communities, low-income people, and other key demographics posed challenges that urgently needed solving before the onset of the pandemic and are even more essential to address in its midst.

SRH Indicators and Data Points

SRH indicators can be used to identify a problem, set goals, and declare success. Frequently used to describe outcomes at the population level, these indicators are at times also used to measure success at the individual level. An example of this is the use of “unintended pregnancy” as a family planning indicator. In many instances, this indicator has been used by researchers, advocates, and public health practitioners as a measure of progress toward an ultimate goal of preventing unintended pregnancy. However, a simple measure of “unintended” does not reflect how an individual feels about that particular pregnancy. For some, it could be disastrous; for others, it could be a welcomed surprise. Measures of unintended pregnancy, like many other widely used SRH indicators, are imperfect measures of people’s experience and satisfaction in accessing SRH services. Since many SRH indicators offer an incomplete picture, ideally, quality-of-care measures and qualitative data that provides a more comprehensive picture of people’s ability to access services that meet their needs would be presented alongside the SRH indicators available. Until new measures are available to shift the narrative to be more inclusive, the Population Institute (PI) will continue to try to expand the narrative around these commonly used SRH indicators to reflect a more patient-centered approach to SRH. PI intentionally uses the terms “women” or “girls” when describing data that did not include nonbinary people or trans men in the research. Otherwise, PI is committed to using gender-inclusive language to represent all individuals who deserve full access to SRHR services.

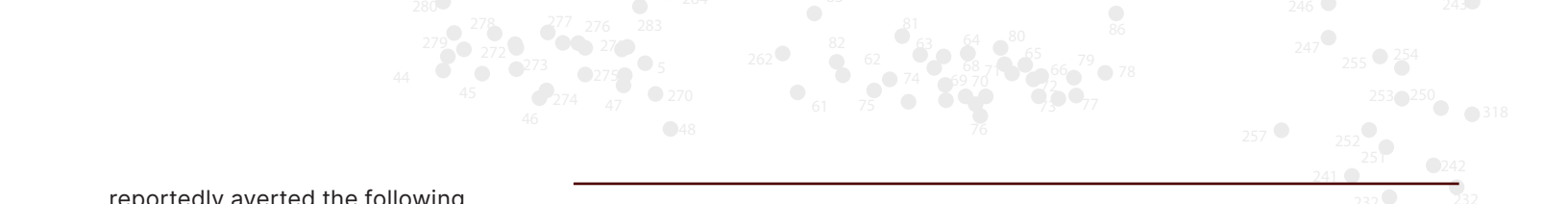
Family Planning

Access to family planning services is critical to the health of people and communities worldwide. “Family planning” is the ability of individuals and couples to attain their desired number of children, if any, and to determine the spacing and timing of births. It is achieved through the use of contraceptive methods and/or infertility treatments (see “Infertility” section).⁵⁶ Contraceptive information and services have long been a foundation of SRH as it enables people to choose whether and when to have children.

The benefits that stem from family planning are far reaching. Those who are able to decide if, when, and how many children they want to have can take better advantage of educational and economic prospects, creating greater opportunities to more fully participate in society.⁵⁷ Additionally, research shows that family planning helps to lower poor maternal health and pregnancy-related deaths as approximately one-third of maternal deaths could be prevented annually if women who did not wish to become pregnant had access to and used

effective contraception.⁵⁸ Family planning also has a major impact on reducing infant mortality rates.⁵⁹ Access to a full range of contraceptive choices for patients also reduces the need for unsafe abortion, as does access to safe, legal abortion (see “Safe Abortion” section).⁶⁰

Research shows that in 2019, 705 million women in LMICs used modern methods of contraception, thus preventing 376 million unintended pregnancies.⁶¹ The use of modern methods of contraception has



reportedly averted the following outcomes in 2019:

- **79 million unplanned births;**
- **100 million unsafe abortions;**
- **39 million miscarriages; and**
- **2 million stillbirths.**⁶²

While there is much to applaud about the progress made in family planning, more work needs to be accomplished so that everyone, everywhere has access to the family planning services they want and need. Approximately 218 million women of reproductive age (15–49 years) in LMICs have an unmet need for modern contraception, meaning they do not wish to get pregnant and are not using a modern method of contraception.⁶³ Among those who want to avoid a pregnancy, adolescents have a higher unmet need for modern contraception (43 percent) than do all women of reproductive age (24 percent).⁶⁴ An estimated 27,000 adolescent women in LMICs die each year from pregnancy complications, including unsafe abortion, or childbirth.⁶⁵ Reasons for the unmet need for contraception include limited access to contraception, a limited choice of methods, a fear or experience of

Despite the global progress in maternal health over the past decades, tens of millions of women in the Global South still have an unmet need for maternal health care, resulting in devastating statistics.

side-effects, cultural or religious opposition, poor quality of available services, users' and providers' bias against some methods, and gender-based barriers.⁶⁶

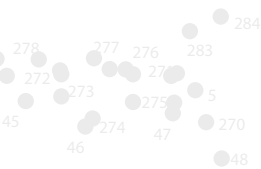
According to data from 2019, of the 228 million pregnancies occurring each year in LMICs, 111 million—about half (49 percent)—are unintended.⁶⁷ It is important to note that the unintended pregnancy indicator does not fully describe the feelings of the person toward that pregnancy—that is to say, not all unintended pregnancies are viewed as a negative outcome. However, unintended pregnancies can have negative impacts on the lives of women and girls, including poor mental health and physical health outcomes, being forced into marriage, having to leave

school or their jobs, or sliding into poverty.⁶⁸ Unintended pregnancies can be extremely harmful to women and girls as they can result in unsafe abortions. UNFPA estimates that 60 percent of all unintended pregnancies end in abortion, and with 45 percent of *all* abortions being considered unsafe, this gives rise to a public health emergency.⁶⁹ Research from 2019 showed that unintended pregnancies in LMICs resulted in the following estimated outcomes:

- **30 million unplanned births;**
- **35 million unsafe abortions;**
- **12 million miscarriages; and**
- **1 million stillbirths.**⁷⁰

SRHR in the SDGs

The 2030 Agenda for Sustainable Development was adopted by all U.N. Member States to recognize the universality of the challenges we face across the globe, as well as to help unify nations in tackling the root causes of development issues.⁷¹ The 17 SDGs and 169 targets are meant to be a blueprint for nations to follow to improve community well-being.⁷² SDGs are not only important in agenda setting in countries, but also in driving global funding and donor policy priorities.⁷³ These goals are meant to build upon the MDGs in helping to align donor investments and tracking progress in major challenge areas through benchmarks.⁷⁴ The SDGs include several relevant benchmarks and goals specifically related to SRHR topics, including general health access and quality, educational opportunity, climate change and environmental sustainability, and gender equality.⁷⁵ For example, the SDGs indicate that the proportion of family planning demand that is being met with modern contraception is a key measurement to understanding the global status of universal access to SRH services.⁷⁶ The inclusion and prioritization of SRHR issues in the SDGs implies a global recognition of the importance of SRHR topics. As a major donor and influential body in reproductive rights, the U.S. should prioritize equitable funding in SRHR topics to inspire real change toward accomplishing the SDGs and realizing sexual freedom and reproductive rights for all women and girls.



Maternal Health

Each stage of maternal health (pregnancy, childbirth, and the postnatal period) should be a positive experience, ensuring the health and well-being of both the birthing people and their babies. A comprehensive set of essential SRH services, which includes antenatal, perinatal, postpartum, and newborn care, is necessary to protect and enhance a pregnant person’s health during and after pregnancy.

From 2000 to 2017, the global maternal mortality ratio (MMR), which is the number of maternal deaths per 100,000 live births, fell by nearly 38 percent.⁷⁷ Southern Asia achieved the greatest overall reduction in MMR with a decline of nearly 60 percent, while sub-Saharan Africa saw a substantial reduction of nearly 40 percent.⁷⁸ Overall, the MMR in LMICs declined by nearly 50 percent.⁷⁹

Despite the global progress in maternal health over the past decades, tens of millions of women in the Global South still have an unmet need for maternal health care, resulting in devastating statistics. In 2020, the global MMR was 152 deaths per 100,000 live births.⁸⁰ Projections indicate that this number could fall to 133 deaths per 100,000 live births by 2030, but that figure is still nearly double the SDG target of 70 per 100,000 live births.⁸¹

Of the 127 million women who have a live birth each year, the following numbers of women experience gaps in essential services:

- **50 million make fewer than four antenatal visits;^a**

- **31 million do not deliver their babies in a health facility;^b**
- **16 million need, but do not receive, care for major obstetric complications; and**
- **13 million have newborns who need, but do not receive care, for major complications.⁸²**

Many women whose pregnancies do not end in a live birth also experience a lack of needed services, including the services necessary for safe abortions (see “Safe Abortion” section) and post-miscarriage care. It is estimated that two million women do not receive the care they need after experiencing a miscarriage.⁸³

Additionally, the pregnancy and postpartum periods are strongly associated with an increased risk of depression.⁸⁴ In LMICs, prevalence rates of depression reach 25 percent during the prenatal period and almost 20 percent during the postnatal period, compared to an estimated 15 percent prevalence rate of prenatal depression and a 10 percent prevalence rate of postnatal depression in high-income countries.⁸⁵ Challenges in identifying and treating depression

are exacerbated by low rates of recognition of mental health disorders by primary care health workers and a shortage of clinicians to treat and assess mental health disorders in LMICs.⁸⁶

Infertility Care and Treatment

WHO has recognized that the provision of high-quality services for family planning includes infertility care as one of the core elements of reproductive health.⁸⁷ Infertility affects millions of couples worldwide, yet availability, access, and quality of treatment remain a global challenge, particularly in the Global South. While prevalence rates are difficult to determine and research is currently lacking, past studies have shown that infertility—defined as the inability to conceive after 12 months or more of regular unprotected heterosexual intercourse—affects about 15 percent of couples of reproductive age globally.^{88,89} In 2012, WHO analyzed 277 health surveys and estimated that roughly 48.5 million couples worldwide experienced infertility, half of whom were in Sub-Saharan Africa and Southern Asia.⁹⁰ An article in *The Lancet* reported on three large-scale analyses with results ranging from 48.5 to 186 million couples affected by primary or secondary infertility.⁹¹

Diagnosis and treatment of infertility is often not prioritized in most population and development policies, nor in many reproductive health strategies.

a Quality antenatal care directly improves the survival and health of the expecting mother and child by linking families with the formal health system.³⁶⁰ However, families in the Global South can experience major financial and cultural barriers in accessing antenatal care. High cost of care, lack of reliable transportation, poor quality of care, and shortage of medical equipment and other supplies all contribute to systematic barriers to accessing care.^{361,362} Additionally, socio-cultural practices not aligned with antenatal care practices, lack of spousal support, and bias play a role in preventing individuals from completing the four recommended visits.^{363,364}

b Consistent and timely management and treatment can prevent maternal and neonatal deaths, whether that be in a health facility or by an alternative health professional in a different setting. Available data reports that more than 90 percent of all births benefit from the presence of a trained health professional.³⁶⁵ An individual’s decision to deliver in a health facility is influenced by a number of factors including risk perception; quality of care in the area; previous experience; cultural and familial values; and physical and socioeconomic factors, such as lack of money for transport and the requirement to bring baby clothes and food while staying at the clinic.^{366,367} Different experiences, preferences, and circumstances with giving birth influences a person’s decision or ability to utilize a health facility.

While access to safe methods of abortion care has expanded in recent years, many abortions still occur under unsafe conditions.

Several factors can cause infertility in both the male and female reproductive systems; however, it is sometimes not possible to explain the cause of infertility. Infertility can be associated with increasing age and can be caused by untreated reproductive tract infections, including gonorrhea and chlamydia, postabortion infections (which mainly result from unsafe abortions), and postpartum infections. An estimated 40 percent of women with untreated gonorrhea or chlamydia infection develop pelvic inflammatory disease, which, if untreated, leads to infertility in one in four cases.⁹² Of the estimated 82.5 million untreated new cases of gonorrhea and chlamydia each year in LMICs, 40 percent, or about 33 million people, will develop pelvic inflammatory disease, and about a quarter of those cases, or about 8.3 million people, will experience infertility.⁹³

Assisted reproductive technologies have been available for more than four decades as treatment for subfertility/infertility, and it is estimated that more than eight million births globally have resulted from in vitro fertilization.⁹⁴ However, diagnosis and treatment of infertility is often not prioritized in most population and development policies, nor in many reproductive health strategies. Furthermore, treatment is rarely covered through public health financing and the high costs of the

medicines and procedures are often major barriers—even in countries that are actively addressing infertility.⁹⁵

Safe Abortion

Comprehensive abortion care includes the provision of information, abortion management, and postabortion care.⁹⁶ Safe abortion can be defined by an abortion that meets two criteria:

- (1) It is administered by a trained provider, and**
- (2) It is performed using a recommended method.⁹⁷**

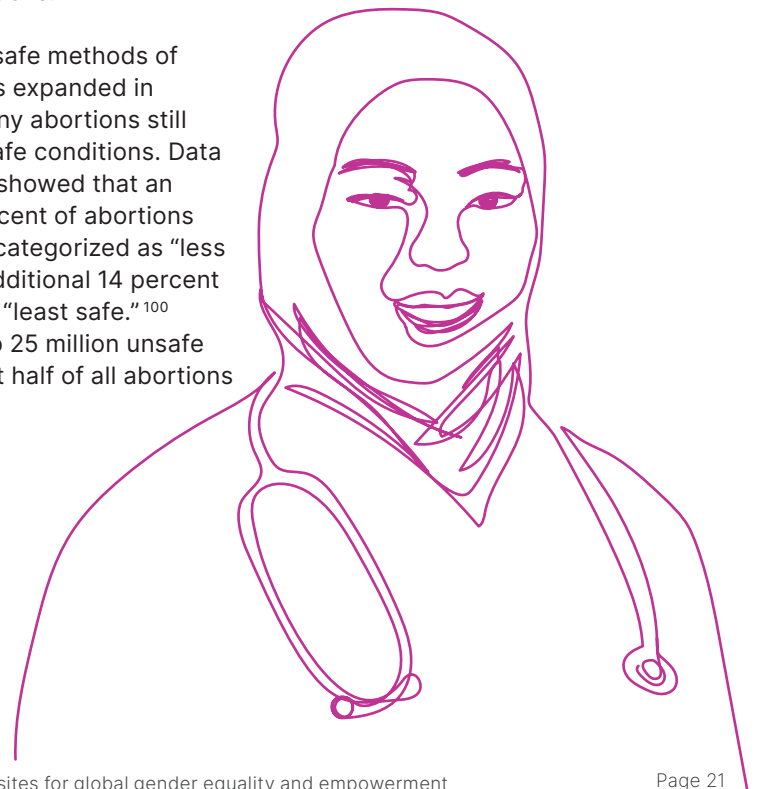
Unsafe abortion can be defined in two different categories: “less safe” and “least safe.” A “less safe” abortion only meets one of the above criteria, whereas a “least safe” abortion meets neither criterion.⁹⁸

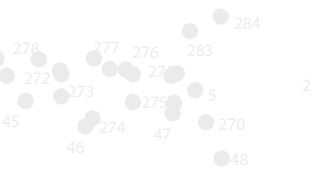
Postabortion care involves both curative care and preventive care. Curative care refers to treating incomplete abortion and its complications, while preventive care refers to contraceptive counseling and services.⁹⁹ High quality postabortion care is critical in health care settings because it can significantly reduce the morbidity and mortality associated with unsafe abortions.

While access to safe methods of abortion care has expanded in recent years, many abortions still occur under unsafe conditions. Data from 2010–2014 showed that an estimated 31 percent of abortions worldwide were categorized as “less safe,” while an additional 14 percent were considered “least safe.”¹⁰⁰ This translates to 25 million unsafe abortions, almost half of all abortions

that occurred worldwide during that time frame.¹⁰¹ Ninety-seven percent of those unsafe abortions take place in LMICs.¹⁰² More than half of all unsafe abortions take place in Asia, and roughly three in four abortions that take place in Latin America and Africa are unsafe.¹⁰³ People turn to unsafe abortion for a variety of reasons, including restrictive abortion regulations that may prevent access to safe abortion and can cause distress and stigma, financial and emotional hardships, and lack of partner or family support that can force someone to turn to unsafe methods. Pregnant adolescents are more likely than adults to seek unsafe abortions, as an estimated three million unsafe abortions occur globally every year among girls aged 15–19.¹⁰⁴

Every year, up to 11 percent of maternal deaths globally can be attributed to unsafe abortion.¹⁰⁵ This translates to upwards of 31,000 lives unnecessarily lost each year due to unsafe abortion.¹⁰⁶ However, maternal mortality is not the only potential negative outcome of unsafe abortion; maternal morbidity as a result of unsafe abortion can have lasting





impacts on the health and well-being of women and girls over the course of their lifetimes. Some of the other physical health risks associated with unsafe abortion that contribute to maternal morbidity include:

- **Hemorrhage (heavy bleeding);**
- **Infection;**
- **Uterine perforation (caused when the uterus is pierced by a sharp object); and**
- **Damage to the genital tract and internal organs as a consequence of inserting dangerous objects into the vagina or anus.¹⁰⁷**

The Overturning of *Roe*: Harm felt beyond the U.S.

On June 24, 2022, the U.S. Supreme Court reversed nearly fifty years of precedent by overturning its 1973 landmark decision in *Roe v. Wade* that recognized a person’s decision to seek an abortion as protected personal privacy under the Constitutional right to liberty. With a six-to-three majority decision, the Supreme Court ruled in *Dobbs v. Jackson Women’s Health Organization* that the right to abortion is not constitutionally protected,¹⁰⁸ permitting states to independently decide the legal parameters regarding abortion access and care. This decision disproportionately impacts the reproductive lives of individuals belonging to the Black, Indigenous, and people of color communities; low-income people; young people; the LGBTQI+ community; and people with disabilities living in states that have since passed antiabortion laws.¹⁰⁹ Furthermore, it may also have dire consequences on SRHR abroad by emboldening antiabortion policymakers, further stigmatizing abortion, and potentially creating a chilling effect among SRHR-implementing partners in the Global South.

While the degree of harm is not yet fully known, reproductive health advocates predict that the Supreme Court decision to overturn *Roe* will reverberate around the world.¹¹⁰ Concerns regarding the exportation of U.S. domestic policy on abortion abroad include destabilizing local efforts to liberalize abortion policy and halting progress made in recent years. By rolling back abortion rights domestically, SRHR advocates are warning that the U.S. is sending an alarming and erroneous message that there is no fundamental human right to safe abortion.¹¹¹

Nations in Central and South America have some of the most restrictive abortion laws in the world. For example, El Salvador criminalizes abortion in all circumstances, even when necessary to save a pregnant person’s life. Those prosecuted for abortion can be punished by imprisonment for up to eight years; however, judges often find women guilty of “aggravated homicide” instead, which has a prison sentence of up to 50 years.¹¹² While El Salvador leads many countries in the region in upholding strict abortion laws, some countries have taken steps to liberalize their policies. In late 2020, Argentina lawmakers, inspired by the voices of the Green Wave activists, voted to legalize abortion up to 14 weeks of pregnancy, after its previous laws criminalized abortions except in the cases of rape or to save the life of the mother.¹¹³ The Green Wave movement continued throughout the region, as Mexico and Colombia also liberalized their abortion laws in 2021 and 2022, respectively, after finding their stringent abortion bans to be unconstitutional. Now, in some jurisdictions in Mexico, abortion is permitted in the first 12 weeks of a pregnancy, and abortion up to 24 weeks into a pregnancy is legal in Colombia.^{114,115} While abortion rights activists celebrate progress in these countries and urge lawmakers in neighboring countries to take similar steps, many are concerned how the *Dobbs* decision will impact the advancement of abortion rights globally.

U.S. Supreme Court rulings do not have jurisdiction in other countries, but decisions passed down from the Court can influence laws beyond U.S. borders. Abortion rights activists fear that its recent decision in the *Dobbs* case could have a ripple effect in regions where progress is being made, setting an example for other governments to deny reproductive rights.^{116,117} Brazil’s minister of the family, the woman, and human rights at the time of *Dobbs* celebrated the Supreme Court’s decision and communicated that the overturning of *Roe* would be the “world trend.”¹¹⁸ In Bangladesh, antiabortion groups are reportedly using the overturning of *Roe* to support their arguments against expanding access to SRHR and abortion.¹¹⁹ Furthermore, advocates say it puts the U.S.’s reputation as a public health world leader at risk because it joins a small handful of countries that have rolled back abortion rights, including El Salvador, Honduras, Iran, Nicaragua, and Poland.¹²⁰

Funding for international family planning programs is also at stake due to the Supreme Court’s decision to overturn *Roe*. While the decision does not directly impact U.S. foreign policy and foreign assistance, it could create stigma and uncertainty among implementing partners about what is allowable under existing abortion restrictions, causing a chilling effect similar to when the GGR was enforced.¹²¹ Organizations and implementing partners operating with U.S. funds may refrain from providing abortion and emergency contraception with their own funds in an effort to not inadvertently lose funding due to a lack of clarity on U.S. policy.¹²²

Comprehensive Sexuality Education

According to The United Nations Educational, Scientific and Cultural Organization, or more commonly referred to as UNESCO, comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.¹²³

CSE plays a major role in improving SRHR, especially for young people. However, it remains unavailable or poorly funded in many parts of the world, especially in the Global South. Beyond supporting young people's ability to decide whether and when to have sex, CSE also prepares youth with knowledge and skills necessary to lead healthy sexual lives. While CSE is an important piece of SRHR, more data are needed to fully understand its impact.

In many places globally, "abstinence-only-until-marriage" programs have dominated the sex education landscape. In recent years, research has indicated how these programs are ineffective in stopping or delaying young people from having sex, and instead, can increase the risk of pregnancy and STIs for adolescents.¹²⁴

CSE, on the other hand, is directly tied to positive SRHR outcomes. A 2014 review of school-based sexuality education programs in the Global South showed increased

self-efficacy related to increased HIV knowledge, increased contraception and condom use, a reduced number of sexual partners, and later initiation of first sexual intercourse.¹²⁵ CSE is recognized by the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the African Union as one of the key recommendations in fast-tracking the HIV response and ending the AIDS epidemic in Africa due to its positive impact on voluntary HIV testing, reduced pregnancy among adolescent girls, and increased condom usage.¹²⁶

Globally, young people are making it clear that CSE is a priority to them. Some calls to action that highlight CSE as a top priority for both the realization of human rights and the achievement of the SDGs include:

The 2011 Mali Call to Action

- **More than 150 young HIV activists from across the world gathered in Mali to provide a youth-led response to HIV in the lead-up to the U.N. General Assembly High Level Meeting on AIDS in 2011.¹²⁷ The youths called upon heads of states and governments and all leaders to: 1) secure resources and funding to support new youth leadership for a sustainable HIV response; 2) protect and promote human rights to eliminate stigma and discrimination from legal frameworks; and 3) deliver HIV information and services that meet the diverse needs of young key-affected populations, including comprehensive and targeted sexuality education inside and outside schools.¹²⁸**

The 2012 Bali Global Youth Forum Declaration

- **In 2012, the Global Youth Forum produced a set of recommendations that outlined the vision of young people**

Globally, young people are making it clear that CSE is a priority to them.

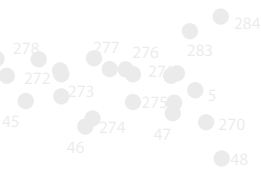
around the world for their future in the context of the review and follow-up to the implementation of the Programme of Action for ICPD 2014 and beyond. Major themes included: comprehensive education; youth-rights and well-being, including sexuality; and leadership and meaningful participation.¹²⁹

The 2014 Colombo Declaration on Youth

- **In 2014, youth delegates and policymakers gathered in Sri Lanka for the World Conference on Youth to explore strategies for youth empowerment. One of the 88 recommended actions requested that government and leaders provide non-discriminatory, rights-based, age-appropriate, gender-sensitive health education, including CSE.¹³⁰**

The UN Major Group for Children and Youth

- **The Major Group for Children and Youth is the U.N. General Assembly-mandated and self-organized mechanism for young people to meaningfully engage in certain U.N. processes.¹³¹ This group recommended acknowledging the role of youth organizations in nonformal education and incorporating CSE in the understanding of "free" education in the zero-order, or first, declaration section for the SDGs.¹³²**



The 2017 Family Planning Summit's Youth Advisory Group

- **During the Family Planning Summit that took place in the United Kingdom (U.K.) in 2017, multiple stakeholders made commitments to accelerate progress on rights-based family planning programs.¹³³ Here, the Youth Advisory Group developed an accountability framework to mobilize young people to advocate for the full implementation of the commitments, highlighting the importance of offering individuals a wider range of contraceptive options in rights-based CSE.¹³⁴**

The 2022 Generation Equality Forum

- **The Youth Coalition on Sexual and Reproductive Rights actively participated in discussions to revise the Action Coalition blueprints released in the Generation Equality Forum held in Mexico in March 2022.¹³⁵ Their key demands include that all children, adolescents, and young people must have access to age-appropriate CSE; all CSE programs must be inclusive of diverse ethnicities, body types, genders, sexualities, and disabilities; young people must be involved in CSE development; and COVID-19 should not interrupt access to CSE.¹³⁶**

CSE is an important aspect of realizing the SRHR agenda. More research and funding are needed from all development actors and funders to ensure all students in the Global South are receiving quality school-based sexuality education that is both inclusive and comprehensive.

STIs, HIV/AIDS, and Reproductive Cancers

STI and HIV/AIDS treatment and care play a critical role in the SRH and well-being of people globally. Significant progress has been made in prevention and treatment of HIV/AIDS. In 2020, 73 percent of all people living with HIV were accessing treatment, and new HIV infections had been reduced by 52 percent since 1997.¹³⁷ Furthermore, as of June 2021, 28.2 million people globally had access to antiretroviral therapy, a significant improvement from the 7.8 million people with access in 2010.¹³⁸

The world has also seen improvements in treatment and prevention of STIs. The vaccine for human papillomavirus (HPV), one type of STI, was introduced as part of routine immunization programs in 111 countries by the end of 2020.¹³⁹ HPV is a leading cause of cervical cancer, so improved vaccination coverage for this STI also has positive implications for reproductive cancer rates.

While the progress made has been tremendous, there are still a number of gaps to fill, especially to ensure that the most vulnerable communities globally have access to prevention and treatment options. Despite continuous improvement in the usage of barrier contraceptive methods such as condoms, more than 1 million STIs are acquired every day.¹⁴⁰ Each year, the four most common curable STIs—chlamydia, gonorrhea, syphilis, and trichomoniasis—account for an estimated 376 million new infections among men and women worldwide.¹⁴¹ Of the 157 million women and girls aged 15–49 in LMICs each year with a new, curable STI, the large majority do not receive medical care.¹⁴² In

addition, the mostly incurable viral STIs—genital herpes, HPV, and HIV—affect hundreds of millions of people.^{143,144,145}

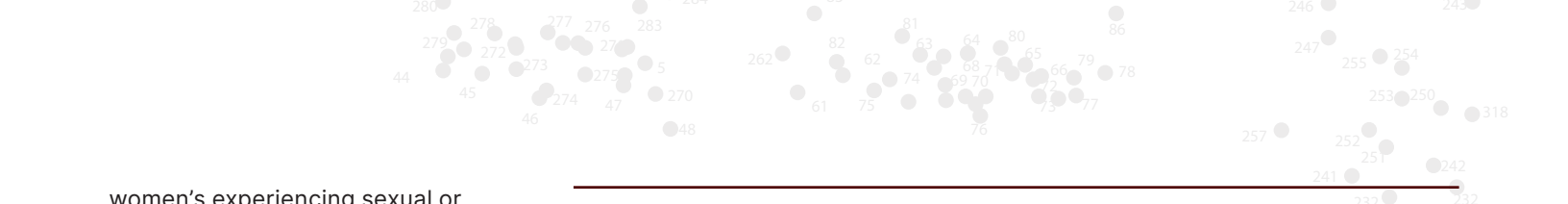
Reproductive cancers are also important, yet often overlooked and underfunded elements of SRHR. Reproductive cancers in women include the gynecologic cancers—cervical cancer, ovarian cancer, uterine cancer, vaginal cancer, and vulvar cancer—and breast cancer. Every year, 3.6 million women are diagnosed with gynecologic and breast cancers worldwide, and more than 1 million women die from these causes, mostly in LMICs.¹⁴⁶

Reproductive cancers in men affect the prostate, testicles, and penis. An estimated 1.41 million men worldwide were newly diagnosed with prostate cancer in 2020—the second most common cancer in men.^{147,148} About half of the 300,000 deaths that occur annually due to prostate cancer are from LMICs.¹⁴⁹

Gender-Based Violence

Gender-based violence, or GBV, refers to any harmful acts directed at an individual based on their gender.¹⁵⁰ These types of actions are rooted in gender inequality and take advantage of imbalanced power dynamics in society.¹⁵¹ Acts of GBV encompass sexual, physical, mental, or economic harm inflicted on an individual in public or private.¹⁵² Included under GBV is child, early, and forced marriage (CEFM) and female genital mutilation/cutting (FGM/C).

Although GBV can impact all individuals, women and girls are disproportionately impacted. Acts of GBV are extremely common, with a reported one-in-three



women's experiencing sexual or physical violence in their lifetime.¹⁵³ Approximately 15 million adolescent girls worldwide have experienced rape or another forced sexual act.¹⁵⁴ Moreover, 137 women are killed by a member of their family every day.¹⁵⁵ Furthermore, legislative and judicial bodies are not always helpful in these situations, since they are currently dominated by men, entrenched with gender bias, and law enforcement is often cited as not dedicating enough time to addressing GBV.¹⁵⁶ In some cases, these bodies perpetuate prejudices in their response to GBV that are ineffective and retraumatize the survivors.¹⁵⁷

In addition to fatal outcomes, injuries, and psychological impacts, GBV is also an economic issue. The cost of violence against women specifically is estimated to be around 5.26 percent of global gross domestic product (GDP).¹⁵⁸ International studies report that investing \$1 in GBV prevention can save the economy \$5 to \$20 in future service costs.¹⁵⁹ Providing a full range of survivor-centered services is crucial for survivor empowerment and input.¹⁶⁰ Survivors need access to comprehensive health services, including urgent medical treatment, emergency contraception, mental health care, and legal support.¹⁶¹ Employing trauma-informed and culturally inclusive services ensures survivor safety and dignity.

FGM/C

FGM/C is a cultural practice that involves the total or partial removal of the female genitalia, without any medical purpose.¹⁶² This is usually practiced on women and girls between the ages of infancy and 15 years old.¹⁶³ Despite the persistence of FGM/C around the world, this practice is a human rights violation and has no health benefits.

Even with legislation in many countries restricting the formal or informal union between a child under the age of 18 and an adult, the practice is still common in many countries in the Global South.

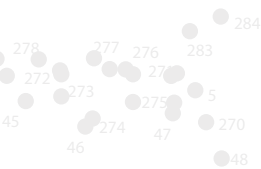
FGM/C is linked to a number of health risks throughout a woman's life, ranging from short-term issues such as excessive bleeding and painful urination to long-term issues such as chronic pelvic infections and painful labor and delivery. Moreover, FGM/C is a traumatic event that is the root of lasting psychological effects such as post-traumatic stress disorder, anxiety disorders, and depression.¹⁶⁴

There are an estimated 200 million girls and women alive today who have undergone FGM/C.¹⁶⁵ The practice of FGM/C is present in at least 92 countries in the world, including in the U.S., but it is most widely practiced in 30 African countries, some Middle Eastern countries, and parts of Southeast Asia.¹⁶⁶ There has been some progress on the decrease in prevalence of FGM/C. According to a weighted average of comparable data of countries where it is most prevalent, the prevalence of FGM/C among girls 15 to 19 years old decreased from 51 percent in 1985 to 37 percent in 2016.¹⁶⁷ However UNFPA estimates that over four million girls are still at risk of undergoing FGM/C every year—potentially even more due to COVID-19 (see “COVID-19 and SRHR” section).¹⁶⁸

Child, Early, and Forced Marriage

CEFM is a widespread human rights issue of abuse, gender inequality, poverty, and unequal education that is exacerbated by COVID-19, climate and natural emergencies, and conflict. It perpetuates the cycle of poverty by limiting young girls' opportunities for development and employment.¹⁶⁹ The Office of the United Nations High Commissioner for Human Rights defines child marriage as any marriage where at least one of the parties is under 18 years of age, and forced marriage as a marriage in which one and/or both parties have not personally expressed their full and free consent to the union.¹⁷⁰ A child marriage is a form of forced marriage as one and/or both parties have not expressed full, free, and informed consent.¹⁷¹

Even with legislation in many countries restricting the formal or informal union between a child under the age of 18 and an adult, the practice is still common in many countries in the Global South, with one in five girls married as children.¹⁷² West and Central Africa, as well as South Asia, report high numbers of child brides. Nearly four in ten girls are child brides in West and Central Africa, while one in five girls are child



brides in South Asia.^{173, 174} Boys are impacted by child marriage, as well, but not at as high rates as girls.¹⁷⁵ An estimated 12 million girls are reported to be married before they turn 18 each year.¹⁷⁶

This practice is a major deterrent to global development. Girls who are poor, have minimal education, live in rural areas, and face high levels of insecurity are most likely to be forced into child marriage.¹⁷⁷ These girls are then often restricted from continuing their schooling and finding decent employment in the future, perpetuating a cycle of poverty, and preserving an unequal class division in the community.¹⁷⁸ Moreover, child brides have many unmet health needs. For example, estimates show that the total unmet need for family planning among married adolescents increased between 1990

and 2019, from 44 percent to 51.6 percent.¹⁷⁹ This can negatively impact family dynamics and the health of adolescent girls. Adolescents are particularly vulnerable to negative health outcomes during pregnancy and birth as their bodies may not be physically ready. Complications from pregnancy and childbirth are among the leading causes of death for girls aged 15–19 years globally.¹⁸⁰ Serious conditions such as obstetric fistula, eclampsia, puerperal endometritis, and systemic infections can commonly occur during adolescent pregnancies and births.¹⁸¹ Adolescent pregnancies are also more likely to result in stillbirths and newborn deaths, where stillbirths and newborn deaths are 50 percent higher among infants born to adolescent mothers than among those born to mothers aged 20–29 years.¹⁸²

Humanitarian Emergencies and SRHR

SRHR needs do not abruptly halt during an emergency. On the contrary, the need to access comprehensive SRH services may become greater as humanitarian emergencies—including armed conflict, political instability, natural and climate related disasters, epidemics, and famine—have dire consequences on SRHR. Under these circumstances, SRH information and services are frequently disrupted and there are often increased risks of sexual violence and forced marriage, disproportionately affecting women, adolescents, and members of marginalized groups. These human rights violations contribute to unintended pregnancies, unsafe abortion, and complications during pregnancy and childbirth.¹⁸⁹ Furthermore, violations of SRHR, including acts of GBV, greatly undermine the mental and physical well-being of survivors, requiring a greater need for integrated health care that is safe and accessible for people in humanitarian crises.

U.N. agencies, donors, governments, and non-governmental organizations (NGOs) coordinate to deliver humanitarian relief, with UNFPA's taking a leading role in delivering SRH services.¹⁹⁰ UNFPA estimates that roughly 54 million women, girls, and young people—including 35 million women of reproductive age, 29 million adolescents and young people, and over 4 million pregnant women—were in need of SRH services in humanitarian emergencies in 2021.¹⁹¹ Despite

The Intersection of Climate Change and SRHR

Climate justice, the SRHR field, and the gender equality movement are all undeniably and inextricably linked. Climate change risks such as rising global temperatures, extreme weather events, and heatwaves particularly impact the health and well-being of women and girls.¹⁸³ For example, the impacts of climate change exacerbate conditions that increase the practice of child marriage in a community.¹⁸⁴ Climate disasters and extreme weather events negatively impact economic sustainability and food supplies of families, sometimes forcing them to turn to child marriage to alleviate economic insecurities.^{185,186} Furthermore, climate crises can force people from their homes, compounding the need for better access to SRH services in humanitarian settings.¹⁸⁷ In addition, women are important agents of change in their communities, and evidence suggests that strengthening SRHR can strengthen the resilience and adaptive capacity of women, their families, and their communities as they face climate change impacts.¹⁸⁸ Recognizing the links between the climate justice movement and SRHR field is crucial in assessing appropriate and adequate investments for women and girls to enact adaptive and effective responses to climate change.

Violations of SRHR, including acts of GBV, greatly undermine the mental and physical well-being of survivors, requiring a greater need for integrated health care that is safe and accessible for people in humanitarian crises.

some increased support for SRHR in humanitarian settings since the ICPD, SRHR services in humanitarian crises remain variable and underfunded.¹⁹² Deficient health systems, shortages of skilled health providers, supply stock-outs, and restrictive policies hinder effective SRH provision, disproportionately impacting adolescents and members of other marginalized populations.^{193,194} These same challenges were often present before but are further exacerbated by the humanitarian crisis. Socio-economic and cultural barriers, gender inequality, and a lack of information about the availability of care also contribute to hindered access to SRH services in a humanitarian setting.¹⁹⁵

COVID-19 and SRHR

While the data is still somewhat limited, evidence shows that COVID-19 has had noticeable impacts on SRHR around the world. Findings from the U.N., academia, civil society, governments, and other institutions have shown widespread losses in access to SRH information and services and increased concerns over gender-based violence due to COVID-19.¹⁹⁶ While COVID-19 continues to have devastating impacts on communities around the world, studies show that individuals whose human rights are least protected—refugees, displaced peoples, conflict-affected

populations, indigenous peoples, and those living in low-income settings—are disproportionately burdened by COVID-19 impacts and more likely to experience difficulties in accessing SRH services.¹⁹⁷

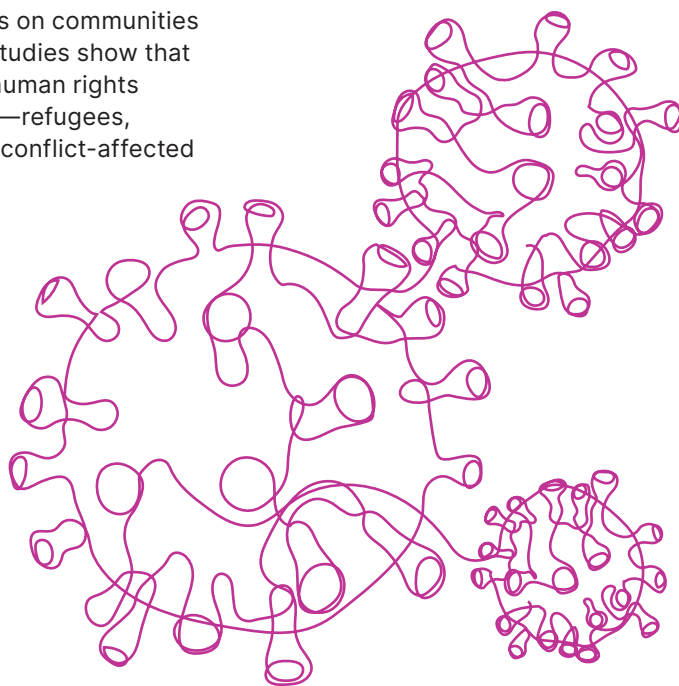
According to a report released in March 2021 by UNFPA, disruptions of supplies and services lasted an average of 3.6 months causing nearly 12 million women around the world to lose access to modern contraceptives.¹⁹⁸ As a result, as many as 1.4 million unintended pregnancies may have occurred before people were able to resume use of family planning services.¹⁹⁹ In a survey conducted by UNFPA of more than 70 countries, 41 percent reported that services were interrupted due to COVID-19.²⁰⁰

Family planning services were not the only SRH component to be disrupted, however. Concerns regarding increases in GBV, including FGM/C and child marriage, were also heightened at the beginning of the pandemic. A report, from Oxfam International, of 10 countries reveals a 25 to 111 percentage

increase in calls made, by survivors, to domestic-violence hotlines.²⁰¹ Furthermore, UNFPA predicted that COVID-19 would also cause a one-third reduction in the progress toward ending FGM/C by 2030. Disruptions in prevention programs could result in two million FGM/C cases that would have otherwise been averted over the next decade.²⁰² It was anticipated that efforts to end child marriage and wide-reaching economic consequences due to the pandemic would result in a total of 13 million child marriages that would have otherwise not occurred between 2020 and 2030.²⁰³ These devastating impacts are already being observed, as 2020 saw the largest increase in child marriage rates in 25 years.²⁰⁴

Global maternal health outcomes have also worsened during the pandemic. Evidence has shown that COVID-19 has had an impact on maternal deaths, stillbirths, ruptured ectopic pregnancies, and maternal depression worldwide.²⁰⁵ One study's findings suggest that an increase in adverse outcomes might be driven by the inefficiency of healthcare systems and their inability to cope with the pandemic, as opposed to pandemic mitigation measures.²⁰⁶

The full picture of the effects COVID-19 has had, and continues to have, on SRHR is still unclear. As the body of research surrounding this topic continues to grow, experts will have a stronger ability to assess the impact of the evolving pandemic on SRHR.



Chapter 3

Adding SRHR to the Gender Equality Equation



SRHR is a prerequisite for girls' education, women's economic empowerment, political involvement, and WPS efforts. These issues are all critical to achieving gender equality and sustainable development globally and are directly impacted by the availability and accessibility of comprehensive SRHR. By funding comprehensive SRHR, the human rights of women and girls can be more fully realized.

A reluctance or refusal to support comprehensive SRHR policy prevents the U.S. from being able to fully address global issues that are widely considered critical across party lines. Channeling funding to efforts to improve women's empowerment without connecting the dots between women's access to SRHR and their consequent ability to participate in education, the workforce, political decision-making, and peace and security will inevitably weaken those efforts. As the research in this chapter indicates, these issues are inextricably intertwined with SRHR. This is an imperative point for policymakers to understand when funding priorities are being considered during the annual appropriations process.

Girls' Education

Access to quality education is a necessary element of gender equality for girls and a basic human right. Girls' education has been cited as the world's best investment with the widest-ranging returns.²⁰⁷ Investing in girls' education in the Global South not only strengthens economies, enables women to earn higher incomes, and improves gender equality, but it also has a positive impact on the health of communities in areas like reducing rates of infant mortality, maternal mortality, child marriage, and the incidence of HIV/AIDS and malaria. Additionally, it positively impacts agricultural productivity and fosters stronger resilience to natural disasters.²⁰⁸

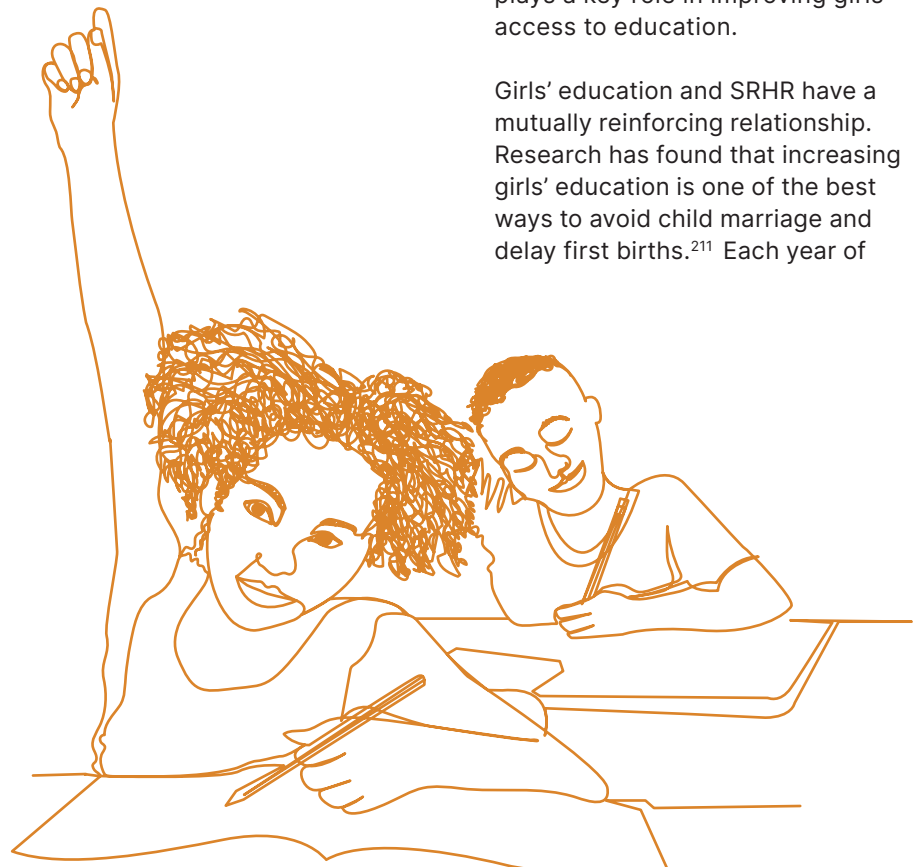
The Return on Investment

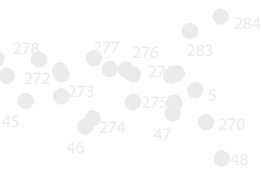
According to the United Nations Children's Fund (UNICEF), investing in girls' secondary education:

- Increases the lifetime earnings of girls dramatically;
- Raises the national economic growth rates;
- Reduces child marriage rates;
- Reduces child mortality rates;
- Reduces maternal mortality rates; and
- Improves child stunting statistics.²⁰⁹

Currently, 129 million girls globally are out of school, including 32 million of primary school age, 30 million of lower-secondary school age, and 67 million of upper-secondary school age.²¹⁰ Girls in the Global South are less likely than boys to complete their secondary education, creating significant inequality. The reasons girls have less access to education compared to their male counterparts vary greatly among countries and cultures. Increasing funding for SRHR, especially improved funding to programs that prevent child marriage and adolescent pregnancy, plays a key role in improving girls' access to education.

Girls' education and SRHR have a mutually reinforcing relationship. Research has found that increasing girls' education is one of the best ways to avoid child marriage and delay first births.²¹¹ Each year of

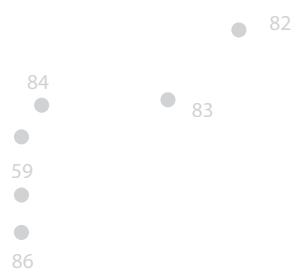




secondary education reduces the likelihood of marrying as a child or having a first child before the age of 18 by six percentage points on average across 15 countries.²¹²

Child marriage reduces educational opportunities for girls worldwide. Every year, 12 million girls are married before the age of 18.²¹³ In some regions of the world, when a girl marries, she is expected to drop out of school to tend to her new duties on the home front, such as caring for children and extended family.²¹⁴ Additionally, girls who are married before the age of 18 are more likely to have early pregnancies and significantly less likely to complete secondary school.^{215,216}

While the causal relationship between adolescent pregnancies and early school dropouts may be difficult to clearly establish, studies have shown that early and unintended pregnancies can lead adolescents to drop out of school.²¹⁷ Of the 261 million adolescent girls aged 15–19 living in LMICs, an estimated 32 million are sexually active and do not want a child in the next two years; and yet, 14 million of those adolescent girls have an unmet need for modern contraception and are thus at elevated risk of unintended pregnancy.²¹⁸ This unmet need translates into 21 million pregnancies of adolescent girls each year, 50 percent of which are unintended.²¹⁹ A lack of access to SRH services drives high rates of unplanned adolescent pregnancy, putting global commitments to girls' education at risk.



Measuring the skills and resources that enable economic advancement is relatively easy to quantify; measuring power and agency to benefit from economic activities, however, is more complex.

The *U.S. Government Strategy on International Basic Education for FY 2019—2023* aims to improve the effectiveness and efficiency of basic education programs and partnerships through USAID. To accomplish the goal of achieving a world where education systems in partner countries enable all individuals to acquire the education and skills needed to be productive members of society, two primary objectives must be met: 1) improve learning outcomes, and 2) expand access to quality basic education for all, particularly systemically marginalized populations, including girls.²²⁰

Furthermore, USAID endorsed the *G-7's Declaration on Girls' Education: Recovering from COVID-19 and Unlocking Agenda 2030* and two new milestone objectives for SDG 4:

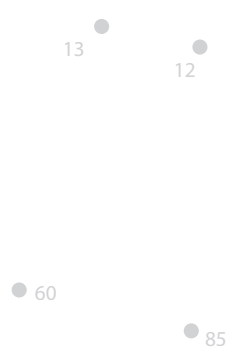
- **By 2026, 40 million more girls in school in low- and lower-middle-income countries; and**
- **By 2026, 20 million more girls reading by age 10 or by the end of primary school in low- and lower-middle-income countries.**²²¹

Women's Economic Empowerment

The International Center for Research on Women defines women's economic empowerment as much more than a woman's participation in the labor force: "A woman is economically empowered when she has both the ability to succeed and advance economically and the power to make and act on economic decisions:

- **To succeed and advance economically, women need the skills and resources to compete in markets, as well as fair and equal access to economic institutions; and**
- **To have the power and agency to benefit from economic activities, women need to have the ability to make and act on decisions and control resources and profits.**²²²

Measuring the skills and resources that enable economic advancement is relatively easy to quantify; measuring power and agency to benefit from economic activities, however, is more complex. Societal norms and culture shape the opportunities that are available to women, and women's personal experiences and access



to resources contribute to their agency.²²³ Having control over one's own reproductive life creates more agency for engagement in economic activities. Research shows that women's ability to choose where and when to work is linked to their ability to choose the timing, spacing, and number of their births.²²⁴

An unmet need for contraception is one of the leading causes for women's constrained labor force participation, especially in the Global South.²²⁵ Research has found that improvements in reproductive health can lead to greater economic empowerment for women, with outcomes that include:

- **More decision-making power in the household, higher levels of education, and greater rates of labor force participation for women who have access to and use contraceptives;**
- **Greater likelihood to complete school and participate in the formal labor market for older first-time mothers; and**
- **Increased rates of participation in the labor market for mothers who have longer intervals between births and have fewer children.**²²⁶

Pregnancy and childbearing have deep impacts on women's economic outcomes.²²⁷ The 'motherhood pay gap,' identified in one study across 21 countries, indicates that the average mother made 42 percent less than women with no children.²²⁸ In the Global South, where there is a greater unmet need for family planning, a larger portion of women are relegated to working in the informal sector.²²⁹ The International Labor Organization, in collaboration with Gallup, found that a total of 70 percent of women

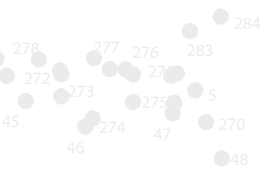
prefer to work at paid jobs.²³⁰

However, as of 2021, only 46 percent of working-age women participate in the global labor force, compared to 72 percent of men.^{231,232} While the COVID-19 pandemic has had a strong influence on these statistics in recent years, especially when it comes to women's participation in the formal labor market,²³³ so too does access to SRH services. Despite the centrality of reproductive health to women's participation in the formal labor market, access to SRH and childcare services is often not considered in labor market policies.²³⁴

While economic participation is an important measure of gender equality, this is not to discount the value of motherhood or its cultural relevance in many of the countries where women's workforce participation is low. However, women who have already expressed a desire for fewer children and want to gain economic independence are often unable to do so without access to a full range of SRH services, including access to contraception and safe and legal abortion.

Much of U.S. foreign policy efforts to improve gender equality and economic development involves women's economic empowerment. President Biden outlined, in the *Executive Order on the Establishment of the White House Gender Policy Council*, the need to improve gender equity and equality through economic security programs, policies that address structural barriers to women's labor force participation, and decreased wage and wealth gaps, as well as initiatives to increase access to comprehensive health care, address health disparities, and promote SRHR.²³⁵

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The White House Gender Policy Council has since proposed the *National Strategy on Gender Equity and Equality*. The strategy addresses the intersectional dimensions of gender equality and how improving economic security and protecting, improving, and expanding access to SRH services are interconnected priorities.²³⁶ It's crucial that U.S. foreign assistance targeted toward women's economic empowerment reflects these interconnected priorities, as policies and programs that aim to improve women's economic empowerment will consistently fall short unless adequate attention is paid to SRHR.

Missing the Connection: The Women's Global Development and Prosperity Initiative

In 2019, President Trump established the Women's Global Development and Prosperity Initiative, led and created by Advisor to the President, Ivanka Trump. The initiative aimed to enhance opportunities for women to participate meaningfully in the economy and advance both prosperity and national security by focusing on three pillars: women prospering in the workforce, women succeeding as entrepreneurs, and women enabled in the economy.²³⁷ Noticeably missing from the initiative is any mention of improving access to SRH services, including family planning. A critique noted the absence of efforts to promote access to the resources that create economic growth and address barriers to participation, including issues like GBV, unpaid care work, and access to quality healthcare and education.²³⁸

A lack of women's political participation often hinges on their ability to exercise control and autonomy over their own bodies and reproduction.

Women's Political Involvement

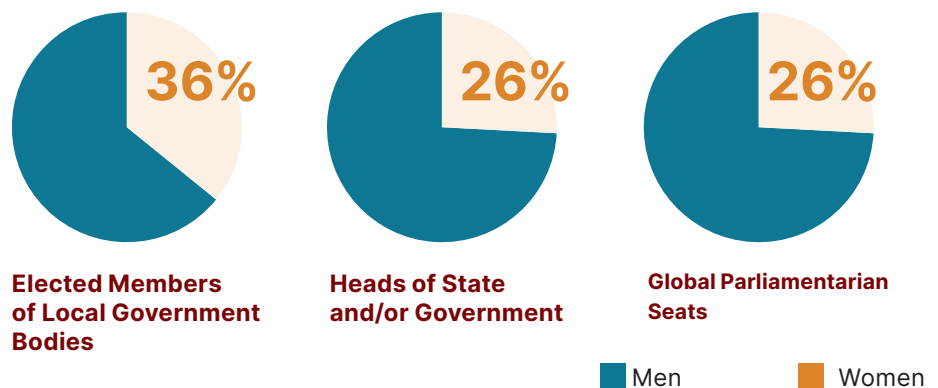
A lack of women's political participation often hinges on their ability to exercise control and autonomy over their own bodies and reproduction. Therefore, strengthening women's political engagement and improving their participation in government will lead to improvements in SRHR conditions worldwide, and is, moreover, reinforced by funding SRHR programs. It is necessary to elect and advocate for more women to be sitting at tables where decisions are being made that affect them, their families, and their communities to improve SRHR conditions. Women as equal participants in shaping SRHR policies is key to women and youth empowerment, an important foundation for gender equality, functioning democracy, and the achievement of the SDGs.

Women Deliver, a leading global advocate championing gender equality, has identified the following among the key investment areas needed to strengthen women's political participation and decision-making power:

- 1. Meet the demand for modern contraception and reproductive health;**
- 2. Dramatically reduce GBV and harmful practices; and**
- 3. Respect, protect, and fulfill sexual health and rights.²³⁹**

Unequal gender power dynamics and lack of women's political participation is a worldwide concern. The number of countries in which women hold 50 percent or more of ministerial positions dropped from 14 in 2020 to 13 in 2021, with a total of only 26 percent of parliamentary seats held by women globally in 2021.^{240,241} Moreover, in 2021, only 26 percent of women served as Heads of State and/or Government, and only 36 percent of elected members in local deliberative bodies.

Figure 1: Women at the Table (2021)



The Beijing Declaration and Platform for Action, as well as the SDGs, include balanced political power-sharing between women and men in decision-making as an internationally agreed upon target, and yet most countries have not achieved such balance.²⁴² Similarly to women's participation in any job within the formal economy, having access to comprehensive SRHR is often a prerequisite to women's being able to participate in the political labor force as decision-makers.

The U.S. government has initiated a number of international programs to increase women's political involvement. These include the Advancing Women's and Girls' Civic and Political Leadership Initiative, announced by U.S. Trade Representative Katherine Tai at the Summit for Democracy in 2021,²⁴³ and the Presidential Initiative for Democratic Renewal, through which the U.S. State Department and USAID have allocated \$33.5 million to strengthen women-led civil society organizations and tackle barriers to women's political and economic participation.²⁴⁴

“[The Advancing Women's and Girls' Civic and Political Leadership Initiative] will adopt a pipeline of civic-minded and politically interested women and girls, while helping them exercise their rights and achieve greater representation.”²⁴⁵

–Ambassador Katherine Tai

Supporting Her Empowerment: Women's Inclusion for New Security (WINS)

One step the U.S. government is currently taking to address women's political involvement globally is the creation of the WINS program. The Secretary's Office of Global Women's Issues at the U.S. Department of State worked with government partners to develop the WINS program that plans to provide local, women-led civil society organizations with grants and technical assistance to support women's leadership in sub-Saharan Africa, the Middle East and North Africa region, and South and Central Asia.²⁴⁶ Activities will include women from ethnic and religious minorities, LGBTQI+ women, youth, and women with disabilities in addressing peace and security challenges in their communities, including the prevention and response to GBV.²⁴⁷

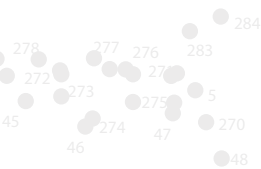
Women, Peace, and Security

Matters of peace and security are of the utmost importance to women and girls globally, especially in the Global South. The urgency of this issue cannot be more pressing. From Afghanistan to Ethiopia to Myanmar, women's human rights have been under attack.^{248,249,250} Armed conflict and crises inhibit women's access to basic services, including SRH services, and heighten ongoing threats of GBV, sometimes subjecting women and children to widescale sexual violence.²⁵¹

The U.N. Security Council adopted resolution S/RES/1325 on WPS in October 2000 to reaffirm the important role of women in peacebuilding and humanitarian response.²⁵² And yet, women are rarely included in the spaces where decision-making around peace and security efforts occur. Between 1992 and 2019, on average, women made up 13 percent of negotiators, 6 percent of mediators, and 6 percent of signatories in major peace processes globally.²⁵³

When women occupy positions of authority, they are more likely than their male counterparts to resolve national crises without violence, advocate for social issues that benefit all, and allocate budgets to health and education.²⁵⁴ Additionally, women's political participation is associated with more equitable policy outcomes and a reduced likelihood of renewed conflict.²⁵⁵ A gender-sensitive approach to conflict resolution, starting with including women in decision-making processes, can be critical in order to meet the needs of victims of conflict-related sexual violence and combat impunity for perpetrators.²⁵⁶

The U.S. has demonstrated strong commitment to supporting WPS efforts. *The U.S. Women, Peace, and Security Act* was drafted to ensure meaningful participation of women in mediation and negotiation processes.²⁵⁷ This policy framework, signed into law in 2017 with bipartisan support, is meant to recognize the role of women in peacemaking discussions in promoting sustainability and equality.²⁵⁸



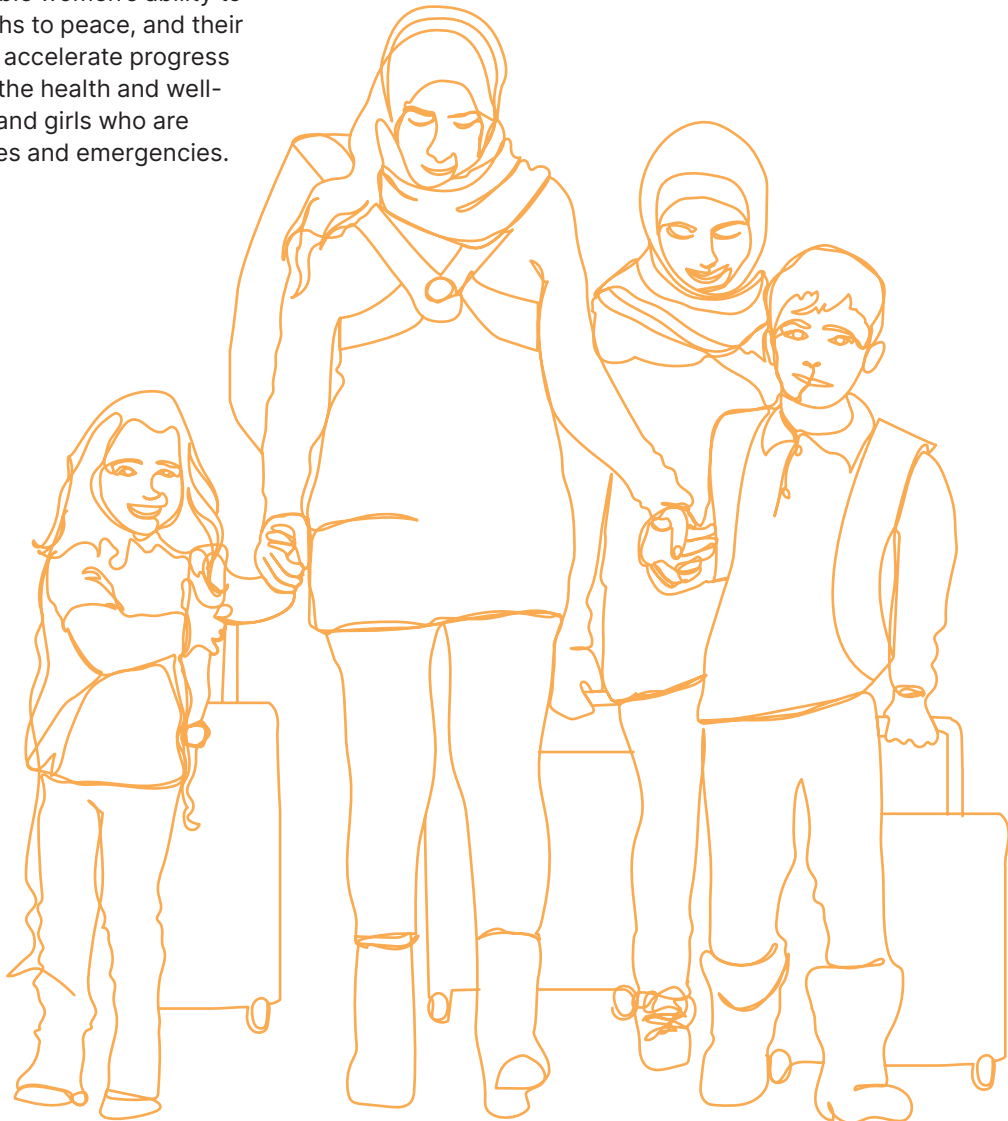
Part of this, for example, includes gender considerations in training for employees on international human rights law and violence prevention.²⁵⁹ Recognizing the critical link between women’s participation in security efforts and peacebuilding results in a higher likelihood of lasting peaceful resolutions with stronger advocacy for women’s rights.²⁶⁰

Total global military expenditure increased by 0.7 percent in 2021, reaching \$2.1 trillion, with the U.S. being a top contributor, accounting for 38 percent of this spending at \$801 billion.²⁶¹ Yet, funding for SRHR continues to be a critical component that is often forgotten in matters of peace and security. Access to SRH services can enable women’s ability to participate in paths to peace, and their participation can accelerate progress toward ensuring the health and well-being of women and girls who are impacted by crises and emergencies.

The U.S. Strategy on Women, Peace, and Security
 The WPS Strategy, launched in 2019 by the Trump administration, establishes three strategic objectives to meet by 2023:

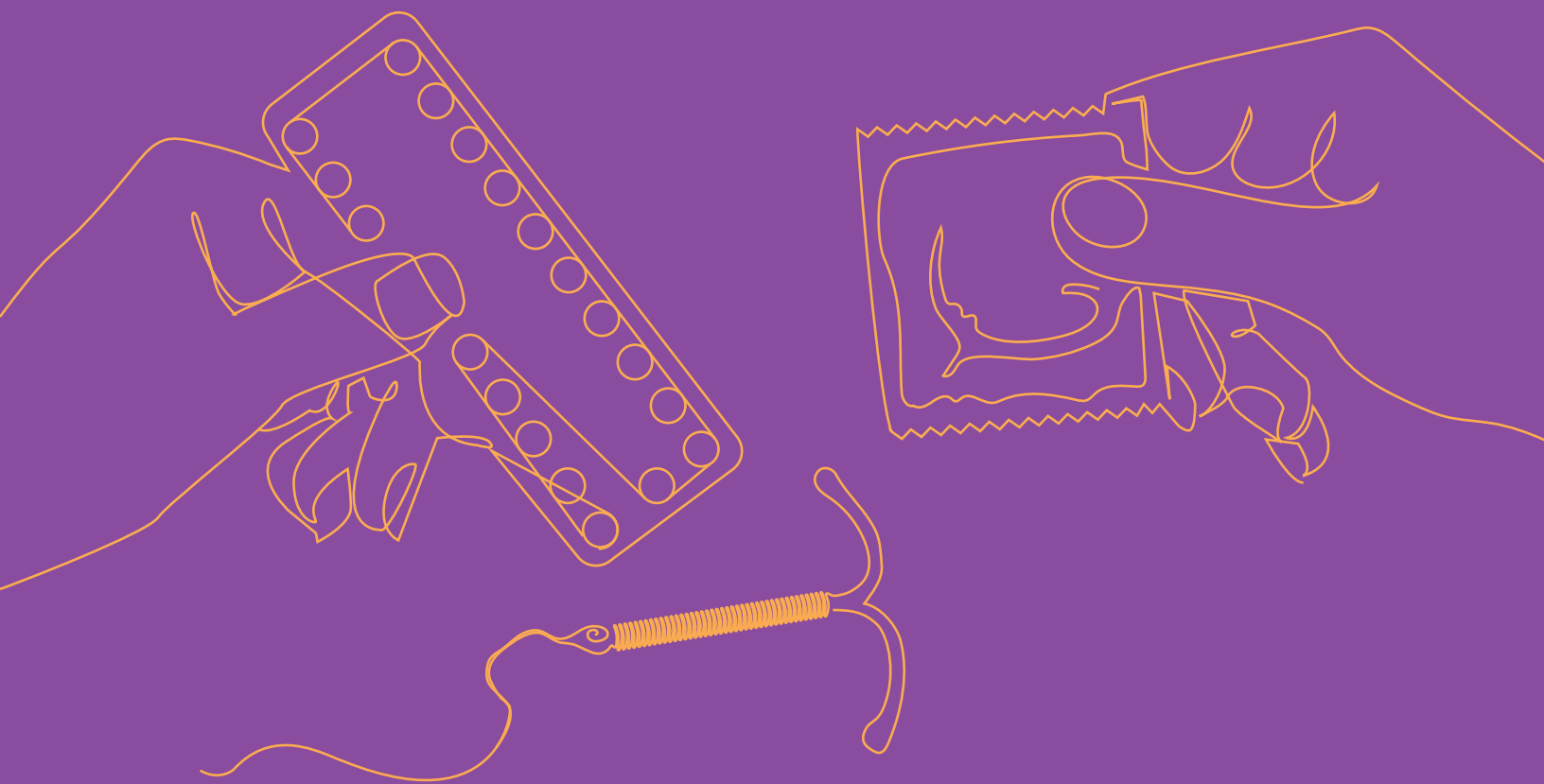
1. Women are more prepared and increasingly able to participate in efforts that promote stable and lasting peace.
2. Women and girls are safer, better protected, and have equal access to government and private assistance programs, including from the U.S., international partners, and host nations.
3. U.S. and partner governments have improved institutionalization and capacity to ensure that WPS efforts are sustainable and long-lasting.²⁶²

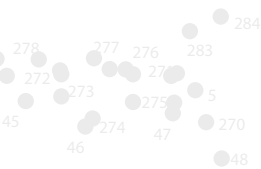
While the topic of violence against women and girls is referenced, notably missing from the original strategy are mentions of any other SRHR objectives. In 2022, the Biden administration bolstered these efforts to include increasing prevention and response to GBV, including the harmful practice of FGM/C, as well as increasing funding commitments to reduce CEFM in areas of conflict and crisis.²⁶³



Chapter 4

Current Status of U.S. Assistance for Global Sexual and Reproductive Health and Rights





For more than a century, the U.S. has been engaged in international health activities and interventions. Today, the U.S. government is the largest funder and implementer of global health assistance worldwide, allocating \$10.6 billion to the State Department and USAID through the Global Health Programs account for fiscal year (FY) 2023.^{264,265}

U.S. Funding for Global SRHR

Using the full definition of SRHR and incorporating all the components of the SRHR Index, the following figures represent current U.S. funding levels for global SRHR:

Family Planning/Reproductive Health—\$607.5 Million

U.S. funding for Family Planning/Reproductive Health (FP/RH) has remained relatively flat over the years. Consistent with years prior, Congress appropriated approximately \$575 million in funds for bilateral FP/RH assistance and \$32.5 million for multilateral FP/RH assistance through contributions to UNFPA for FY 2023.²⁶⁶ FP/RH funding supports a wide range of interventions that cover many (but not all) of the components of the SRHR Index (see Table 1). USAID administers the majority of FP/RH funding, which Congress appropriates primarily through the Global Health Programs account in the annual State, Foreign Operations, and Related Programs appropriations bill.²⁶⁷

Since Congressional appropriations for FP/RH have remained at the same

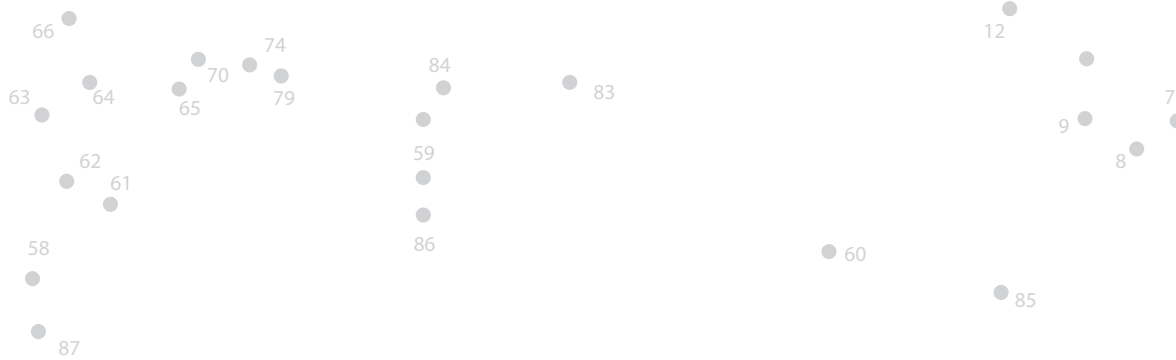
level in recent years, proponents of increased funding assert that consistently flat funding FP/RH is equivalent to spending cuts.²⁶⁸ While the U.S. government is currently the

largest donor in absolute terms,²⁶⁹ it would need to invest \$1.736 billion to meet its “fair share” of development assistance for FP/RH funding (see Chapter 5).

Table 1: U.S. Government-Funded Family Planning/Reproductive Health (FP/RH) Interventions

• Addressing child marriage
• Addressing GBV
• Biomedical and contraceptive research and development
• Contraceptive supplies and their distribution
• Contributions to UNFPA
• Counseling and services such as birth spacing
• Eliminating FGM/C
• Financial management
• Linking FP with HIV/AIDS & STD information/services
• Linking FP with maternity services
• Postabortion care
• Prevention and repair of obstetric fistula
• Public education and marketing
• Sexuality & reproductive health education
• Training of health workers

**The SRHR core components noticeably missing from this list of interventions are abortion care and infertility care and treatment.*



HIV/AIDS—\$7.4 Billion

This is U.S. funding for PEPFAR, the U.S. government’s global effort to combat HIV and the largest global health program devoted to a single disease. All U.S. funding for global HIV falls under PEPFAR, including U.S. multilateral contributions to the Global Fund and UNAIDS. Funding supports multiple interventions in the categories of prevention, treatment and care, and other activities, as outlined in Table 2. Funding for HIV/AIDS efforts totaled \$7 billion in FY 2022, with \$5.49 billion allocated for U.S. bilateral funding for HIV efforts and \$1.6 billion allocated for multilateral efforts (\$1.56 billion of that for the Global Fund and \$50 million for UNAIDS).²⁷² Funding for bilateral HIV/AIDS efforts remains the same for FY 2023, though an additional \$440 million has been allocated toward multilateral efforts, specifically to the Global Fund, bringing its total funding from the U.S. to \$2 billion in FY 2023.²⁷³

MCH—\$1.1 Billion

The U.S. has been involved in MCH efforts since the 1960s and is the largest government donor to MCH activities in the world.²⁷⁴ MCH interventions supported by U.S. funding include those targeted toward mothers as well as newborns and children, as outlined in Table 2. It includes bilateral support, as well as contributions to multilateral institutions, such as Gavi the Vaccine Alliance and UNICEF. Funding for MCH is provided through USAID, the CDC, and the State Department. In FY 2022, the U.S. allocated \$1.28 billion toward MCH efforts.²⁷⁵ MCH accounted for the third largest share of U.S. funding for global health (10 percent) in FY 2022.²⁷⁶ Funding allocated for MCH in FY 2023 totals \$1.1 billion, which includes \$910 million from the Global Health Programs account and an additional \$135.5 million for UNICEF.²⁷⁷

Figure 1: Funding levels for FP/RH over the past 10 years^{270,271}

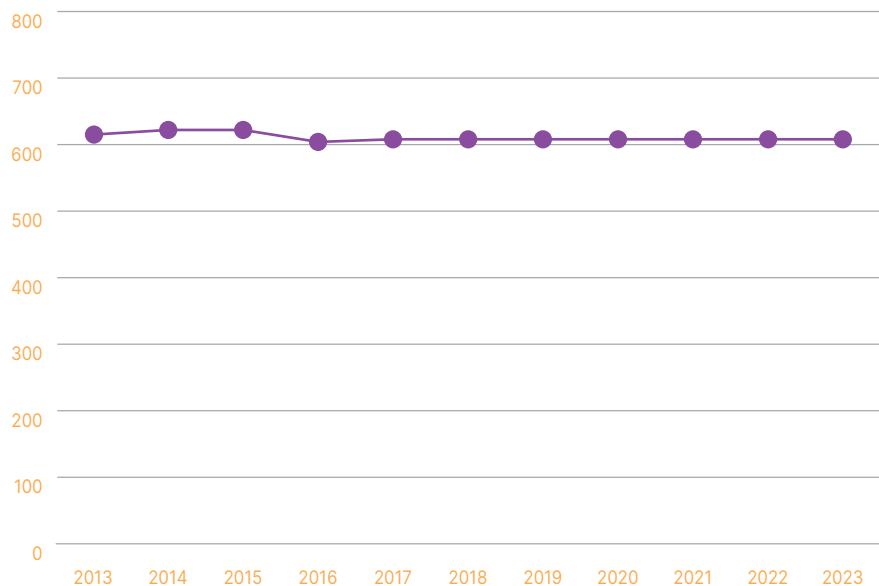
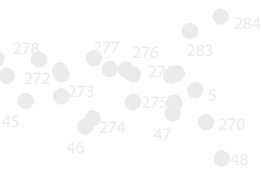


Table 2: Key PEPFAR-Funded HIV Interventions

Prevention	Treatment & Care	Other Activities
<ul style="list-style-type: none"> Blood supply safety Injection safety Prevention of mother-to-children transmission (PMTCT) of HIV Risk reduction for youth, including sexual violence prevention Sexual prevention programs, including condoms, contraceptive counseling, and pre-exposure prophylaxis (PrEP) Harm reduction efforts for injecting drug users (IDUs) and non-injecting drug use Voluntary medical male circumcision (VMMC) 	<ul style="list-style-type: none"> Antiretroviral (ARV) drugs for adults and children Care and support for adults and children living with HIV HIV testing services TB screening and TB preventative therapy for people living with HIV 	<ul style="list-style-type: none"> Support for orphans and vulnerable children (OVC) Health systems strengthening (health workforce, strategic information systems, laboratory infrastructure)



Other Related Funding

Additional U.S. funding for related priorities in FY 2023 has contributed to advancing the SRHR agenda. This includes:

- **\$250 million to prevent and respond to GBV globally;**
- **\$70 million for programs to reduce violence against women and girls in Central America;**
- **\$200 million for the U.S. Gender Equity and Equality Action (GEEA) Fund to advance economic security for women and girls globally;**
- **\$50 million to increase leadership opportunities for women in countries where women and girls suffer discrimination due to law, policy, or practice;**
- **\$150 million to improve the coordination of efforts to empower women as equal partners in conflict prevention, peace building, transitional processes, and reconstruction efforts;**
- **\$970 million for basic education programs, of which \$150 million is allocated for the education of girls in areas of conflict.²⁷⁸**

U.S. Policies Restricting Global SRHR Efforts

Some U.S. policies play an oversized role in limiting access to the full range of SRH services in countries that receive U.S. foreign assistance. U.S. funding for FP/RH, in particular, is governed by several policy restrictions. The Trump administration's most recent iteration of the GGR, for example, expanded restrictions to include to all U.S. government global health assistance, including PEPFAR and MCH funding.

The Kemp-Kasten Amendment

The U.S. government aided in the

Table 3: U.S. Government-Funded Maternal & Child Health (MCH) Interventions

Newborns and Children	Women
Essential newborn care	Skilled care at birth
Postnatal visits	Emergency obstetric care
Prevention and treatment of severe childhood diseases	Improved access to FP/RH and birth spacing
Immunizations, including those for polio, measles, and tetanus	Antenatal care, including aseptic techniques to prevent sepsis
Malaria prevention (including ITNs) and, for mothers, intermittent preventive treatment during pregnancy (IPTp)	
HIV prevention/treatment/care, including prevention of mother-to-child-transmission (PMTCT) of HIV	
Improved nutrition/supplementation	
Clean water, sanitation, and hygiene efforts	
Health systems strengthening (health workforce, information systems, pharmaceutical management, infrastructure development)	
Implementation science and operational research	

creation of UNFPA in 1969 and remains a leading contributor today, though contributions have been subject to both Congressional and Administration politics. The enactment of the Kemp-Kasten Amendment by Congress in 1985 has limited U.S. support for UNFPA over the years. The Kemp-Kasten Amendment states that the provision of U.S. foreign aid may not be made available to "any organization or program which, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization." Though the Kemp-Kasten Amendment technically could apply to funding provided to any organization or program, the U.S. government has only ever issued determinations about UNFPA, citing concerns about China's population control policies and UNFPA's work in China.²⁷⁹ **Evaluations by the U.S. government and other impartial institutions have found no evidence that UNFPA engaged or engages**

in coercive abortion or involuntary sterilization in China.²⁸⁰ And yet, multiple Republican administrations have invoked the Kemp-Kasten Amendment, and as a result, U.S. funding for UNFPA has been withheld in 19 of the past 36 fiscal years. While Congress has kept the amendment in place annually, it remains up to the President to determine whether to invoke the Kemp-Kasten Amendment as a reason to withhold funding from an organization.²⁸¹ Invoking and revoking the Kemp-Kasten Amendment is used as a political tool along party lines.

Other UNFPA Restrictions

In addition to the Kemp-Kasten Amendment, Congress has also enacted several other provisions to set conditions on U.S. funding for UNFPA. These provisions include:

- **Requiring UNFPA to keep U.S. funding in a separate account, apart from other funds;**
- **Prohibiting UNFPA from funding abortion;**

- **Prohibiting the use of any U.S. funds for UNFPA's programming in China, as well as reducing the U.S. contribution to UNFPA by one dollar for every dollar spent by UNFPA on programming in China; and**
- **In some years, enacting funding schedules that state that not more than half of the U.S. funding contribution to UNFPA be released before a particular date, which varies by fiscal year. This provision is currently not in effect.²⁸²**

The Helms Amendment

First enacted in 1973, the Helms Amendment states that “no foreign assistance funds may be used to pay for the performance of abortion as a method of family planning.”²⁸³ Despite its originally stated intent, the amendment has been overinterpreted as an outright ban on any abortion-related services and information—even in cases of rape, incest, or a life-threatening pregnancy. Research shows that, without the Helms Amendment, there would be 19 million fewer unsafe abortions, 17,000 fewer maternal deaths, and 12 million fewer women with abortion-related medical complications every year.²⁸⁴ The Helms Amendment has long been criticized as a racist and neo-colonialist policy that disenfranchises Black, brown, and other systemically marginalized people around the world.²⁸⁵

The Global Gag Rule (Mexico City Policy)

The Mexico City Policy, more commonly referred to as the “global gag rule” or GGR, prohibits performing or promoting legal abortion services as “a method of family planning” by foreign NGOs who are receiving U.S. family planning assistance, even if the activities are implemented with the NGO’s private, non-USG funds. Introduced by the Reagan administration in 1984, the GGR has been rescinded and reinstated by subsequent

administrations along party lines.²⁸⁶ The Trump/Pence administration further expanded the reach of the GGR, renaming the policy “Protecting Life in Global Health Assistance,” to apply to *all* U.S. government global health assistance.²⁸⁷ In 2021, the Biden administration rescinded the GGR. Like the Kemp-Kasten Amendment, the GGR is also used as a political tool, rescinded and reinstated along party lines. The GGR has also long been criticized as a racist and neo-colonialist policy.²⁸⁸

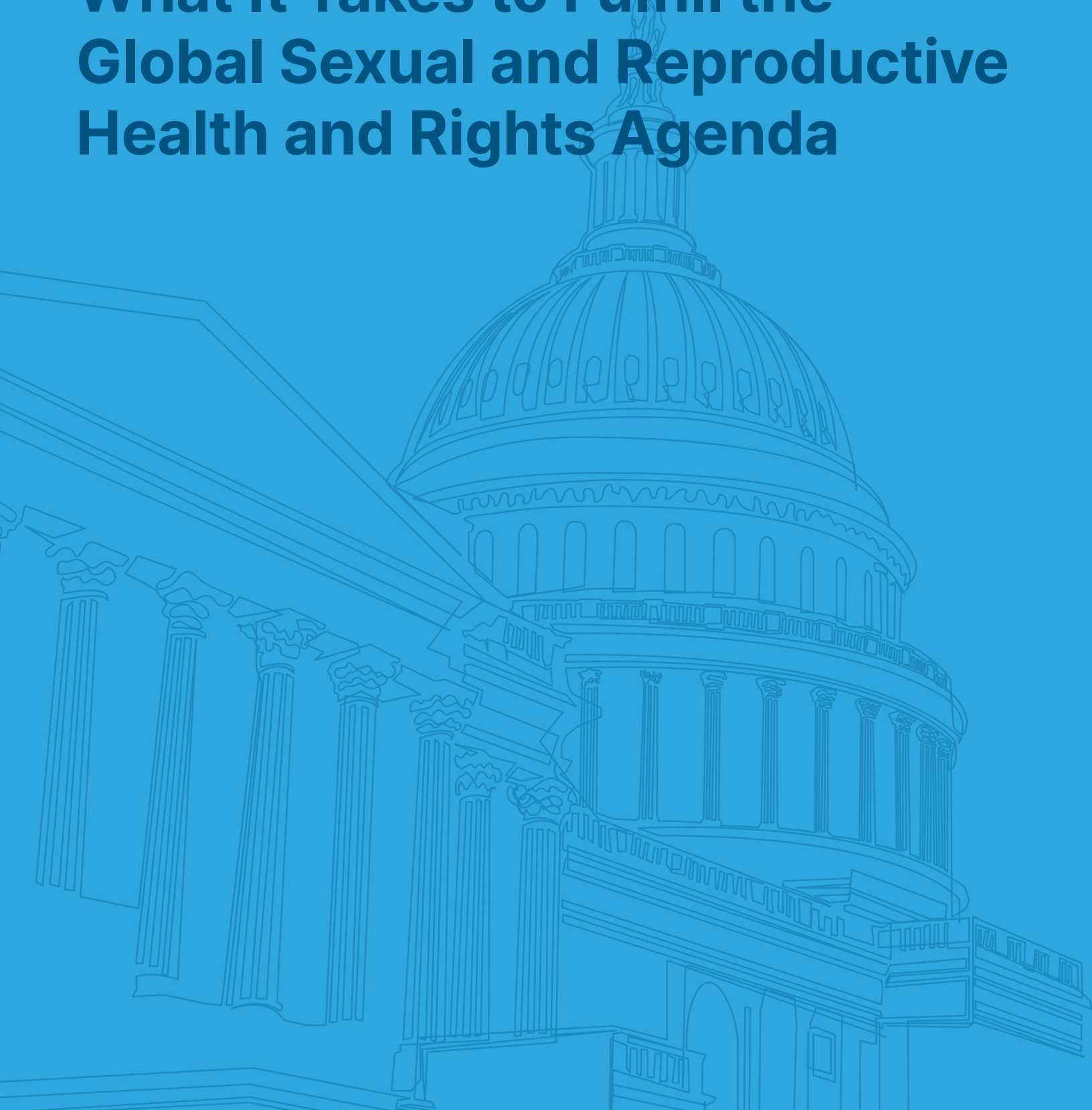


U.S. Foreign Policies on Abortion: An Explanation of the Criticism

Some U.S. foreign policies related to SRHR are criticized for utilizing legal and monetary pressures that impose compliance to U.S. political views on abortion rather than promote, respect, and protect it as a reproductive right. This type of economic influence over other sovereign countries and other recipients of U.S. foreign assistance is often condemned as neo-colonialist and racist.²⁸⁹ The Helms Amendment, for example, places confines on U.S. foreign assistance to exclude funding for “abortion as a method of family planning.”²⁹⁰ SRHR activists assert that this U.S. policy advances an antiabortion agenda in other countries where abortion may be legal and endangers those who might be forced to seek unsafe abortions in the absence of safe and legal abortion services.²⁹¹ The GGR is also said to reinforce a restrictive abortion agenda by incapacitating foreign NGO health programs by either forcing them to choose between advocating for—or referring patients to—abortion services but having to forego U.S. funding or by accepting the much needed funding with limitations on their ability to provide comprehensive SRH services with private, non-U.S. funding.²⁹²

Chapter 5

What It Takes to Fulfill the Global Sexual and Reproductive Health and Rights Agenda



FUNDING

SRH program funding requires robust support to actualize SRHR for all people. Increased investment in SRHR from the U.S. government can help ensure all aspects of SRHR are being met.

U.S. Funding Streams for SRHR

As outlined in Chapter 4, U.S. support for various components of the SRHR agenda flows through multiple budget and appropriations line items, such as bilateral FP/RH programming, MCH, PEPFAR, contributions to UNFPA and other multilateral institutions, and others. U.S. funding for SRHR depends on a complex process involving the President's budget proposals and the recommendations of the Foreign Relations and Appropriations committees in both chambers of the U.S. Congress. Since SRHR is interwoven in many development priorities that are part of U.S. foreign assistance, it is difficult to pinpoint the exact current U.S. expenditure on SRHR programming or to make specific recommendations about the level of finance that would be required to fully meet existing needs across all components of SRHR. This report makes the case for specific funding increases for FP/RH and MCH and demonstrates the need for increased funding for other components of the SRHR agenda, including for components that to date have been overlooked in U.S. foreign assistance.

The Case for Increased Funding

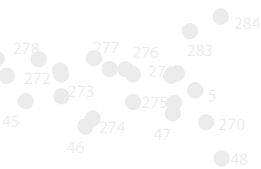
The Guttmacher Institute reported, in its 2019 summary of SRHR service costs and impact entitled *Adding It Up*, that for approximately \$10.60 per capita in LMICs annually, all women of reproductive age could receive the pregnancy-related and STI care that they need; all newborns could receive essential, lifesaving

care during and just after birth; and all women could receive the contraceptive services they need to be able to decide whether and when to have children.²⁹³ An investment of \$10.60 per capita represents an increase of about \$4.80 over current global expenditures, and the resulting package of care would total **\$68.8 billion annually** in 2019 US dollars (see Table 1).²⁹⁴

Table 1: Guttmacher Institute's Analysis of Annual Costs of Contraceptive Services, Pregnancy-Related and Newborn Care, and STI Treatment for Women Aged 15–49 and Their Newborns in LMICs, 2019²⁹⁵

SRHR Components of Care	All Needs Met
Modern Contraception	\$12.6 billion
Pregnancy-related and Newborn Care	\$54.0 billion
Antenatal Care (including care of all pregnancies, whether ending in a live birth, miscarriage, stillbirth, or ectopic pregnancy)	\$18.3 billion
Delivery and Postnatal Care	\$26.1 billion
Newborn Care	\$5.8 billion
HIV Care for Pregnant Women and Newborns	\$2.2 billion
Abortion and Postabortion Care	\$1.5 billion
STI Treatments	\$2.2 billion
Total	\$122.7 billion





The Concept of “Fair Share”

At the 1994 ICPD in Cairo, 179 U.N. member states agreed by consensus on a costed implementation plan designed to achieve the goal of significantly expanding access to reproductive health care.²⁹⁶ The ICPD Programme of Action recommended that developing countries themselves bear the responsibility for two-thirds of the annual costs, while the remaining one-third should come from donors, including the U.S.²⁹⁷ Therefore, using the ICPD burden-sharing rationale, donor nations would be expected to contribute \$4.2 billion for modern contraception, \$18 billion for pregnancy-related and newborn care, and \$733 million for STI treatments, or one-third of the total current costs to meet all needs.

A further consideration is determining each donor’s equitable share of all funds. A recommendation espoused by PAI and other SRHR advocacy organizations is that each donor’s share of total funds should be based on the wealth of the donor country as measured by its gross national income (GNI)—an internationally accepted indicator of national wealth.²⁹⁸ According to this formula, in 2018 (the latest year data were available), the U.S. GNI made up **41.34 percent** of the Development Assistance Committee nations’ GNI.²⁹⁹

The cost of fulfilling the unmet need for some components of SRHR is reasonably well documented; for example, the costs of family planning, safe childbirth services, and HIV/AIDS. For other components of SRHR, like infertility and CSE, there are considerably fewer costing data points based on well-studied interventions. For the purposes of this report, the one-third fair share figure and GNI percentage of 41.34 percent for FP/RH funding will be the standard used.

U.S.’s Fair Share for Investments in FP/RH Programming

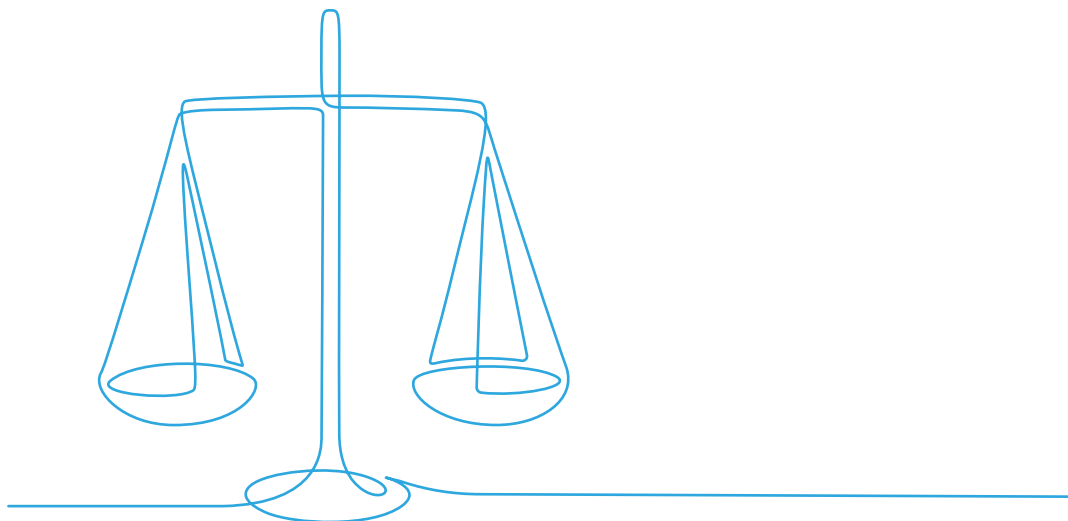
To be in accordance with the estimated fair share of one-third of funding needed for contraception globally, PAI calculated that the U.S. would need to raise its support for FP/RH programming to **\$1.736 billion** annually, an increase from the current stagnant funding level of \$607.5

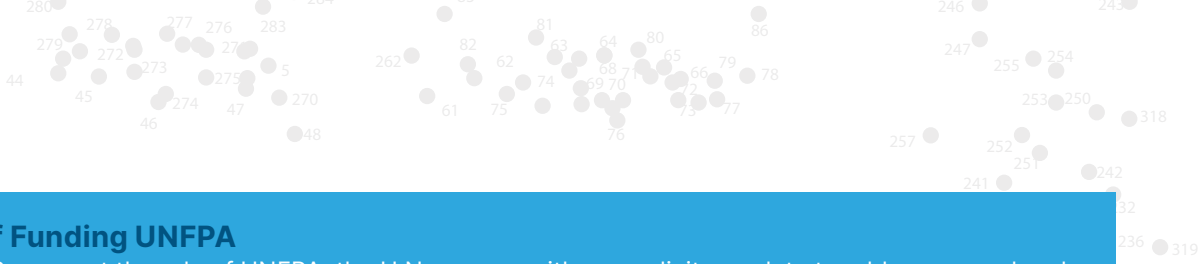
million.³⁰⁰ This number is derived from the Guttmacher Institute’s analysis that it would take \$12.6 billion to ensure that all women of reproductive age in LMICs have their modern contraception needs met. Of that number, the one-third from donor countries would equal \$4.2 billion. The U.S.’s fair share calculation would be 41.34 percent of that figure, totaling \$1.736 billion.

With the U.S. providing its fair share of funding for FP/RH programming, the gap in unmet need for modern contraception would narrow and improvements in global reproductive health would ensue. Nearly 90 major national organizations, including PI, have endorsed the calculations by PAI and submitted a joint request to congressional appropriators for inclusion of \$1.74 billion in the FY 2024 budget.³⁰¹

Table 2: Current and Fair Share Funding for FP/RH Programming

	Current Funding Amount	U.S.’s Fair Share	Difference
FP/RH Bilateral Programming	\$575 million	\$1.62 billion	\$1.045 billion
UNFPA Core Contribution	\$32.5 million	\$116 million	\$83.5million
Total	\$607.5 million	\$1.736 billion	\$1.1285 billion





The Importance of Funding UNFPA

It is critical that the U.S. support the role of UNFPA, the U.N. agency with an explicit mandate to address sexual and reproductive health needs worldwide. The U.S. played a key role in the creation of UNFPA, which was established in 1969. As a U.N. entity and the world’s largest provider of sexual and reproductive health programs, UNFPA operates in over 150 countries and territories, comprising more than 80 percent of the world’s population.³⁰² Since UNFPA programs serve beneficiaries in some of the most pressing humanitarian emergencies and in the most remote and hard-to-reach communities that are beyond the scope of U.S. development programs, U.S. investments in UNFPA are able to have a wider reach around the world. UNFPA funding helps to close funding gaps that are not met through bilateral financing programs. As an expedited emergency response system, finances through UNFPA equip country offices to respond to emergencies quickly before the initiation of other funds.³⁰³

Support for UNFPA from the U.S. resumed in 2021.³⁰⁴ This renewed partnership is broad and extends to key areas of UNFPA’s efforts, including humanitarian and development programs, as well as UNFPA’s work to respond and recover from the COVID-19 pandemic, which has given rise to a shadow pandemic of gender-based violence.³⁰⁵ The U.S. provided a core investment of **\$32.5 million** in FY 2022.³⁰⁶ The Biden administration specified a request of a \$56 million contribution to UNFPA for FY 2023,³⁰⁷ though Congress appropriated a flat funding level of \$32.5 million like previous years.³⁰⁸ Both the requested and the appropriated figures are considerably lower than the fair share annual investment of **\$116 million** requested by the International Family Planning Coalition.³⁰⁹

U.S. Funding in Perspective

In 2021, family planning funding from donor governments totaled U.S. \$1.39 billion.³¹⁰ The U.S. continued to be the largest donor to bilateral family planning assistance, providing 41.6 percent of total bilateral funding from governments.³¹¹ In years past, the U.K. had been the world’s second largest donor, but the U.K. government’s decision to reduce overall Official Development Assistance (ODA) caused a significant decline in their funding amount in 2021.³¹² Therefore, the Netherlands was the second largest donor with 13.7 percent, followed by Sweden’s 13 percent, then the U.K. at 11.4 percent, and Canada with 7.1 percent.³¹³

Furthermore, according to the Organization for Economic Co-operation and Development, the U.S. is only providing a fraction of the minimum amount of its GNI for development assistance.³¹⁴ Preliminary figures of ODA show that although the U.S. was by far the largest donor with a contribution of \$42.3 billion in development assistance in 2021, it gave only 0.18 percent of GNI, well short of the internationally agreed upon 0.7 percent of GNI from donor countries for development assistance.³¹⁵

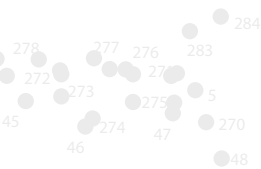
The U.S.’s percentage of GNI for development assistance also falls well behind other donor countries’ contributions. Several

donor countries succeed, and in some cases exceed, in providing their 0.7 percent of GNI share of development assistance. In 2021, countries that met or exceeded the 0.7 percentage include Sweden (0.92 percent), Norway (0.93 percent), Luxembourg (0.99 percent), Denmark (0.70 percent), and Germany (0.74 percent).³¹⁶ Additionally, preliminary figures for 2021 show that Turkey exceeded the target with 0.95 percent.³¹⁷

Table 3: Countries’ Percentage of GNI for Development Assistance

Sweden	0.92%
Norway	0.93%
Luxembourg	0.99%
Denmark	0.70%
Germany	0.74%
Turkey	0.95%
U.S.	0.18%

With the U.S. providing its fair share of funding for FP/RH programming, the gap in unmet need for modern contraception would narrow and improvements in global reproductive health would ensue.



0.7 Percent of GNI

In 1970, the U.N. General Assembly adopted resolution A/RES/2626(XXV) that stated: “[e]ach economically advanced country will progressively increase its official development assistance to the developing countries and will exert its best efforts to reach a minimum net amount of 0.7 percent of its gross national product [GNP] ... by the middle of the Decade.”³¹⁸ In the years since, donors have reconfirmed their commitment to the 0.7 percent target.^{319,320} However, the U.S. delegation to the U.N. stated that, while it supports the general aims of the Resolution, it did not subscribe to specific targets or timetables.³²¹ In 1993, GNP was replaced by GNI, and the 0.7 percent target is now shown in terms of ODA/GNI ratios, as opposed to the previously used ODA/GNP.³²²

Increasing Funding for Other SRHR Components

Additional funding for other core components of SRHR is also critical to ensure full realization of the SRHR agenda. Many of these core components are integrated and mutually reinforcing—for example, fulfilling the unmet need for modern contraception would also have positive impacts on unintended pregnancies, unsafe abortions, and maternal deaths.³²⁵ Therefore, it is difficult to accurately calculate the costs associated with each component individually, especially since many SRHR programs are implemented in an integrated manner. Additionally, data to support estimated figures for some of the components, like reproductive cancers and infertility care and treatment, are not robust.

The U.S. continues to be the largest donor to HIV/AIDS efforts globally, providing \$5.49 billion in bilateral HIV funding and \$1.6 billion for multilateral efforts, with \$1.56 billion of that going to the Global Fund and \$50 million for UNAIDS.³²⁶ The U.S. currently provides a greater share of total HIV resources than its share of total GNI, though advocates point toward the need for greater resources to protect hard-won progress in reducing HIV infections and AIDS-related deaths. The Global AIDS Policy Partnership is advocating for no less than \$7.12 billion for Global Health Programs at the Department of State for the FY 2023.³²⁷ This also includes \$5.12 billion for PEPFAR; \$2 billion for the Global fund to Fight AIDS, Tuberculosis, and Malaria; and \$55 million for UNAIDS.³²⁸

Expanding the Reach of U.S. Foreign Assistance

SRHR advocates agree U.S. funding for international FP/RH programming should be increased to **\$1.736 billion**. While there are comprehensive figures to document FP/RH expenditures and needs, there are other components of the SRHR agenda that are not as well documented from a cost and need perspective. While it is difficult to accurately quantify additional needs due to data limitations, it can be assumed that additional funding would be needed to ensure that all SRHR core components are fully realized. Furthermore, critical components of the SRHR agenda that are overlooked or currently left out of U.S. SRHR programming, such as abortion care and infertility, also need to be included.

that it would take \$54.0 billion to meet all pregnancy and newborn care needs in LMICs.³²³ This number includes services associated with antenatal care, delivery and postnatal care, newborn care, HIV care for pregnant women and newborns, and abortion and postabortion care.

Using the same methodology employed by PAI to estimate the U.S.’s fair share of funding for FP/RH, the U.S.’s fair share of funding for pregnancy-related and newborn care is roughly calculated to be **\$7.44 billion**, a much higher number than the current funding level of \$1.235 billion allocated for MCH, which covers an expansive list of interventions detailed in Chapter 4.³²⁴ However, due to U.S. laws restricting U.S. foreign assistance for abortion, the U.S. is currently unable to contribute funding for safe abortion care (see “Expanding Programming” section), which is included in the \$7.44 billion fair share calculation. Progressive policy changes are needed to ensure that U.S. foreign assistance can help people in the Global South access the full range of comprehensive SRH services, including abortion care (see “Progressive Policies” section).

Increasing Funding for Maternal Health (Pregnancy-related and Newborn Care)

Pregnancy-related and newborn care, including safe abortion and postabortion care, are important components of the SRHR agenda. The Guttmacher Institute estimated

Mutually Reinforcing Components

The interconnectedness of SRH activities is important to recognize in determining the value of supporting all its components. Funding any one component has positive ripple effects on other SRH indicators. Funding different programs and services contributes to achieving a successful collective impact. For example, making contraceptives widely available in the Global South in an effort to reduce the spread of HIV would also positively affect other SRH outcomes, such as reducing unintended pregnancies, unsafe abortions, and maternal deaths.³²⁹ Conversely, funding programs to increase access to SRH services, such as widespread contraceptive use to reduce unintended pregnancies, can have positive impacts reducing the spread of HIV and other STIs.³³⁰

Expanding Programming

In addition to increased funding for the components of the SRHR agenda, it is critical for the U.S. to recognize all the components of the agenda and include those currently overlooked or left out in programs that receive U.S. support.

Infertility Care and Treatment

As outlined in Chapter 1, millions of couples around the world experience infertility. The inability to become pregnant and give birth can cause difficulties participating in social settings, feelings of inadequate social support, social isolation, depression, and anxiety, and for these and other reasons, treatment and care of infertility are critical component

of the SRHR agenda.^{331,332} And yet, effective treatment and care remain out of reach for most infertile couples in the Global South. Where treatment and care are available, the focus tends to be on treating STIs, raising awareness about infertility, reducing the stigma surrounding it, focusing on prevention, and counseling couples about their options.

Among the more effective strategies available to treat infertility, in vitro fertilization (IVF) is an option that requires high-tech lab work and specialized clinical skills. In the U.S., the average cost of IVF is about \$11,000 to \$12,000 for each cycle.³³³ Current IVF costs in some LMICs are roughly \$1,200–\$3,000 in India, \$5,000 in Brazil, and up to \$8,000 in South Africa.^{334,335,336} However, lower-cost fertility drugs and less-expensive laboratories are starting to become available.³³⁷ A project supported by the Walking Egg Foundation was able to set up a low-cost IVF laboratory for less than €300,000, or roughly \$340,000, as compared to the cost of an IVF laboratory in a high-income country costing somewhere between \$1.69 to \$3.37 million.³³⁸ Other infertility treatments such as ovarian stimulation and/or intrauterine insemination are significantly less expensive, but they are also less effective.³³⁹

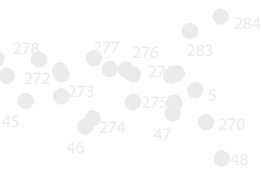
Currently, infertility care and treatment are not included in U.S. government-funded FP/RH interventions (see Chapter 4 for full list). Many SRHR components currently funded by U.S. foreign assistance, like STI treatment and care, contraceptives and family planning services, and sexuality and reproductive health education indirectly reduce the burden of infertility for people in the Global South, though direct and explicit programming that addresses infertility

care and treatment has not yet been a component of U.S. foreign assistance.^{332,336,319}

Abortion Care

Also noticeably missing from the list of U.S. government-funded FP/RH interventions is abortion care. While postabortion care can be funded by U.S. dollars, U.S. funding for reproductive health is governed by several legislative and policy restrictions. This includes a ban on the direct use of U.S. funding overseas for abortion as a method of family planning, and in some years, a broad restriction on foreign organizations receiving U.S. funding that further limits access to abortion care (see Chapter 4). These restrictions limit the U.S. government's ability to fully address the problems of unsafe abortion and maternal mortality and morbidity in the Global South.

The Guttmacher Institute estimated that it would take \$1.5 billion to ensure safe abortion and postabortion care in LMICs (see Table 1), assuming there are no changes in abortion laws or practice in these countries. This estimate is lower than the current total estimated expenditure of abortion-related care in LMICs of \$2.8 billion, which includes \$1 billion for abortions provided under both safe and unsafe conditions and \$1.7 billion for postabortion care.³⁴⁰ The assumption is that if women's contraceptive needs were fully met in LMICs, that would, in turn, reduce the number of unintended pregnancies, resulting in a decline in abortions, especially unsafe abortions. The health complications resulting from unsafe abortions would also drop, resulting in less need for postabortion care.³⁴¹



Summing It Up

The total of funds recommended in this report as the fair share of U.S. development assistance for FP/RH is \$1.736 billion, an increase of \$1.33 billion over what is currently appropriated for FP/RH programming. An increase from the current 0.17 percent of GNI to the recommended 0.7 percent of GNI would increase U.S. development assistance from \$35.5 billion to \$152 billion. This

increase of more than \$100 billion could fund the FP/RH programs as called for by SRHR advocates. Providing the needed funds to adequately support the full range of SRHR activities in the Global South would foster reproductive justice globally and improve health and well-being of people, families, and communities worldwide.

However, it is important to note that this requested funding number alone is not enough to fully realize SRHR for all people in the Global South. U.S. foreign assistance should include all components of the SRHR agenda to ensure best outcomes, and to do that, it will take progressive policy change to expand U.S. programming for SRHR to include all the core components of the agenda, including those that are currently overlooked or left out.

POLICIES

For all the core components of SRHR to be included in current U.S. foreign assistance, change to U.S. foreign policy is required to enable more progressive and supportive funding and programming. As U.S. policy directly and indirectly influences a person's ability to access SRH services worldwide, it is important to highlight how certain SRHR policies are hindering progress in areas of gender equality and empowerment.

Pro-SRHR Policies

Policy change around SRHR is needed if the U.S. is to remain a leader in global health assistance. Current U.S. foreign policy creates a hostile environment for many seeking SRH services around the world and limits achievements in the SRHR field. Policy changes that would advance SRHR globally include the following:

The Abortion is Health Care Everywhere Act

If enacted, the *Abortion is Health Care Everywhere Act* would repeal the Helms Amendment and replace it with language explicitly stating that U.S. foreign assistance can be used to provide comprehensive reproductive healthcare and information that also includes abortion services, training, and equipment.³⁴²

Clarification for the Application of the Helms Amendment

The current administration has an important role to play in abating the

harm of the Helms Amendment, even before the passage of the *Abortion is Health Care Everywhere Act*. The amendment states that U.S. funds cannot be used for "abortion as a method of family planning"; therefore, it is possible for the President to issue guidance that would clarify the application of the amendment to allow for exceptions—namely, for rape, incest, and threat to a pregnant person's life.³⁴³

The Global Health, Empowerment and Rights Act (Global HER Act)

The *Global HER Act* would permanently repeal the GGR, preventing any future administrations' being able to reinstate it. The bill was reintroduced in the House and Senate in January 2021. Passage of the *Global HER Act* would remove eligibility restrictions for recipients of U.S. foreign assistance, ensuring that foreign NGOs can also use their own non-U.S. funds to provide access

to safe and legal abortion services and guaranteeing free speech for foreign NGOs receiving U.S. foreign assistance.³⁴⁴

Modification to the Kemp-Kasten Amendment

The Kemp-Kasten Amendment includes a provision that U.S. funds cannot be made available to any organization that is determined by the President of the U.S. to support or participate in the management of a program of coercive abortion or involuntary sterilization. Modification of this amendment is needed to ensure that U.S. funds are not wrongfully withheld from UNFPA because of willful misinterpretation of the amendment by policymakers who are hostile to the U.N. agency.³⁴⁵ The Kemp-Kasten Amendment should be reworked to require language that states an organization must be determined to be "directly" engaged in coercive practices before being denied U.S. funding.

Other Restrictions on UNFPA

Additionally, Congress must work to repeal other restrictions on UNFPA in order to ensure that programming is not confined to work within the limits of requiring separate accounts for U.S. funding, prohibiting funds toward abortion, and enacting dollar-to-dollar withholding for UNFPA programs in China.

The Reproductive Rights are Human Rights Act

The annual U.S. Department of State Human Rights Reports are required to cover “internationally recognized individual, civil, political, and worker rights, as set forth in the UDHR and other international agreements.” However, in 2018, the Trump administration eliminated comprehensive reporting on SRHR. The Biden administration has since restored the reporting of SRHR to the Human Rights Reports, but there is a need for legislation to mandate this reporting’s going forward, regardless of administration. *The Reproductive Rights are Human Rights Act* would ensure that the State Department is required to report on the status of: Access to abortion, contraception, and family planning information;

- **Access to safe and respectful maternity care;**
- **Rates of preventable pregnancy related deaths and injuries, including disaggregated data to understand if marginalized communities are disproportionately impacted; and**
- **Information on systemic forms of reproductive coercion, including coerced abortion, involuntary sterilization, coerced pregnancy, and obstetric violence.³⁴⁶**

Modifications to Global Health Sector Equity (“notwithstanding” clause)

Under current law, governments that seize power through a coup, seek to obtain nuclear weapons, default on loans to the U.S. government, expropriate U.S. assets, or engage in other offenses are subject to a variety of prohibitions on the provision of U.S. foreign assistance. However, many life-saving global health interventions—including child survival, HIV/AIDS, and other disease-specific programs—are currently exempt from these country-assistance prohibitions. FP/RH is currently the only global health sector that is not exempt in these circumstances. Annual appropriations bills describing these exemptions should read “global health programs” rather than “child survival activities or disease programs” to allow FP/RH activities and assistance to continue without interruption.³⁴⁷

Modification to the HIV/AIDS Working Capital Fund

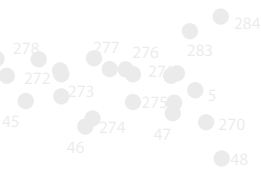
Modifications to the current HIV/AIDS Working Capital Fund law are needed so that USAID is allowed the option of procuring contraceptive commodities. Currently, the law only allows “child survival, malaria, tuberculosis, and emerging infectious disease” programs to use the HIV/AIDS Working Capital Fund to procure and distribute pharmaceutical commodities for use in U.S. government-funded programs “to the same extent as HIV/AIDS pharmaceuticals and other products.” A simple wording change of “other global health” to the existing statute’s inserted annual appropriations bills would broaden the eligibility for FP/RH programs to participate.³⁴⁸

Modification of the Siljander Amendment

The Siljander Amendment was enacted in 1981 to prohibit the use of foreign assistance funds to lobby for or against abortion.³⁴⁹ Modifying this amendment so that it only prohibits the use of funds to lobby against abortion is crucial for the increasing access to safe abortion worldwide. Allowing for diplomatic engagement and foreign assistance to promote safe and legal abortion could be significant in decreasing maternal mortality and increasing holistic health and well-being worldwide.

Repealing of the Livingston-Obey Amendment

The Livingston-Obey Amendment prohibits discrimination by the U.S. in providing funds to organizations that offer only “natural family planning” due to religious or conscientious reasons.³⁵⁰ By funding organizations that refuse to offer a full range of contraceptive methods, informed choice and access to family planning services is restricted worldwide. The U.S. should ensure that partner organizations and funded family planning programs include a full range of contraceptive services to enable people to utilize the method that is most conducive to their situation. Allowing for government-funded programs to only offer natural family planning can be life-threatening, as these methods have reportedly lower use-effectiveness rates.



Additional Gender Policies and Initiatives

Policy changes and support of gender initiatives are also needed to ensure that the SRHR agenda is fully realized. Important pieces of legislation or initiatives Congress can pass or support that promote full gender equity include the following:

Repealing of the Anti-Prostitution Loyalty Oath

The anti-prostitution loyalty oath, or APLO, is a provision of the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*. The APLO requires foreign-based NGOs or foreign affiliates of U.S.-based NGOs to include a “policy explicitly opposing prostitution” in order to receive funding from PEPFAR.³⁵¹ The APLO should be repealed by Congress, as it creates a barrier to reducing HIV infections globally and promotes stigma and discrimination against sex workers, effectively preventing sex workers from accessing HIV programs and services.³⁵²

Keeping Girls in School Act

The *Keeping Girls in School Act* would support empowerment, economic security, and educational opportunities for adolescent girls around the world.³⁵³ Education helps adolescent girls to live longer, marry later, reduce incidence of

intimate partner violence, increase lifetime expected earnings, and gain more decision-making power in the household.^{354, 355}

The U.S. Women, Peace, and Security Act

The *Women, Peace, and Security Act of 2017* promotes women’s inclusion and participation in peace and security processes to prevent, mitigate, or resolve violent conflict. The law gives Congress oversight of the U.S.’s efforts of integrating gender perspectives across its diplomatic, development, and defense-related work in conflict-affected regions.³⁵⁶ Congress should ensure adequate funding for a robust implementation of the law so that women are meaningfully included in peace and security processes worldwide.

Support for the Gender Equity and Equality Action Fund

The new GEEA Fund, established in 2021 with a \$100 million allocation, aims to advance economic security for women and girls globally, prevent and respond to gender-based violence, and support underserved and marginalized populations. The GEEA Fund also helps to address the disproportionate impact that COVID-19, climate change, and conflict and crisis have on women and girls.³⁵⁷ Funding from Congress should

meet the request from the President’s budget of \$200 million for FY 2023.³⁵⁸

International Violence Against Women Act

The *International Violence Against Women Act (I-VAWA)* would ensure a comprehensive response from the U.S. to end violence against women and girls globally.³⁵⁹ Passage of I-VAWA would represent the U.S. government’s commitment to ending gender-based violence and make gender equality a cornerstone of U.S. foreign policy.

Greater Leadership Overseas for the Benefit of Equality Act


The *Greater Leadership Overseas for the Benefit of Equality Act (GLOBE Act)* would protect LGBTQI+ human rights worldwide and codify a non-discrimination policy to ensure that LGBTQI+ people are fully included in all U.S. foreign assistance programs. This would make support of the LGBTQI+ community a foreign policy priority and position the U.S. as leader in promoting LGBTQI+ equality globally. Additionally, the *GLOBE Act* would authorize sanctions against foreign individuals who commit anti-LGBTQI+ human rights violations and require that the State Department report on anti-LGBTQI+ issues in the annual Human Rights Report.³⁶⁰



Chapter 6

The Impact of a Fully Realized Global SRHR Agenda





Significant progress has been made on the SRHR agenda over the past decades; however, the agenda remains unfinished. With the largest generation of youth in history and the number of individuals of reproductive age expected to grow, it is crucial that there is robust support for the SRHR agenda to meet the needs of all. Meaningful funding increases and political will from the U.S. are required to meet the unmet need for SRH services worldwide. It is important that the U.S. reengages as world leader on these issues, as the impact of a fully realized SRHR agenda would be substantial to the health and well-being of millions around the world.

According to the Guttmacher Institute, if *all* women in LMICs wanting to avoid a pregnancy were to have access to and use modern contraceptives and *all* pregnant women were to receive the care at the standards recommended by the WHO, the world would see:

- **Unintended pregnancies drop by 68 percent;**
- **Unsafe abortion drop by 72 percent; and**
- **Maternal deaths drop by 62 percent.**³⁶¹

Furthermore, cases of pelvic inflammatory disease and infertility caused by chlamydia or gonorrhea would be eliminated if all women infected with these STIs were given effective and timely treatment.³⁶²

These figures are astonishing. What is more, they are achievable. If the U.S. strengthens its support for SRHR through greater investment and small but impactful changes to foreign policies on SRHR, these outcomes could be within reach.

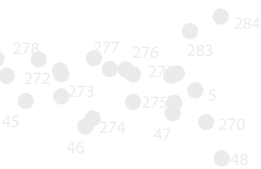
Policymakers must shift their mindsets from seeing SRHR as a siloed and contentious public health issue and, instead, shape their understanding of SRHR as a prerequisite for bipartisan policy goals related to gender equality and empowerment. It is imperative that the U.S. increase its support for FP/RH programming to its estimated fair share of \$1.736 billion annually, including \$116 million for UNFPA. However, it is also important for policymakers to understand that current FP/RH programming and other sources of SRHR funding are not inclusive of the entire SRHR agenda, namely abortion care and infertility treatment and care, and further U.S. funding is needed to ensure all SRHR components are fully realized.

When it comes to the core components of SRHR, there cannot be any exceptions or exclusions; the U.S. should expand its SRHR programming to include all core components of the SRHR agenda. This will require a change in U.S. foreign policy—notably to enable

more progressive and supportive SRHR funding and programming, such as passage of the *Global HER Act*, permanently repealing the global gag rule; passage of the *Abortion is Health Care Everywhere Act*, repealing the Helms Amendment; and modifications to the Kemp-Kasten Amendment, ensuring U.S. funds are not wrongfully withheld from UNFPA. Furthermore, a dedicated and focused attention on SRHR foreign assistance is necessary to ensure the needs of everyone—and specifically those who are systemically marginalized—are fully addressed.

It will take full investment—both financially and politically—from the U.S. to assure that the SRHR agenda is more fully realized. It will also take a dedicated focus to ensure that U.S.-funded programming is fully inclusive and centers on those who are systemically marginalized. The timing has never been more critical. The U.S. needs to reengage as a world leader on SRHR in order to fulfill its other priority goals. Achieving these crucial elements of the SRHR agenda can allow for real progress in gender equality and empowerment.

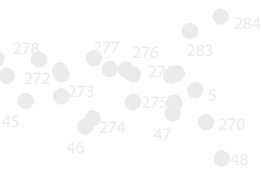
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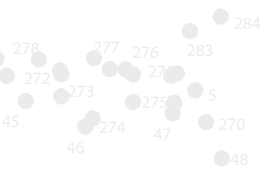
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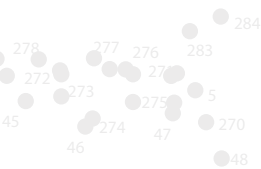
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