UNFPA state of world population 2017

WORLDS APART

Reproductive health and rights in an age of inequality

The State of World Population 2017

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EDITOR-IN-CHIEF
Arthur Erken, Director, UNFPA Division of Communications and Strategic Partnerships

SENIOR RESEARCH ADVISER
Raquel Fernández

LEAD CHAPTER RESEARCHERS AND AUTHORS
Mercedes Mateo Diaz
Robert Engelman
Jeni Klugman
Gretchen Luchsinger
Elyse Shaw

UNFPA TECHNICAL ADVISER
Howard Friedman

EDITORIAL TEAM
Editor: Richard Kollodge
Editorial associate and digital edition manager: Katheline Ruiz
Digital developer: Hanno Ranck
Publication and web design and production: Prographics, Inc.

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Reproductive health and rights in an age of inequality

state of world population 2017

STATE OF WORLD POPULATION 2017

"Economic disparities are only part of the inequality story."

— Dr. Babatunde Osotimehin

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While some privileged households budget for billions ...

... many hundreds of millions barely scrape by on less than $1.25 a day.

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FOREWORD

In today's world, gaps in wealth have grown shockingly wide. Billions of people linger at the bottom, denied their human rights and prospects for a better life. At the top, resources and privileges accrue at explosive rates, pushing the world ever further from the vision of equality embodied in the Universal Declaration of Human Rights.

Right now, the combined wealth of the world's 2,473 billionaires, as calculated by Wealth-X, exceeds $7.7 trillion. That's equivalent to the combined gross domestic product of an astonishing four fifths of the world's countries in 2015. It means that while some privileged households budget for billions, many hundreds of millions of families barely scrape by on less than $1.25 a day.

This is a path that we pursue at our peril. The yawning gap between the richest and the poorest is not only unfair, but a risk to economies, communities and nations. In 2015, in recognition of this risk, the world's governments agreed that the path to sustainable development for the next 15 years must be built on a foundation of equality, inclusiveness and universal enjoyment of rights.

Inequality is often understood in terms of income or wealth—the dividing line between the rich and poor. But, in reality, economic disparities are only one part of the inequality story. Many other social, racial, political and institutional dimensions feed on each other, and together block hope for progress among people on the margins.

Two critical dimensions are gender inequality, and inequalities in realizing sexual and reproductive health and rights; the latter, in particular, still receives inadequate attention. Neither explains the totality of inequality in the world today, but both are essential pieces that demand much more action. Without such action, many women and girls will remain caught in a vicious cycle of poverty, diminished capabilities, unfulfilled human rights and

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unrealized potential—especially in developing countries, where gaps are widest.

The unmet demand for family planning in developing countries, for example, is generally greatest among women in the poorest 20 per cent of households. Without access to contraception, poor women, particularly those who are less educated and live in rural areas, are at heightened risk of unintended pregnancy. This may result in health risks and lifelong economic repercussions. The lack of power to decide whether, when or how often to become pregnant can limit education, delay entry into the paid labour force and reduce earnings.

Making information and services more widely available and accessible will lead to better reproductive health outcomes. But this is only part of the solution. Unless we start addressing the structural and multidimensional inequalities within our societies, we will never attain the highest

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standard of sexual and reproductive health for all. This standard was envisaged by the 179 governments that endorsed the Programme of Action of the 1994 International Conference on Population and Development (ICPD), which guides the work of UNFPA, the United Nations Population Fund. The ICPD affirmed that closing disparities for women and girls in income, education, employment and other areas will largely depend on enabling women and girls to fully realize their reproductive rights. If the objectives of the ICPD—and the new 2030 Agenda for Sustainable Development—are met, humanity will be well on its way to a more equal world, with more inclusive and vibrant economies. Most important of all, this is the path to human dignity for every woman and every girl, everywhere.

The late Dr. Babatunde Osotimehin (1949–2017)
United Nations Under-Secretary-General and Executive Director
UNFPA, the United Nations Population Fund

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She was born to a poor family, in a rural community, in a poor country.

Unlike her brother or her more affluent relatives in the city, she is poised to be left behind by a world that is surging forward.

As her life unfolds, she may go to school, but probably for fewer years than boys her age. Schooling may end prematurely because she is married young or expected to care for younger siblings. By the time she is an adolescent, she may know how to perform household tasks and cultivate a field, but little else that might help her one day join the paid labour force.

If her brother can hope to travel to a city to find decent work, she is more likely to stay home and start bearing children before she even exits her teens. Giving birth at an early age is already risky, and the dangers will be compounded because her rural community lacks quality maternal health services.

Looking ahead in her life, she can expect that at least some of the disparities she suffers will be transmitted to her children, particularly her daughters.

Caught in a tangled web of inequalities, at some point she may get a glimpse of another world, one that is both better off and out of reach. It may make her wonder why she has so little, and so little opportunity for gaining anything more.

OVERVIEW

The case for a more equal world

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Unrealized rights, unequal prospects

No country today—even those considered the wealthiest and most developed—can claim to be fully inclusive, where all people have equal opportunities and protections, and fully enjoy their human rights.

Among the internationally agreed human rights central to human well-being is the right to sexual and reproductive health. This right was endorsed by 179 governments in the 1994 Programme of Action of the International Conference on Population and Development. The Programme of Action stated that individual rights and dignity—including the equal rights of women and girls, and universal access to sexual and reproductive health and rights—are necessary for the achievement of sustainable development.

Many gaps remain in meeting these commitments, however. Some of the worst are among women and girls already marginalized by other forms of exclusion—most notably, poverty. In many developing countries, women who are poor, in the bottom 20 per cent of the income scale, and particularly those

In 34 countries,

INCOME GAPS WIDENED

between 2008 and 2013

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68 countries had
LARGER GENDER GAPS
in 2016 than in 2015

who are in rural areas, are far less likely to have access to contraceptives and to care during pregnancy and birth than their wealthier urban counterparts.

Among adolescents, who face the extra vulnerabilities associated with being young, those in the poorest 20 per cent of households in developing countries have about three times as many births as adolescents in the richest 20 per cent of households. Those in rural areas have twice as many births as their counterparts in cities.

The many facets of inequality

Inequality is often thought of primarily as a lopsided distribution of wealth or income. However, it is a more complex phenomenon, reinforced by diverse forms of disparity—between the sexes, between races and ethnicities, and between urban and rural residents. Inequality has many facets, each a symptom—and cause—of some other inequality.

Multiple inequalities tend to feed on each other, locking people in a downward spiral of deprivation and lost human potential. Although some people have opportunities and abilities to interrupt this damaging trajectory, many do not have enough of one or the other, or both.

In recent years, economic inequality between countries has begun to close. But, in many countries, it has worsened. In at least 34 countries,

gaps widened between 2008 and 2013, with incomes for the wealthiest 60 per cent of the population growing faster than those for the bottom 40 per cent. In many cases, those being left behind are also losing out in terms of access to quality health and other services essential to human rights and well-being.

Another dimension of inequality that is worsening in some parts of the world is tied to gender. Impinging on all spheres of life, it correlates to a large extent with economic inequality, although other factors are at work, including unequal access to sexual and reproductive health care.

The World Economic Forum calculates a global gender gap index that captures differences between men and women in accessing resources and opportunities—for example, in income and labour-force participation, education, health and political empowerment. Of the 142 countries covered by the index in 2016, 68 had larger gender gaps than a year earlier.

Inequality, and sexual and reproductive health and rights

Exclusion built on many reinforcing sources can have profound consequences. Inequalities in

sexual and reproductive health and rights, while often given limited attention, have implications that run from individuals to entire nations. Intersections with other forms of inequality mean that a poor, uneducated woman in a rural area who cannot make choices about pregnancy will be unlikely to gain an education or join the paid labour force. As a result, she will probably remain trapped in poverty and marginalization.

When millions of other women struggle with similar deprivations, the costs are compounded for societies and economies as a whole. Prospects dim for realizing human rights and achieving a stable, fair society, and an inclusive, sustainable economy.

An alternative course—one that tackles multiple inequalities, including those in sexual and reproductive health—can unleash significant benefits, including health, human capital development and the eradication of poverty.

Poorer countries with large or emerging youth populations that reduce gaps in sexual and reproductive health care and promote gender equality also have the potential to reap and maximize a demographic dividend, generated

in part by having more healthy and productive people in the workforce, and fewer dependants.

Commitments to change

International law has established a sweeping series of political, economic, social and cultural rights, including human rights for groups, such as women and children, who are particularly vulnerable to exclusion. Since the 1994 Programme of Action was agreed, people have mobilized to extend access to sexual and reproductive health services across the globe, and gaps have narrowed across countries. Access is improving in more countries than not, across urban and rural areas, and levels of income.

Still, disparities are not closing fast enough—for example, to meet the high ambitions of the recently agreed 2030 Agenda for Sustainable Development. Affirmed by 193 countries, the Agenda is a global blueprint for progress by 2030. It identifies poverty as the greatest global challenge and calls for freeing the world from this "tyranny", leaving no one behind.

The Agenda repeatedly emphasizes that all societies and economies should be inclusive. Measures linked to equality cut across its 17 Sustainable Development Goals, such as through a target for universal health care. The fifth goal aims to achieve gender equality. The

tenth goal is dedicated to reducing inequality within and among countries. All of the goals are interdependent; progress as a whole depends on progress towards each of the 17.

Stopping the downward spiral

Stopping the downward spiral of inequality will require a vision for inclusive societies and shared prosperity, grounded in principles of human rights, and backed by new and better-targeted resources.

Actions on multiple fronts must tackle all forms of inequality—social and economic—and both the consequences and the root causes, since any of these can prevent people and societies from breaking free.

In the area of sexual and reproductive health and rights, some countries have shown the way forward—for example, by including sexual and reproductive health services in broader objectives to achieve universal access to health. Investments in reproductive health can not only ensure that reproductive rights are enjoyed by all, not just the wealthy, but can also benefit whole societies. In the Republic of Korea, for example, investments in health, including reproductive health services, coupled with investments in education, contributed to an economic "miracle", opening opportunities for all.

Inclusive societies are a conscious, achievable choice, built through supportive public policies and laws, services and social norms. It is past time for every country and the global community to fully embrace that choice. We all gain when human rights and dignity are universally upheld, with no exceptions and no one left behind.

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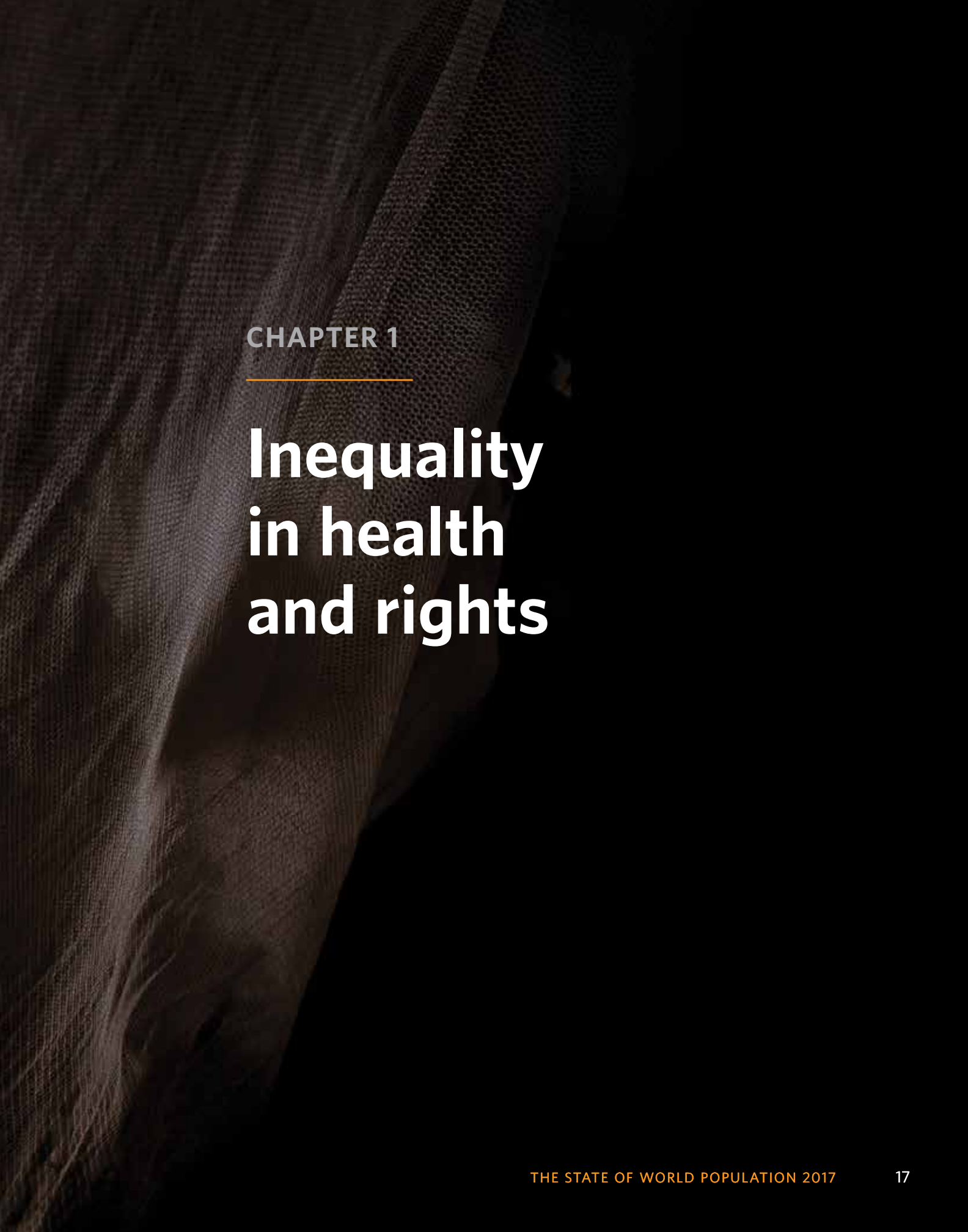


CHAPTER 1

Inequality in health and rights

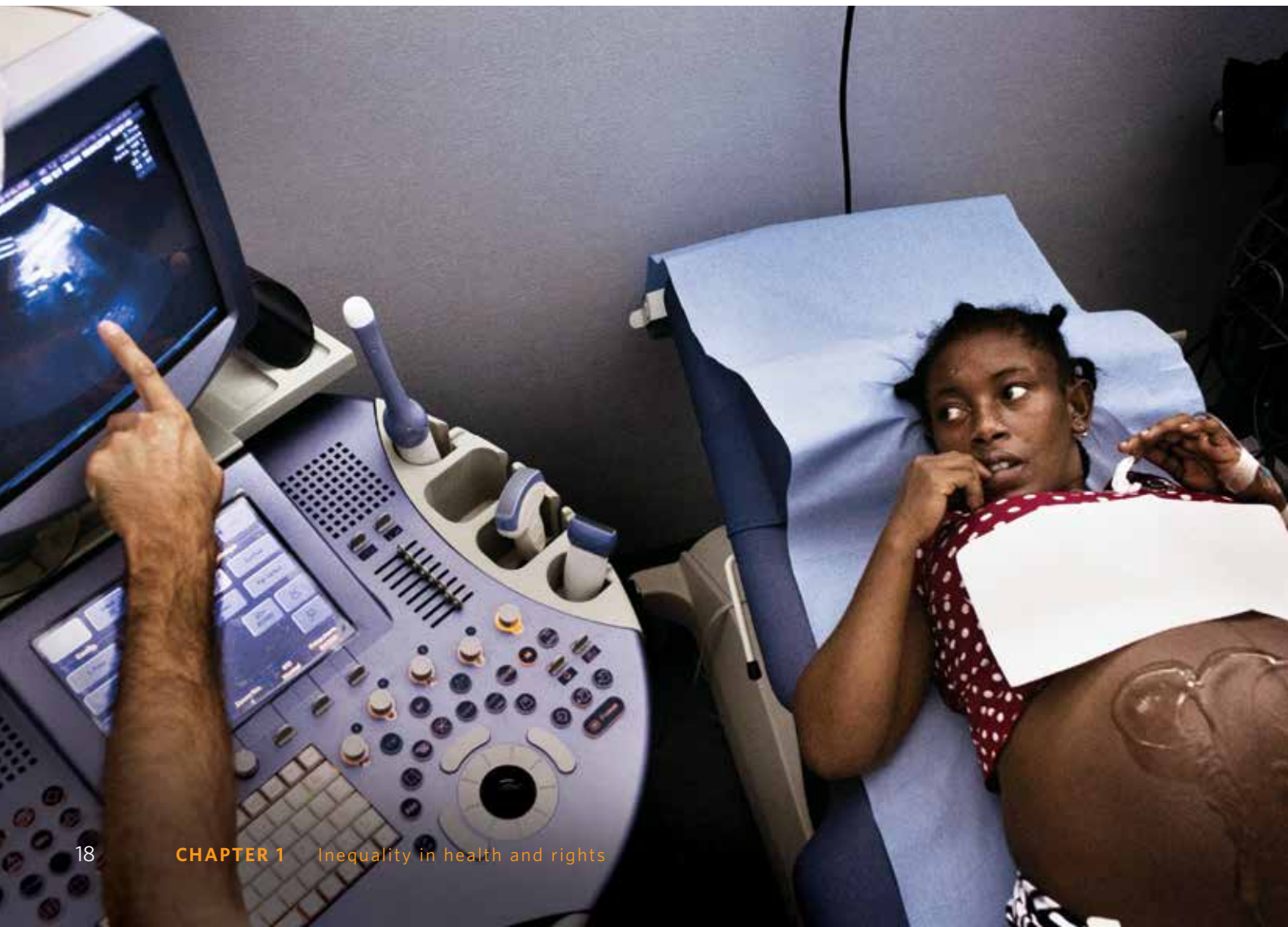
Having the information, power and means to decide whether, when and how often one becomes pregnant is a universal human right. That is what 179 governments agreed at the International Conference on Population and Development in 1994.

A universal right is one that applies to everyone, everywhere, regardless of income, ethnicity, place of residence or any other characteristic. But the reality is that today, across the developing world, that right is far from universally realized, with hundreds of millions of women still struggling to obtain information, services and supplies to prevent a pregnancy or to give birth safely.

Whether a woman is able to exercise her reproductive rights depends in part on whether she lives in a city or a rural area, how much education she has and whether she is affluent or poor.

An educated woman in an affluent household in a city, for example, is likely to have access to a full range of modern contraceptive choices; to have the power to decide whether, when and how often to become pregnant; and, if she chooses to become pregnant, to give birth safely in a hospital or a clinic under the care of a health professional.

In contrast, a poor woman with little education in a rural area is likely to have few options for preventing pregnancies, staying healthy during pregnancy or delivering with the assistance of a skilled birth attendant. And, in seeking to exercise her reproductive rights, she may face social and



institutional obstacles that her affluent, educated and urban counterpart may never encounter or may easily overcome.

Inequalities in sexual and reproductive health correlate with economic inequality. Within most developing countries today, access to critical sexual and reproductive health care is generally lowest among the poorest 20 per cent of households and highest among the richest 20 per cent.

Demographic and health surveys of women and men in developing and some developed countries have collected extensive data on access and outcomes relating to sexual and reproductive health. These data indicate varying levels of inequality, even as, in some cases, access and outcomes have improved. This chapter shows the status of, and trends in, unequal access to sexual and reproductive health services, and correlations with economic inequalities.

Meeting the demand for contraception: inequality in two dimensions

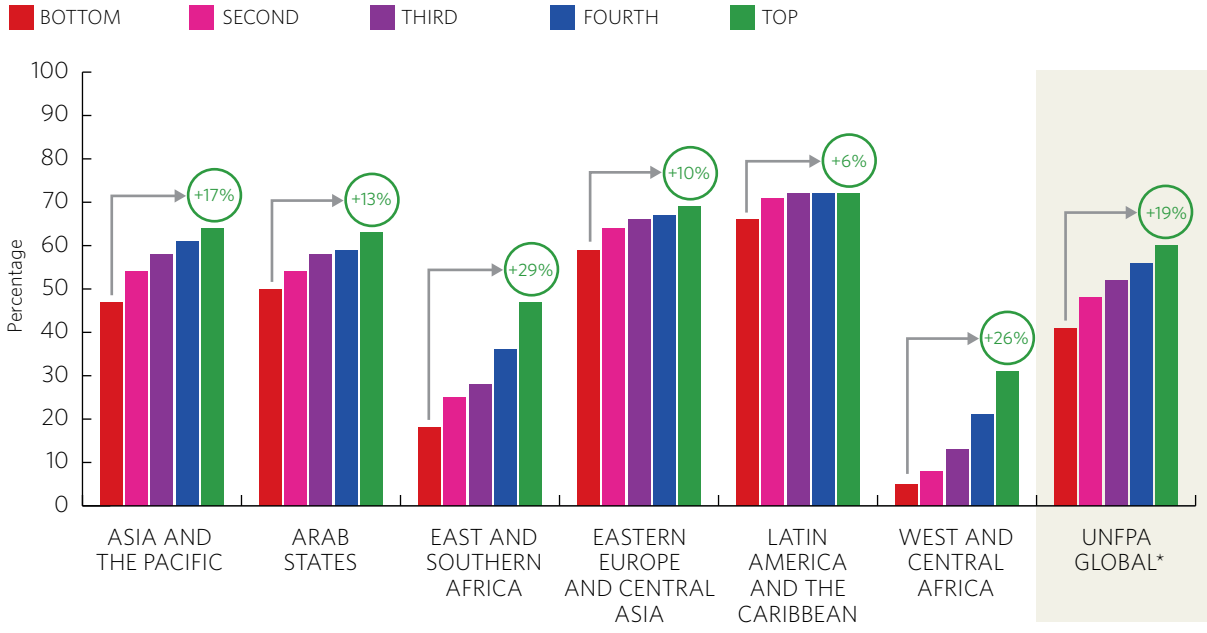
One measure of access to sexual and reproductive health services is the extent to which a woman who wants to use a modern method of contraception has access to it. Access to family planning services is a foundational element, not just of reproductive health, but of social and economic equality, since unintended

pregnancy constrains opportunities that women would otherwise have for education, civic participation and economic advancement.

Use of modern methods of contraception by women between the ages of 15 and 49 who are married or in a union varies by income group in most developing countries (figure 1). Data from developing countries suggest that, in the majority of such countries, contraceptive prevalence is lower among women who are poorer, rural or less educated than among their richer, urban and more highly educated counterparts (UNFPA, 2013a). But there are exceptions, where use of family planning is generally more equitable. In Bangladesh, Bhutan, Cambodia and Thailand, for example, contraceptive prevalence rates are higher among the poorest 20 per cent of the population than they are among the richest 20 per cent. In these and several other countries, concerted efforts to expand family planning coverage have led to almost universal access to modern contraception, and near-equitable rates of contraceptive prevalence across the wealth spectrum—among the richest and poorest households.

Contraceptive prevalence also varies by place of residence. Throughout the developing world, contraceptive prevalence is higher in cities than

FIGURE 1 **Contraceptive prevalence rates among women aged 15 to 49 who are married or in a union, by region and wealth quintile**



*Refers to weighted average of 155 countries and territories where UNFPA works.

Note: Graph is based on the latest available data.
Source: UNFPA (2016b)

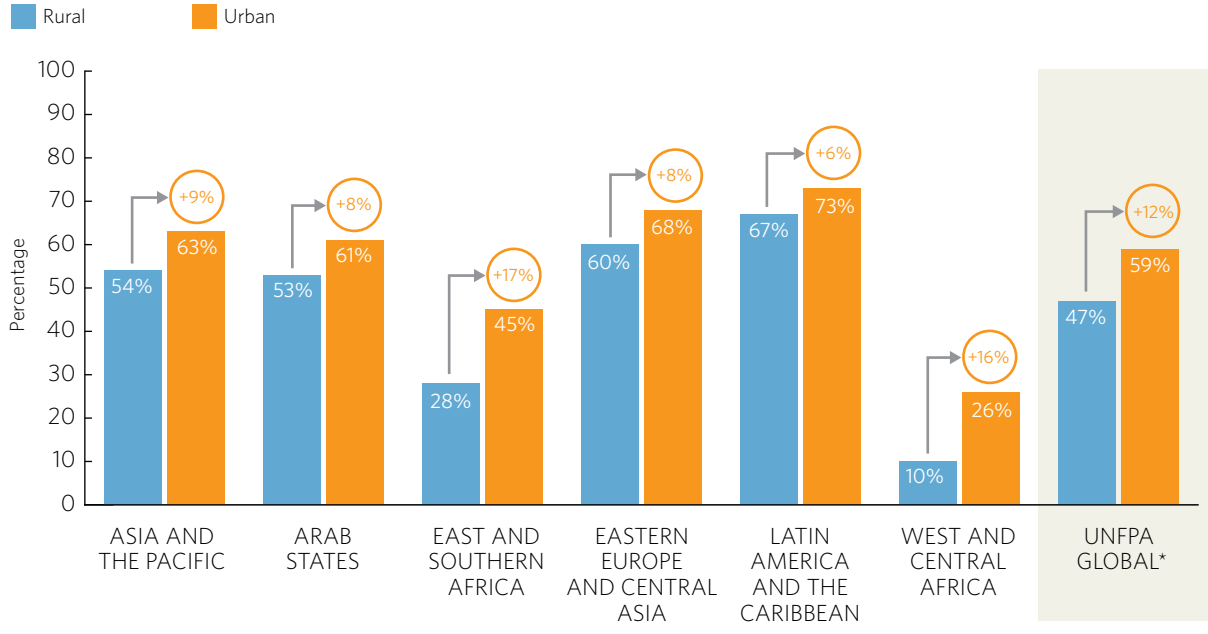
in rural areas (figure 2); the largest gaps are in sub-Saharan Africa.

An analysis of data on the proportion of demand for family planning satisfied through modern contraception shows that women who are married or in a union in the least developed countries have less access than those in other developing countries. It also shows that, regardless of a country's income grouping, the richest 20 per cent (quintile) of the population within the country on average has the most access, and the poorest 20 per cent has the least access (figure 3). At the same time, women in urban areas are more able to meet their demand for modern contraception than their rural counterparts.

The greatest wealth-based inequalities in satisfying the demand for family planning are in West and Central Africa, followed by East and Southern Africa. In 13 of 20 West and Central African countries, women from the richest 20 per cent of households are more than twice as likely to have their demand for contraception satisfied as women from the poorest 20 per cent of households.

Wealth-based inequalities are less evident in Asia and the Pacific, Eastern Europe and Central Asia, and Latin America and the Caribbean.

FIGURE 2 Contraceptive prevalence rates among women aged 15 to 49 who are married or in a union, by place of residence



*Refers to weighted average of 155 countries and territories where UNFPA works.

Note: Graph is based on the latest available data.
Source: UNFPA (2016b)

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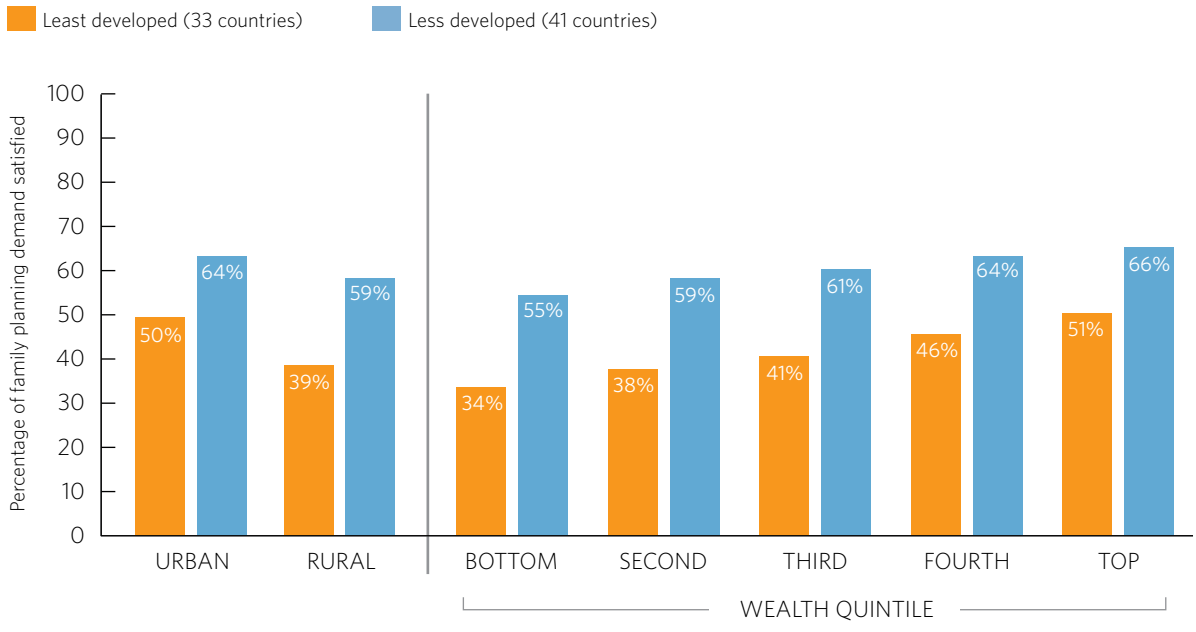
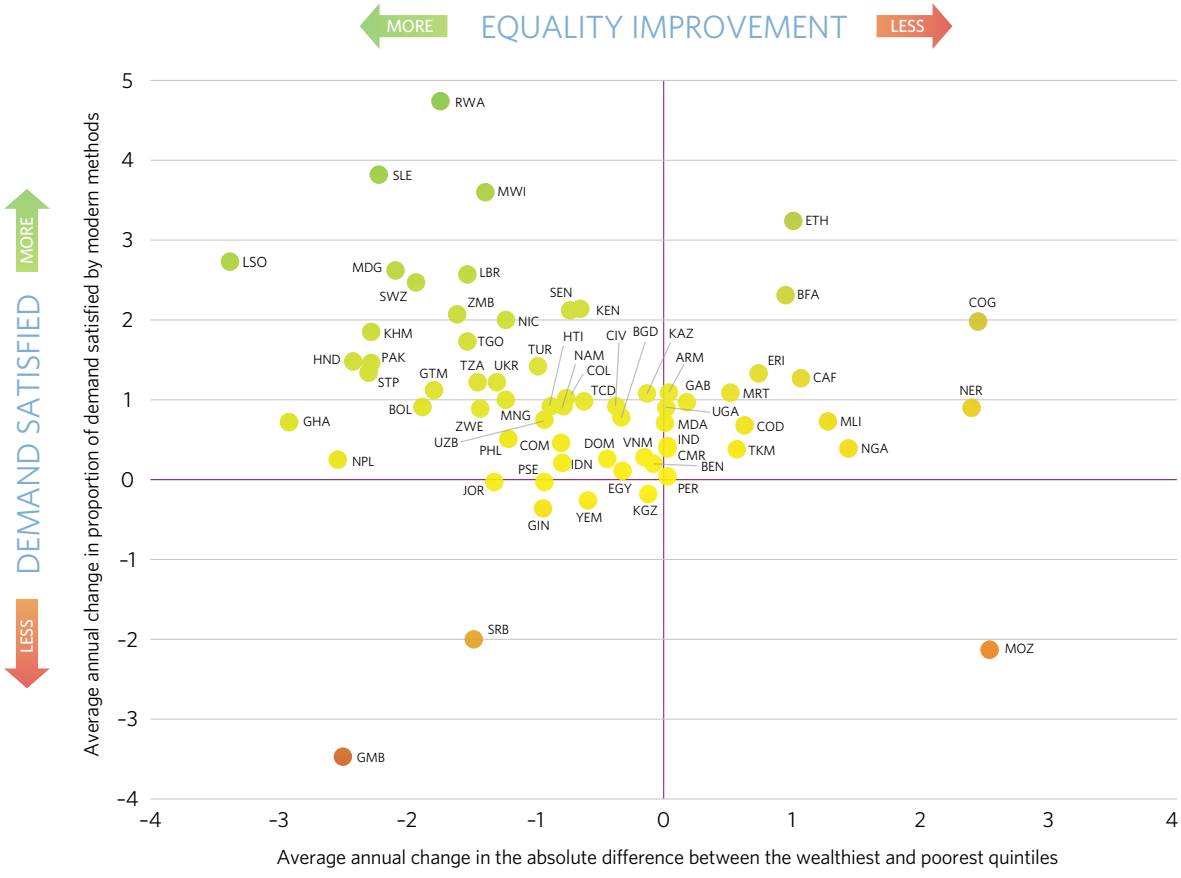
FIGURE 3 Proportion of demand for family planning met with modern contraception, by development level, place of residence and wealth quintile, latest year available



Many developing countries have improved their capacity to provide modern contraception for women seeking to avoid or delay pregnancy and to reduce wealth-based inequality in satisfying this demand (figure 4).

Each dot in figure 4, and in similar figures in this chapter, represents a country. Its position on the x-axis indicates the average annual change in the gap (the difference) between the proportion of the demand for family planning that is satisfied (for women and adolescents who are married or in a union) with modern contraception, for the top versus the bottom wealth quintile in a country. Thus, the more to the left a country is, the faster the country managed to reduce absolute inequality. Its position on the y-axis measures the average change in the proportion of women with a need for family planning who are satisfied with modern contraception. Hence, the higher a country is above the zero line, the faster its coverage has increased over time; the lower a country is below the horizontal line, the more demand satisfied for

FIGURE 4 **Annual change in proportion of demand for family planning satisfied by modern contraception, and in the difference between wealthiest and poorest quintiles**



Abbreviations are for countries and territories listed on page 104.

family planning has decreased. Thinking in terms of the quadrants in the graph, most countries are in the upper left quadrant, where demand satisfied increased over time and inequality decreased. The best-performing countries are those in the extreme upper left, such as Rwanda and Sierra Leone. The second most populated quadrant is the upper right, where demand satisfied increased over time, but inequalities also increased. Ethiopia, for instance, achieved an increase in demand satisfied, but the difference between the wealthiest and poorest wealth quintiles increased, on average, by 1 percentage point per year. Data for individual countries are for different years but generally cover the most recent 10-year period.

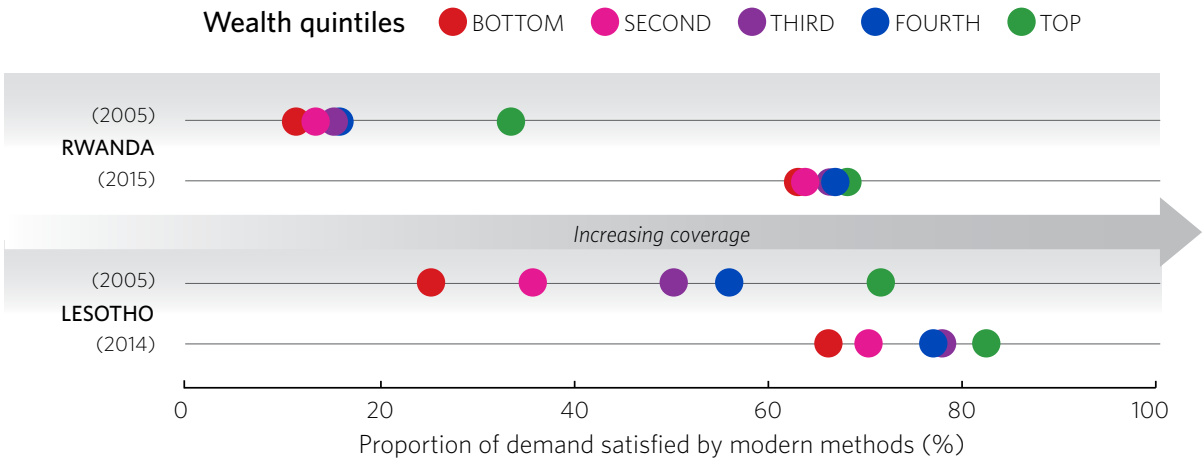
Some countries have made more progress in reducing inequality of access to contraception, while others have made more progress in expanding coverage of contraceptive services. Some have made progress in both areas.

In figure 5, each dot, looking like a bead on an abacus, represents one of the five wealth quintiles positioned relative to its proportion of demand satisfied with modern contraception. A reduction in inequality between two points in time is indicated by dots that are closer together. An overall shift to the right means that there has been an overall improvement in coverage of modern contraception.

Figure 5 shows the two countries that made the most progress over about a 10-year period in reducing inequality in meeting the demand for modern methods of contraception across wealth quintiles (Lesotho), and in increasing coverage of modern methods of contraception (Rwanda).

Rwanda transformed both access and equality between 2005 and 2015. Especially notable was the relatively advanced position of the wealthiest quintile compared with all the others in 2005, even though less than 40 per cent of the demand for family planning in this quintile was being satisfied by modern contraception. A decade later, the gaps among all five quintiles effectively closed—at an access proportion of close to 70 per cent.

FIGURE 5 Proportion of demand for family planning satisfied by modern contraception in Rwanda (2005 and 2015) and Lesotho (2005 and 2014), by wealth quintile



Poorest women have least access to antenatal care

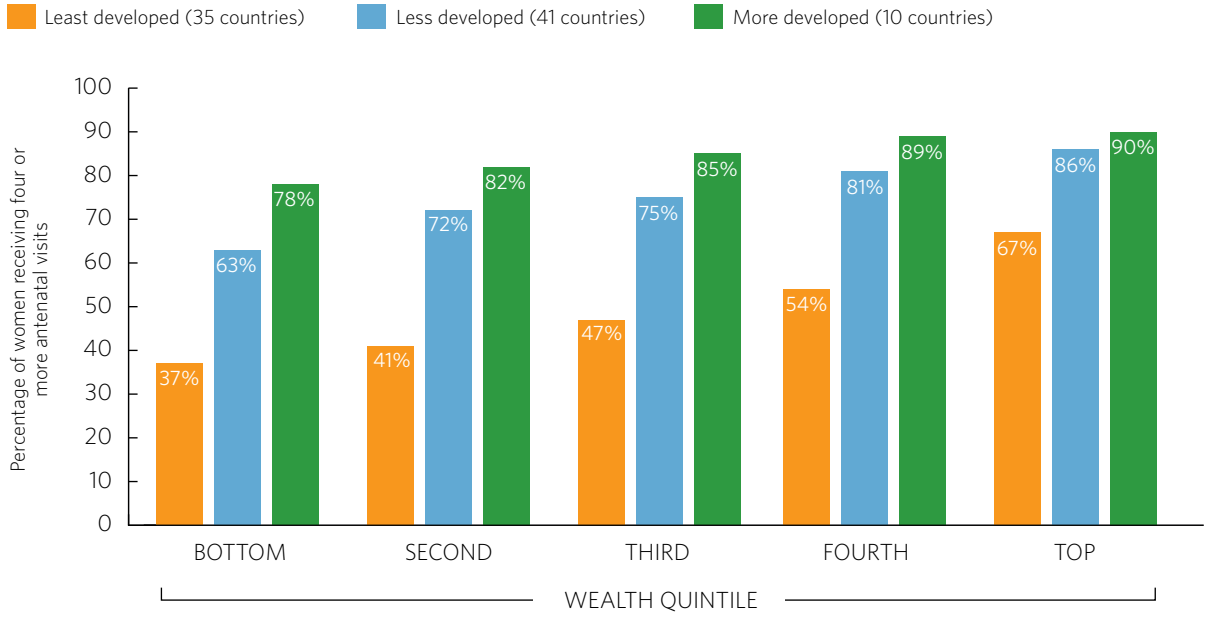
Antenatal care helps ensure the best health conditions for mother and fetus. It also provides a platform for health promotion and education, enables screening and diagnosis of risks, and can help prevent or manage pregnancy-related illnesses.

Four antenatal visits to (or by) a qualified health-care provider were, until November 2016, considered the minimum needed for a safe and healthy pregnancy. Women in the poorest 20 per cent of households have the lowest access to antenatal care, compared with other wealth quintiles.

Although access to antenatal care is growing worldwide, women in developing countries, particularly in sub-Saharan Africa and South Asia, routinely make or receive fewer than four antenatal visits. The situation is even worse in rural areas, where costs associated with travelling long distances for care can be prohibitively high.

Wealth-based inequality in antenatal care is greatest in the 48 least developed countries; countries with very low overall coverage of antenatal care often have the greatest disparities in accessing that care (figure 6). For example, in Afghanistan, Ethiopia and Yemen, where less than 25 per cent of women have four or more antenatal care visits, women in urban areas are at least 2.5 times as likely as women living in rural areas to have the recommended minimum number of visits. Inequality based on place of residence is less marked in Latin America and the Caribbean. In the Dominican Republic, Guatemala, Guyana, Honduras and Peru, for example, the proportions of women having four or more antenatal care visits are similar in urban and rural areas.

FIGURE 6 Proportion of women having four or more antenatal visits, by development level and wealth quintile, latest year available



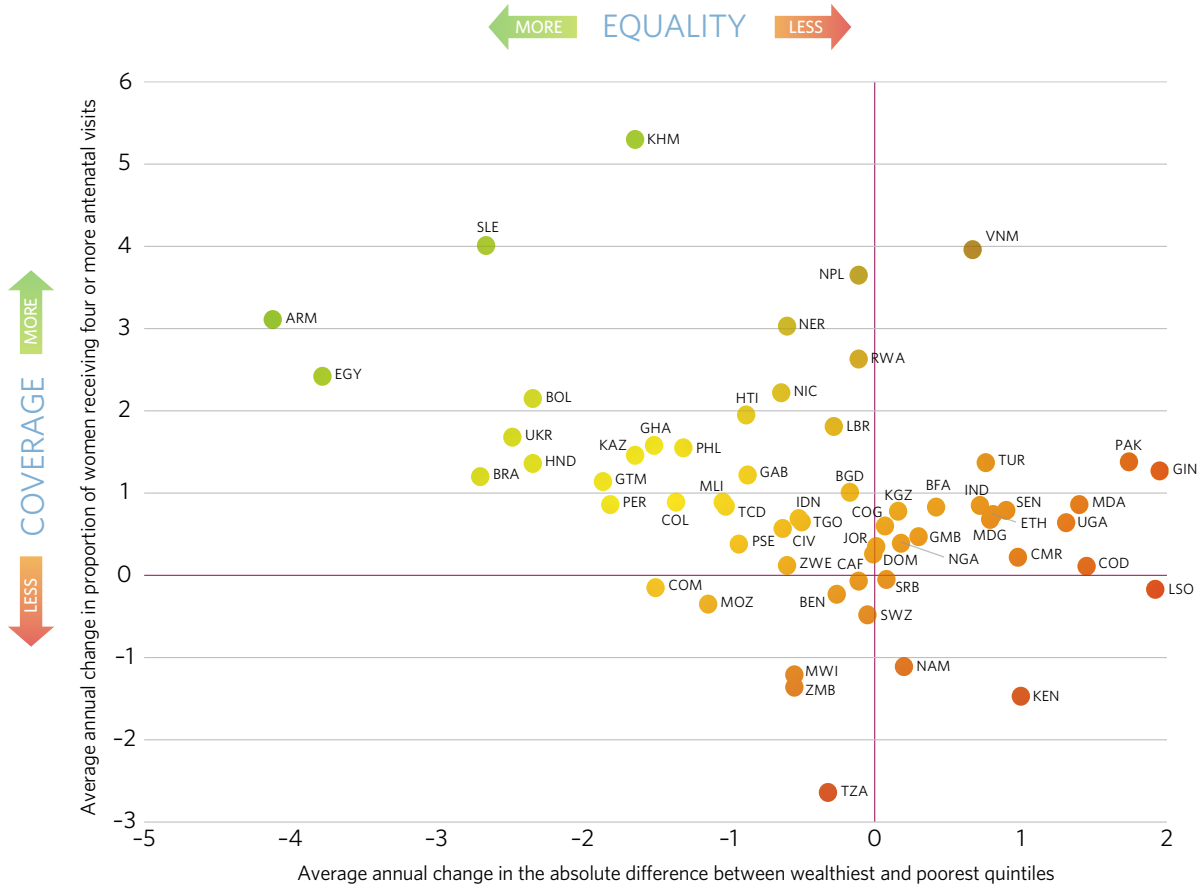
Globally, women in the richest 40 per cent of households are the most likely to have four or more antenatal visits (figure 6). In Chad, Ethiopia and Pakistan, for example, women from the richest 20 per cent of households are more than four times as likely to have at least four antenatal visits as women from the poorest 20 per cent of households.

However, most countries for which data are available have moved in the direction of both greater access to antenatal visits and less wealth-based inequality in doing so. In figure 7, dots in the upper left-hand quadrant represent improvements in both access and equality.

Among the countries included in this analysis, Cambodia made the most progress in assuring multiple visits by health-care providers for pregnant women, with better coverage for the poorest quintile in 2014 than for the wealthiest in 2005 (figure 8). Equality in access among the wealth quintiles improved as well, but only modestly.

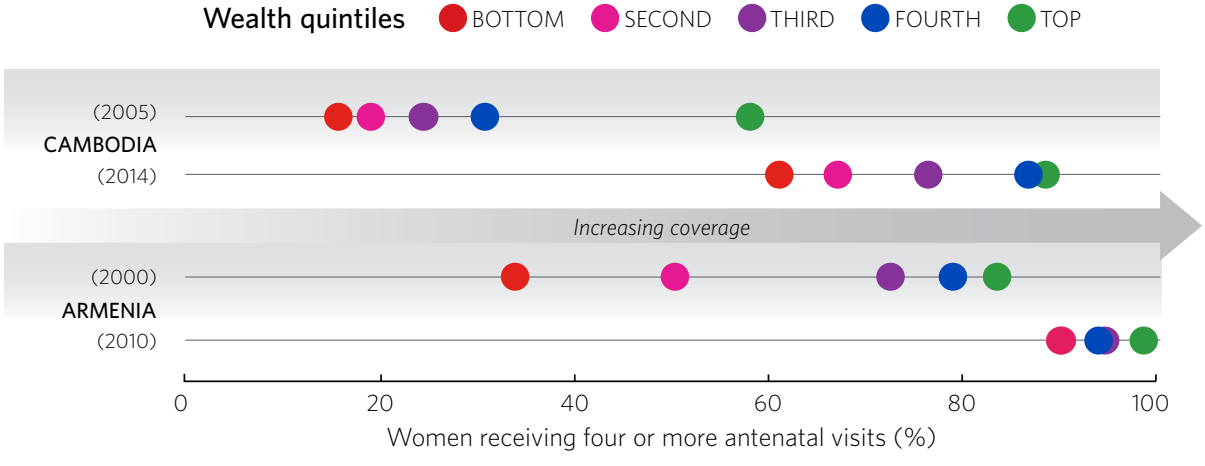
Armenia made the most improvement in equality of access to antenatal visits among all the countries surveyed. Not only were all wealth quintiles elevated above all previous positions in 2010 compared with 2000, but women in all quintiles were receiving nearly identical proportions of access—at almost 100 per cent—in 2010.

FIGURE 7 Annual change in proportion of women having four or more antenatal visits, and in the difference between wealthiest and poorest quintiles



Abbreviations are for countries and territories listed on page 104.

FIGURE 8 Proportion of women having four or more antenatal visits in Cambodia (2005 and 2014) and Armenia (2005 and 2010), by wealth quintile



In developing countries, the

POOREST 20%

of women are more likely to

GIVE BIRTH WITHOUT ASSISTANCE

than women in the top 20%

Poorest women are most likely to give birth on their own

Births assisted by skilled attendants, such as midwives, are a mark of access to reproductive health care and a recommendation of the World Health Organization for all births.

Use of skilled birth attendants is highly correlated with lower maternal mortality rates and reductions in neonatal mortality (Snow et al., 2015).

As with other reproductive health indicators, skilled birth attendance is near universal in more developed countries and least prevalent in the least developed countries (figure 9).

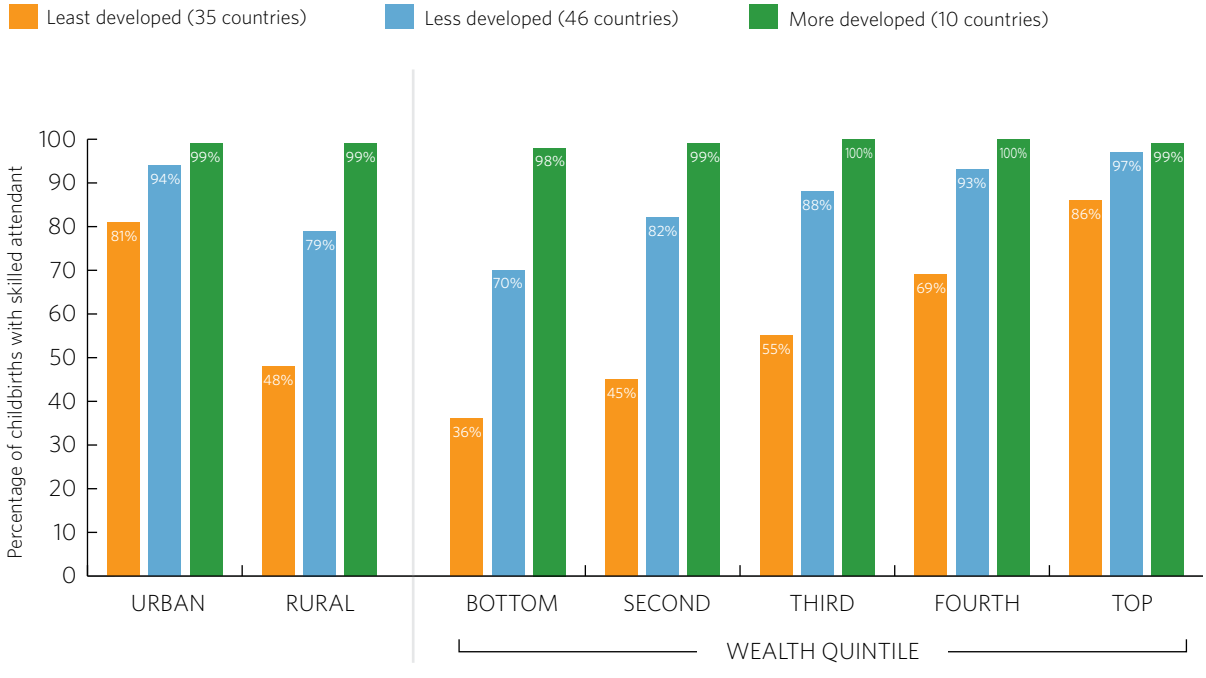
A report by Wang et al. (2011) cites a strong positive relationship between household wealth and skilled care at birth. In developing countries, the poorest 20 per cent of women are far more likely to give birth without assistance than women in the top wealth quintile.

The greatest wealth-based inequality in use of skilled birth care is in West and Central Africa, followed by Asia and the Pacific, and East and Southern Africa. In 14 of 20 West and Central African countries, the use of skilled birth attendants among women from the richest 20 per cent of households is double that among women from the poorest 20 per cent of households.

In Afghanistan, Bangladesh, Cameroon, Guinea, Niger and Nigeria, use of skilled birth care is extremely low among the poorest women, at less than 20 per cent, compared with at least 70 per cent among the wealthiest women.

Wealth-based inequality in skilled birth care is minimal in most countries of Eastern Europe and Central Asia, the Arab States, and Latin America and the Caribbean.

FIGURE 9 Proportion of births with skilled attendants, by development category, place of residence and wealth quintile, latest year available

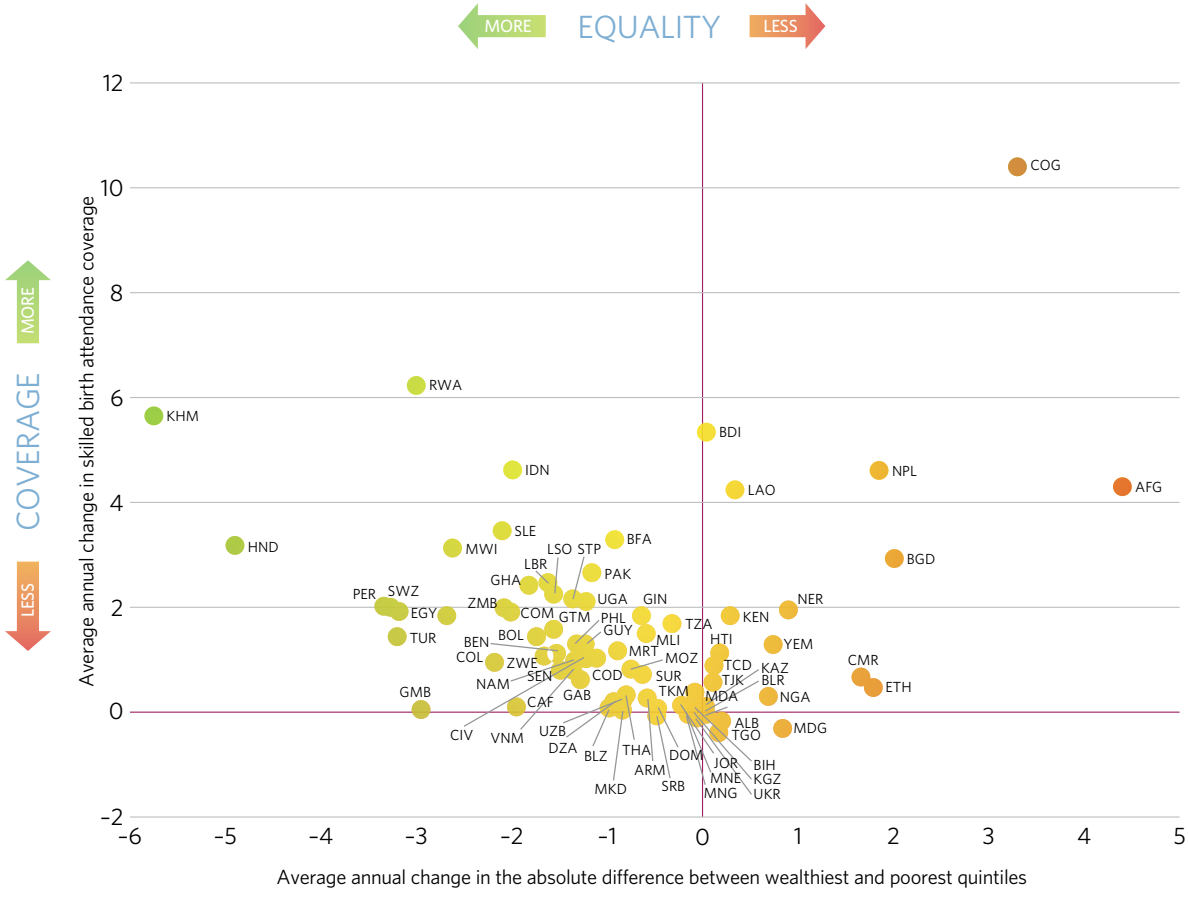


Dots in the upper left quadrant of figure 10 represent countries that have made progress in both coverage of skilled birth attendance and equality in recent years.

Among countries included in this analysis, the Republic of the Congo made by far the best improvement in coverage of skilled birth attendance, even though equality of coverage among wealth quintiles declined from 2005 to 2011 (figure 11). In 2011, the poorest quintile of women had higher proportions of skilled attendance at births than the wealthiest quintile just six years earlier. However, women in the poorest quintile in 2011 had significantly less access to skilled birth attendance than those of every quintile, despite the improvement from the earlier year.

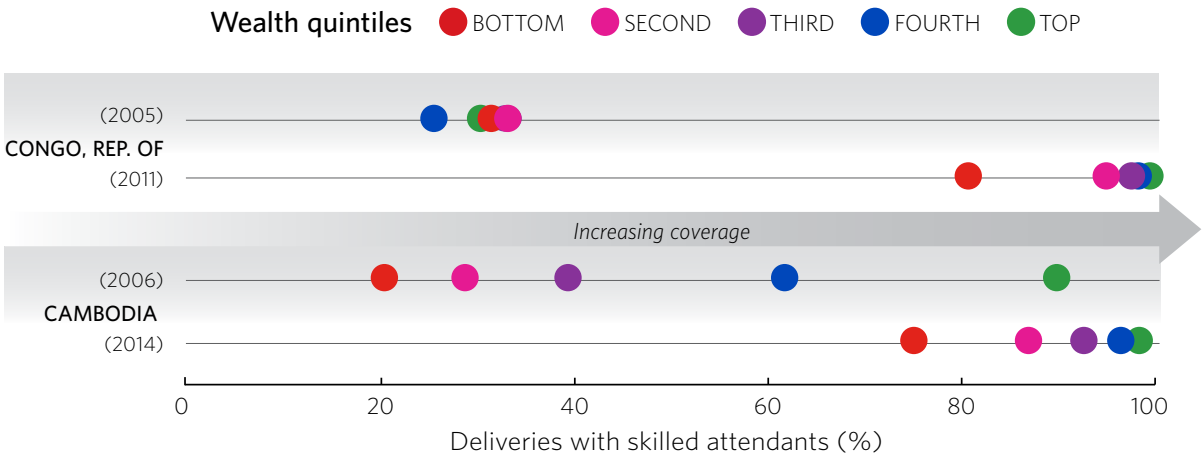
Cambodia, in contrast, had a less dramatic improvement in access to skilled attendants at birth between its two recent surveys (2006 and 2014), but made the most progress in improving a significant inequality of access (figure 11).

FIGURE 10 Annual change in proportion of births with skilled attendant, and in the difference between wealthiest and poorest quintiles, 2005–2011



Abbreviations are for countries and territories listed on page 104.

FIGURE 11 Proportion of births with skilled attendants in the Republic of the Congo (2005 and 2011) and Cambodia (2006 and 2014), by wealth quintile



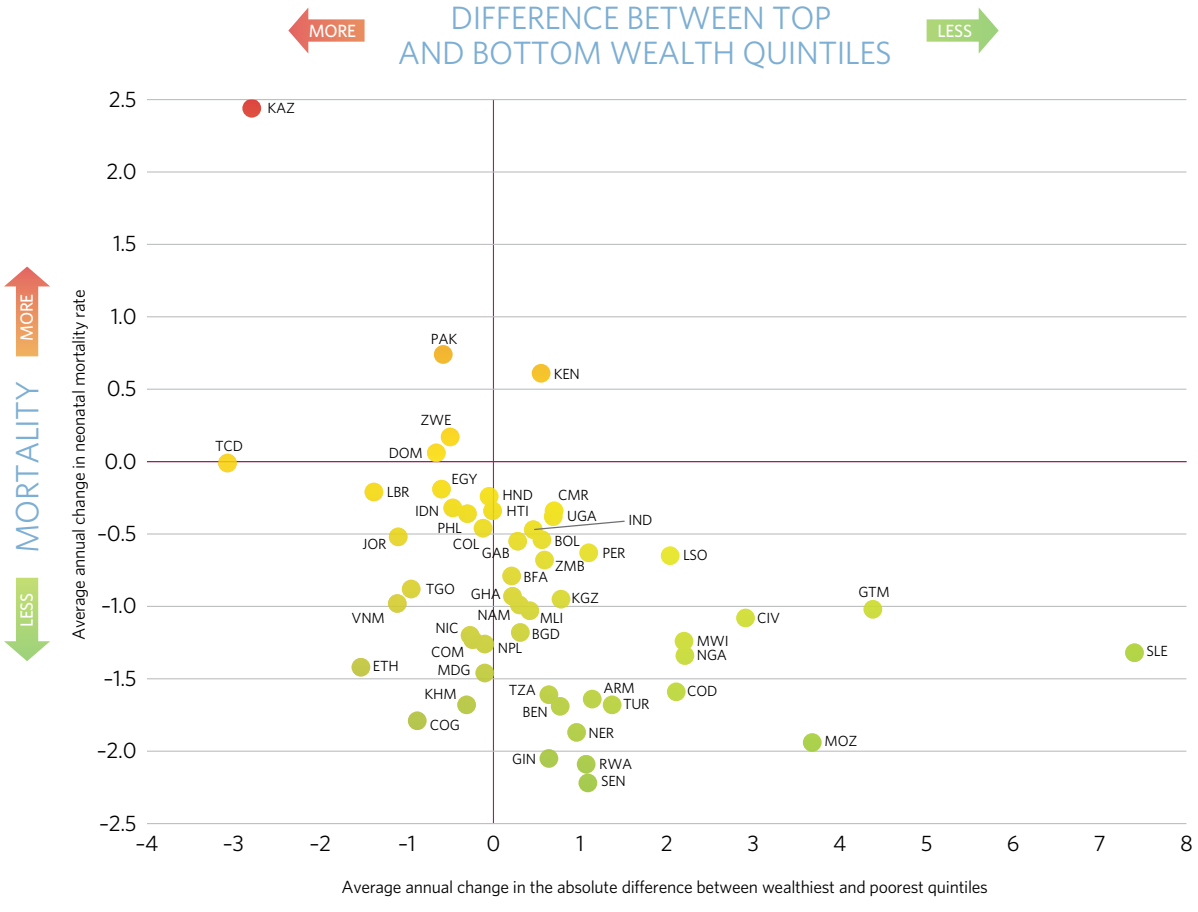
Inequalities in maternal health and the survival of newborns

One of the most important indicators of access and equality in sexual and reproductive health care is the proportion of newborns (neonates) who survive their first month of life. Neonatal mortality is a sign of poor maternal health and substandard care received by mothers during pregnancy and at birth. Neonatal mortality rates vary according to whether the mother and newborn are in urban or rural areas, and whether they are among a country's poorest or richest 20 per cent of the population.

Overall neonatal mortality is declining in all but a few countries. However, inequality by wealth quintile is rising in most. In figure 12, dots below the central horizontal line have moved in recent surveys towards greater survival of infants past their first month. Those to the right of the central vertical line have moved towards greater inequality in survival rates of neonates—that is, the difference between the rate among the wealthiest and the poorest quintiles has grown in recent years.

Among countries included in this chart, Senegal had the greatest overall reduction in neonatal mortality over a recent 10-year period,

FIGURE 12 Annual change in neonatal mortality rate, and in the difference between wealthiest and poorest quintiles



Abbreviations are for countries and territories listed on page 104.

with a small change in the difference between the poorest and wealthiest quintiles in this indicator (figure 13). Neonatal mortality in Chad, in contrast, changed little between 1996 and 2004. Incidence of neonatal mortality nonetheless burdened families in all wealth quintiles somewhat more equally.

Towards equality in reproductive health and rights

In developing countries, limited access to sexual and reproductive health services and negative health outcomes correlate strongly with poverty.

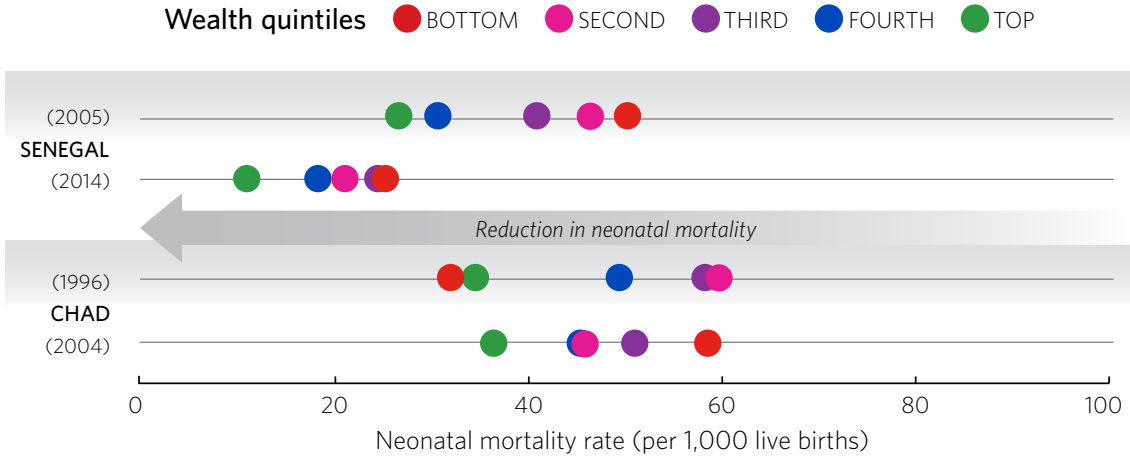
Women in the poorest 20 per cent of households may find themselves with little or no access to sexual and reproductive health care, including contraception, leading to unintended pregnancies, higher risk of illness or death from pregnancy or childbirth, and the need to give birth on their own, without the assistance of a doctor, nurse or midwife. For these poor women, their poor sexual and reproductive health can block opportunities, blunt their potential and solidify their position at the bottom rung of the economic ladder.

Women in the wealthiest 20 per cent of households typically have greater access to the care and services that will enable them to exercise their reproductive rights. The services available to these women can help unlock opportunities to pursue higher education, enter or remain in the paid labour force, earn higher incomes and realize their full potential in life. These opportunities reinforce or boost their economic and social status in their communities or nations.

Although access to services and reproductive health outcomes correlate with whether a woman is on the top or the bottom of the wealth scale in any given country, numerous social, institutional, political, geographic and economic forces are also at play. Reproductive health inequalities are deeply affected by the quality and reach of health systems and by gender inequality, which can have a profound impact on how much control a woman has over her own sexual and reproductive health.

Overcoming these obstacles and addressing underlying gender inequality are critical to progress in reducing inequalities in sexual and reproductive health, and may also lead to progress in reducing economic inequalities.

FIGURE 13 Neonatal mortality rates in Senegal (2005 and 2014) and Chad (1996 and 2004), by wealth quintile



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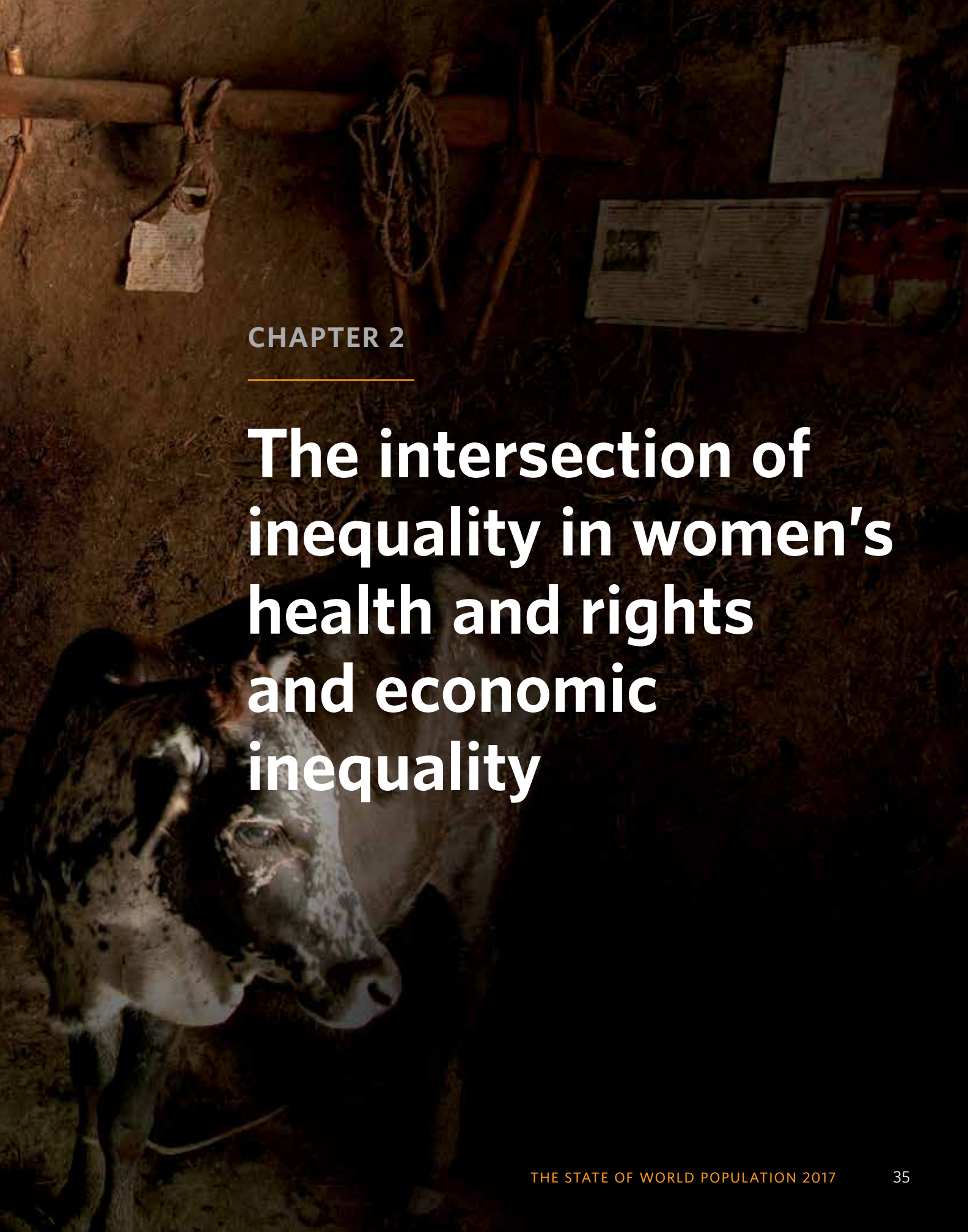


CHAPTER 2

The intersection of inequality in women's health and rights and economic inequality

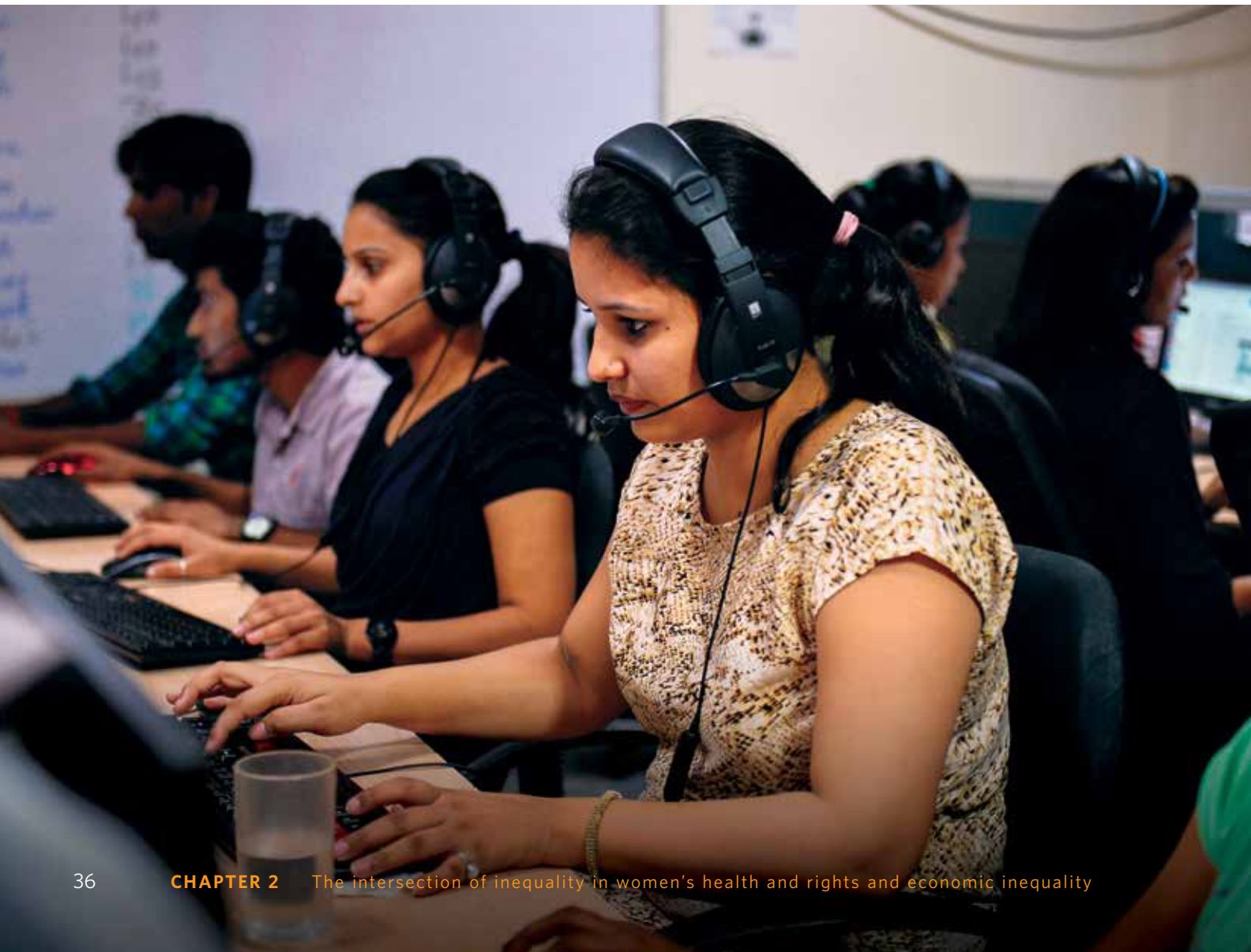
Whether a woman is able to exercise her reproductive rights can influence whether she will realize her full potential and will be able to seize opportunities in education or compete for a job. Her options in life may be curtailed by limited options in sexual and reproductive health.

A woman with no control over her fertility may find herself unable to join the paid labour force because she has more children than she intended. Or it may be too difficult for her to stay in a job because childcare is prohibitively expensive. And, once in the job market, she may be passed over for promotion because her employer imagines that she will leave work because of pregnancy.

Inequalities in work and pay in most parts of the world mirror—and are reinforced by—inequalities in sexual and reproductive health and rights.

Although the ways in which inequalities in women's health and rights intersect with economic inequality are complex and often not linear, the impact is clear. The poorest women have the least access to sexual and reproductive health, are least able to exercise their reproductive rights, and are most likely to be unemployed or underemployed and earn less than men.

Inequalities in sexual and reproductive health and rights are intertwined with gender inequality.



Together, these multiple dimensions of inequality have a profound impact on virtually every sphere of a woman's life, including her work life.

Sexual and reproductive health, jobs and earnings

As fertility has declined worldwide, labour-force participation of women aged 25 to 54 has increased in almost all regions over the past 20 years (United Nations, 2014). Where women participate in the labour force at high rates, the resulting trends have been towards lower fertility, due in part to the struggles of balancing educational and career aspirations with having and caring for children. In high-fertility countries, particularly the least developed countries, women's enrolment in the labour force as wage and salaried employees remains low: 20 per cent in South Asia and 22 per cent in sub-Saharan Africa.

For women everywhere, pregnancy and child-rearing can mean exclusion from the labour force or lower earnings.

The challenges are even greater for women who lack the means to decide whether, when or how often they become pregnant. In general, as shown in chapter 1, contraception is less accessible to women who are poor, less educated and in rural areas.

Gender inequality, gender-based discrimination and other forces prevent millions of women from accessing modern methods of contraception. Husbands or partners may pressure women to bear children as soon and as frequently as possible. Judgmental service providers may deny contraception to women or adolescents who are not married or in a union. Other providers may see contraception as a decision to be made only by men.

Women who lack access to contraception or the contraceptive method of their choice have higher rates of unintended pregnancy. An estimated 89 million unintended pregnancies occur annually in the developing world (Guttmacher Institute, 2017). The unmet demand for modern methods of contraception is highest among poor women. A rapid succession of pregnancies can prevent a woman from entering or remaining in the paid labour force, or undermine her long-term prospects for securing a high-paying job.

In developing countries, 12.8 million adolescent girls have an unmet demand for family planning (UNFPA, 2016a). Adolescents, especially those who are not married or in a union, face more obstacles than adults in obtaining contraceptives because of restrictive laws and policies, concerns about confidentiality, or stigma associated with sex at an early age. In many parts of the developing world, adolescent girls are often forced into marriage, usually to a much older man. The age difference can mean that girls have less power in decisions about use of contraception.

In developing countries,
12.8 MILLION
adolescent girls have an unmet demand for FAMILY PLANNING

In 2015, there were an estimated 14.5 million births to adolescents in 156 developing countries, territories and other areas (UNFPA, 2016a).

Giving birth at age 19 or younger can mean higher risks of complications and maternal death. Becoming a parent in adolescence can also lead to leaving school, not developing important knowledge and skills, and thus undermining future employment opportunities and earnings potential. Where adolescent birth rates are high, gender inequality in wages is generally worse (figure 14).

Unequal labour-force participation: a symptom of underlying inequalities in sexual and reproductive health and rights

About 50 per cent of women, compared with 76 per cent of men, participated in the global labour force in 2015 (ILO, 2016c).

Meanwhile, women are more likely to be unemployed than men. Globally, 6.2 per cent of women are unemployed, compared with 5.5 per cent of men. The largest differences in men's and women's unemployment are in Northern Africa and the Arab States (ILO, 2016c). Unemployment affects young women more than young men nearly everywhere. In both Northern Africa and the Arab States, the female youth unemployment rate—44 per cent—is almost double the rate for male youth (ILO, 2016c).

Norms and attitudes hamper women's labour-force participation

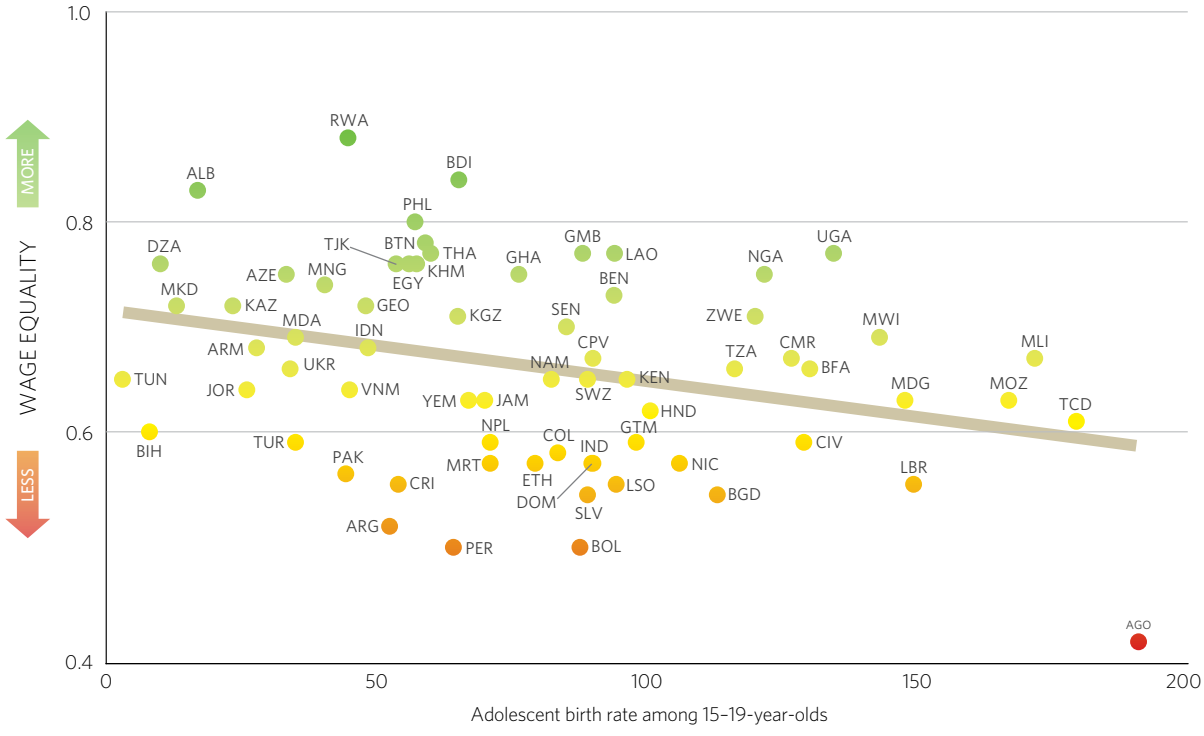
Gender inequality is pervasive worldwide, with negative or discriminatory attitudes,

norms, policies and laws preventing women and girls from developing their capacities, seizing opportunities, entering the labour force, realizing their full potential and claiming their human rights.

Gender-unequal norms not only influence whether a woman enters the labour force but can also dictate which types of jobs she may pursue, determine how much she will be paid and hinder her advancement in the workplace. Countries with norms that prioritize employment for men over women have greater gender inequality in labour-force participation.

An analysis of recent World Values Survey findings from 58 countries shows that the majority of people agree that women and men should have equal access to a university education (figure 15). But, in the area of employment, most believe that, when jobs are scarce, men should have priority over women. This negative attitude about women's equality in the labour force is more pronounced in countries where women's participation in the labour force is lower than for men (figure 15). The World Values Survey, started in 1981, tracks changing values, and their impact on social and political life worldwide.

FIGURE 14 Higher adolescent birth rates correlate with greater gender wage inequality



Based on indicators for the Sustainable Development Goals and data from the World Economic Forum (2016). Values on the x-axis indicate the number of adolescent births for every thousand women aged 15 to 19. Values on the y-axis measure the level of equality between men's and women's wages for similar work. A wage equality value closer to 1 indicates a similar wage for similar work between men and women.

Abbreviations are for countries and territories listed on page 104.

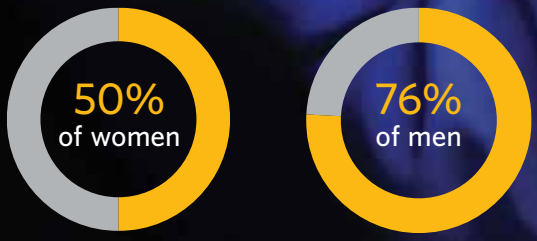
DO YOU AGREE?

LABOUR-FORCE PARTICIPATION

There is widespread agreement that men and women should have equal access to a university education, but less so when it comes to equal access to employment when jobs are scarce.

Figure 15 shows the percentage of respondents who DO NOT AGREE with the following statements: "a university education is more important for a boy than for a girl" and "when jobs are scarce, men should have more right to a job than women". The grey area between the left and right points for each country represents the gap between public support or equal access to education and public support for equal access to employment when jobs are scarce.

Participation in global labour force

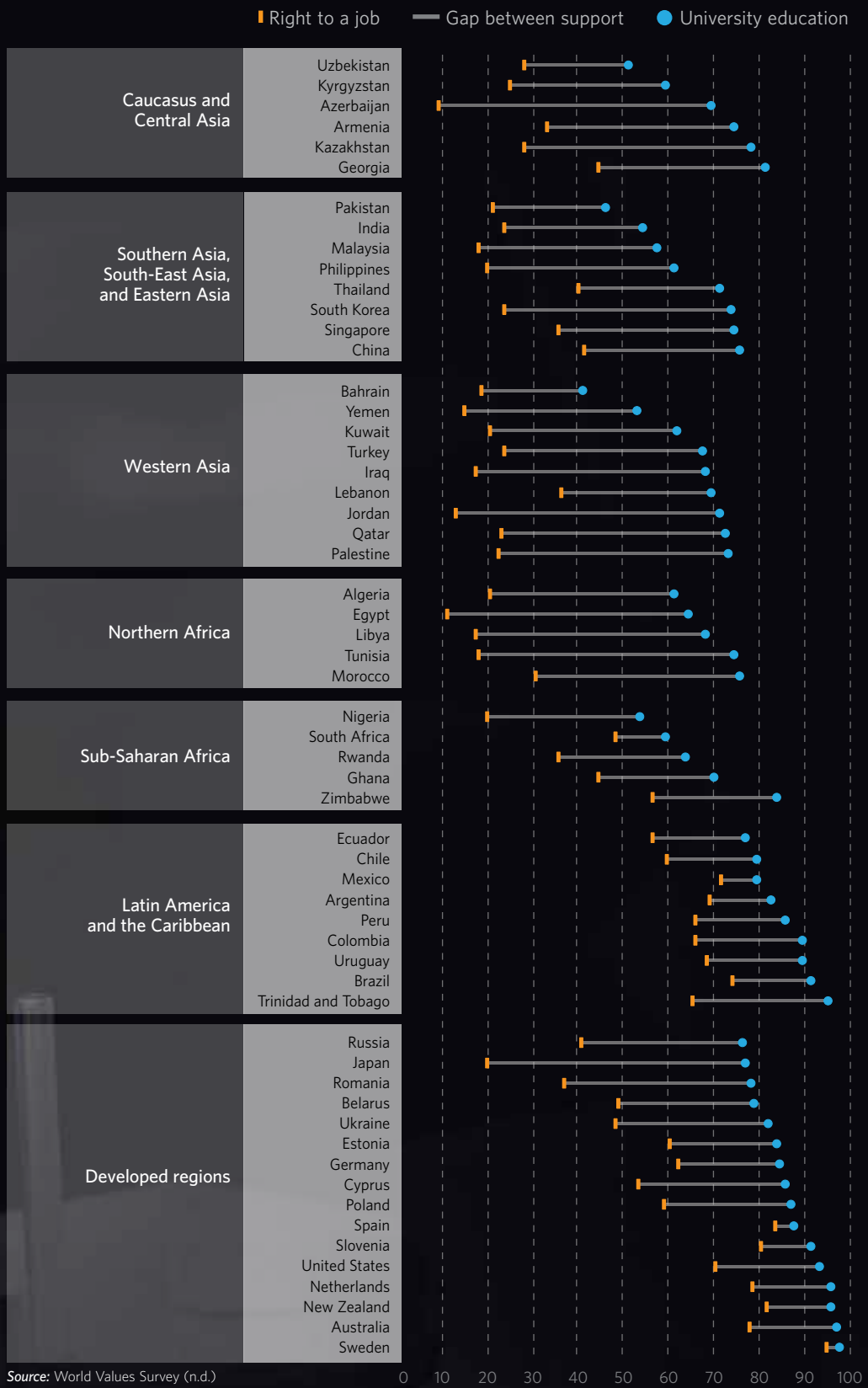


Global unemployment

6.2% of women are unemployed

5.5% of men are unemployed

FIGURE 15 **Respondent's opinion on university education and access to employment for men and women**



Source: World Values Survey (n.d.)

Institutional discrimination holds women back

Discrimination against women and girls is entrenched in many social institutions.

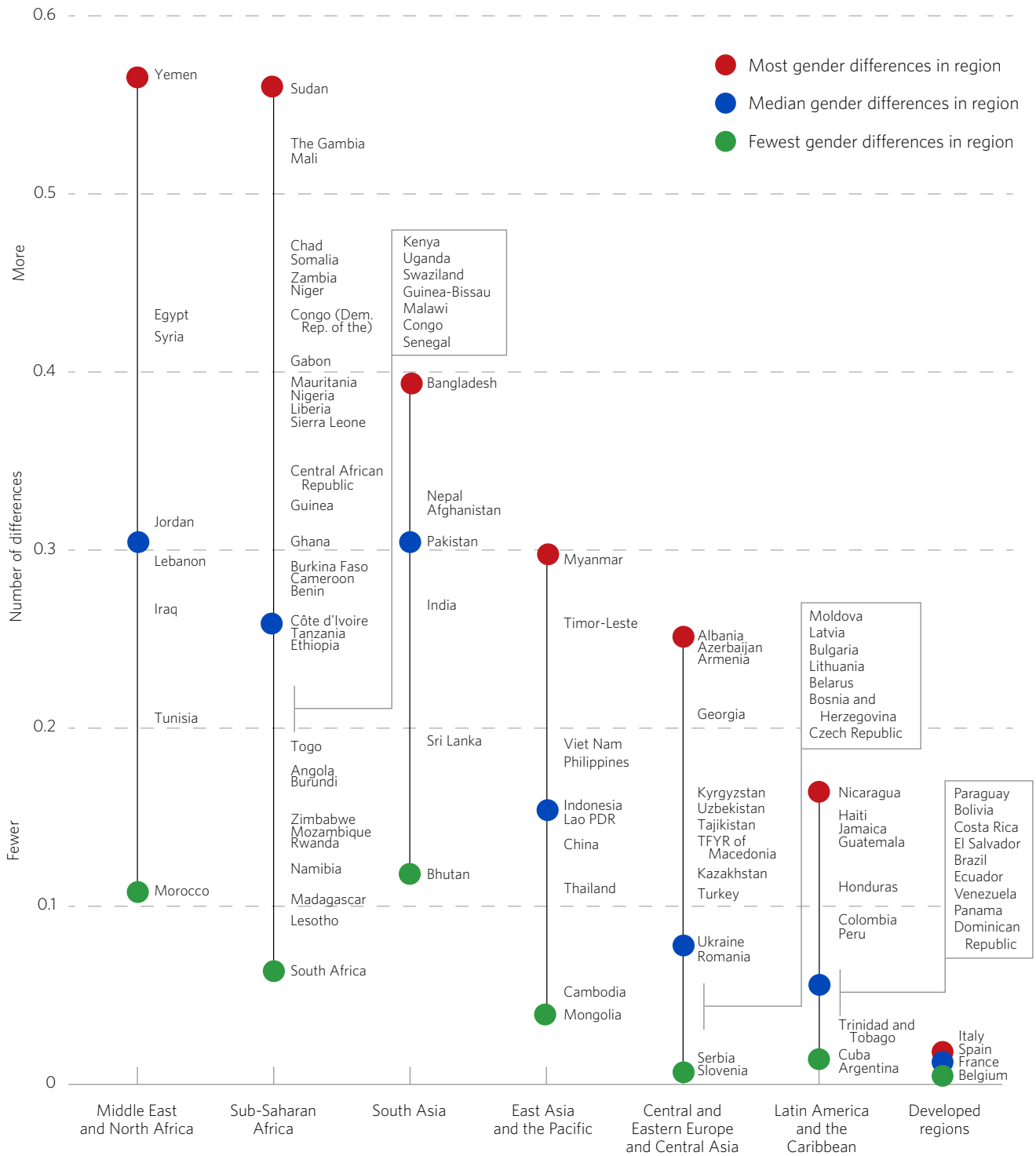
The Social Institutions and Gender Index (SIGI), published by the Organisation for Economic Co-operation and Development (OECD), offers a composite view of gender discrimination in about 160 countries (figure 16). The index covers discrimination against women and girls manifested in family code, restricted physical integrity, preference for sons, restricted resources and assets, and restricted civil liberties. Indicators used to calculate the index include variables such as inheritance rights, the incidence of child marriage and gender-based violence, and inequality in land and property rights. The index accounts for all stages of life to show how discriminatory social institutions can contribute to poverty and powerlessness.

SIGI values are between 0 and 1, with 0 indicating no inequality and 1 indicating complete inequality.

Countries with very low SIGIs (below 0.04) are characterized by laws and measures that provide equal rights in the family code, and equal access to resources and assets, and that promote women's civil liberties. In most of these countries, women and men have equal parental and inheritance rights. Women do not face restrictions on their access to public space or their participation in politics. Neither son preference nor female genital mutilation is a concern. However, the countries may still lack laws to protect women from violence or measures to implement such laws, and women still need better access to justice.

Countries with very high SIGIs (above 0.35) are characterized by high levels of discrimination in legal frameworks and customary practices. In these countries, about one in three girls is married

FIGURE 16 Social Institutions and Gender Index, by region, 2014



by age 19, and women face severe discrimination in inheritance rights. Women's rights to own and control land and other resources, and to access public space are extremely limited. There are serious infringements on their physical integrity, matched by high levels of acceptance and prevalence of domestic violence.

Social institutions that put women and girls at a disadvantage in key spheres of their lives also put them at a disadvantage in entering the labour force.

Laws can exclude women from the paid labour force

Laws can reflect or reinforce discriminatory norms and attitudes that block women's access to the labour force or drag down their earnings relative to those of men. Figure 17 shows countries' legal systems that have gender differences in family, labour and criminal law.

For example, laws can prevent women from working or restrict their access to certain types of jobs. In a review of 143 countries, 128 had at least one legal obstacle to women's participation in certain economic opportunities (Clinton Foundation and Bill and Melinda Gates Foundation, 2015). In 18 countries, men can legally prevent their wives from working outside the home (World Bank, 2015).

Gender inequality is also present in laws regarding property ownership and inheritances (World Bank, 2015). Similarly, laws in some countries limit women's access to banking and credit, which can limit their earnings potential.

Access to property increases financial security and opportunities, and can improve bargaining power within the household. In Colombia, for example, a recent report found that women who owned property were more likely to move freely, negotiate their right to work and have control over their income (World Bank, 2015).

In rural work, when women lack security of land tenure and access to credit and agricultural inputs, agricultural yields—and earnings from them—are lower.

In firms and other businesses, when women lack access to productive inputs as a result of discrimination or other factors, female-led firms have a harder time being as productive and profitable as male-led firms (World Bank, 2012).

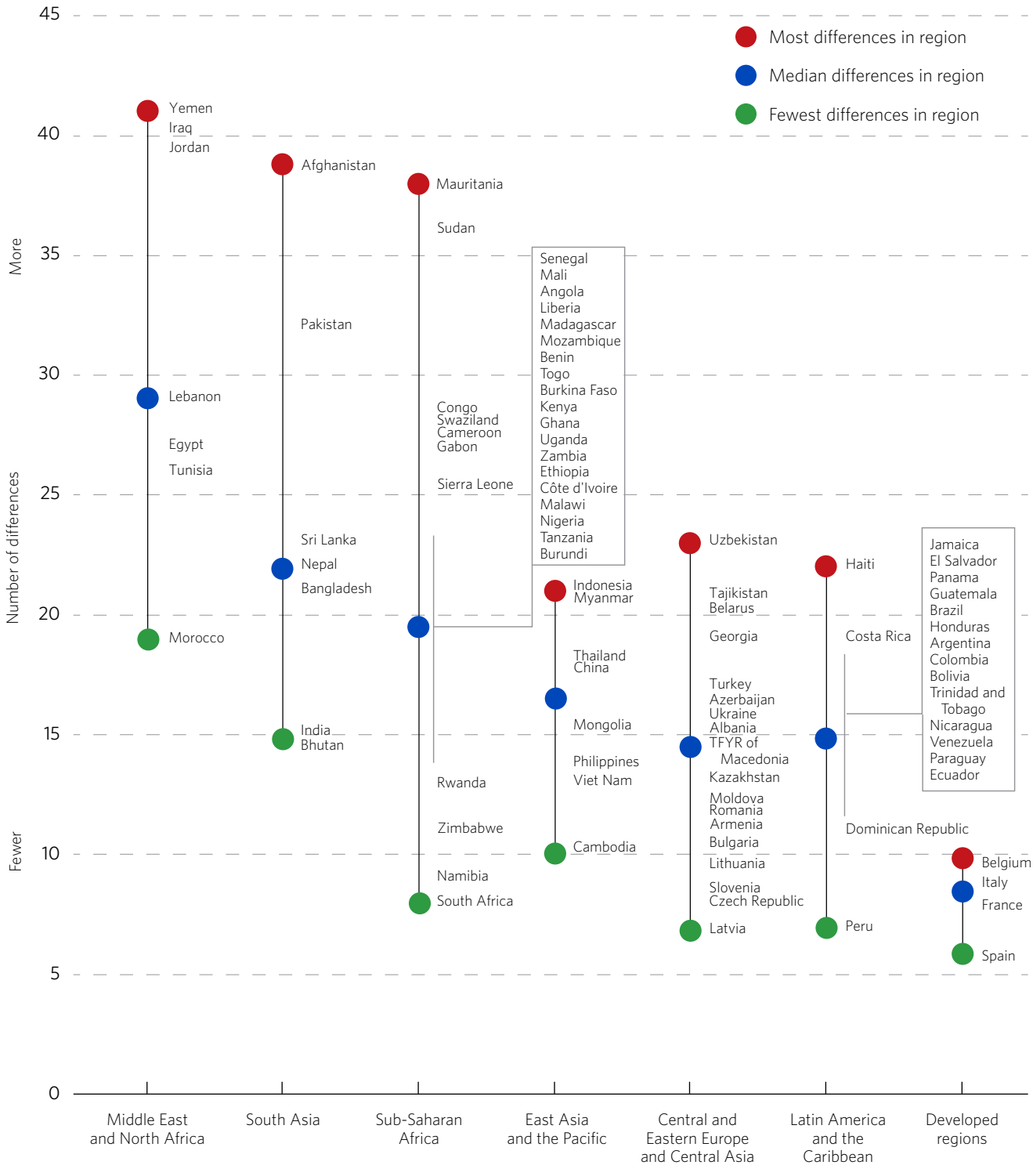
46 of 173
countries had NO DOMESTIC VIOLENCE LAWS

Laws—or their absence or inadequate enforcement—can affect the health and well-being of women, and thus influence women's labour-force participation and their ability to earn an income. Inadequate legal protections against gender-based violence or the failure to enforce such laws can result in long-term physical and psychological harm or disability (World Bank, 2015). Around the world, nearly one in three women will be subjected to gender-based violence in their lifetime (OECD, 2014).

Forty-six of 173 countries examined in a World Bank report had no domestic violence laws, and 41 had no laws pertaining to sexual harassment (World Bank, 2015).

Laws protecting against "economic violence" are rare (World Bank, 2015). Economic violence occurs when a woman is deprived of the economic means to leave an abusive relationship, because her partner either controls the economic resources or prevents the woman from having or keeping a job.

FIGURE 17 **Legal systems with gender differences in family, labour and criminal law, 2015**



Analysis is based on Iqbal et al., 2016.

Pervasive gender inequality in categories of work

Statistics on overall labour-force participation rates mask substantial inequalities in the types of work that women and men are undertaking and the economic risks that some categories of workers face.

Once women are in the labour force, they account for a larger share of work in household enterprises and a smaller share of waged or salaried employees than their male counterparts (figure 18).

According to the International Labour Organization, "employees" are holders of explicit or implicit employment contracts. "Employers" work on their own account and have engaged one or more people to work for them as employees. "Own-account workers" are self-employed.

"Contributing family workers" are those who work in a market-oriented enterprise of a relative living in the same household, mainly in rural sectors in developing countries. Even though this form of work contributes to additional family income, it is often unpaid for the individual worker. Contributing family workers and own-account workers are less likely to benefit from formal work arrangements, so these categories are at a higher risk of being excluded from social security and pension schemes, as well as employer-protection legislation. Accordingly, the International Labour Organization defines these two groups as workers in vulnerable employment (ILO, 2016b)

Globally, vulnerable employment affects slightly less than half of all people who are active in the labour force, and men and women are equally likely to be in this category. Nonetheless, women are overrepresented among contributing family workers in all regions in which this is a relevant category.

In the past two decades, the global share of female contributing family workers has decreased from 36 per cent to 16 per cent, paralleling women's shrinking share of employment in the agricultural sector, except in sub-Saharan and Northern Africa. Contributing family work remains widespread in sub-Saharan Africa, Southern Asia, Northern Africa, and South-East Asia and the Pacific.

In all countries in sub-Saharan Africa, the share of workers who are informally employed is higher for women than for men.

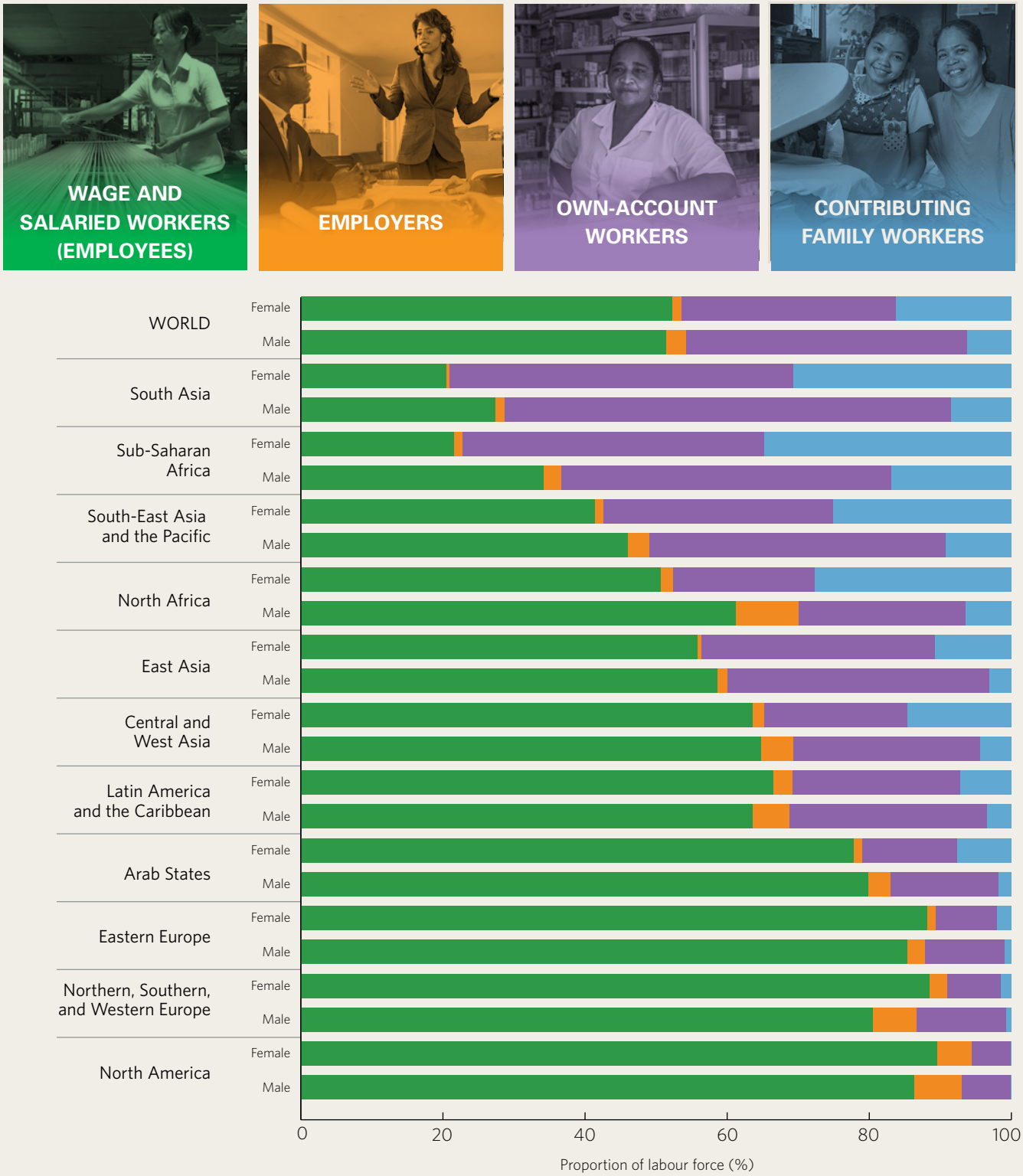
Inequalities in reproductive rights, gender and earnings

Once in the paid labour force, women everywhere find themselves earning less than men for the same types of work; engaging more frequently in unskilled, low-wage labour; or spending less time in income-generating work and more time in unpaid caregiving work at home.

Within any country, earnings for women compared with men depend on a variety of factors, including educational attainment, the extent of gender-discriminatory norms and practices in the home and the labour market, the range of available occupational opportunities, and how much say a woman has in decisions about whether, when and how often she becomes pregnant.

The gender wage gap is the percentage shortfall in the average wage of women relative to the average wage of men (figure 19). Globally, the gender wage gap is about 23 per cent. In other words, women earn 77 per cent of what men earn (ILO, 2016c). Worldwide, the gender gap has narrowed somewhat in recent years, but progress has been slow. At current trends, it will take more than 70 years before the gender wage gap is closed (ILO, 2016c).

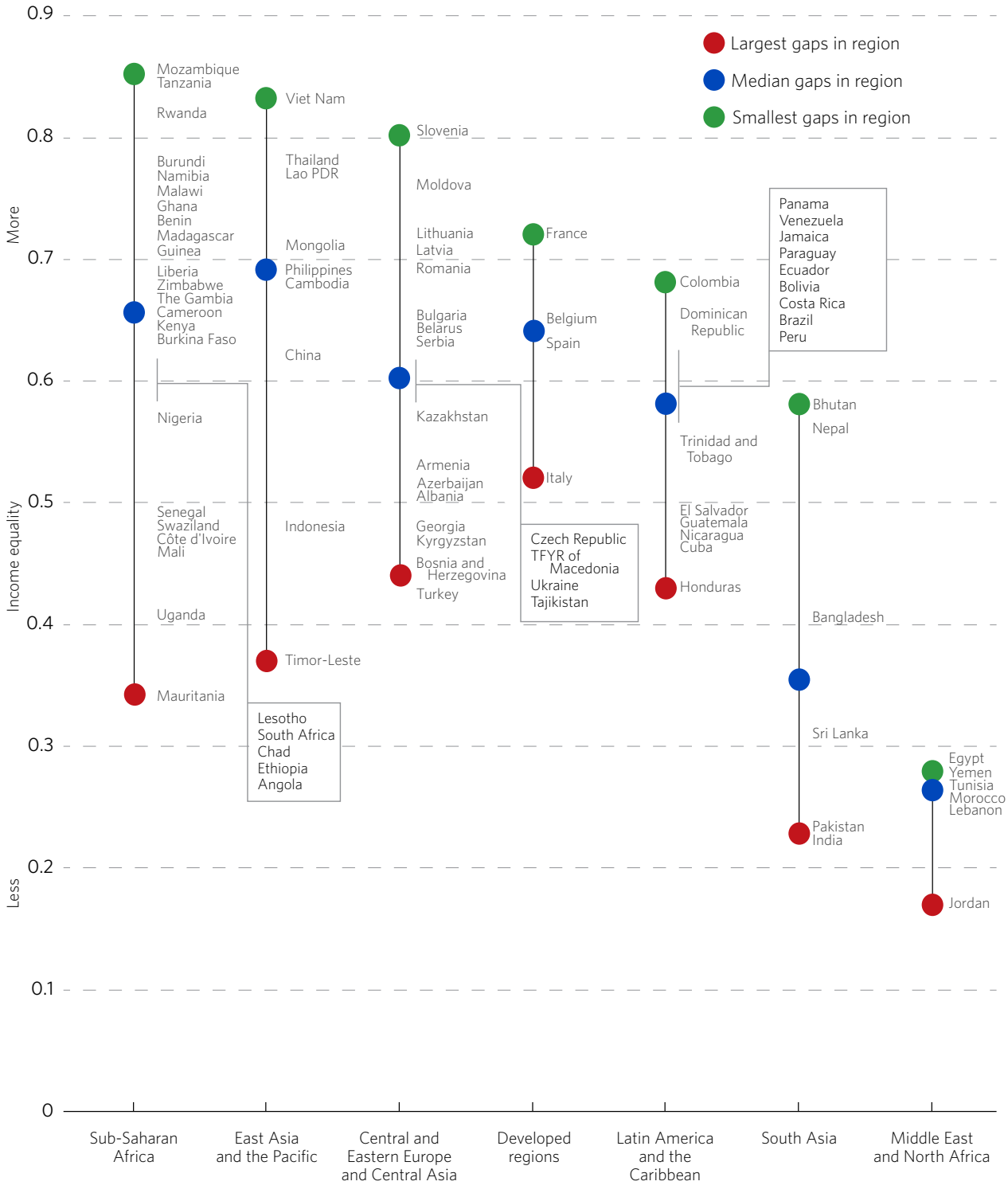
FIGURE 18 Categories of work and employment, by sex



Source: ILO (2016c)

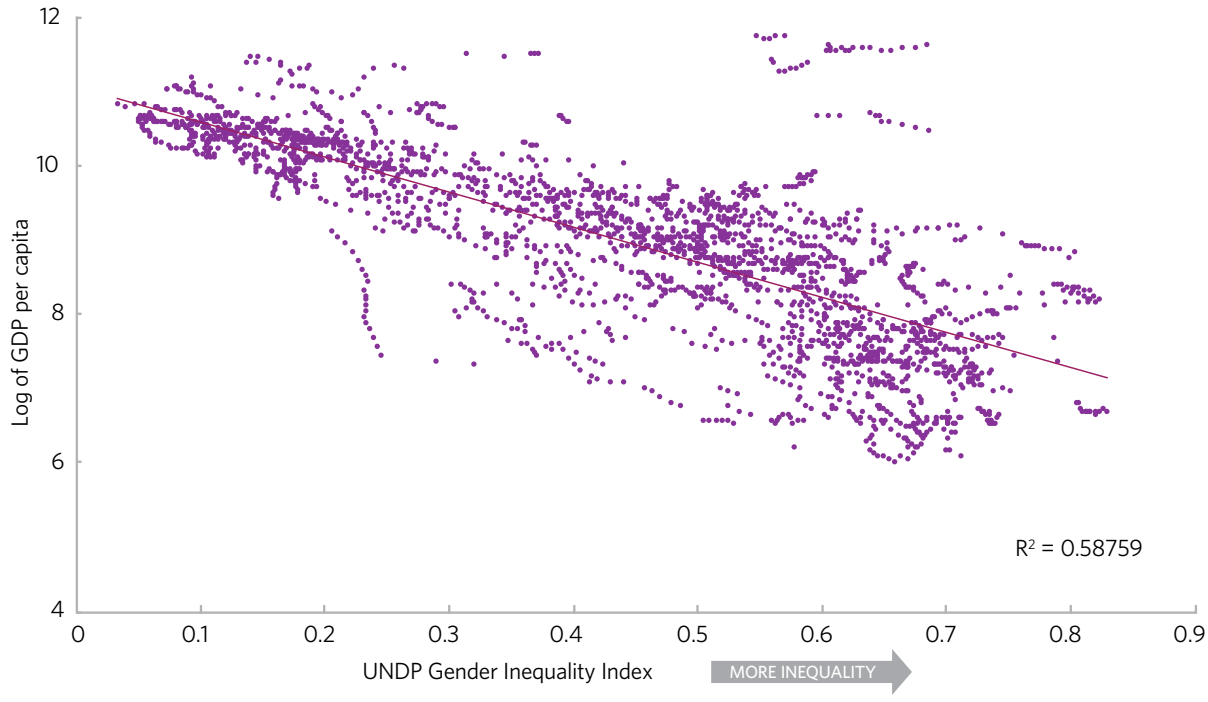
Photos, left to right: © 2012 Jose Carlos Alexandre, Courtesy of Photoshare; © Elnari/stock.adobe.com; © UNFPA/Daniel Baldotto; © Paula Bronstein/Getty Images Reportage

FIGURE 19 Gender wage gaps, as ratio of female-to-male average incomes, 2016



This figure, based on data from the World Economic Forum and on a methodology established by the United Nations Development Programme, shows differences between women's and men's average incomes, expressed as a ratio, for 90 countries. Higher values reflect higher female-to-male income equality. A value of 1 means total equality between women's and men's income.

FIGURE 20 Higher per capita gross domestic product correlates with less gender inequality



Source: Gonzales et al. (2015a)

Gender inequality in education leads to lower earnings for women

Entry into the labour force and earnings depend in part on educational attainment, the quality of the education and the relevance of the education to the labour market. Gender inequality can result in worse educational outcomes and dim prospects for women's earnings.

Of the world's estimated 758 million illiterate adults, about 479 million are women and about 279 million are men (UNESCO Institute for Statistics, 2016). Illiteracy is a reflection of gender discrimination and a factor in reproducing female poverty.

Illiterate people earn up to 42 per cent less than their literate counterparts. And illiteracy can prevent people from acquiring vocational training that could lead to greater earnings (World Literacy Foundation, 2015).

While there is near gender parity in primary education worldwide, the gender gap in enrolments in some countries is wide, which means that millions of girls of primary school age are not in the classroom. Gender gaps in enrolments widen at the secondary level in the Arab States, East and Southern Africa, and West and Central Africa. Higher educational attainment is correlated with higher earnings later in life.

In addition to attainment, educational quality, as measured by cognitive achievement, can also raise earnings. The cognitive skills of a population are powerfully related to individual earnings, income distribution and economic growth (Tembon and Fort, 2008).

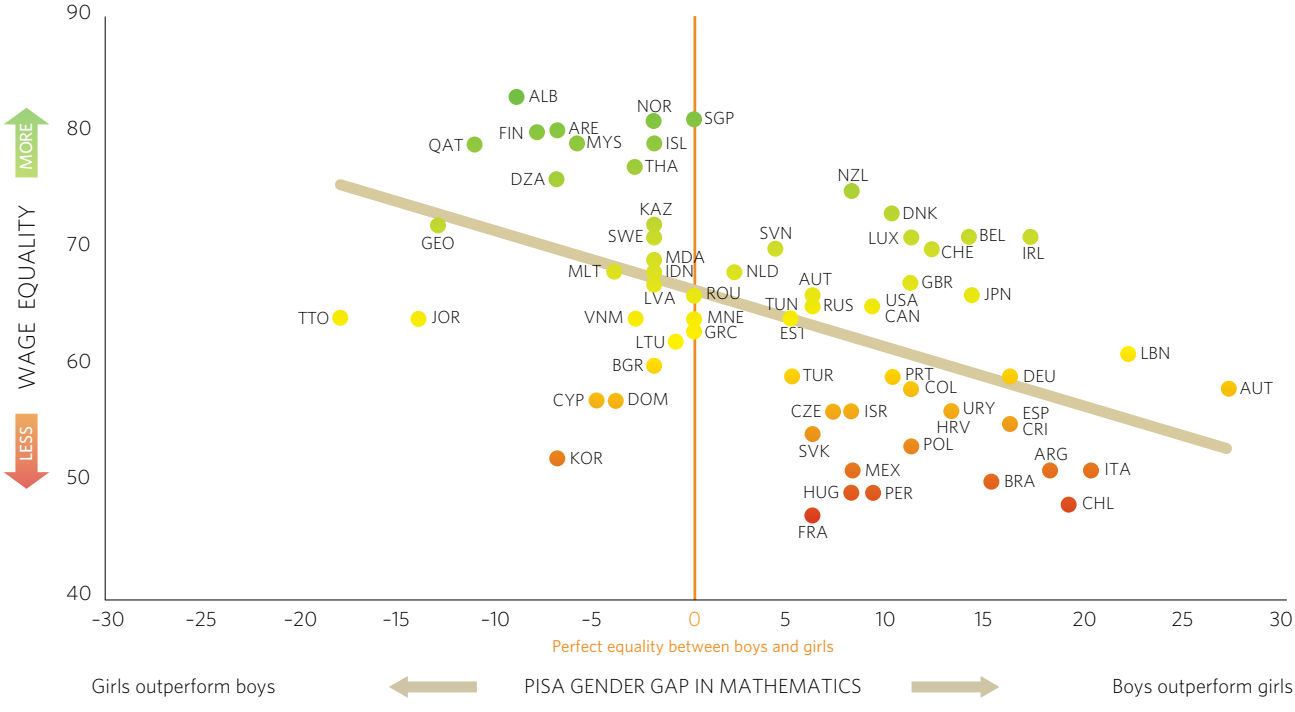
Among girls and boys who enrol in secondary education, only a fraction complete upper secondary schooling. In the least developed countries, for example, 20 per cent of boys finish upper secondary education, compared with only 15 per cent of girls (UNICEF, 2016). Those who leave school early lack skills and knowledge needed to acquire higher-paying jobs.

Subtle or overt pressure from, or discrimination by, teachers, can lead girls to forgo, or be excluded from, advanced science and mathematics courses, limiting their future occupational choices (Bassi et al., 2016; UNICEF, n.d.). Attainment of education in mathematics is a good predictor of career choices and future earnings (Nollenberger et al., 2016). The gender gap in mathematics is highly correlated with wage inequality (figure 21).

In addition, education has been documented to reduce the incidence of adolescent pregnancy. The longer a girl stays in school, the less likely she is to be married as a child or to become pregnant (figure 22). This has long-term implications for labour-force participation and lifetime earnings.

When girls are excluded from the educational opportunities that boys have, their future incomes will be lower than those of boys. Targeted efforts to increase educational equality have been found to narrow the wage gap between men and women. For example, women with a primary education in Pakistan earn 51 per cent of the incomes of their male counterparts, whereas women with a secondary education earn 70 per cent of the incomes of their male counterparts (UNESCO, 2013). Education for women is also vitally

FIGURE 21 Wage equality and girls' and boys' performance on mathematics tests



Based on data from OECD (2015) and World Economic Forum (2016a). PISA, the OECD's Programme for International Student Assessment, is an internationally standardized measurement of students' learning in key subjects. The PISA gender gap in mathematics is the difference between average scores of boys and girls on mathematics tests. A higher PISA score represents a more extreme gender gap. A negative PISA score means that girls outperform boys in mathematics.

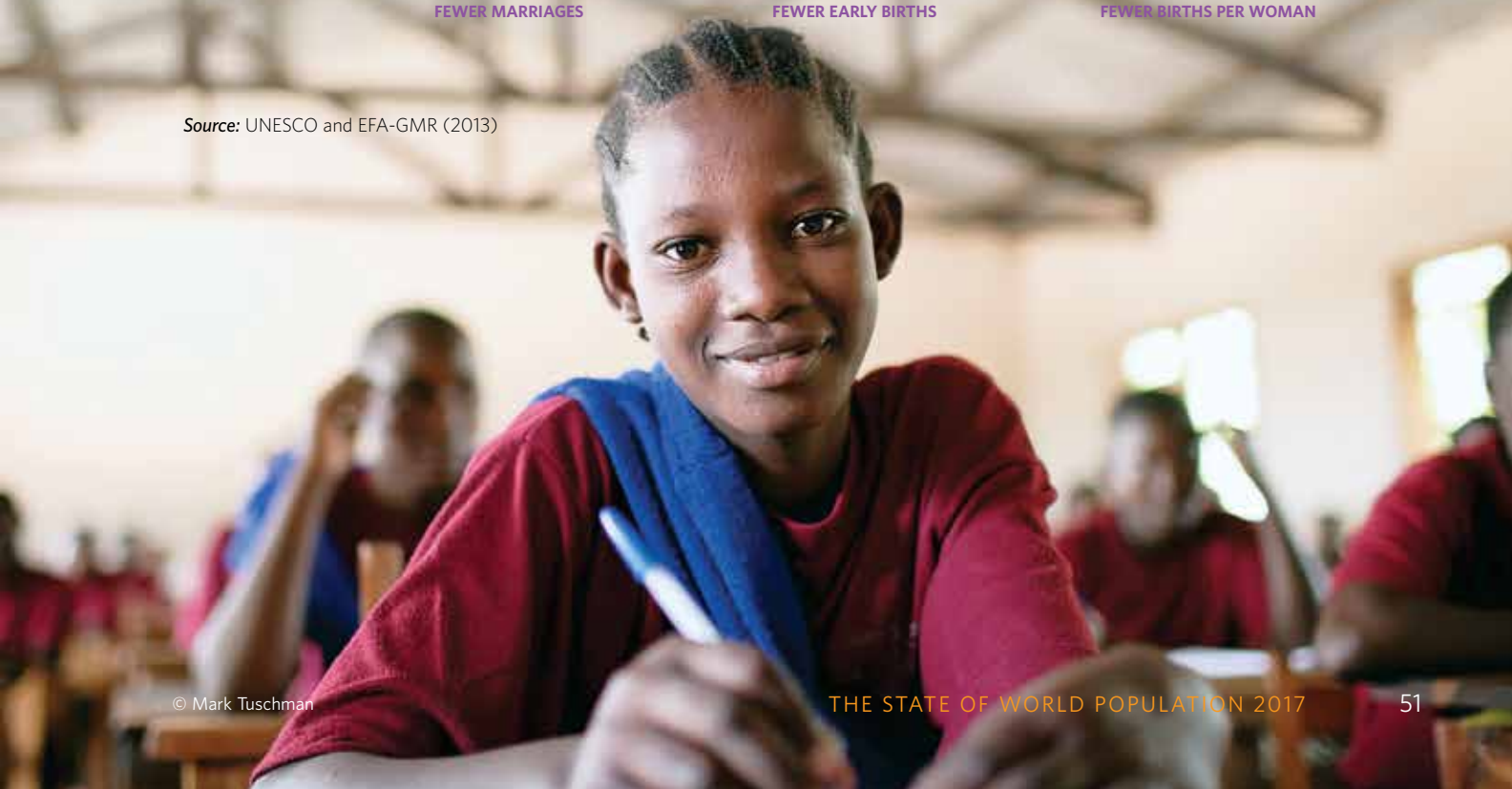
Source: ILO (2016a)

Abbreviations are for countries and territories listed on page 104.

FIGURE 22 The effect of education on fertility

	CHILD MARRIAGE *All girls by age 15 in sub-Saharan Africa and South and West Asia*	EARLY BIRTHS *All girls by age 17 in sub-Saharan Africa and South and West Asia*	FERTILITY RATE *Average number of births per woman in sub-Saharan Africa*
With current levels of girls' educational attainment	***2,867,000***	***3,397,000***	***6.7***
If all girls received primary education	***2,459,000*** ↓14% FEWER MARRIAGES	***3,071,000*** ↓10% FEWER EARLY BIRTHS	***5.8*** ↓13% FEWER BIRTHS PER WOMAN
If all girls received secondary education	***1,044,000*** ↓64% FEWER MARRIAGES	***1,393,000*** ↓59% FEWER EARLY BIRTHS	***3.9*** ↓42% FEWER BIRTHS PER WOMAN

Source: UNESCO and EFA-GMR (2013)



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important for income security: in Jordan, 25 per cent of rural women with a primary education work for no pay, compared with only 7 per cent of rural women with a secondary education (UNESCO, 2013).

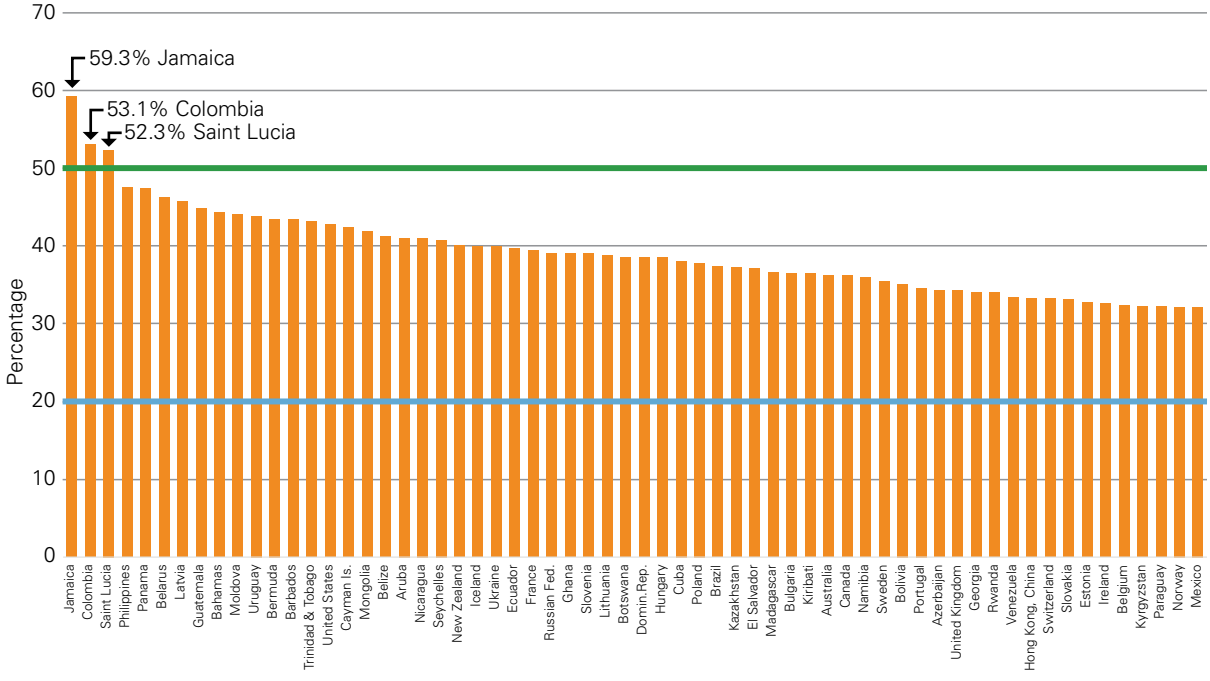
Equal access to quality education not only addresses absolute deprivation by providing individuals with a pathway out of poverty, but also increases overall national productivity and innovation, by generating far greater opportunity for all people to develop their skills, find their niche and define their future areas of work. Increasing the collective capabilities of the population helps to grow national economies.

Educational inequality has been shown to be one cause of slow per capita income growth. In sub-Saharan Africa, the average annual growth in income per capita over 45 years was 0.8 per cent, compared with an average of 3.4 per cent for East Asia and the Pacific, where the average person spends 2.7 more years in school (UNESCO, 2013). The difference in education in these two regions is estimated to account for about half of the difference in economic growth. If education inequality were cut in half in sub-Saharan Africa, the annual 2005–2010 growth rate would have been approximately 47 per cent higher (UNESCO, 2013).

Women's lower earnings parallel limited occupational opportunities

The earnings gap between women and men is determined in part by occupation and position. Men tend to be employed in more highly

FIGURE 23 Percentage of managers who are women



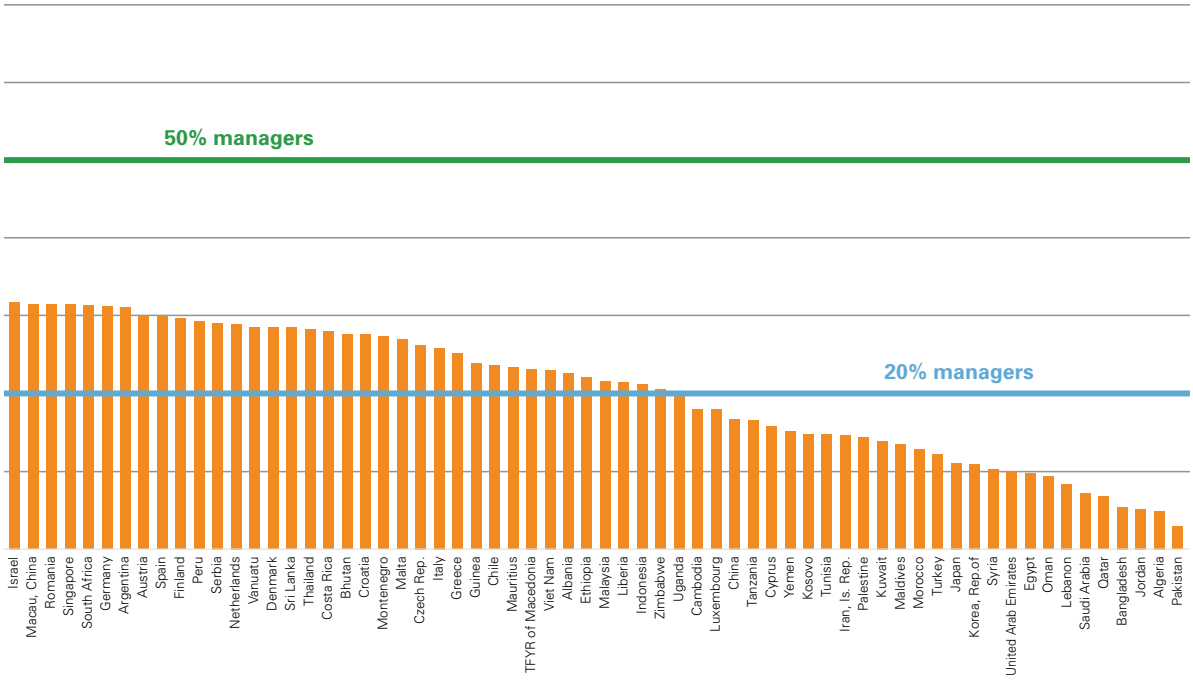
Source: ILO (2015)

remunerated sectors and hold higher positions within them. This uneven distribution across sectors contributes to earnings gaps (Ñopo, 2012).

Gender inequalities in occupational opportunity are apparent in the lower proportion of women who hold positions of power or authority in the workplace (figure 23). Among a group of 126 countries, territories and other areas, only in Colombia, Jamaica and Saint Lucia do women hold at least half of management positions. In most instances, women account for 20 per cent to 40 per cent of all managers; in 27 countries or territories, fewer than 20 per cent of all managers are women.

In high-income countries, the major sources of employment for women are the health and education sectors, which employ more than 30 per cent of all women in the labour market. In low-income and lower-middle-income countries, agriculture remains the most important source of employment for women. In South Asia and sub-Saharan Africa, more than 60 per cent of all working women remain in agriculture—work that is poorly remunerated, seasonal and insecure (ILO, 2016c).

Worldwide, the share of women in engineering fields is low, and the share in computer science is even lower (OECD, 2007). In most developed countries, women account for between 25 per cent and 35 per cent of researchers in technology fields; in some, such as Japan and the Republic of Korea, they account for less than 15 per cent (OECD, 2007). Women account for 10 per cent of computer-related degrees in Belgium, the Netherlands and Switzerland.



Once in the labour market, women tend to be employed in social sectors, such as education, with lower levels of remuneration, while men tend to be employed in financial or technical sectors, with higher salaries.

In today's global economy, which depends on technology, graduates with higher levels of education, especially in technical fields, are in greater demand by employers. Those with technical skills are therefore commanding higher salaries. The relationship between skills and salary is not linear but exponential (Autor et al., 2006; Bertrand et al., 2010; Goos et al., 2009). This results in a wider earnings gap between high- and low-skilled workers (Dabla-Norris et al., 2015). In the context of unequal access to educational opportunities by women and men, it means that women are at an even greater disadvantage in terms of job opportunities and earnings potential.

In globalizing and technologically advanced societies, Internet connectivity and mobile phone services are increasingly important. Those who do not have these services are not only disconnected but are also increasingly disadvantaged personally and professionally (Woetzel et al., 2015). Thus, the digital divide affects gender differences in economic opportunities, as women globally have less access to information and communication technologies than men. Worldwide, women are on average 14 per cent less likely than men to own a mobile phone. A study of Internet access in 144 low- and middle-income countries in 2012 found that women have 25 per cent less access than men (Intel, 2012). In sub-Saharan Africa, that gap increases to nearly 45 per cent.

Women's lower access to information and communication technology partly reflects a lack of money available to acquire it and norms that discourage women's use of it (Antonio and Tuffley, 2014; Gillwald et al., 2010; GSMA, 2015; Hilbert, 2011; Intel, 2012).

In addition to more limited occupational opportunities, women face more limited opportunities in accessing financial assets and formal banking services. So, in some places, even if a woman earned the same income as a man, she could not deposit her earnings into a bank account or make investments that could lead to higher earnings.

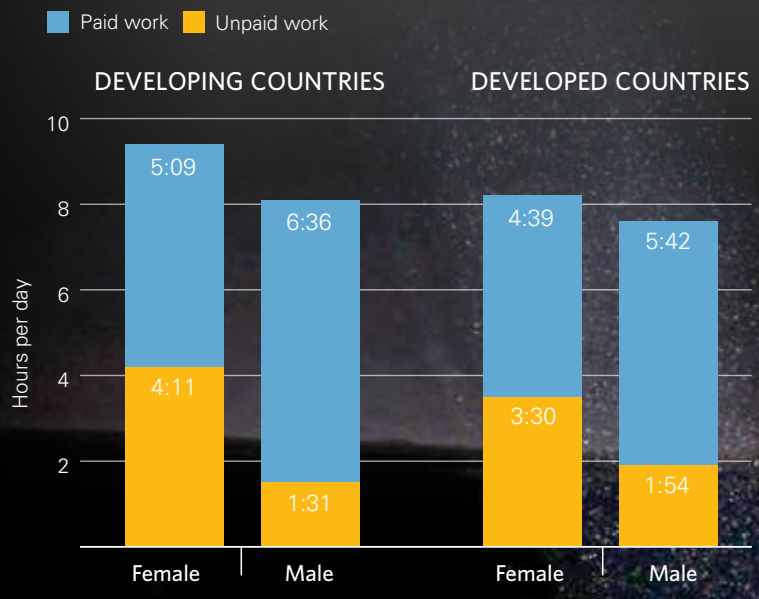
Women's unpaid work at home detracts from earnings potential in the paid labour market

Norms that can keep many women out of the labour force can also limit earnings of those who do enter the labour force.

In most countries, women work fewer hours in paid employment than men, and bear the majority of the burden for unpaid household and care work (figure 24). In countries where reliable data are available, women do on average about 2.5 times more of this work than men (ILO, 2016c).

When women are employed, their additional responsibilities for household work and care mean that they work longer days than men. In developing countries, women spend an average of nine hours and 20 minutes per day on paid and unpaid work, compared with men, who spend an average of eight hours and seven minutes per day on paid and unpaid work. Also, a woman in a developing country spends only 55 per cent of her day doing paid work, compared with a man, who spends 81 per cent on paid work. Women's responsibilities for unpaid household and care work also mean that they have less time available to spend at jobs that generate an income (ILO, 2016c). Unpaid care work is thus an important driver of economic inequality (Mateo Diaz and Rodriguez-Chamussy, 2016; World Bank, 2012).

FIGURE 24 Time spent on paid and unpaid work in 23 developing and 23 developed countries, by sex, latest year available



Source: ILO (2016a)

In most countries, women work fewer hours in paid employment than men and bear the majority of the burden for unpaid household and care work.

Women do on average about

2.5 TIMES MORE

household work than men

Motherhood penalty

In every part of the world, mothers who are in the labour force earn less than women who do not have children (ILO, 2016c). The motherhood wage penalty may linger even after children are grown, because mothers are likely to lose ground in earnings for taking time off during pregnancy or after giving birth.

Employers' expectations about women becoming pregnant can contribute to the gender wage gap. Employers may justify paying women less because of a perception that women lack commitment to their jobs when they have the added work of family (Lips, 2013). Some employers perceive all women as potential mothers and pass them over for more challenging assignments, or even promotions, because of a risk of unexpected pregnancy-related leave (ILO, 2016a).

Workplace discrimination against pregnant women and workers with family responsibilities takes place in many forms and is a violation of labour rights.

Maternity and paternity leave

Lack of maternity leave or guaranteed job retention forces many women to choose between participating in the labour force and giving birth, or between their productive and reproductive roles.

A majority of countries today have some provision for maternity leave. Countries where women are entitled to longer periods of paid maternity leave tend to have higher rates of

female labour-force participation (ILO, 2014; World Bank, 2015).

Depending on the length of mandated leave and who pays for it, employers may discriminate against women of childbearing age at the time of hiring and in terms of remuneration (Mateo Diaz and Rodriguez-Chamussy, 2016; World Bank, 2015).

The International Labour Organization recommends a standard minimum maternity leave period of 14 weeks (ILO, 2016c). Among a group of 185 countries, 98 provide at least 14 weeks of leave, 60 provide 12 to 13 weeks, and 27 provide less time. Although most countries provide some form of maternity protection through maternity leave legislation and income-replacement schemes, in practice, maternity leave coverage is much lower because of disincentives for women and couples to take advantage of such policies. Globally, about 60 per cent of working women do not benefit from any statutory right to maternity leave, and even fewer have access to payment during maternity leave. This is especially the case for the vast proportion of women who are self-employed, working within a family workplace, or in part-time or informal work arrangements, including domestic or agricultural work (ILO, 2014).

Given the insecurity of women's work in many settings, enforcement of protections to guarantee a woman's right to return to her

work after maternity leave without any impact on her pay is challenging, even though 43 countries explicitly prohibit maternity-related discrimination (ILO, 2014).

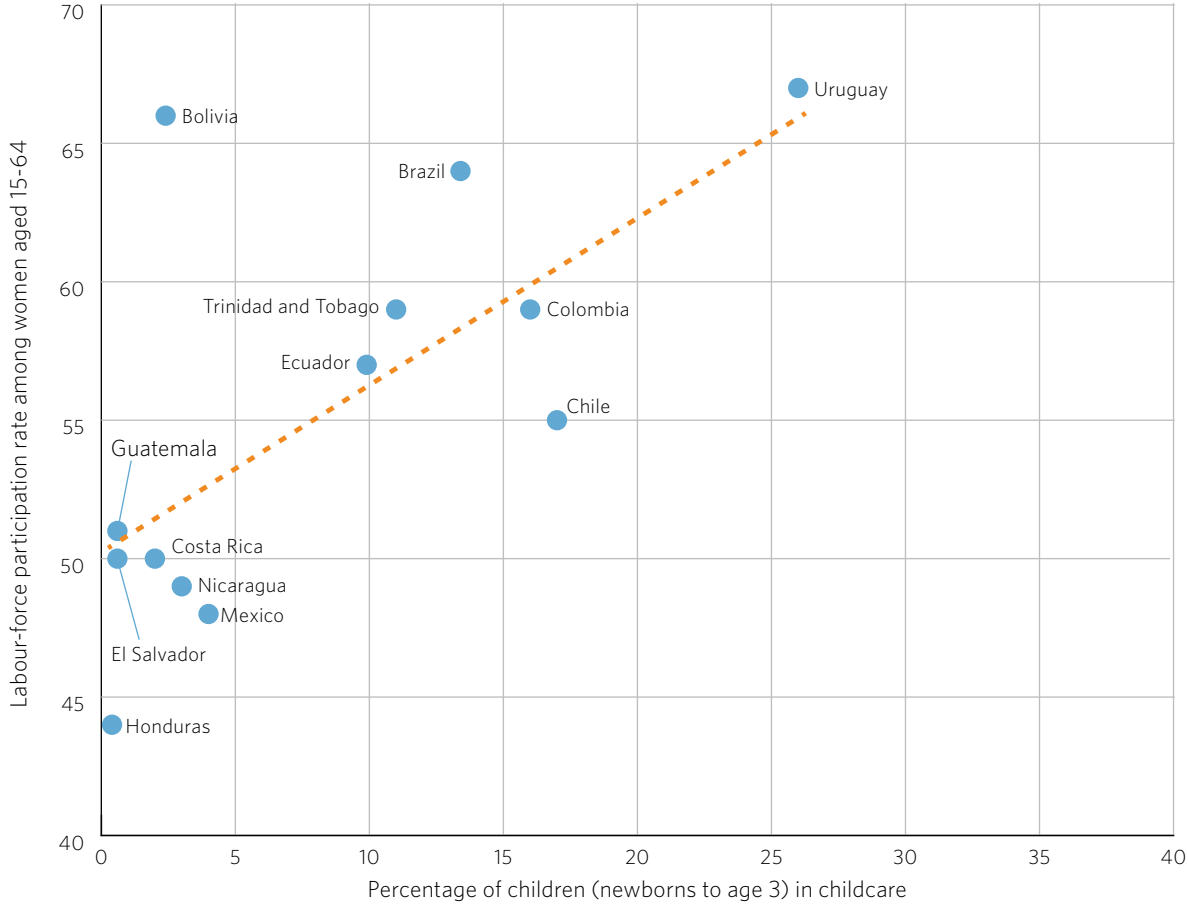
Paternity leave is leave granted to fathers following childbirth or adoption to take care of the child. Among a group of 167 countries, 78 have some level of statutory right to paternity leave, and most leave is paid. However, the duration of paternity leave is limited: employers in most countries in Africa, Asia and North America provide less than one week.

Parental leave and access to childcare

Parental leave allows parents to look after an infant or young child after maternity or paternity leave. Among 169 countries, 66, mainly in Eastern Europe and Central Asia, have parental leave policies. Although these countries enable "shared parental" leave that provides leave for either or both parents, in practice, parental leave is overwhelmingly taken by mothers.

Loss of salary is a common motivation for not exercising parental leave. According to the

FIGURE 25 Female labour-force participation and use of formal childcare for children up to three years old in selected countries in Latin America and the Caribbean, 2012



Based on Mateo Diaz and Rodríguez-Chamussy (2016). Data are from national household surveys, most recent year available.

International Labour Organization, only five countries in Africa had parental leave provisions—all unpaid—in 2013. In Asia, only three of 25 countries had parental leave, with the Republic of Korea providing leave at 40 per cent pay, and Nepal providing only unpaid leave. Five of 10 Middle Eastern countries have unpaid parental care provisions. In contrast, 20 of 24 developed countries provide parental leave.

With or without parental leave, fathers' support in childcare has significant benefits in terms of redressing the unequal share of parents' responsibilities to children and the overall burden of unpaid work at home.

In the context of an uneven distribution of responsibilities and obligations for care, women's ability to enter the workforce often depends on finding affordable, accessible and flexible day care for their children. If a woman has a child but has no access to childcare, or if childcare is too expensive, she may have to stay out of the paid labour force and forgo earnings altogether.

An analysis of data on childcare and labour-force participation in Latin America and the Caribbean (figure 25) shows a positive and significant relationship between the two (Mateo Diaz and Rodriguez-Chamussy, 2016).

A decade of research suggests that flexibility in the labour market provides the greatest chance for women to fully and meaningfully participate in the workforce and have higher earnings, even while exercising their reproductive roles. Flexible workplace hours, the availability of part-time work, and provisions for maternity and paternity leave all have positive effects on women's labour-force participation.

Vicious cycle of lower earnings and diminished capacities for women

Inequality—regardless of the type—is the product of a range of forces in society that interact and create sets of constraints or behavioural boundaries for individuals. These constraints and boundaries limit options, access to resources and choices.

Gender inequality is one such force that results in constraints and boundaries for half the world's population. Many of the inequalities in sexual and reproductive health and rights are intertwined with, or even driven by, gender inequality.

Worldwide, women's earnings are lower than those of men. Lower earnings stem from gender inequality in education and health, and from unequal protection of rights. These inequalities result in diminished capacities for women, as well as in a more limited range of options and opportunities for jobs and livelihoods.

And, with lower earnings, women have fewer resources for critical services, such as family planning, which could empower them to enter the labour force and earn more once they are employed. This situation sets off a vicious cycle that can prevent women, their children and their children's children from rising out of poverty (United Nations, 2014).

For the sake of equality and shared prosperity, it is essential to level the playing field for girls and boys, women and men. This means equalizing the rules of the game—in the application of laws and rights, in the institutions that perpetuate gender-unequal norms and attitudes, and in education and health, especially reproductive health.

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CHAPTER 3

The costs of inequality

Agenda 2030 defines sustainable development not only as an "absolute reduction in human deprivation" (for example, in eradicating poverty or maternal mortality), but also as including "greater equality" among all people, both within and between countries.

Inequality, whether economic, social, political or in health, is an impediment to sustainable human development. It enfranchises some at the expense of others, and the relative lack of participation of entire segments of the population stifles ideas and solutions, and reduces the vitality and resilience of society. In short, lost opportunities for some limit long-term prosperity for all.

Inequality blocks the path to the world we want. It allows development to benefit some but not others, marginalizes some groups and individuals, and distorts political, social and economic relations. Inequalities lead to social and geographic clustering of privilege and deprivation. This results in less social contact between these groups through school, work or housing, and diminished understanding, contributing to extremes in political discourse.

Despite recent progress in stemming extreme poverty worldwide, rising economic inequality rebukes claims of shared prosperity, or that life is improving for all. Increasing economic inequality impedes trust and social cohesion, threatens public health, and marginalizes the political influence of the poor and middle class. Its persistence demonstrates that human rights are not yet universal. If left unaddressed, it can foster unrest, and undermine governance and peace.

Narrowing the gaps between the affluent and the poor, women and men, the privileged and the excluded, is a matter of respecting and capitalizing on the potential of all people. Improving absolute and relative opportunities and outcomes could advance social negotiation, contribute to governments that serve many instead of a few, and stimulate long-term economic growth and shared prosperity.

Throughout the developing world, the poorest women and adolescent girls are less able than their wealthier counterparts to exercise their reproductive rights and protect their health. Inequalities in sexual and reproductive health may be even more pronounced depending on place of residence—in a city or a rural area—and on level of education. Rural and less educated women typically have less access to services and worse reproductive health outcomes than more educated women in urban areas.

When health and rights are out of reach for a large share of a country's population, everyone is harmed in some way. A poor woman who cannot access family planning, for example, may have more children than she desires. As a result, she may be unable to join the paid labour force and contribute to her country's economic growth and development.

Inequalities in sexual and reproductive health and rights have costs to the individual, the community, nations and the entire global community.

Unequal reproductive risks

In the developing world, 43 per cent of pregnancies are unplanned (Guttmacher Institute, 2017).

Unintended pregnancy is more prevalent among rural, poor and less educated women. In the majority of countries, fertility rates are higher among the poorer segments of the population than among the top-income groups. In countries where the overall fertility rate is relatively low, the fertility gap between rich and poor is also relatively small. But in high-fertility countries, the gap between the top and bottom wealth quintiles can be large. In Zambia, for example, the fertility rate among the bottom income

quintile is more than double the rate among the top income quintile (World Bank, 2012).

Each year in developing countries, there are 89 million unintended pregnancies, 48 million abortions, 10 million miscarriages and 1 million stillbirths (Guttmacher Institute, 2017).

Unintended pregnancies are linked to increasing poverty and reduced prospects for women's economic mobility (UNFPA, 2012).

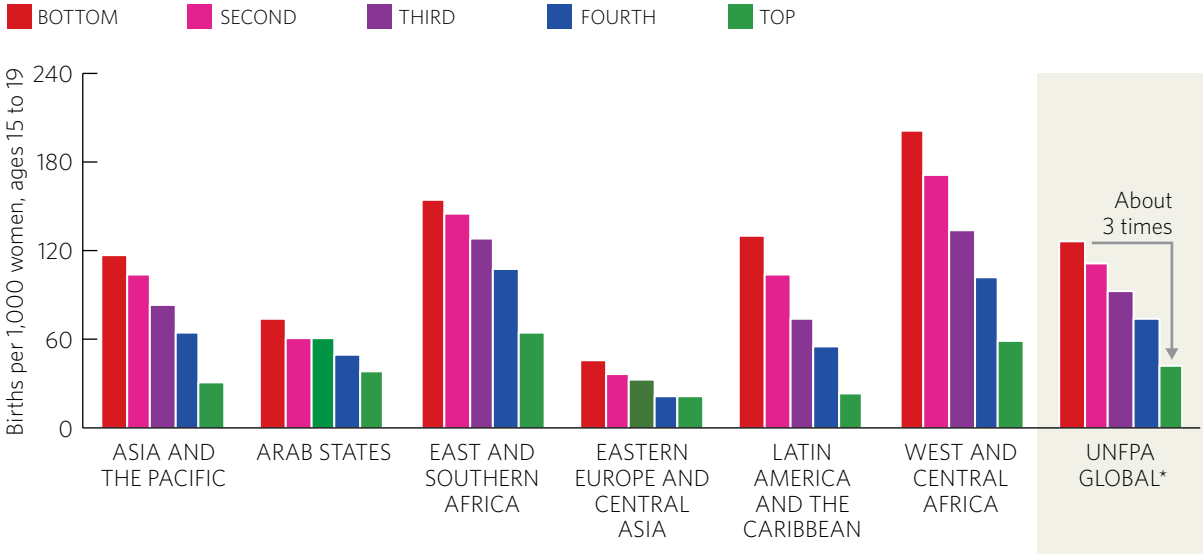
An estimated 214 million women in developing countries have an unmet demand for family planning (Guttmacher Institute, 2017). Data from 98 developing countries show that the unmet demand for family planning is greater among women who are poorer, rural and less educated than among their richer, urban, more highly educated counterparts (UNFPA, 2013a).

Disparities in unmet demand are significant in all regions except West and Central Africa, where unmet demand is consistently high across all demographic, social and economic groups.

When poorer women in developing countries do become pregnant, their limited and unequal access to reproductive health care, as well as their unmet nutritional needs, can lead to serious complications for both mother and fetus. Despite reductions in maternal deaths worldwide, the maternal mortality ratio in the least developed countries remains at 436 deaths per 100,000 births, compared with 12 deaths per 100,000 births in developed countries.

More than 96 per cent of all low-birthweight babies are born in developing countries (WHO, 2017). Although access to antenatal care is

FIGURE 26 Adolescent birth rates (ages 15 to 19), by region and wealth quintile



*Refers to the weighted average of 155 countries and territories where UNFPA works.

Note: Graph is based on the latest available data.
Source: UNFPA (2016a)

growing worldwide, women in developing regions, particularly sub-Saharan Africa and South Asia, often receive fewer than four antenatal visits—the minimum number that had been recommended by the World Health Organization until November 2016, when the recommended number rose to eight (WHO, 2016). The situation is even worse in rural areas within developing countries, where the costs associated with travelling long distances for antenatal care are prohibitively high (Finlayson and Downe, 2013).

Poor health for mothers has intergenerational implications as well, with one study finding that adverse health in mothers affects child health and survival (Bhalotra and Rawlings, 2011). This study posited that poor intergenerational health may be intimately linked to earnings and economic well-being, and inequality.

Girls under age 15 account for 1.1 million of the 7.3 million births among adolescent girls under age 18 every year in developing countries (UNFPA, 2013b). Most of the world's births

to adolescents—95 per cent—occur in developing countries, and nine in 10 of these births occur within marriage or a union. Child marriages are generally more frequent in countries where poverty is extreme and among the poorest groups within countries (UNFPA, 2013b).

Adolescents (between the ages of 15 and 19) in the poorest 20 per cent of households in developing countries have about three times as many births as adolescents in the richest 20 per cent of households (figure 26). Adolescents in rural areas have on average twice as many births (as a rate per 1,000 females) as their counterparts in cities (figure 27).

Variations in adolescent birth rates within a country stem in part from inequitable access to sexual and reproductive health services. Adolescent girls typically have less access to contraception than adolescent boys because of discriminatory policies, judgmental service providers or prevailing attitudes about what is acceptable behaviour for girls.

A pregnancy can have immediate and lasting consequences for a girl's health, education and income-earning potential, and often alters the course of her entire life. The risk of maternal death for mothers under age 15 in low- and middle-income countries is double that for older women; this younger group also faces significantly higher rates of obstetric fistulae than their older peers (UNFPA, 2013b).

Adolescent births are closely related to income inequality and the incidence of poverty (Gonzales et al., 2015a). High birth rates have been associated with reduced economic activity by women—especially by adolescents, who, after becoming pregnant, often leave school, undermining their future potential as they enter the labour market. High adolescent birth rates can therefore increase inequality in education, economic participation and earnings potential.

A World Bank study (Chaaban and Cunningham, 2011) suggests that the lifetime opportunity cost related to adolescent pregnancy—measured by the mother's forgone annual income over her lifetime—ranges from 1 per cent of annual gross domestic product (GDP) in China to 30 per cent of annual GDP in Uganda.

Studies have linked early childbearing with poor physical and mental health later in life; several of these studies have found that teenage motherhood compounds disadvantage for girls of low socioeconomic status (Hodgkinson et al., 2014; Patel and Sen, 2012).

Adolescents face additional reproductive risks because they have less access than adults to services, particularly contraception and HIV prevention. Among adolescents, girls are at greater risk than boys.

HIV/AIDS is today the leading cause of death among adolescent girls in East and Southern Africa, and girls make up 80 per cent of new HIV infections among adolescents in this region (Fleischman and Peck, 2015). Globally, young women and adolescent girls (ages 15 to 24) account for 60 per cent of all young people living with HIV, and 58 per cent of all new HIV infections among young people (UN Women, 2016).

HIV/AIDS has a larger impact on the poor than those who are more affluent and have greater access to quality health care. Although treatment for those in low- and middle-income countries has improved in recent years, 60 per cent of those infected do not have access to life-saving antiretroviral medications, which can be prohibitively expensive (UNAIDS, 2015). Without treatment, households already in poverty are at risk of even greater poverty when an income-generating family member passes away.

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TOO YOUNG

ADOLESCENT PREGNANCY

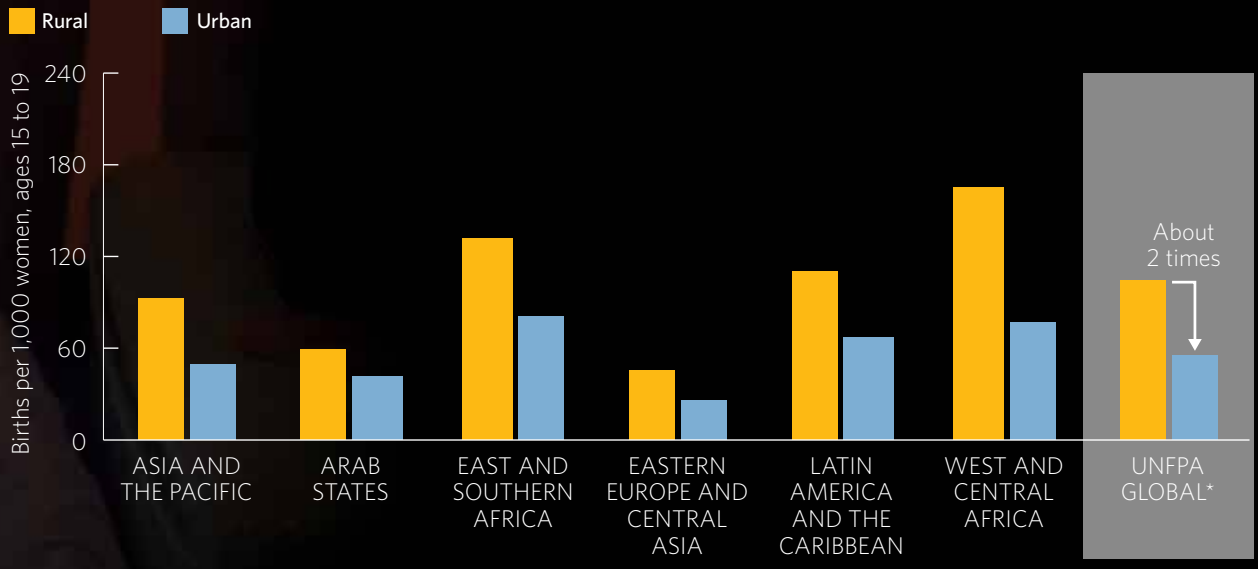
95 PER CENT
of the world's births to adolescents occur in developing countries

Girls under age 15 account for
1.1 MILLION
OF THE
7.3 MILLION
births among adolescent girls under age 18 every year in developing countries

9 IN 10
adolescent births occur within marriage or a union

Among 96 developing countries for which data are available, **adolescent birth rates are higher in rural areas,** and where adolescents are poorer and less educated.

FIGURE 27 Adolescent birth rates (ages 15 to 19), by place of residence



*Refers to the weighted average of 155 countries and territories where UNFPA works.

Note: Graph is based on the latest available data.
Source: UNFPA (2016a)

Intersection of inequalities in health, education and gender

Despite progress towards gender equality in education over the past three decades, girls are still more likely than boys to be out of school at the primary level and even more likely not to be enrolled at the secondary level (UNICEF and UNESCO Institute for Statistics, 2015). Girls who are rural, poor, or from racial, ethnic or religious minority groups are at even greater risk of not being in school than their urban, affluent counterparts from ethnic and religious majority groups (Global Partnership for Education, 2013; UNICEF and UNESCO Institute for Statistics, 2015).

Lower enrolments, attendance and completion rates are the result of many social, geographic and economic factors that place girls at a disadvantage in education, especially as they enter adolescence.

A lack of separate bathrooms and the unavailability of menstruation products in schools, for instance, can force pubescent girls to miss class. Visible evidence of menstruation caused by a dearth of sanitary products can leave them vulnerable to harassment and sexual abuse (Sommer, 2010).

Child marriage, too, keeps girls out of school and threatens their health and well-being. Marriage is often followed by pregnancy, even if a girl is not yet physically or mentally ready. Complications from pregnancy and childbirth are the leading cause of death among adolescent girls aged 15 to 19 worldwide (WHO, 2017b).

When girls marry, they are often forced to drop out of school so that they can assume household responsibilities. This is a denial of their right to an

education. Girls who leave school have worse health and economic outcomes than those who stay in school, and their children fare worse as well.

Fears of being assaulted on the way to or from school are one reason for girls in rural areas being more likely to start school at a later age than rural boys (UNICEF and UNESCO Institute for Statistics, 2015). Starting school at a later age leaves children more likely to perform poorly in the classroom, repeat grades and drop out (Nonoyama-Tarumi et al., 2010; Wils, 2004); this relationship is even stronger when children are from households with lower socioeconomic status (Nonoyama-Tarumi et al., 2010).

Ethnicity also plays a major factor in the gender gap in education. An estimated two thirds of girls who are out of school worldwide are from ethnic minorities of their countries (World Bank, 2012). One of the most striking examples of educational inequality can be found among the Roma in Europe: in some countries, more than 30 per cent of young Roma lacked even a primary education, and nowhere did the share of Roma with a university degree exceed 1 per cent (Brüggemann, 2012). The cost of educational exclusion of the Roma is high, with an estimated loss of 3.7 per cent of GDP in Bulgaria alone (World Bank, 2010). The educational inequality among the Roma disproportionately affects girls because they are much more likely to be married before age 18. In Serbia, for example, 57 per cent of Roma women were married before 18 compared with 7 per cent of the overall population (UNICEF, 2014).

When a girl is not in school, she misses out on opportunities to gain knowledge and build skills that may help her realize her full potential later in life

(figure 28). In addition, girls who are not in school may miss out on comprehensive sexuality education and life-skills training, where they could learn about their bodies, and about gender and power relations. In school, they could also build communication and negotiation skills, without which they will be additionally disadvantaged as they transition through adolescence into adulthood. Comprehensive sexuality education is a rights-based and gender-focused approach to sexuality education, whether in school or out of school. It is taught over several years, providing age-appropriate information consistent with the evolving capacities of young people.

An analysis has shown that countries with high out-of-school rates generally also have high adolescent birth rates, with rates highest for girls in Africa (United Nations, 2013a). One study of girls' education in Kenya found that an adolescent girl's chance of giving birth as a teenager dropped by 7.3 per cent if she had at least a primary education and by 5.6 per cent if she had at least a secondary education (Ferré, 2009).

Levels of educational attainment are similar among boys and girls in the wealthier segments of society around the world. For the majority of countries, the differences between boys and girls become more pronounced in the poorer segments. In India, for example, boys and girls between ages 15 and 19 in the wealthiest fifth of the population are both likely to reach grade 10. But boys from the poorest fifth of the population are likely to reach only grade 6, while girls are likely to reach only grade 1 (World Bank, 2012).

Inequalities in sexual and reproductive health and economic inequality

Inequalities in sexual and reproductive health correlate with economic inequality: women in the poorest wealth quintile of developing countries generally have least access to services essential for exercising their rights to prevent pregnancy, stay healthy during pregnancy and deliver safely.

Poverty excludes millions of women from life-saving services that are readily available to those in the top economic strata. This exclusion can lead to poor reproductive health outcomes, with repercussions not only for a woman's health, but also for the well-being of her household, her community, and the nation's economic and social development.

Inequalities in reproductive health and economic inequality may therefore be mutually reinforcing and have the potential to trap women in a vicious cycle of poverty, diminished capabilities and unrealized potential. Although the pathways between one dimension of inequality and another are not linear, the connections are clear.

Intersecting forms of inequality may have huge consequences for societies as a whole, with large numbers of women suffering ill health or being unable to decide whether, when or how often to become pregnant, and thus lacking the power to enter the paid labour force and realize their full potential. The damaging effects may span a lifetime for individuals and reach into the next generation.

Economic inequality is worsening in many parts of the world, especially in developing countries.

Research by institutions such as the World Bank, the International Monetary Fund and the Organisation for Economic Co-operation and Development (OECD), shows that extreme within-country income inequality can drag down economic growth.

One OECD study suggests that the long-term growth potential of developing countries is at stake when income inequality is wide, even in countries where remarkable progress has been made in reducing the incidence of extreme poverty (OECD, 2015). Conversely, narrowing inequality may boost

FIGURE 28

Percentage of poorest females aged 7-16 who have never been to school

Rank	Country	%
1	Somalia	95
2	Niger	78
3	Liberia	77
4	Mali	75
5	Burkina Faso	71
6	Guinea	68
7	Pakistan	62
8	Yemen	58
9	Benin	55
10	Côte d'Ivoire	52

Average years of education for the poorest 17-to-22-year-old females

Rank	Country	Years
1	Somalia	0.3
2	Niger	0.4
3	Mali	0.5
4	Guinea	0.5
5	Guinea-Bissau	0.8
6	Yemen	0.8
7	Central African Republic	0.8
8	Burkina Faso	0.9
9	Pakistan	1.0
10	Benin	1.1

Source: UNESCO and EFA-GMR, 2013

When a girl is not in school, she misses out on opportunities to gain knowledge and build skills that may help her realize HER FULL POTENTIAL LATER IN LIFE

economic growth and accelerate the reduction of poverty (World Bank, 2016).

Income inequality has a negative impact on growth largely because it reduces people's capacities and curbs opportunities of the poorest to build their human capital (OECD, 2015).

Although progress has been made in previous decades in reducing poverty, persistent economic inequality still hinders the progress of untold millions of people. Income inequality has been growing in most developed countries, widening the gap between the rich and the poor, and leading to economic stagnation for those at the bottom. OECD research also shows that people from poorer households spend less time in education and develop weaker literacy skills, leading to fewer opportunities for quality jobs and employment (OECD, 2015).

Compounding inequalities

When looking at the characteristics of those who are poor, it becomes clear that individuals in poverty are also those most likely to face other forms of inequality. The poor are more likely to be rural, less educated and living in households with more children: 80 per cent of the poor live in rural areas, 44 per cent are aged 14 or younger, and 39 per cent have no formal education (World Bank, 2016).

The interconnected, multidimensional nature of inequalities—in income, between the sexes, in reproductive health and in education—often makes it difficult to determine which forces are at play and in which ways. However, all of these inequalities interact, and have long-term and compounding consequences for people around the world.

Economic inequalities are often evident in wide or growing differences in health outcomes, which reflect inequalities in opportunity; and in access to information, quality health care or other public goods. Such inequalities in opportunity and access underpin health inequalities throughout the world, via unequal access to information technology, health education, modern health care and the benefits of scientific progress.

Attempts to address inequalities in outcomes or opportunities fall short if they fail to address the long-standing structural gender inequalities faced by women and girls, which operate in all societies, and which reinforce both relative and absolute deprivations.

The effects of income inequality are amplified and reproduced because of gender inequality, making the gender poverty gap one of the most resilient inequalities worldwide. A recent study showed that gender inequality is strongly associated with income inequality, which arises mainly from gender gaps in economic participation in higher-income countries, and with gender gaps in education, political empowerment and health in middle- and low-income countries (Gonzales et al., 2015a).

Structural gender inequality denies women the right to decide whether, when or whom to marry; and whether, when or how often to become pregnant. This lack of choice limits women's life trajectories early in life. The structural inequalities facing women and girls result in clustered and compounded inequalities that undermine the contributions of half the world's people.

Inequalities of outcome and opportunity reinforce other types of inequality, such as inequality of participation, decision-making, justice or protection under the law; unequal voice or access to media; unequal chances for leadership; and many more.

Inequalities also operate at multiple levels—they affect individuals in relation to their neighbours or fellow citizens, but also in relation to other household or family members.

Clustering of multiple types of inequality reinforces relative and absolute deprivation. It also contributes to spatial inequalities and large differences between communities in access to transport, employment and electrical power; proximity to environmental threats; and access to basic services.

Inequalities may also lead also to internal and international migration, as people relocate in an effort to cast off entrenched spatial inequalities, and find greater opportunities and better outcomes in new surroundings.

Similar to poverty and inequality at the level of individuals and households, poverty and inequality at the level of countries and regions can be self-perpetuating. The fact that the world's least developed countries are the main locus of human-made crises and disasters is not a coincidence. Inequalities may be at the heart of fragility, which may in turn magnify risks and increase the likelihood of crisis.

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CHAPTER 4

Towards equality by reaching the furthest behind first

Among the objectives and goals of the Programme of Action of the International Conference on Population and Development (ICPD), which guides the work of UNFPA, the United Nations Population Fund, are: "sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health".

The Programme of Action underlines "the essential task of eradicating poverty as an indispensable requirement for sustainable development, in order to decrease the disparities in standards of living and better meet the needs of the majority of the people of the world". Government activities in response to the ICPD agreement have contributed to remarkable gains over 20 years in gender equality, health and life expectancy, and the emergence of an estimated 1 billion people from extreme poverty (United Nations, 2014).

A new global agenda, with equality at its core

When nations of the world came together in 2015 to chart the course towards sustainable development for the next 15 years, they committed to ending poverty and hunger everywhere, to combating inequalities within and among countries, and to building inclusive societies that leave no one behind. They pledged to "reach the furthest behind first".

The 2030 Agenda for Sustainable Development and its accompanying 17 Sustainable Development Goals are grounded in principles of rights, fairness, inclusiveness and equality.

Nations of the world agreed that the new vision for sustainable development may only be realized if all of humanity is united and engaged in the effort, and that development in the future must benefit all, not just those at the top rungs of countries' economic, political or social ladders. "We are determined to end poverty and hunger, in all their forms and dimensions, and to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment", stated the United Nations resolution formally launching these goals.

Sustainable Development Goal 10 aims to reduce inequality within and among nations. It embraces specific targets, including sustaining income growth of the bottom 40 per cent of the population at a rate higher than the national average, and empowering and promoting the social, economic and political inclusion of all. The latter target touches on the many forms of inequality beyond the obvious economic ones associated with differential income and wealth, such as labour-force participation and wage inequality; political inequality, such as the denial of the right to vote and hold elected office; and inequality of access to quality education and health care.

Included in the global vision for the 2030 Agenda for Sustainable Development is the notion of "shared prosperity" and "a world of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination ... and of equal opportunity permitting the full realization of human potential …". Sustainable Development Goal 1, to end extreme poverty by 2030, and shared prosperity are more likely to be achieved if the incomes of the poorest 40 per cent of people grow more quickly than average incomes. The larger the growth rate in the incomes of the bottom 40 per cent of a population, the more quickly economic progress is shared with the poorer segments of society (World Bank, 2016).

Accelerating the growth in incomes among the bottom 40 per cent, however, requires major

investments in human capital, particularly in the education and health of children.

Other Sustainable Development Goals make clear that economic equality, whether of income or of individual wealth, is not the only measure of equality or human well-being. Goal 5 aims to achieve gender equality and empower all women and girls, and Goal 4 stresses inclusive and equitable quality education for all.

Achieving the Sustainable Development Goals by 2030 may be out of reach without a renewed focus on the poorest in all populations, and those for whom gender discrimination is harshest, educational attainment is most out of reach, and sexual and reproductive health and rights are anything but universal.

Laying the foundations for a demographic dividend

Reducing inequality in health, particularly reproductive health, can have a positive impact on economies through a "demographic dividend".

A demographic dividend is the potential for economic growth that can result from shifts in a population's age structure, when the share of the working-age population expands relative to that of the non-working-age population.

A demographic dividend is linked to a demographic transition, which begins when child and infant death rates decrease in response to increased access to vaccines, antibiotics, safe water, sanitation and better nutrition. As couples realize that they do not need to have as many children to

reach their desired family size, fertility rates begin falling.

Over time, desired family size itself decreases, and the ratio of the working-age population to the non-working-age population grows. The high ratio of workers to children and elderly dependent on them creates the potential for a major boost to economic growth, as resources that might otherwise be needed to support dependants can instead be diverted to savings and human capital. Meanwhile, having smaller families allows more women to enter the labour force and increase household incomes (UNFPA, 2016b).

Countries with large and rapidly growing populations of young people are poised to reap demographic dividends that could lead to long-term inclusive, equitable and strong economic growth, as well as sustainable human development (Bloom, 2016).

Prospects for reaping a large demographic dividend cannot be overstated, given that about 60 per cent of the population in least developed countries is aged 24 or younger. The size of the economic boost depends in part on how well a country invests in the human capital of its young people. Critical human capital investments include ones that enable girls, especially ones from poor households, to complete a secondary education, access comprehensive sexuality education and, later, access sexual and reproductive health information, services and supplies, including contraceptives.

The demographic dividend sets in motion a virtuous cycle in which enhancement of human capabilities—through investments in health, nutrition and education—accelerates economic growth. Economic growth in turn increases the potential for families and governments to invest additional resources in health, education and the capabilities of the next generation.

Yet, the world remains deeply unequal in terms of prospects for decent work or livelihoods. Compared with adults, young people are disproportionately unemployed, underemployed or working under highly vulnerable and insecure job conditions, and are more likely to lack access to essential sexual and reproductive health services. Young women are especially vulnerable to being trapped in informal and low-paid jobs because of pervasive gender inequality in the labour market, their disadvantage with respect to schooling, their potential responsibility for raising children, and rights violations through practices such as child marriage.

Young women are especially vulnerable to being trapped in INFORMAL AND LOW-PAID JOBS

The existence of large numbers of disadvantaged and systematically disempowered youth can undermine a country's potential to realize inclusive and sustainable development, and can perpetuate inequalities. Depriving young people of future prospects can further contribute to conflicts, and undermine countries' capacities to cope with humanitarian threats and climate change.

The demographic dividend offers a new approach and vision for the prospects and pathways to sustainable development in countries with high proportions of young people. Expanded investments in empowerment, including sexual and reproductive health and rights, and quality education, particularly at the critical juncture of adolescence, have lasting effects throughout life. When such investments extend broadly and equitably

across the population, they result in a surge of human capital into society. When this surge coincides with an increase in the share of the population that is young, as a result of reductions in childbearing, the result is an especially high proportion of the population with better health and education moving into their most productive years. If these young people are met with a society and economy that offer real opportunities for decent work, development can accelerate dramatically over the course of a generation.

Since 2015, UNFPA has supported 30 African countries with national appraisals of the potential for reaping and maximizing a demographic dividend. This has included analyses of population age structures, educational attainment and employment opportunities, and guidance on investment that can help realize a demographic dividend and help achieve the Sustainable Development Goals. Through the Sahel Women's Empowerment and Demographic Dividend—a joint initiative by the World Bank and UNFPA—Burkina Faso, Chad, Côte d'Ivoire, Mali, Mauritania and Niger are prioritizing the demographic dividend as a means to address human capital deficits and rapid population growth.

The realization of the demographic dividend depends on empowerment, education and employment, which are critically dependent on equality in sexual and reproductive health and rights.

Millions of girls, for example, are at risk of becoming child brides or teenage mothers, undermining their chances for an education and for realizing their full potential. With fewer skills, and with the health and other constraints that often accompany early pregnancy, these girls will find it difficult to enter the paid labour force. If they do find a job, they are likely to have lower incomes than their female counterparts who were not married or pregnant as adolescents. The result is a deprivation of rights, a lifetime of poverty, diminished opportunities and expectations, lost productivity and undeveloped human capital, with negative repercussions for households, communities, and countries' economic and social progress.

The development of human capital is essential for economic growth and the realization of the demographic dividend. Without a greater and equitable engagement of women, the demographic dividend will remain an elusive objective.

Universal health care: one pathway to equality

According to a World Bank study (2016), "progress toward universal health care constitutes the most promising and fair strategy to reduce health inequalities, raise the human capital of the poor, and contribute to increasing future earnings and narrowing income gaps simultaneously". Health care that is universal is care that is accessible without resulting in financial hardship.

Achieving universal health care therefore entails making services, including sexual and reproductive health care, available to people who have been excluded from them because of cost, gender or geography. It also requires expanding coverage more rapidly among the poorest 20 per cent of the population—the furthest behind—first.

Progress towards universal health care has been made in at least a dozen countries, ranging from Cambodia to Colombia, resulting in better health outcomes among, and lower costs to, the poor (World Bank, 2016). "Reducing health inequalities is not only fair, it also promotes improvement in the well-being of the poorest" and "enables their accumulation of human capital".

Investing in women's and adolescents' health, including their sexual and reproductive health, can yield substantial economic gains for countries.

Evidence presented, for instance, in the United Nations Global Strategy for Women's, Children's and Adolescents' Health shows that almost one quarter of income growth in low- and middle-income countries between 2000 and 2011 resulted from improved health outcomes overall (United Nations, 2016).

Well-targeted investments towards a continuum of care that includes reproductive, maternal, newborn and child health services respond to the fundamental right to health and enable countries to move closer to universal health coverage—services that are available to all without causing financial hardship for people paying for them (Black et al., 2016).

Investments in high-impact interventions across this continuum of care also have large economic and social returns, in addition to the impact on health outcomes, with a benefit-to-cost ratio of up to 8.7 to 1 (Black et al., 2016). Investments can lead to lower fertility rates, which can boost a country's economic growth by enabling more women to enter the paid labour force, and reinvest earnings into the health and education of their children, setting off an intergenerational cycle of poverty reduction and rising incomes (Black et al., 2016).

Investments specifically in contraception have been shown to yield substantial returns to economies. The unmet demand for contraception around the world is highest among the poorest households, among women with less education and among women living in rural areas, compared with wealthier, better educated, urban women. The unmet demand is also disproportionately greater in low-income countries (Guttmacher Institute and UNFPA, 2014).

Meeting all unmet demand in developing countries is about upholding the rights of all, but would also boost economies by eliminating the economic and human costs associated with unplanned pregnancies. If all unmet demand were addressed, unintended pregnancies each year would drop by about 75 per cent, from 89 million to 22 million (Guttmacher Institute, 2017).

Addressing multidimensional inequality from all directions

Patterns of inequality in income and wealth, education, health and gender may be traced to discrimination and adverse norms entrenched in law as well as in practice, creating systematic barriers to economic opportunity, voice or agency.

For a government seeking to address any single form of inequality, multiple actions may be needed in economic policy, legal systems, financial regulations and the social safety net. When the goal is to address multidimensional inequality, the challenges multiply and may overwhelm policymakers seeking to effect maximum change within an environment of scarce financial and technical resources.

The multidimensional and persistent nature of the challenge means that there is no single or easy way to close gaps between women and men, rich and poor, rural and urban, and the healthy and those who have no access to care. As the Lancet Commission noted in its seminal report on adolescent health and well-being, "the most powerful actions are inter-sectoral, multilevel and multi-component" (Lancet Commission, 2016).

Still, progress is possible, without addressing every dimension of inequality at the same time. Progress in one dimension can enable progress in others. Even small steps can open the path to great strides.

Governments, civil society and development institutions have piloted programmes that have

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FIGURE 29 **The benefits of improved sexual and reproductive health care for all extend far beyond health**

FOR SOCIETIES

- ↑ Increase in growth of GDP and GDP per capita
- ↑ Increase in number of working-age adults relative to dependent children
- ↓ Decrease in demand for public expenditure in education, housing and sanitation

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FOR FAMILIES AND HOUSEHOLDS

- ↑ Increase in savings and household assets
- ↓ Reduction in the number of children who become orphans
- ↑ Increase in children's schooling
- ↑ Increase in resources for each child

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FOR WOMEN

- ↑ Increase in ability to continue education
- ↑ Increase in production and earnings
- ↑ Increase in autonomy and self-esteem
- ↑ Increase in gender equity

Source: Guttmacher Institute and UNFPA (2014)

reduced one or more facets of multidimensional inequality by addressing societal and institutional structures that perpetuate or exacerbate inequality, and create barriers for subsets of the population. The promising results of some of these initiatives indicate that they may be scaled up to have a great impact on reducing inequalities in gender, education, access to health—and income and wealth.

A conundrum for any government or other actor aiming to narrow a gap in society is finding the right starting point. The range of possible entry points is wide. A number of countries have had successes in tackling multidimensional inequality by approaching the problem through initiatives to change gender-discriminatory norms, promote equal access to sexual and reproductive health care, and empower excluded groups, particularly women and adolescent girls.

Empowering women and girls may help eliminate multidimensional inequality. The empowerment and autonomy of women, including the most marginalized groups, enables them to freely make decisions on whether and when to have children, on their own reproductive health care, and on their participation in productive life outside the home. Moreover, improvement of women's political, social, economic and health status is essential for the achievement of sustainable development.

A growing number of promising interventions have taken a multifaceted approach, such as increasing access to adolescent sexual and reproductive health services as part of an economic empowerment programme for the poor.

In the quest for equality, a good place to start is with those at the bottom of the economic scale, the marginalized and those who have been left behind.

Changing gender-discriminatory norms, practices and laws

Norms influence how much agency, or power to make decisions, girls and women have with respect to sexual and reproductive health, compared with boys and men.

Norms are deeply related to social and economic structures, and the connections among them can run in both directions. Norms can constrain women's economic prospects by, for example, creating expectations that women be responsible for most or all unpaid work at home.

Changing gender-discriminatory norms is one important entry point for addressing multidimensional inequality. Accumulating evidence suggests that successful efforts tend to work in multiple ways on different levels, rather than as simple, stand-alone interventions. They engage schools, communities, employers, civil society, the media—and women, men, girls and boys—in the transformation (Parsons and McCleary-Sills, 2014).

Economic change itself can influence norms: expanded economic opportunities can help women break free from traditional norms that undervalue women and girls relative to men, and that perpetuate systematic gender inequality inside and outside the home. Greater opportunities for education and work can encourage women and girls to aspire to jobs and greater autonomy outside the home. A study in India, for example, showed that new job opportunities in call centres bolstered parents' aspirations for their daughters' education and job opportunities, generating more equal opportunities for daughters and sons (Jensen, 2012).

In Bangladesh, the expansion of job opportunities for women in the garment sector was associated with a rapid increase in girls' schooling: between 1983 and 2000, villages

within commuting distance of garment factories saw a 27 per cent increase in girls' school enrolment rates (Heath and Mobarak, 2014).

Despite the advances that have been made in women's securing formal employment in line with their educational qualifications, gender-discriminatory norms in employment persist. These include not only gender pay gaps, particularly between men and women, but also preferences for employing men rather than women, particularly single women and women without children—for fear that future childbearing will undercut the long-term value of female employees. Changing gender-discriminatory norms in the workplace is thus critical to addressing multidimensional inequality.

Studies have found a positive association between gender equality, per capita gross domestic product (GDP) and levels of human development. The improvement in gender equality that comes from a higher proportion of women in the labour force has been associated with lower income inequality (Gonzales et al., 2015a).

Gender equality in employment can add substantially to a country's GDP. For example, if women in Cabo Verde participated in the labour force at the same rate as men, GDP would increase by 12.2 per cent (Marone, 2016). Currently, the labour-force participation rate in Cabo Verde is about 51 per cent for women and 65 per cent for men.

A McKinsey Global Institute report (Woetzel et al., 2015) shows that $28 trillion could be added to global annual GDP by 2025 if women's participation in labour markets were identical to that of men. If women in India, for example, participated in the labour force at the same rate as men, an estimated $700 billion would be added to the country's annual GDP by 2025, raising the country's annual GDP growth rate by 1.4 percentage points.

Studies have found a
POSITIVE ASSOCIATION
between gender equality, per capita GDP and levels of human development

Community-level interventions can help end practices that harm women and girls

Community-led programmes have been identified as necessary to tackle the social conventions regarding female genital mutilation. Evaluations of initiatives aimed at abandoning this harmful practice suggest that community involvement is key to creating sustainable change. Community-led interventions have aimed to promote the empowerment of women and girls, and the community at large, to enable them to critically examine their own tradition and to gain the power to abandon the practice for their own benefit. Experience shows that large-scale abandonment can only be expected when female genital mutilation is no longer a dominant social norm and when families may abandon the practice without the risk of stigmatization and exclusion.

The successful involvement of men and women as part of a community-wide approach to shifting deep-rooted unequal norms is critical for the abandonment of female genital mutilation. Research has assessed the process of change among men and boys reached through Ethiopia's Kembatti Mentti Gezzimma initiative, which has challenged social acceptance and reduced the prevalence of this harmful practice at phenomenal rates (Stern and Anderson, 2015). Through this initiative, boys and men are agents of change for gender equality, and disseminators of information about

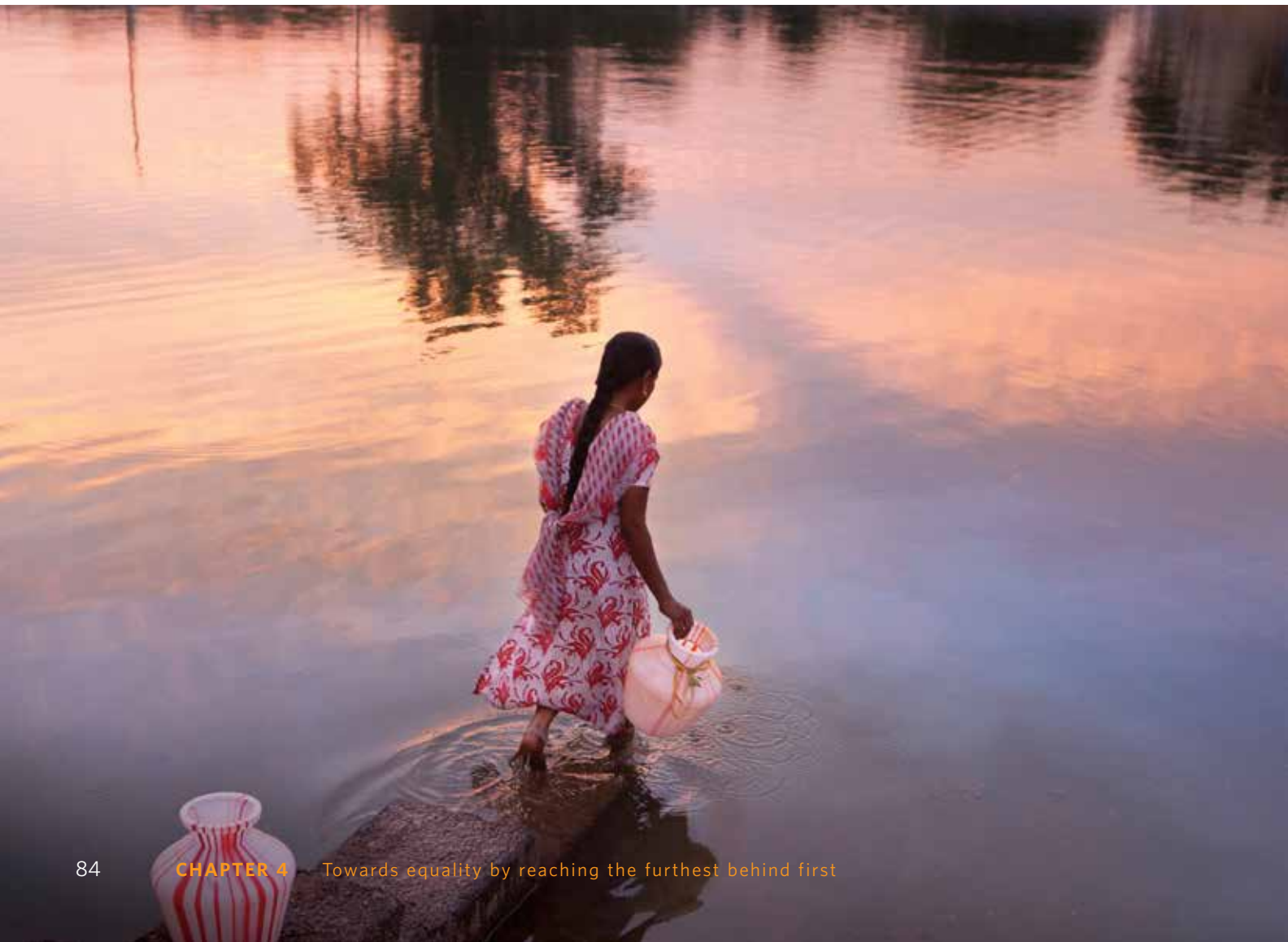
the practice and its harms. The initiative included alternative income-generating opportunities for traditional circumcisers and celebrations of whole-body, "healthy life" events to replace rituals during which the harmful practice occurred. Integrating economic development into the effort also helped boost community support for abandonment of the practice.

The intervention also diminished other harmful practices, such as bride abduction, because it helped shift men's and women's ideas about gender inequality. It led to support for women's access to property inheritance, political participation and household decision-making, and for reducing women's domestic burden.

Community involvement can bolster the status of girls and women

Community involvement can amplify the results of initiatives in schools, clubs and safe spaces to empower girls and change gender-unequal norms. Community-based life-skills programmes, such as Berhane Hewan in Ethiopia, have resulted in later age of marriage, greater educational attainment and increased use of contraception among participating adolescent girls, compared with adolescents not in the programme (Erulkar and Muthengi, 2009).

In Uganda, a vocational training programme—paired with safe spaces for young women to interact with each other, and to receive information on health and risky behaviours—reduced the share



of young women experiencing forced sex from 21 per cent to nearly zero. It also increased engagement in income-generating activities by 35 per cent (Bandiera et al., 2015).

A number of countries have brought about changes in gender-unequal norms through workshops and training that engaged men and boys in discussions about gender stereotypes, relationships and violence. Examples include the Boys4Change club in Rwanda, the Equal Community Foundation in India, and the Brave Men project in Bangladesh (Barker et al., 2007; Pulerwitz et al., 2006).

Men participating in a programme in Nicaragua spearheaded by Promundo, a non-governmental organization that engages men and boys in the promotion of gender equality in 22 countries, reported men participating more equally in household duties, dedicating more time to their children and partners, and teaching their children values of respect and equality (ECPAT Guatemala et al., 2015).

Some of the most effective actions for positive norm change have involved working with children and adolescents—male and female—usually through life-skills training in schools, girls' clubs or safe spaces, as well as through increasing awareness and information about rights. Norms that are commonly addressed include those about relationships, gender and power.

Schools are communities where respect and equality can be modelled to shape positive attitudes and behaviours at an early stage, to affect lifetime attitudes, with larger spheres of influence. The impact of school-based programmes on attitudes around gender inequality can be profound.

The Gender Equity Movement in Schools (GEMS) programme in India helps boys and girls adopt more gender-equitable norms through role-playing games, extracurricular activities, and lessons about gender-based violence, marriage and sharing of household tasks. An evaluation of a GEMS programme in Mumbai showed that, after two years, students were more likely than students not in the programme to support higher education for girls, and openly express opposition to gender-based violence and child marriage.

Knowledge gained by adolescents and their families at schools, at clinics or through the media can help change gender-discriminatory norms and attitudes. In Ethiopia, Nepal and Viet Nam, for example, families changed their attitudes about child marriage after they learned about the associated health risks to adolescents and the economic benefits of delaying parenthood (ODI, 2015).

In Ethiopia and Kenya, a Youth-to-Youth club initiative aimed at building life skills and self-esteem helped female youth earn incomes, and increase men's acceptance of women's leadership (Tautz, 2011). In the Dominican Republic a life-skills programme, Juventud y Empleo, led to small increases in earnings for participants and a 5 percentage point reduction in adolescent pregnancy (Ibarrarán et al., 2014.)

A female empowerment programme run by BRAC in Uganda that provided teenage girls with vocational training, and information on sex and marriage led to a 26 per cent decline in teenage pregnancy rates, a 58 per cent decline in early marriage or cohabitation, a 50 per cent reduction in the number of girls reporting forced sex and substantial increases in income generation (Bandiera et al., 2015).

Examples of norm-changing programmes may also be found in developed countries. A programme in Victoria, Australia, for example, builds a culture of respect and equality in schools with the aim of fostering respectful relationships, free from violence, as students mature and transition through adolescence into adulthood. The programme began as a pilot initiative in 19 schools. An evaluation of the pilot documented positive shifts in attitudes about gender, and awareness about gender inequality and gender-based violence.

Many countries now constitutionally or otherwise formally **GUARANTEE EQUALITY** under the law, but enforcement may be weak

Partnering with the media can promote gender equality

Although popular images often reinforce negative gender stereotypes, television and radio can be an ally in bringing about change by challenging commonly held gender norms about what is acceptable and typical. They can do this by exposing people to different views and creating a counter-narrative.

One evaluation found that increased access to cable television—regardless of the type of programming—increased acceptance of women working outside the home and reduced tolerance for domestic violence (Jensen and Oster, 2009).

In South Africa, the *Soul City* television drama series, launched in 1994, communicates health and development messages, and models healthy

behaviour. It is supported by radio, print and advocacy campaigns that are designed to prompt and continue the conversation, and has been shown to generate positive changes in perceptions and behaviour, including around violence towards women (Soul City Institute for Health and Development Communication, 2001).

Changes in laws have also made a difference in promoting gender equality, economic equality, and equality in sexual and reproductive health and rights. Many countries now constitutionally or otherwise formally guarantee equality under the law, but enforcement may be weak, and rights not uniformly protected.

Unequal protection under the law has, in the past, resulted in more limited economic opportunities for women than men in some countries (Gonzales et al., 2015b; Hallward-Driemeier and Gajigo 2013). For example, in some societies, only men are legally allowed to inherit property (Deininger et al., 2010). Changing laws to put women and men on an equal footing in inheritance laws has been shown to reduce income inequality between the sexes. For example, reforms to inheritance laws in India resulted in greater economic power for women, later age of marriage for girls, an increase of 11 per cent to 25 per cent in average years of schooling for girls and smaller dowry payments (Roy, 2011).

In Ethiopia, reforms to the country's family law in 2000 removed a husband's ability to deny his wife permission to work. The reforms also require consent of both spouses to sell or lease property owned in common (Hallward-Driemeier and Gajigo, 2013). The reforms were initially implemented in three of the country's nine regions, allowing an assessment of the impact. In regions with the reforms, women's economic activity shifted towards greater participation in work outside the home, full-time employment and jobs requiring higher levels of skill or training.

Other legal reforms in Ethiopia led to a reduction in fertility. Before 1997, laws allocated communal land to families based on family size. After 1997, however, the law eliminated land-related incentives for large families. A geographic analysis coinciding with the roll-out of this reform showed that it was associated with women having, on average, 1.2 fewer children than they would have had two decades earlier (Ali et al., 2015).

Actions aiming for equal access to contraception

Use of modern contraception varies widely in developing regions. Whereas almost nine of 10 married women between the ages of 15 and 49 use a modern method of contraception in East Asia, fewer than one in five do so in sub-Saharan Africa (Guttmacher Institute and UNFPA, 2014). In addition, many women, especially those who are poor, lack access to their preferred contraceptive method.

A concerted global effort, Family Planning 2020 (FP2020), is under way to help 120 million more women access contraception by 2020. Donors contributed $1.4 billion towards the effort in 2014. FP2020 is based on the principle that all women, no matter where they live, have a right to access contraceptives.

Expanding access to contraception requires not only increasing the supplies of quality contraceptives available and information about their safe use, but also making sure that a range of contraceptive methods is available. It also requires tearing down geographic, social and economic barriers to their use.

The Philippines, for example, made contraceptives available for free, to overcome economic barriers for an estimated 6 million women who had an unmet need for family planning. In Myanmar, UNFPA helped the

government expand the range of contraceptive options so that women can choose the method best suited to their circumstances. The government also made contraceptive implants available for free for poor women. Ghana, Tanzania and other African countries are experimenting with drones to deliver contraceptives to remote rural areas. Drones could reduce the time required to deliver contraceptives to some areas from two days to 30 minutes.

As shown in chapter 1, Rwanda made the fastest progress among about 60 developing countries over a 10-year period in satisfying the demand for modern contraception. The success is attributable to government efforts to make family planning services available in each of the country's 14,841 administrative villages through 45,000 community health workers. Measures included introduction of long-lasting contraceptive methods, and integration of family planning services in hospitals and health centres.

Senegal's decentralization of services and improved distribution of supplies has increased the rate of contraceptive prevalence, especially in rural areas, from 7 per cent in 2011 to 15 per cent in 2015.

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Reducing inequalities in services for safer pregnancies and safer deliveries

Poor women in rural areas have less access to quality antenatal and obstetric care than wealthier women in urban areas. An estimated one quarter of pregnant women in developing countries today lack access to skilled birth attendants, and many have no alternative but to deliver on their own (Lancet, 2016).

As shown in chapter 1, some countries have made more progress than others in expanding access to skilled birth attendants, including midwives, and in expanding access to them by the poor, relative to the rich.

Cambodia, for example, has made more progress than about 60 other developing countries in increasing the poor's access to skilled birth attendants over a recent 10-year period. Government actions leading to this progress include training midwives and deploying them to poor, rural areas. Strengthening the midwifery workforce has led to greater availability of antenatal care in poorer communities across the country. A national Health Equity Fund helps the poor, especially in remote areas, pay for reproductive health and safe delivery services.

Also highlighted in chapter 1 is the success of Armenia in reducing inequalities in access to antenatal care by pregnant women in the poorest households, relative to those in the wealthiest

ones. In 2008, Armenia introduced vouchers, or "maternity certificates", to enable poor women to receive free or reduced-cost antenatal care, as well as safe delivery services. Before 2008, about 39 per cent of pregnant women paid for antenatal care. Since then, that share has dropped to about 10 per cent.

Measures to ensure adolescents' equal access to sexual and reproductive health information and services

An estimated one third of adolescent pregnancies are unintended (Hindin et al., 2016).

Adolescents, compared with married adults, often lack access to contraceptives and information about their use. Barriers include a lack of knowledge of where to obtain contraceptives, fear of being rejected by service providers, opposition by a partner, community stigma about contraception or adolescent sexuality, inconvenient locations or clinic hours, costs, and concerns about privacy and confidentiality (UNFPA, 2013b).

To make it easier for adolescents to learn about preventing pregnancy and sexually transmitted infections, including HIV, and to obtain contraceptives, an increasing number of countries have established youth-friendly sexual and reproductive health services. Youth-friendly services typically ensure adolescents' privacy, are in locations—and are open at hours—that are convenient to young people, are staffed by providers who are trained in meeting young people's needs, and offer a complete package of essential services.

Given the high risk of neonatal deaths among mothers under age 18, Senegal, with UNFPA support, provides youth-friendly services through "teen spaces" in health facilities, and contraceptive services and screening for sexually transmitted infections, including HIV. These services helped reduced the adolescent birth rate from 22 per cent in 1997 to 16 per cent in 2015.

Nicaragua enabled adolescents from poor households to access sexual and reproductive health services, including contraception, through vouchers distributed in places where young people congregate or handed out door to door. Vouchers may be used for a free consultation and follow-up visit for contraception, tests for sexually transmitted infections, including HIV, and pregnancy testing (UNFPA, 2013b).

Through Mozambique's Geração Biz programme, the ministries of health, education and human development, and youth and sports jointly provide youth-friendly sexual and reproductive health services, school-based information campaigns about contraception and HIV prevention, and community-based information to reach young people who are not in school. Through a network of 5,000 peer counsellors, Geração Biz provides non-judgmental, confidential information and services to Mozambique's youth.

Education leading to empowerment and better health

Literacy and education are among the most pivotal investments that can help redress inequalities, have redistributive effects and empower individuals and communities (Doss, 2013; Drèze and Sen, 1995; Malhotra et al., 2011; Prettner and Strulik, 2014).

Education increases girls' aspirations for work outside the home and empowers them to compete for good jobs later in life. As women enter the formal workforce, their incomes are augmented and their standards of living improve. The resulting expansion of incomes can raise a

nation's overall productivity and economic growth (Sperling and Winthrop, 2016).

Access to education can open doors to paid employment, which can empower women, reduce the grip of patriarchy by reducing financial dependence on husbands, and lead to greater autonomy and freedom. Higher educational attainment also increases the ability of all disadvantaged groups to secure greater economic stability and organize politically. More education for girls enhances their social status and can later lead to greater bargaining power in their households (United Nations, 2014).

The positive effects of investing in girls' and women's education extend beyond labour-force participation and productivity. Investments yield substantial health benefits as well. For example, greater educational attainment of girls and women is positively associated with better maternal and child health outcomes, and lower mortality rates (UNFPA, 2014).

In addition, closing the gender gap in education would enable more women, particularly those within the poorest 20 per cent of a country's population, to exercise greater control over the timing and spacing of pregnancies, and thus to have more control over other spheres of their lives (Doss, 2013; Malhotra et al., 2011; Prettner and Strulik, 2014).

Closing the gender gap in education can help fuel economic growth within a country and enable progress in reducing income inequality. Sabot et al. (2016) have shown that East Asian economies recorded rapid growth over 30 years, with relatively low levels of, or reductions in, income inequality, through policies that shared and stimulated growth. Investments in education, in particular, were found to be instrumental to reducing inequality.

Levelling the playing field in education

Gender inequality in education is linked to income inequality as well as inequality in access to, and use of, reproductive health services, including contraception. Removing barriers to girls' education can thus help reduce other inequalities.

One barrier that affects girls more than boys is poverty. The direct costs associated with girls attending school, or the opportunity costs of not having a girl stay at home to help with household chores or care for siblings may be too high for families.

Direct costs may be reduced by eliminating fees and subsidizing purchases of school uniforms or textbooks. Opportunity costs for families may be reduced through measures such as conditional cash transfers. Through these transfers, a small amount of cash, often about $10, is provided to a family every month to defray the costs of sending girls to school. One such programme in Malawi not only allowed more girls to attend school and stay in school longer, but was also associated with lower rates of adolescent pregnancy (Baird et al., 2011).

Unconditional cash transfers, not specifically tied to keeping girls in school, have also been effective in enabling girls to attend school and stay in school longer (Baird et al., 2013).

Conditional cash transfers have been used in Peru, not only to increase girls' participation in school, but also as a means to help adolescent girls delay pregnancy (Azevedo et al., 2012). A conditional cash transfer programme in Colombia was also found to reduce adolescent pregnancy rates (Cortés et al., 2011).

The Female School Stipend Programme in India aimed to reduce the gender gap in schooling, in a context of high rates of poverty and child marriage. A payment of about $10 was

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made quarterly to families, conditional on regular school attendance in poorer districts. Among the positive impacts were increased age of marriage, by up to 1.5 years, and an average fertility reduction of 0.4 children, compared with control groups (Glassman and Temin, 2016).

A matter of rights

Narrowing the gaps between the affluent and the poor, women and men, the privileged and the excluded is above all a matter of respecting the human rights of all people to realize their full potential.

Society can reap enormous economic and social benefits when all people are able to enjoy their rights to health and education; when women are able to decide whether, when and how often to become pregnant; and when men and women are on an equal footing in the labour force.

Research shows that raising the incomes and improving the well-being of those at the bottom of the economic ladder helps fuel whole economies and raise living standards for all.

Resolving multidimensional inequality requires actions on many fronts because so many aspects of inequality reinforce each other. The challenge can be overwhelming for any government, especially for those with extreme resource constraints. Prioritizing actions according to urgency and potential impact is therefore necessary.

Developing countries have piloted numerous programmes that have reduced particular dimensions of inequality among specific groups, such as adolescent girls, or the poorest women in the poorest rural communities. The challenge now is to scale up initiatives so that they reach more people, and put more women, men, girls and boys on an equal footing.

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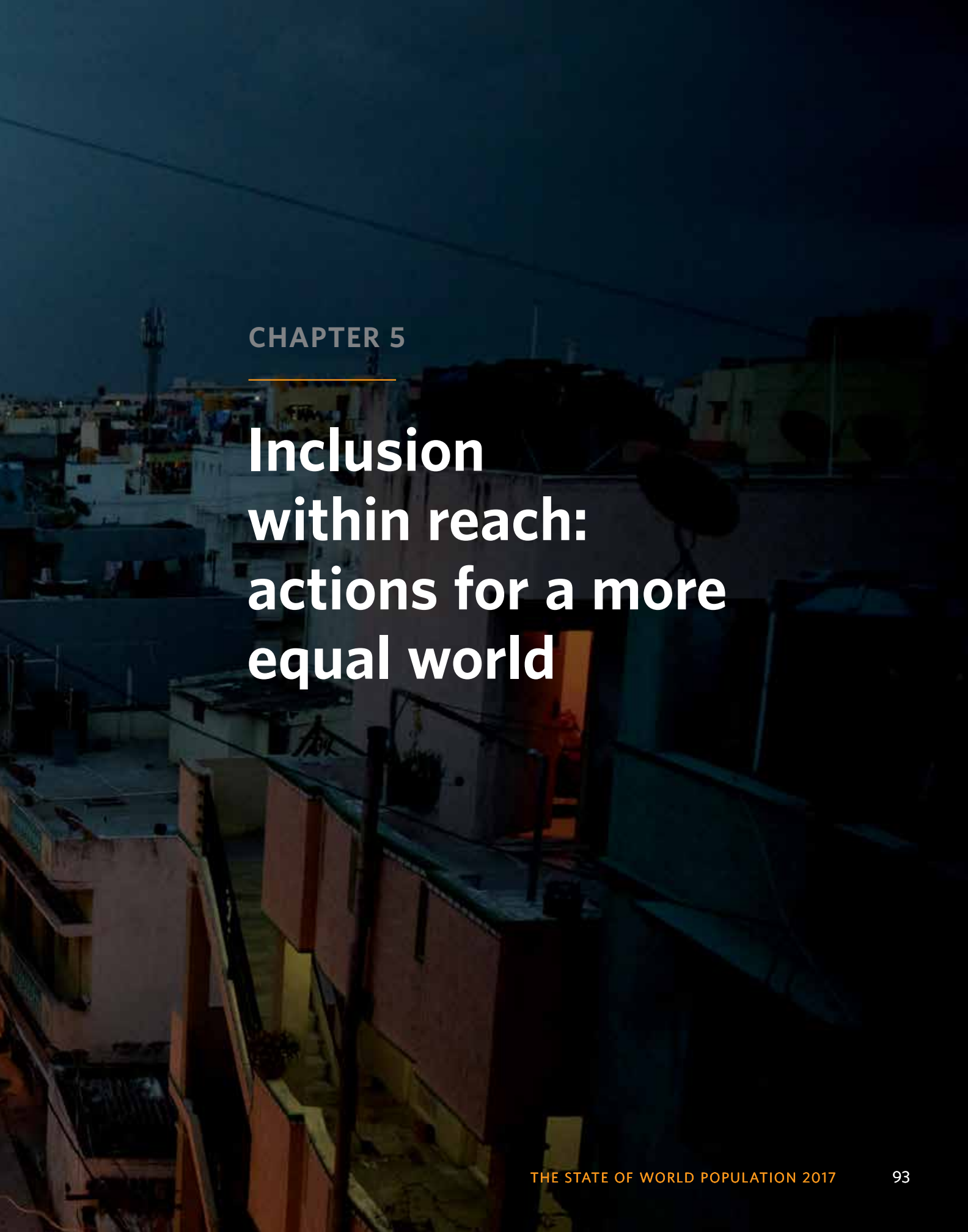

CHAPTER 5

Inclusion within reach: actions for a more equal world

Inequality is not inevitable. If we close the gaps, we fulfil a moral obligation to uphold human rights, and we will all reap the benefits of a more equal world. It will be more just, stable, prosperous and sustainable—one that we will want to leave to future generations.

The most promising ways forward may be those that tackle intersections among inequalities, among individuals, and within societies and economies. Among these are measures to realize reproductive rights and gender equality, with a particular and urgent emphasis on reaching people ranked among the poorest 40 per cent—the furthest behind.

Making reproductive health care universally accessible, for example, not only helps fulfil a poor woman's reproductive rights, but also helps her overcome inequalities in education and income, with benefits that accrue to her, her family and her country.

Many paths lead ahead, depending on diverse circumstances in different countries. The 2030 Agenda for Sustainable Development offers a foundation to guide progress, as do other core international commitments, such as the Programme of Action of the International Conference on Population and Development, which guides the work of UNFPA.

Whatever the course, it is time for stepped-up action, because, the more entrenched the gaps become, the more difficult they will be to close. Progress must be fast and fair, and sustainable over time. A more equal world depends on it.

Uphold universal rights, including to sexual and reproductive health

All countries need to uphold rights to work, education and health, including reproductive health, in line with the Universal Declaration of Human Rights, and a host of other international treaties, conventions and agreements.

Universal health care is one of the foundations of more inclusive societies, as recognized in the 2030 Agenda. A Lancet Commission in 2013 found that scaling up core health interventions in 82 low- and lower-middle-income countries, including to reduce disparities among the poor, rural and ethnic minorities, would save 10 million lives by 2035. Further, services that improve antenatal and maternal health, reduce low birthweight and stunting, and expand preventive child and adolescent health care are among the best investments in economic productivity and lifetime earnings in this and future generations.

For poorer women, in particular, quality health care, including sexual and reproductive health-care services, is essential not only for their own well-being, but also in freeing up time that they otherwise spend in providing health care to family members. This can mean more time to pursue employment or a livelihood, and lead to higher incomes.

Within national health systems, some possible areas of emphasis are those where the poor are still significantly behind: access to family planning, antenatal care and skilled attendance at birth.

The quality of services is also important. For example, reproductive health care that offers a single, marginally acceptable method of contraception to a poor rural population needs to move towards a comprehensive choice of methods, along with providing knowledge to make informed choices, if inequalities are to be reduced.

To advance inclusion, health services need to be tailored across the life cycle, with one major gap currently being the low level of responsiveness to youth and adolescents. Obstacles are higher for young people to obtain contraceptives, as a result of restrictive laws and policies, and stigmas associated with adolescent sex. Only a quarter of young women know enough to protect

themselves from HIV, even though a majority of new infections are in young women and girls (United Nations, 2013b).

A healthier start to life would give many young people a far better chance of overcoming other sources of inequality throughout their lives. Health-care services in many cases need to proactively break down barriers that marginalize adolescents and youth, such as through free and confidential services, specially trained counsellors, and the dissemination of information through new technology or in places where youth may congregate. One priority would be programmes to meet young people's contraception needs, since unintended and early pregnancy can derail education and possibilities to move into the paid workforce.

Make equality a matter of law

Explicitly embedding equal rights for all citizens in national law and legal practice can underpin other steps to reduce disparities. Among other international commitments, this aligns with the Convention on the Elimination of All Forms of Discrimination against Women. Under the convention, all but a handful of United Nations Member States agreed "to embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle".

Making equality a legal principle, especially at the highest level, such as a constitution, would open the door to removing discriminatory laws and practices. It requires putting in place measures that actively counteract not just legal but also economic, social and political patterns that allow inequality to persist and result in shortfalls in human rights.

Through the law, currently marginalized people can gain a platform to claim their human rights, especially if measures are in place to guarantee equal protection under the law and equal access to justice systems. This can lead to the correction of biases in public services that favour urban over rural areas, for example, or to closing pay gaps when women and men perform the same jobs.

Where resources are constrained, equalizing measures may be adopted over time, provided that the process is non-discriminatory and maximizes the use of available resources. The International Covenant on Economic, Social and Cultural Rights recognizes the principle of "progressive realization", as do conventions on children and disabilities.

Scale up to achieve rights and returns

The 2030 Agenda calls for great ambition, aimed at transformation. Realizing its aspirations, including to leave no one behind, will depend greatly on scaling up resources and development strategies. In particular, people already facing the greatest inequalities are unlikely to be reached by business-as-usual scenarios, which so far have mostly maintained or even deepened their exclusion.

The case for scaling up rests on several arguments. First, extending quality essential services to all upholds human rights. Second, there is now a vast body of knowledge about what works, whether the issue is preventing the transmission of HIV or extending access to financial services. Third, scaled-up investments pay off. For instance, according to the Guttmacher Institute, every $1 spent on contraceptive services reduces the cost of pregnancy-related care by $2.22 (Guttmacher Institute, 2017).

Most of the need is in low- and lower-middle-income countries, and, within them, in the poorest communities.

Scaling up and strengthening health systems are essential to ensuring equitable and universal access to care and services across different locations

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and income levels, and addressing other factors that underpin marginalization. For example, the disproportionate concentration of health-care workers in urban areas, as is the case in most countries, needs to be tackled. Some approaches to reach rural areas are health worker rotations, new uses of mobile technologies, and rural-urban links in the health system and related areas such as transport. Health services also improve when ordinary people are consulted about their needs and about how they experience the health-care system.

Scaling up, while requiring extra resources in the short term, stands to deliver significant returns over the long term, especially in countries with relatively large, young and impoverished populations. Universal sexual and reproductive health services, for example, would build momentum towards a demographic transition, which in turn could accelerate economic growth in countries with large and growing youth populations.

Equally important is to effectively and equitably reapportion existing resources, which may require spending more on groups who have been left behind, particularly the poorest 40 per cent. Making these choices can start in public budget processes modelled on the gender-budgeting exercises that have been applied in a number of countries, at both the national and subnational levels. These review the collection and spending of public resources to see whether current practices align with, or contribute to, gender equality.

Count what's uncounted

Inequalities too often go uncounted or are poorly understood—either way, they may not be well seen. This inhibits adjusting the "rules of the game" to ensure that policies do not disproportionately benefit those who are already well off within societies and the international system. For instance, even while education

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and health care improve overall, women still continue to face greater odds of poverty and unemployment than men, and, even if working in comparable jobs, tend to have lower earnings.

There is no better example of inadequate measurement than the still heavy reliance on gross domestic product (GDP) as an indicator of national well-being. By this standard, one African country grew at a rapid clip of 6 per cent annually between 1998 and 2010. Meanwhile, the poverty rate soared from 43 per cent to 64 per cent, affecting 4 million people. GDP also takes no account of women's unpaid work—even though that amounts to an estimated $10 trillion per year, globally (Oxfam, 2017).

Although GDP has long been recognized as an inadequate measure of well-being, current inequalities make the development of alternatives or complementary options—as called for in the 2030 Agenda—increasingly urgent. In 2009, the Stiglitz-Sen-Fitoussi Commission, which aimed to explore improved measurement of economic and social progress, recommended giving more prominence to the distribution of income, consumption and wealth, and assessing inequalities in *all* dimensions of quality-of-life indicators.

The Sustainable Development Goals are widely seen as a call for a statistical revolution, given the expansive reach of their targets and indicators. One element is to better use existing data as the foundation for investment, particularly to ensure that services and resources, even if they are limited, reach people at the bottom first. Data may also need to be better disaggregated to capture inequalities across all parameters relevant to a given country, nationally or subnationally. It is not enough, for instance, to know how many people have access to contraceptives. More revealing will be the shares across different income groups, which

can then be the basis for scaled-up or targeted efforts to reduce disparities.

National data systems must serve all people, and document and track not only absolute deprivations, but also inequalities, over time, across numerous dimensions of development. In many cases, statistical systems require better coordination and communication, so that the reinforcing nature of inequalities can be dealt with in an integrated manner, not sector by sector, programme by programme, or even data point by data point. Measurements that can show how different interventions influence each other can better guide the multisector interventions that may be most powerful in reducing disparities.

Jumpstart upwards mobility through education and decent work

Realizing the right to a quality education contributes to upward mobility in the labour market, better health and lower fertility. It also reduces the transmission of poverty across generations. Yet remaining in school is often challenging for excluded children, especially poor rural girls. Poorer families may choose to pay school fees only for boys, or marry girls off at a young age so that they become someone else's responsibility. Many girls still leave school to perform household labour.

Some solutions start within education systems, through, for example, eliminating fees or providing subsidies to poor families. Other factors important for inclusion may be teaching in local languages, or ensuring that schools are safe and have separate sanitary facilities for girls. Incentives to sustain girls' education include conditional and unconditional cash transfers to poor families and school feeding programmes.

Schools should offer comprehensive sexuality education, in age-appropriate curricula. This should equip young people and adolescents to make informed and empowered choices about their sexual and reproductive health.

For people on the margins, the value of education is often seen in terms of how much it contributes to future well-being, suggesting closer alignment of curricula with labour markets. In Bangladesh, for example, some evidence indicates that the growth of the garment industry is keeping significantly higher numbers of girls in school, given employers' requirements for basic literacy and numeracy.

Advancing the promise embodied in experiences such as this, including by aiming for decent work across all sectors of the economy, would require measures such as opening more opportunities for girls in all types of vocational and technical education, and eliminating gender biases that channel girls into traditional (and often poorly paid) fields. The numbers of girls and women going into so-called STEM fields—science, technology, engineering and mathematics—are still very low, for example, even though many future jobs will lie there.

By one World Economic Forum estimate, women will gain only one new STEM job for every 20 lost in other areas, whereas the ratio for men is one new job for every four lost elsewhere (World Economic Forum, 2016b). However, if the pace at which women become frequent users of digital technologies is doubled, the workplace could reach gender equality much faster than many current estimates predict (Accenture, 2016). A programme in Costa Rica, for example, is helping girls in impoverished rural areas learn about science and technology in schools, and connecting young women graduates to opportunities to become entrepreneurs in information and communication technology.

Many of the 1 billion people living in poverty around the world are working informally, scraping out a living in subsistence agriculture, in domestic service or as day labourers. These jobs provide no benefits and may not be covered by labour laws. Earnings are often so low that they entrench other inequalities and violations of rights, such as a lack of access to health care or education.

Informal work is typically also low in productivity. Although, in some economies, it may be the only immediate option for the near term, especially for women, a process of transition to formal, decent work is important both for individuals and economies. Additional advantages may accrue in countries poised to take advantage of the greater labour-force participation and productivity that can spur a demographic dividend. In 2015, the International Labour Organization adopted the Transition from the Informal to the Formal Economy Recommendation. It provides a basis for legal frameworks that countries can use to protect informal workers and their livelihoods while moving towards formal employment.

For women, a major barrier to paid work is unpaid care work—typically, the time spent toiling around the home. Poor women, in particular, may spend hours every day collecting water or fuel, compensating for the lack of modern systems that provide these. Unpaid care responsibilities contribute to the significantly larger gender wage gap among women with children in general: in sub-Saharan Africa, it is 31 per cent for women with children compared with 4 per cent for women without (UN Women, 2015).

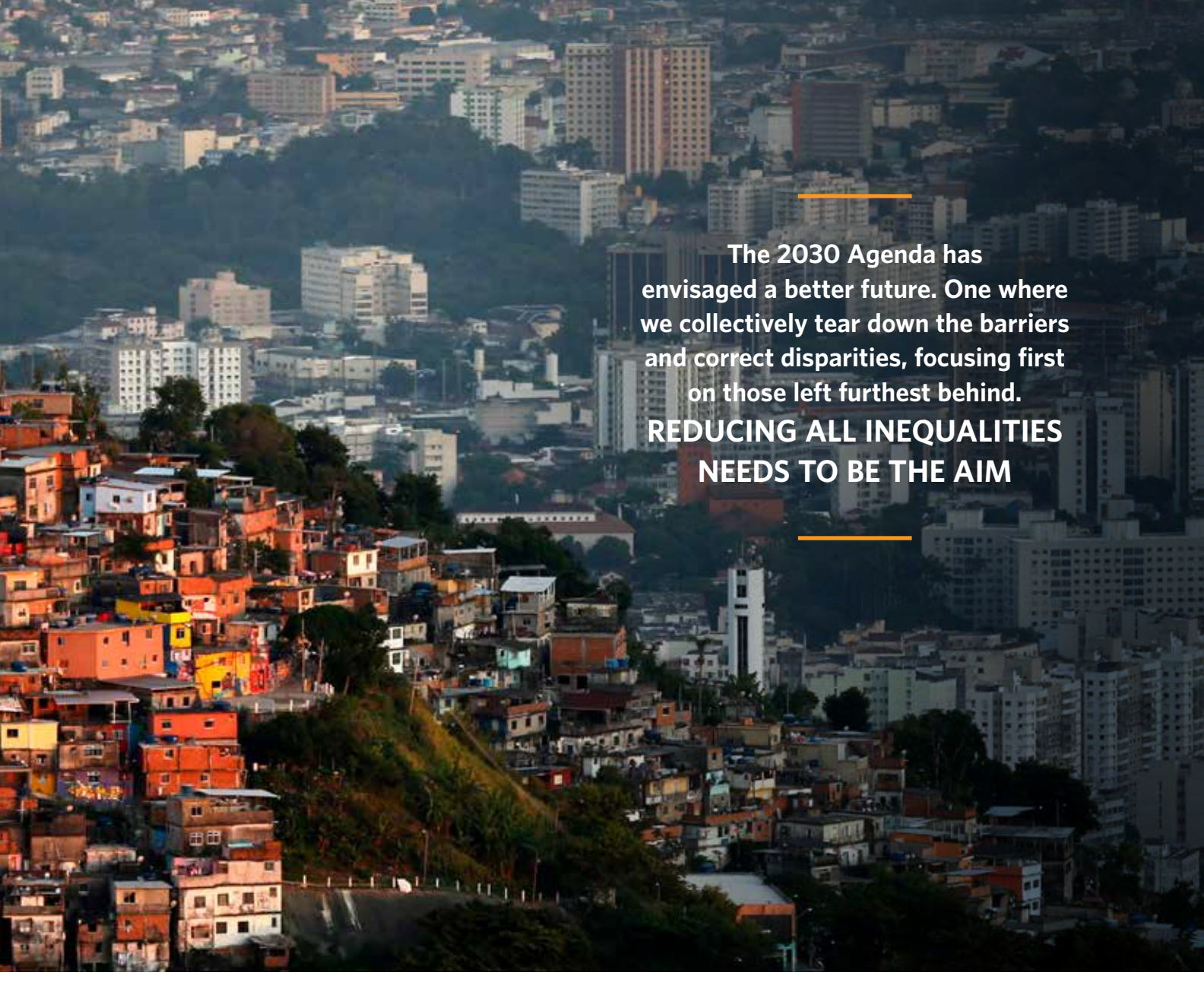
Redistributing the burden of unpaid care requires more men to take up their fair share. Greater public provision of care services could also contribute. According to the United Nations, a programme in Chile to ease access to childcare centres, with a specific emphasis on more marginalized groups, increased the likelihood that women would join the paid labour force by 16 percentage points.

Other issues essential to more equal incomes for women include ending gender discrimination in inheritance and asset ownership. A rural woman who cannot own or inherit land, for example, stands a very high chance of falling into, or remaining in, poverty. Greater financial inclusion requires lower-cost banking and credit products tailored to people who are poor or in remote areas. Tremendous strides have been made in some countries through mobile money and other digital financial services, taking advantage of the growing number of mobile phones in the world.

Aim public policy at levelling the playing field

Ending poverty and achieving inclusion are at the heart of the 2030 Agenda, as well as being linchpins of commitments to universal respect for human rights and dignity. Achieving them depends on accelerating and scaling up actions that reach the poorest 40 per cent of people—those left furthest behind. It requires raising incomes, and investing in health and education to provide more equal opportunities and outcomes for all members of a society.

Given the amount of evidence on how inequalities tend to worsen without deliberate attention to closing the gaps, achieving equity and inclusion in all areas vital to human well-being should be a central goal of national development planning and policymaking, and of actions to achieve the 2030 Agenda across all 17 Sustainable Development Goals. This might mean, for instance, a concerted commitment to extending modern contraception to the poorest women, because their unmet demand is highest within countries and throughout the developing world. Similar discrepancies exist for



The 2030 Agenda has envisaged a better future. One where we collectively tear down the barriers and correct disparities, focusing first on those left furthest behind.

REDUCING ALL INEQUALITIES NEEDS TO BE THE AIM

poor women in terms of delivering their children in health facilities, the care they receive during pregnancy and the mortality rate of their newborn infants.

Beyond actions aimed specifically at reaching and empowering poorer people—the poorest 40 per cent—specific measures driven by central governments may be needed to shift highly unequal patterns in the distribution of wealth and other resources, and to counteract systemic barriers and risks that trap individuals in inequalities. A national inequalities commission could bring together people from different parts of the government, civil society and business to consider options and assess whether policy choices are minimizing or exacerbating inequalities.

Labour policy could set a minimum wage, in line with the International Labour Organization Minimum Wage Fixing Convention, as well as targets for a maximum level of unemployment.

Policies to boost economic productivity could centre on creating more and better-paying jobs that reach excluded people. One study of seven Member States of the Organisation for Economic Co-operation and Development found that investing 2 per cent of GDP in the care industry would increase overall employment by more than 6 per cent, in some cases, and would reduce the gender gap in employment by as much as half. In comparison, similar investment in construction would generate half as many jobs and would worsen the gender gap (UK Women's Budget Group, 2016).

Policies for redistribution to ease wide income gaps include progressive taxation, accompanied by steps to improve the functioning of tax systems. Applying a lens of inclusion might mean considering monetary policy in terms of constraints on access to credit for poorer borrowers, among other issues. Fiscal or budgetary policy can be oriented towards higher levels of targeted spending on excluded groups.

Universal social protection may be one way to control inequalities. It requires everyone—whether they are working in informal jobs, retired or providing unpaid care work—to have access to basic income security, such as through pensions or income support for the working poor. It should also cover maternity, disability, child and similar benefits that are essential to well-being. A study of several poor and middle-income countries found that universal social protection would cost only 1 per cent to 2 per cent of GDP; this is much less than tax revenues that are lost by not taxing the wealthy effectively or tackling inefficiencies in existing public programmes (United Nations, 2013b).

Among poorer countries, the global community can do more to support national efforts to achieve inclusion. Large flows of capital still elude taxation, which undercuts the potential to pay for public services. The United Nations Conference on Trade and Development estimates that developing countries lose at least $100 billion per year through tax avoidance by corporations. According to Oxfam, that is enough to provide an education for 124 million children currently out of school.

Trade agreements could equalize participation in global markets in line with multilateral agreements on inclusive social development and human rights, including to decent work that is safe, and provide wages and benefits that lift people above the poverty line.

Coming closer together

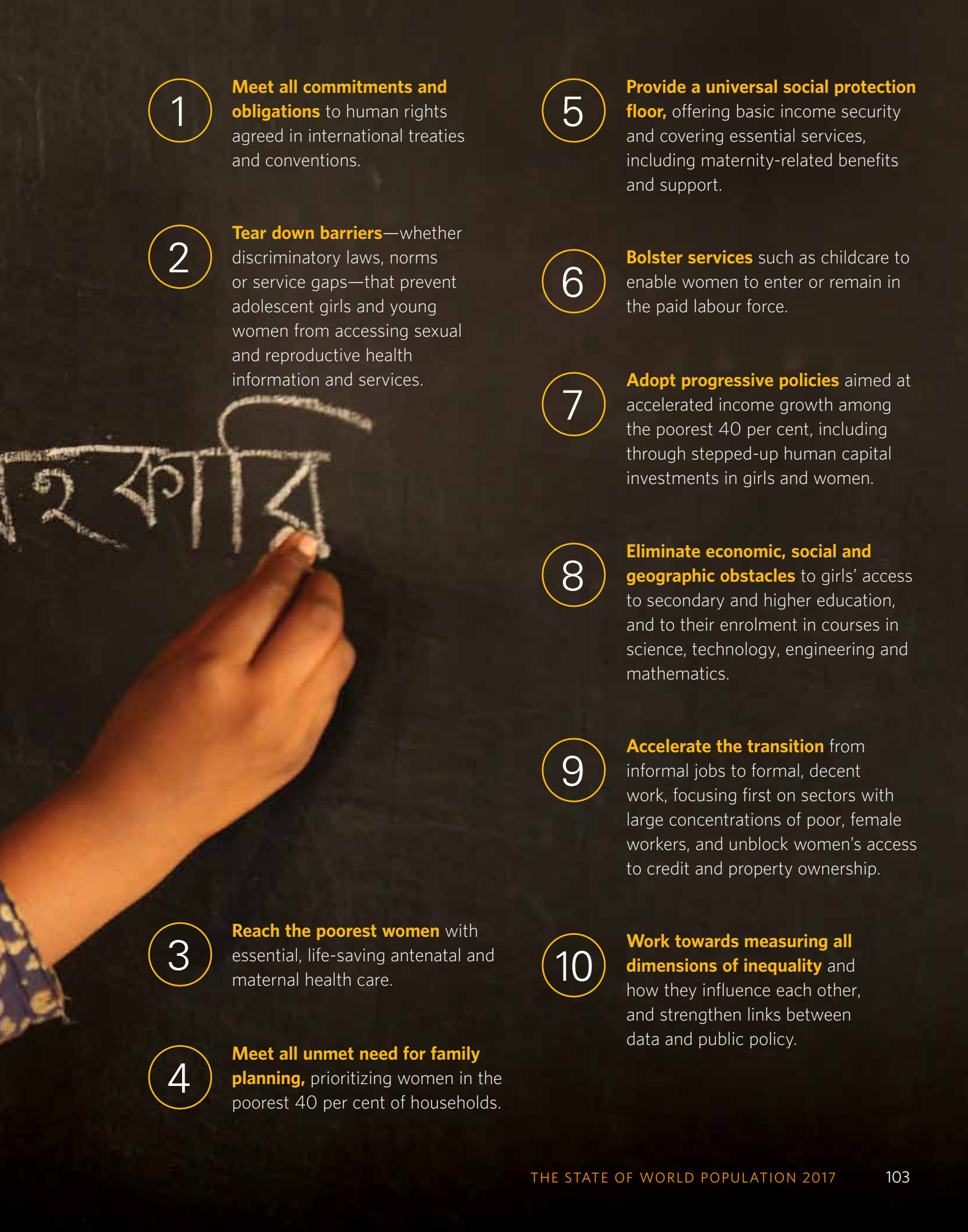
Pulling a world that is apart closer together will not be easy, but it is feasible. From the poorest communities to the most powerful nations, progress towards inclusion can be made. There is no justification for 800 women to die every day giving birth. Or for unwanted pregnancies to overwhelm the resources of the poorest families. Or for young people to watch their futures drain away because early marriage ends their education.

The 2030 Agenda has envisaged a better future. One where we collectively tear down the barriers and correct disparities, focusing first on those left furthest behind. Reducing all inequalities needs to be the aim. Starting points may vary, but should be grounded in the notion that meaningful progress in one dimension can unleash multiple gains. In that respect, some of the most powerful contributions can come from realizing gender equality and women's reproductive rights.

10 ACTIONS FOR A MORE EQUAL WORLD

Expanding access to sexual and reproductive health services is only half of the solution. The other half depends on how well we address the other dimensions of inequality that hold women, particularly the poor, back from realizing their rights and ambitions, and living their lives on an equal footing to men.

We will all benefit—if we all get involved in making a hopeful vision a global reality. We can transform our world.



1. **Meet all commitments and obligations** to human rights agreed in international treaties and conventions.

2. **Tear down barriers**—whether discriminatory laws, norms or service gaps—that prevent adolescent girls and young women from accessing sexual and reproductive health information and services.

3. **Reach the poorest women** with essential, life-saving antenatal and maternal health care.

4. **Meet all unmet need for family planning,** prioritizing women in the poorest 40 per cent of households.

5. **Provide a universal social protection floor,** offering basic income security and covering essential services, including maternity-related benefits and support.

6. **Bolster services** such as childcare to enable women to enter or remain in the paid labour force.

7. **Adopt progressive policies** aimed at accelerated income growth among the poorest 40 per cent, including through stepped-up human capital investments in girls and women.

8. **Eliminate economic, social and geographic obstacles** to girls' access to secondary and higher education, and to their enrolment in courses in science, technology, engineering and mathematics.

9. **Accelerate the transition** from informal jobs to formal, decent work, focusing first on sectors with large concentrations of poor, female workers, and unblock women's access to credit and property ownership.

10. **Work towards measuring all dimensions of inequality** and how they influence each other, and strengthen links between data and public policy.

GEOGRAPHIC ABBREVIATIONS

AFG	Afghanistan
AGO	Angola
ALB	Albania
AND	Andorra
ARE	United Arab Emirates
ARG	Argentina
ARM	Armenia
ATG	Antigua and Barbuda
AUS	Australia
AUT	Austria
AZE	Azerbaijan
BDI	Burundi
BEL	Belgium
BEN	Benin
BFA	Burkina Faso
BGD	Bangladesh
BGR	Bulgaria
BHR	Bahrain
BHS	Bahamas
BIH	Bosnia and Herzegovina
BLR	Belarus
BLZ	Belize
BOL	Bolivia (Plurinational State of)
BRA	Brazil
BRB	Barbados
BRN	Brunei Darussalam
BTN	Bhutan
BWA	Botswana
CAF	Central African Republic
CAN	Canada
CHE	Switzerland
CHL	Chile
CHN	China
CIV	Côte d'Ivoire
CMR	Cameroon
COD	Democratic Republic of the Congo
COG	Congo
COK	Cook Islands
COL	Colombia
COM	Comoros
CPV	Cape Verde
CRI	Costa Rica
CUB	Cuba
CYP	Cyprus
CZE	Czech Republic
DEU	Germany
DJI	Djibouti
DMA	Dominica
DNK	Denmark
DOM	Dominican Republic
DZA	Algeria
ECU	Ecuador
EGY	Egypt
ERI	Eritrea
ESP	Spain
EST	Estonia
ETH	Ethiopia
FIN	Finland
FJI	Fiji
FRA	France
FSM	Micronesia (Federated States of)
GAB	Gabon
GBR	United Kingdom
GEO	Georgia
GHA	Ghana
GIN	Guinea
GMB	Gambia
GNB	Guinea-Bissau
GNQ	Equatorial Guinea
GRC	Greece
GRD	Grenada
GTM	Guatemala
GUY	Guyana
HND	Honduras
HRV	Croatia
HTI	Haiti
HUN	Hungary
IDN	Indonesia
IND	India
IRL	Ireland
IRN	Iran (Islamic Republic of)
IRQ	Iraq
ISL	Iceland
ISR	Israel
ITA	Italy
JAM	Jamaica
JOR	Jordan
JPN	Japan
KAZ	Kazakhstan
KEN	Kenya
KGZ	Kyrgyzstan
KHM	Cambodia
KIR	Kiribati
KNA	Saint Kitts and Nevis
KOR	Republic of Korea
KWT	Kuwait
LAO	Lao People's Democratic Republic
LBN	Lebanon
LBR	Liberia
LBY	Libya
LCA	Saint Lucia
LKA	Sri Lanka
LSO	Lesotho
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAR	Morocco
MCO	Monaco
MDA	Republic of Moldova
MDG	Madagascar
MDV	Maldives
MEX	Mexico
MHL	Marshall Islands
MKD	The former Yugoslav Republic of Macedonia
MLI	Mali
MLT	Malta
MMR	Myanmar
MNE	Montenegro
MNG	Mongolia
MOZ	Mozambique
MRT	Mauritania
MUS	Mauritius
MWI	Malawi
MYS	Malaysia
NAM	Namibia
NER	Niger
NGA	Nigeria
NIC	Nicaragua
NIU	Niue
NLD	Netherlands
NOR	Norway
NPL	Nepal
NRU	Nauru
NZL	New Zealand
OMN	Oman
PAK	Pakistan
PAN	Panama
PER	Peru
PHL	Philippines
PLW	Palau
PNG	Papua New Guinea
POL	Poland
PRK	Democratic People's Republic of Korea
PRT	Portugal
PRY	Paraguay
QAT	Qatar
ROU	Romania
RUS	Russian Federation
RWA	Rwanda
SAU	Saudi Arabia
SDN	Sudan
SEN	Senegal
SGP	Singapore
SLB	Solomon Islands
SLE	Sierra Leone
SLV	El Salvador
SMR	San Marino
SOM	Somalia
SRB	Serbia
STP	São Tomé and Príncipe
SUR	Suriname
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWZ	Swaziland
SYC	Seychelles
SYR	Syrian Arab Republic
TCD	Chad
TGO	Togo
THA	Thailand
TJK	Tajikistan
TKM	Turkmenistan
TLS	Timor-Leste
TON	Tonga
TTO	Trinidad and Tobago
TUN	Tunisia
TUR	Turkey
TUV	Tuvalu
TZA	Tanzania, the United Republic of
UGA	Uganda
UKR	Ukraine
URY	Uruguay
USA	United States of America
UZB	Uzbekistan
VCT	Saint Vincent and the Grenadines
VEN	Venezuela (Bolivarian Republic of)
VNM	Viet Nam
VUT	Vanuatu
WSM	Samoa
YEM	Yemen
ZAF	South Africa
ZMB	Zambia
ZWE	Zimbabwe

EQUIPLOTS: REPRODUCTIVE HEALTH

Measuring progress in reducing inequalities in reproductive health, by wealth quintile

The following equiplots show countries' or territories' progress in four areas of reproductive health and in reducing inequalities among wealth quintiles in those areas:

- The percentage of deliveries assisted by skilled attendants
- The proportion of demand for family planning satisfied with modern methods of contraception
- The percentage of pregnant women who have access to four or more antenatal care visits
- The neonatal mortality rate.

Each dot on a line, looking like a bead on an abacus, represents one of the five wealth quintiles and shows where it stands in terms of an indicator. The position of the five dots together shows how each wealth quintile fares relative to the others. Two lines for each country show the status at two points in time, generally 10 years apart.

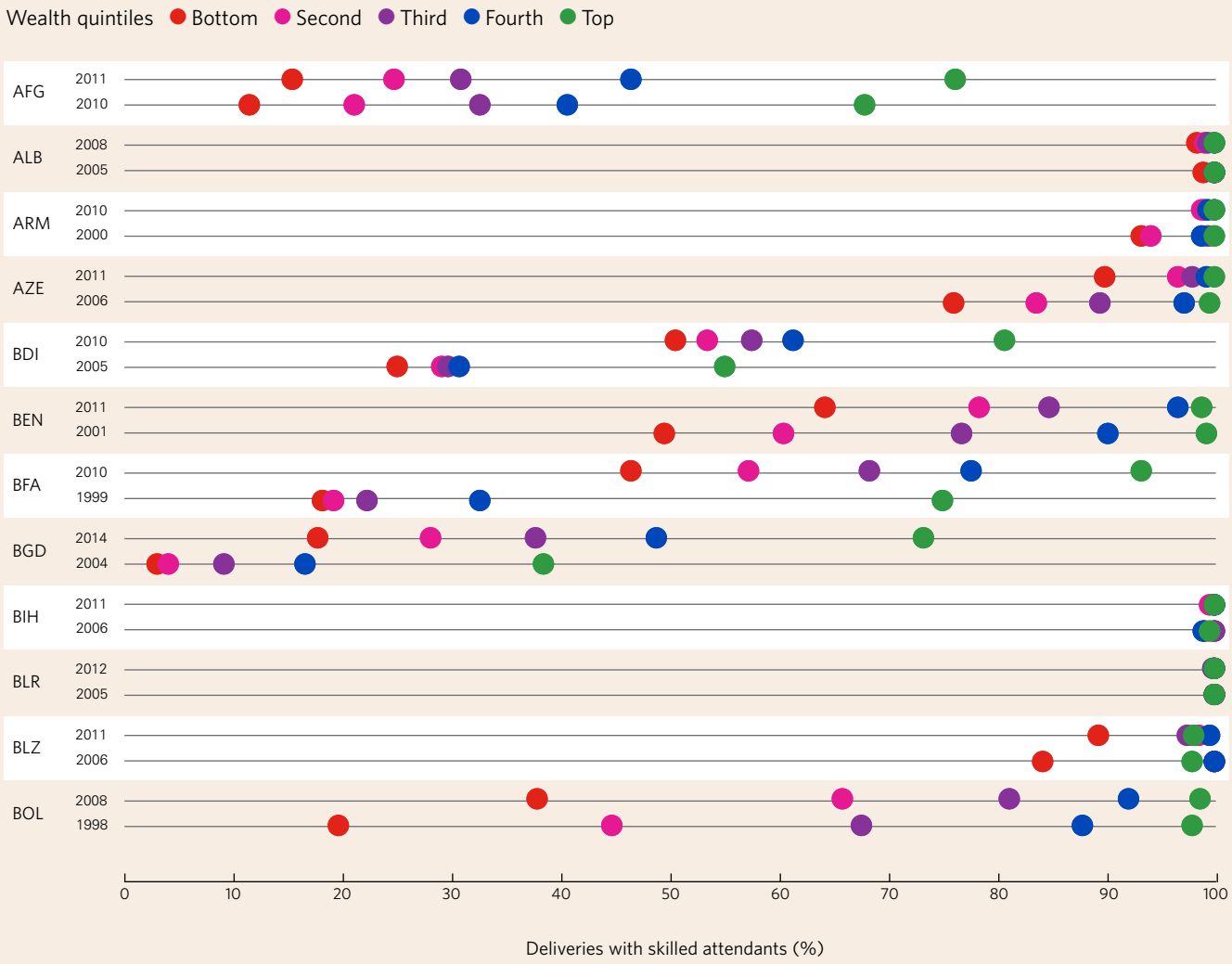
The equiplots for skilled birth attendants show, for example, what percentage of deliveries are attended in the bottom, second, third, fourth and top wealth quintiles in a country. Dots towards the right of each line represent a higher level of skilled birth attendance. Dots towards the left suggest lower levels of attendance.

When comparing two lines for a country, an overall shift to the right means that proportions of births assisted by skilled attendants over time have increased. Dots that are closer to each other between two points in time suggest that access to a skilled birth attendant has increased or at least merged to some extent regardless of wealth income, and thus inequality has been reduced.

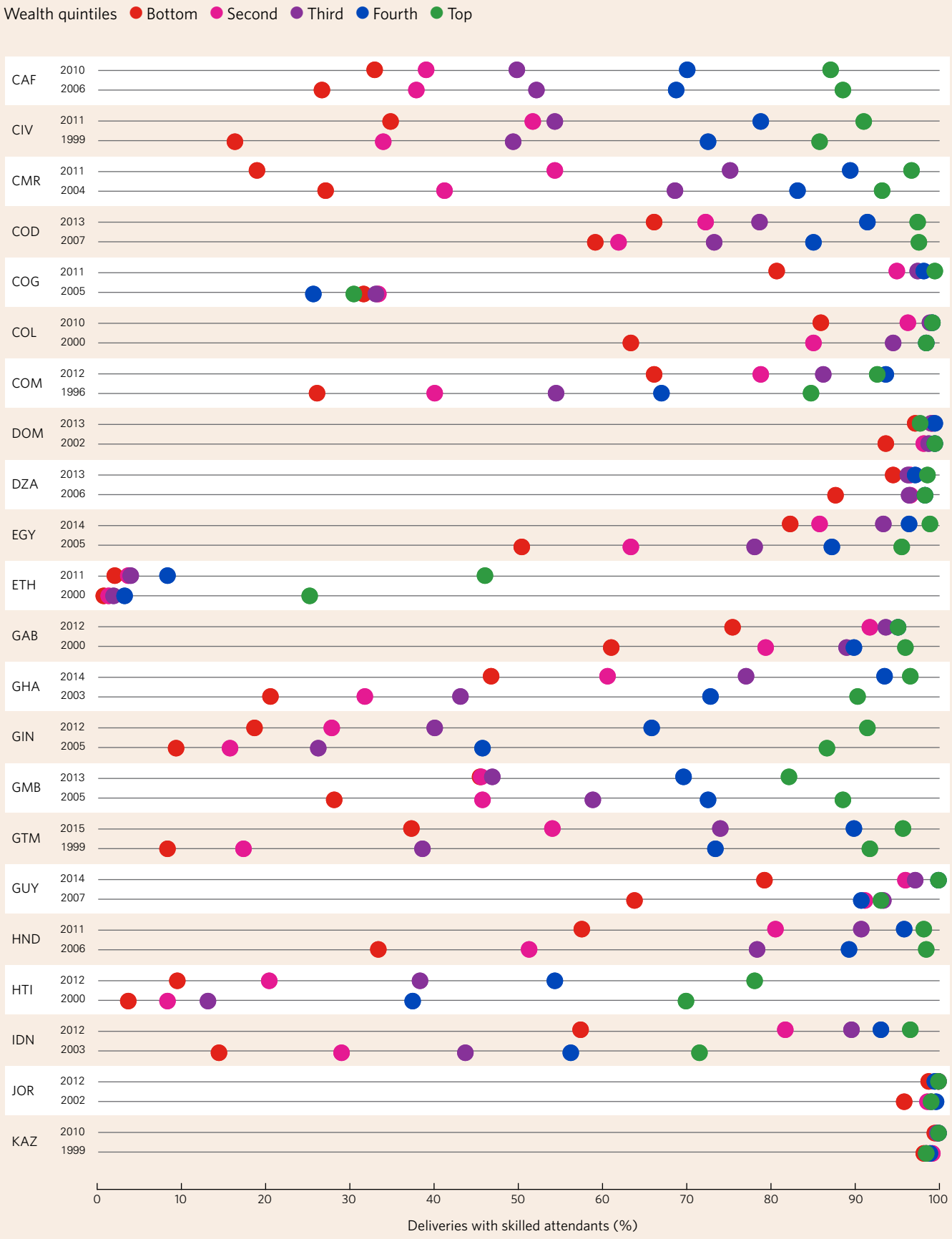
The same visualization applies to the proportion of demand for family planning satisfied by modern methods of contraception and for antenatal care visits: a shift to the right over time suggests an increasing percentage of women having at least four visits. Dots coming closer together suggest reduced inequality among wealth quintiles.

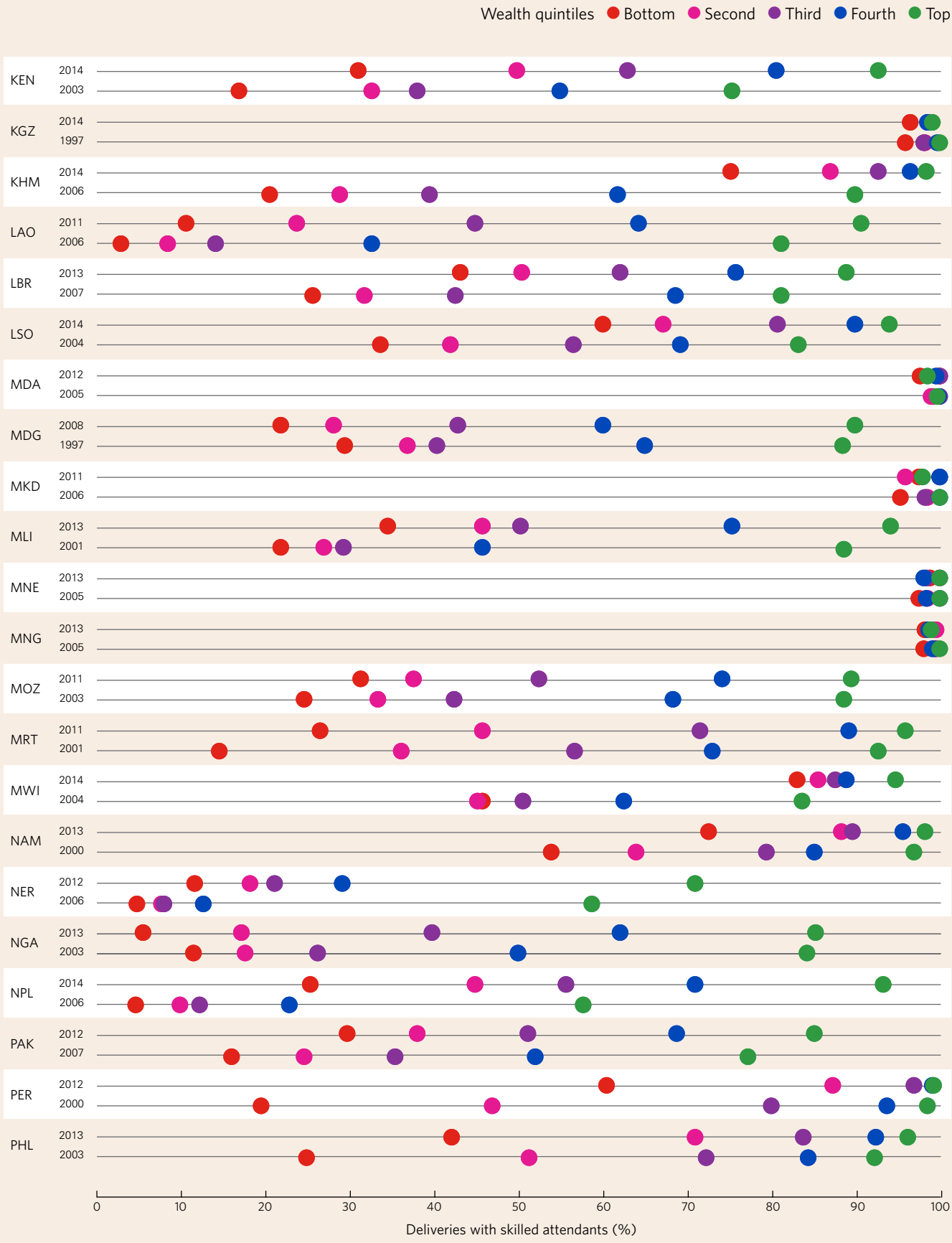
With neonatal mortality, an overall shift to the right suggests progress in reducing neonatal deaths.

Skilled birth attendants at delivery

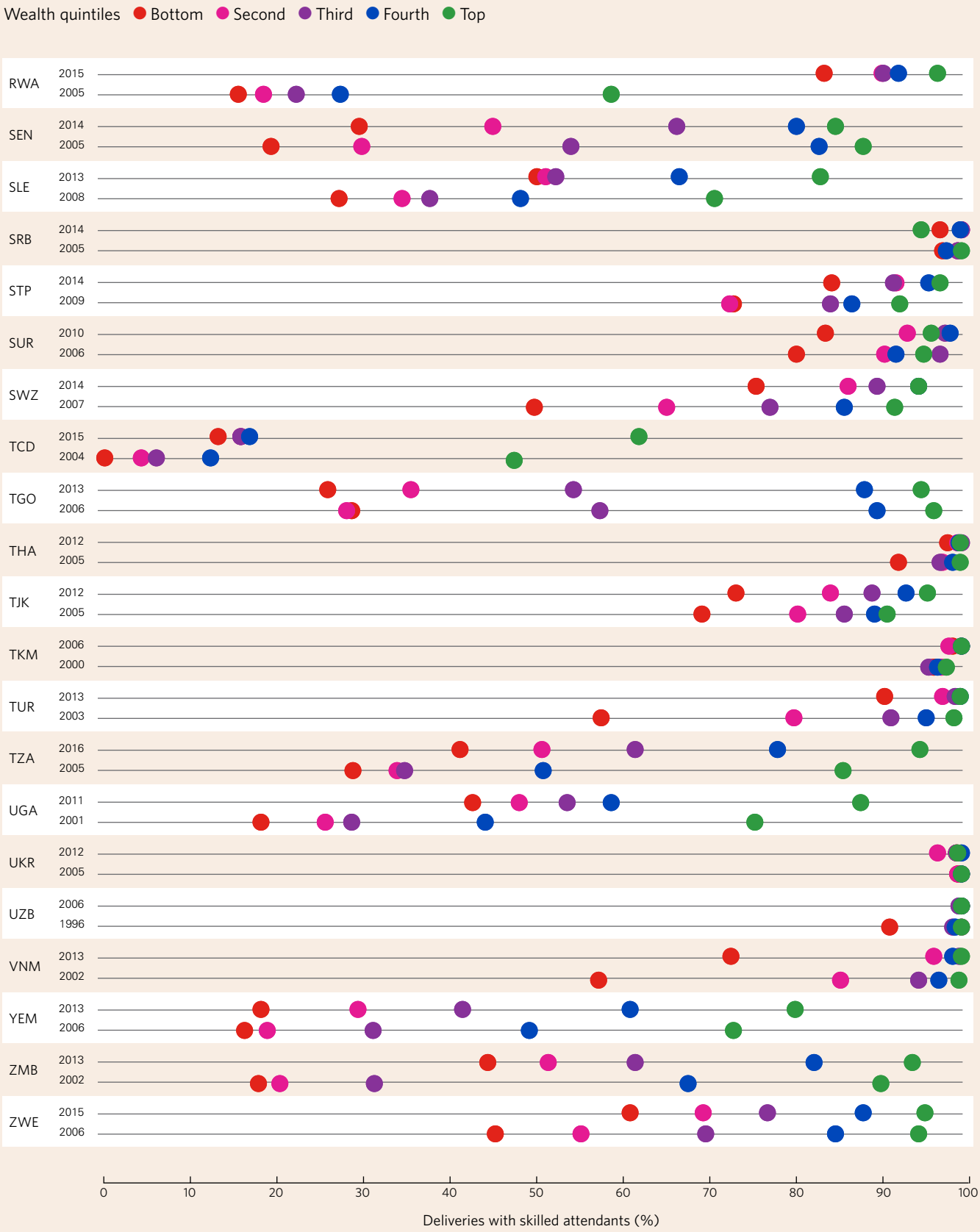


Skilled birth attendants at delivery (continued)

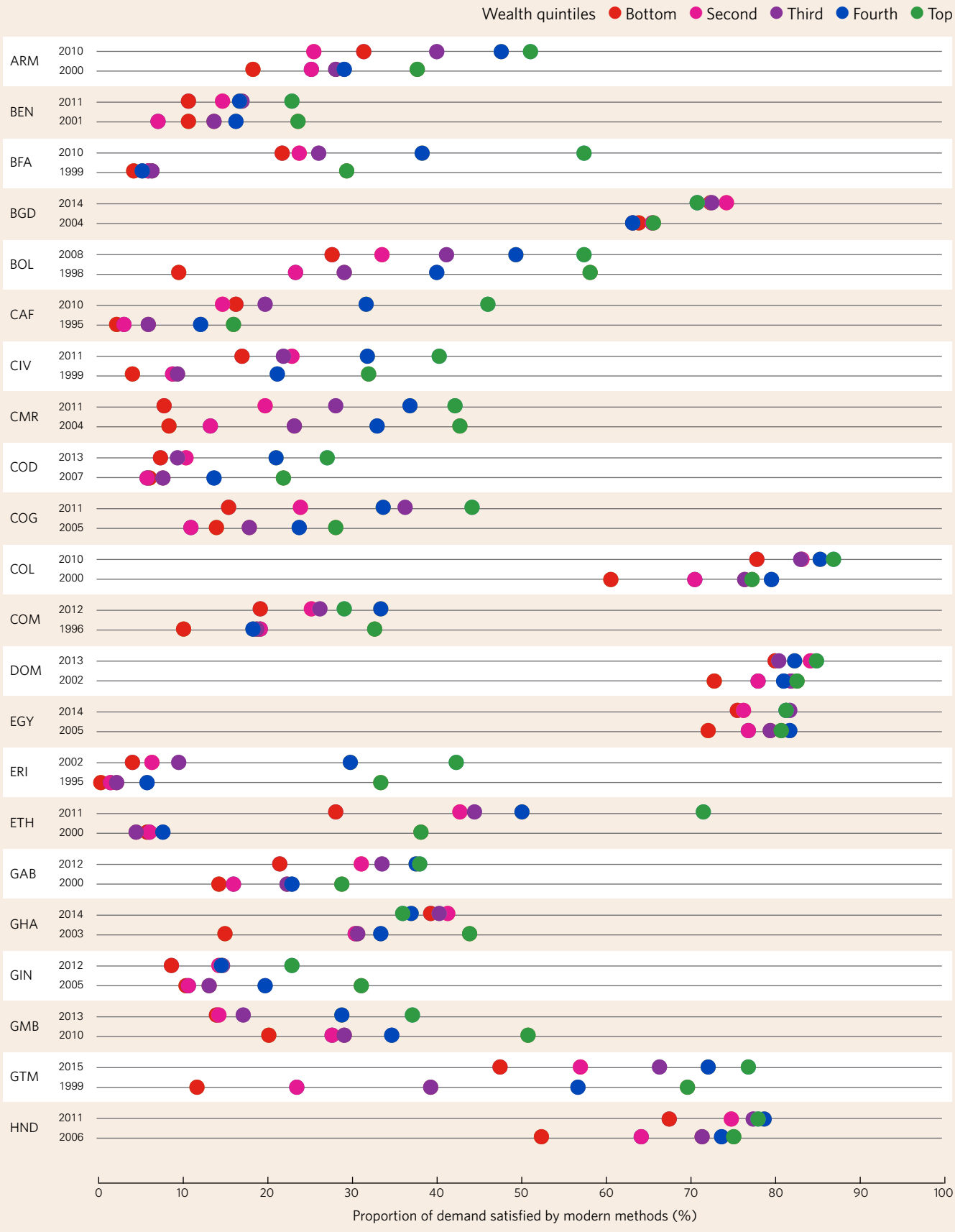



Wealth quintiles
Bottom
Second
Third
Fourth
Top
KEN 2014 2003
KGZ 2014 1997
KHM 2014 2006
LAO 2011 2006
LBR 2013 2007
LSO 2014 2004
MDA 2012 2005
MDG 2008 1997
MKD 2011 2006
MLI 2013 2001
MNE 2013 2005
MNG 2013 2005
MOZ 2011 2003
MRT 2011 2001
MWI 2014 2004
NAM 2013 2000
NER 2012 2006
NGA 2013 2003
NPL 2014 2006
PAK 2012 2007
PER 2012 2000
PHL 2013 2003
0
10
20
30
40
50
60
70
80
90
100
Deliveries with skilled attendants (%)

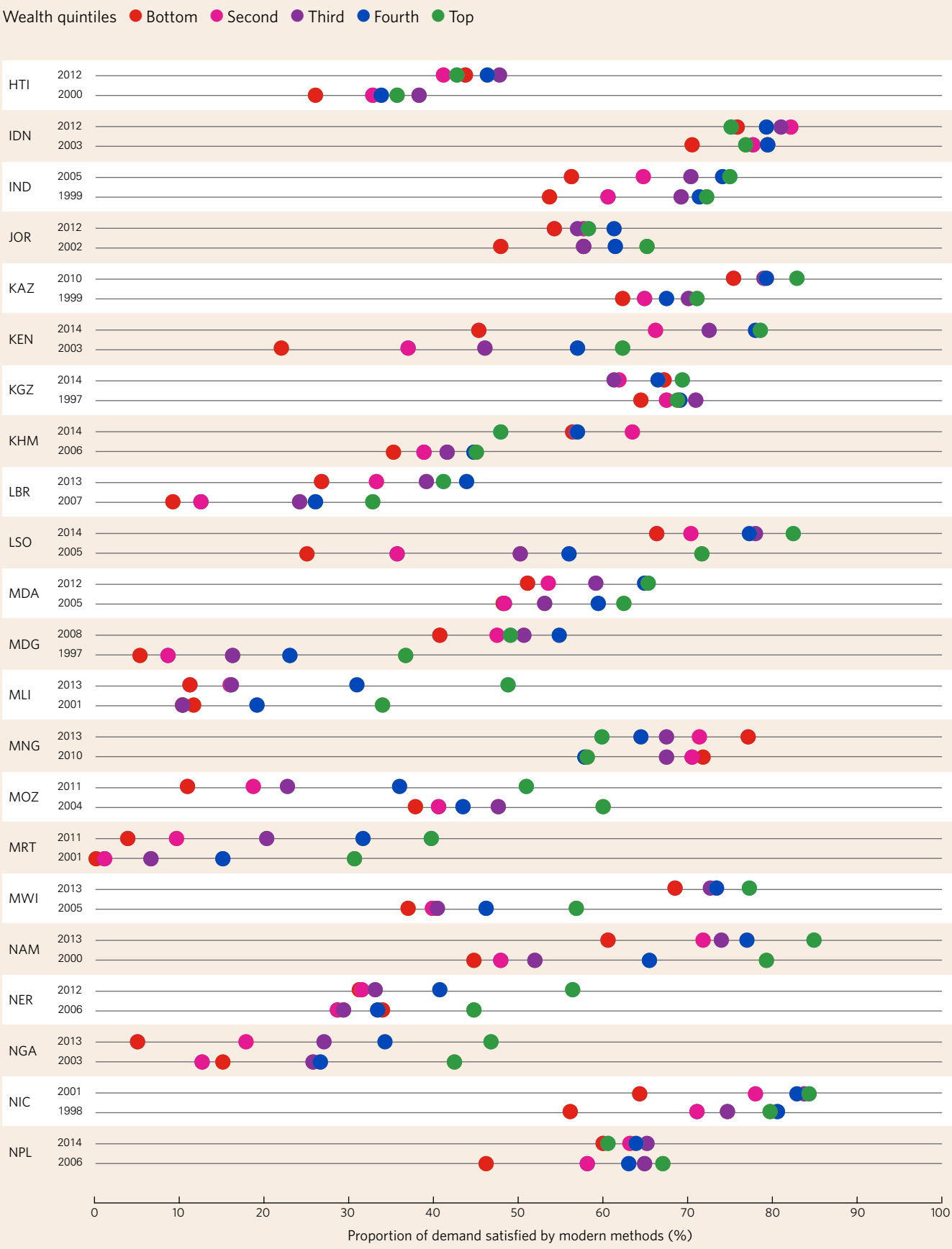
Skilled birth attendants at delivery (continued)

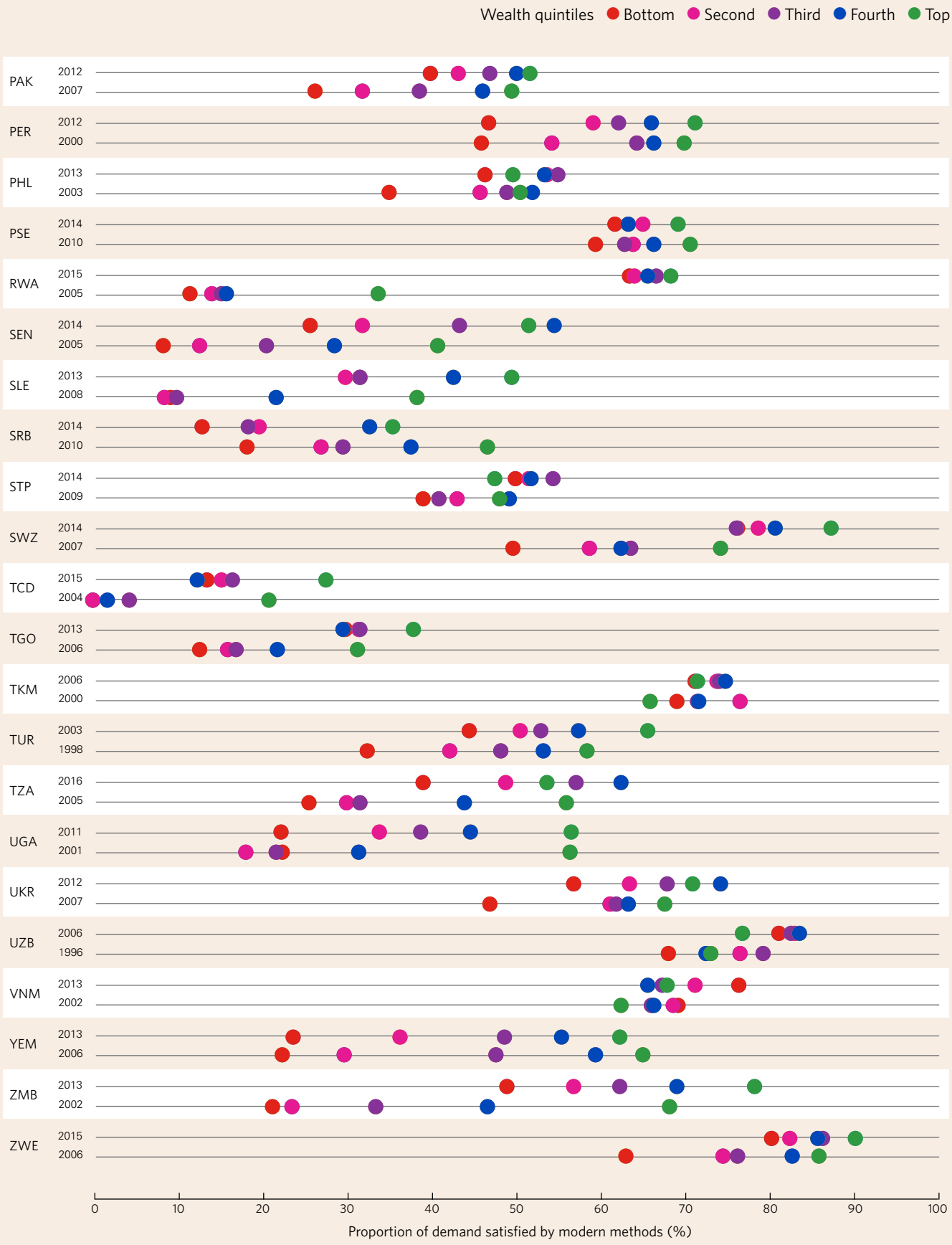


Demand for family planning satisfied with modern methods

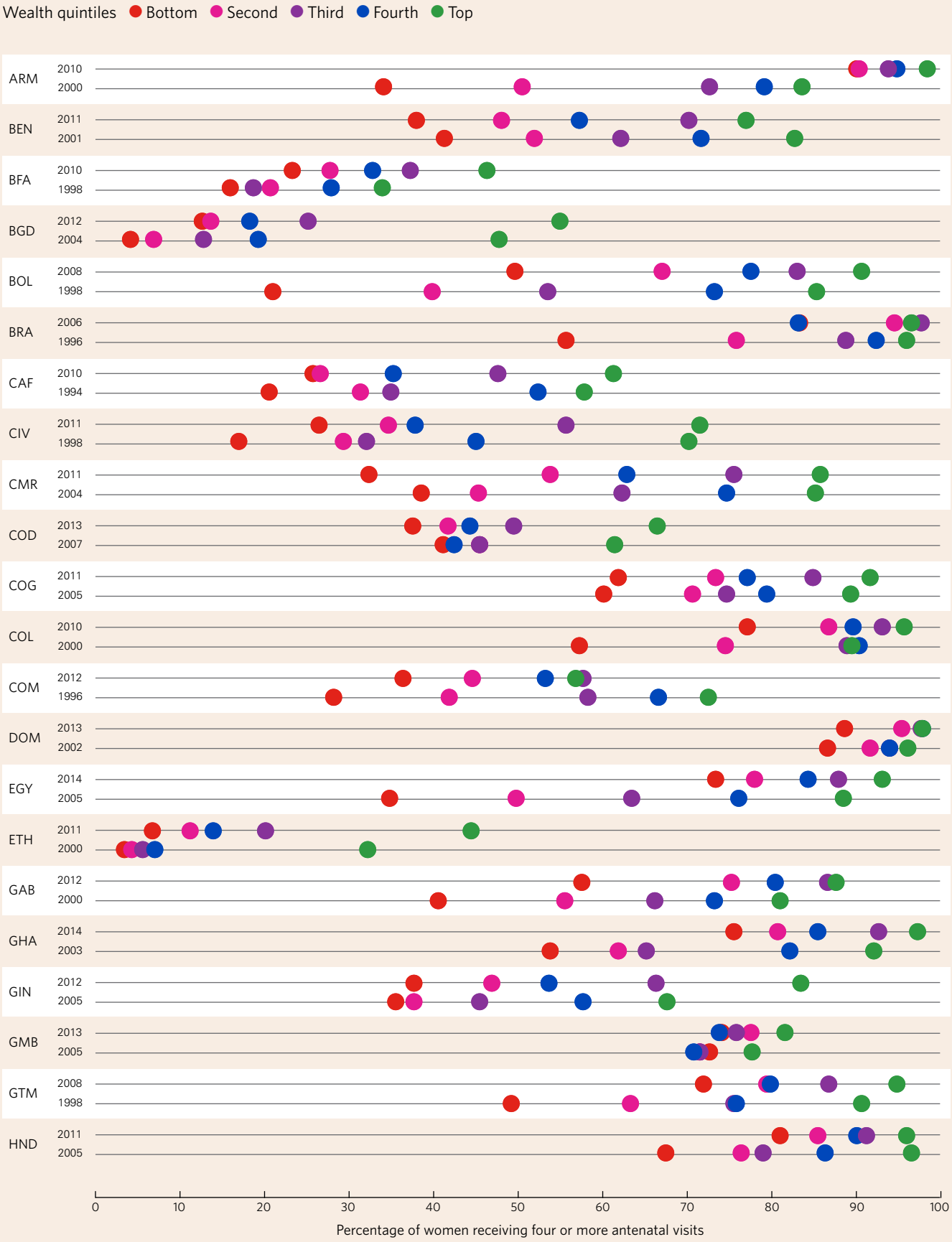


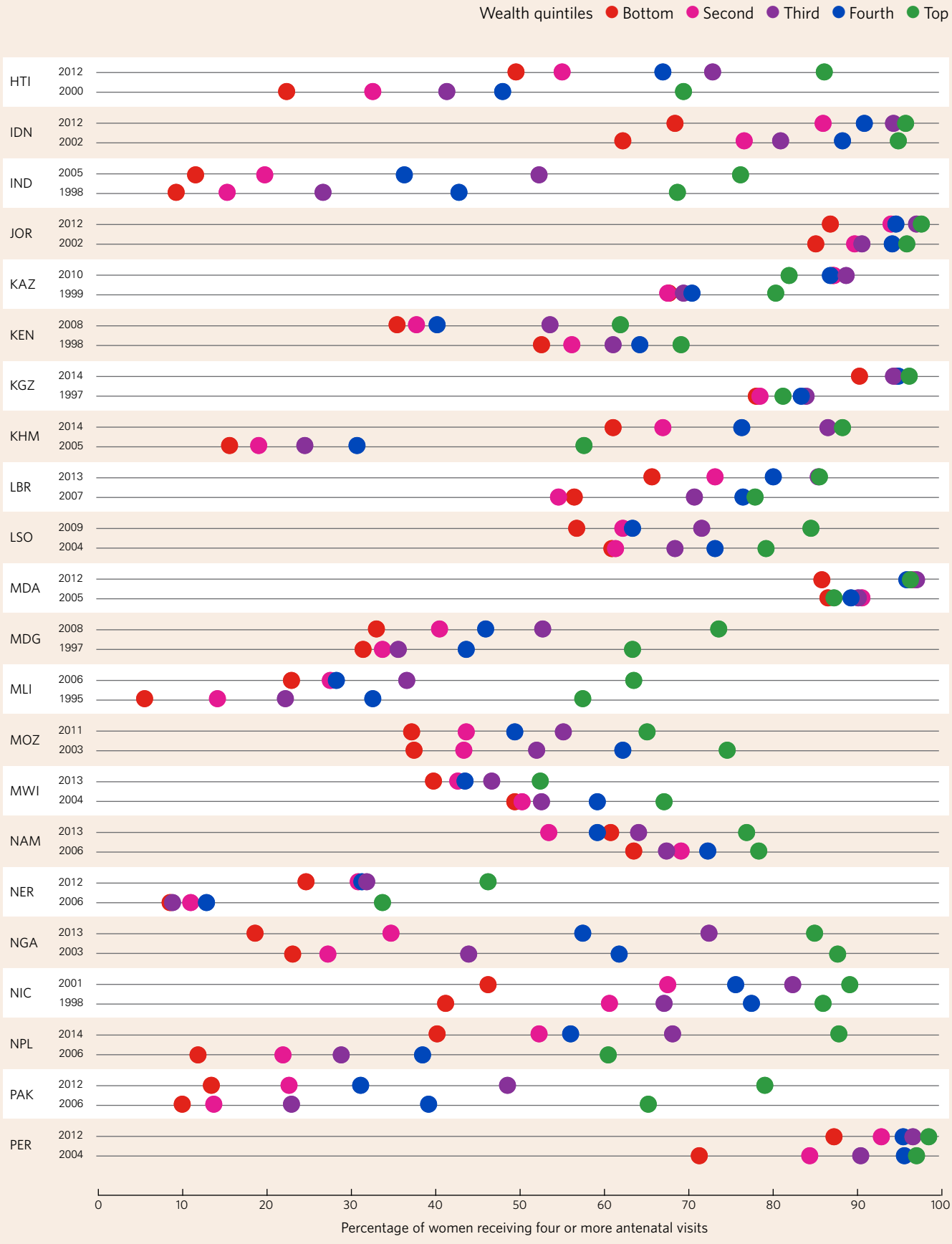
Demand for family planning satisfied with modern methods (continued)



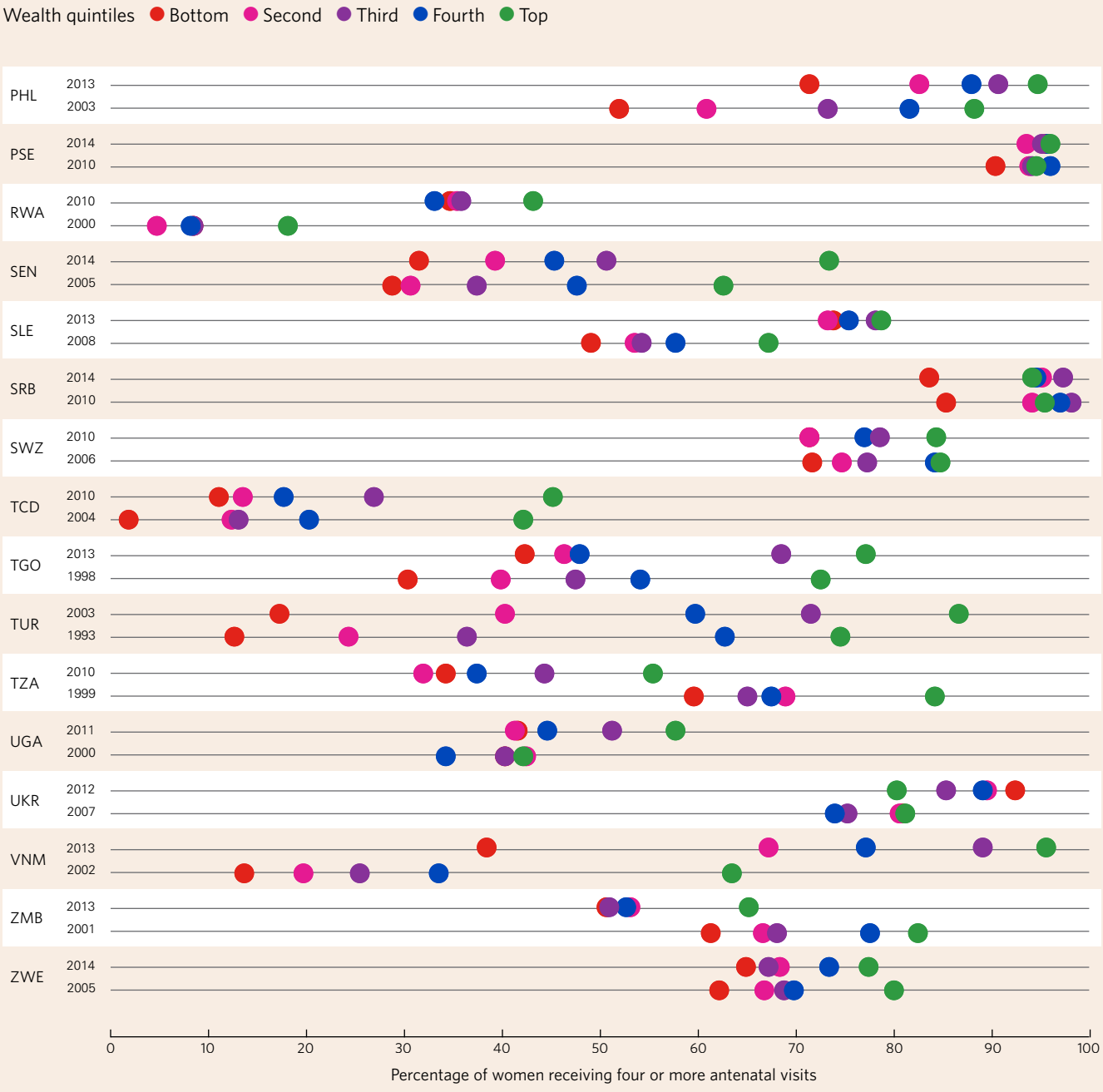

Wealth quintiles
Bottom
Second
Third
Fourth
Top
PAK 2012 2007
PER 2012 2000
PHL 2013 2003
PSE 2014 2010
RWA 2015 2005
SEN 2014 2005
SLE 2013 2008
SRB 2014 2010
STP 2014 2009
SWZ 2014 2007
TCD 2015 2004
TGO 2013 2006
TKM 2006 2000
TUR 2003 1998
TZA 2016 2005
UGA 2011 2001
UKR 2012 2007
UZB 2006 1996
VNM 2013 2002
YEM 2013 2006
ZMB 2013 2002
ZWE 2015 2006
0 10 20 30 40 50 60 70 80 90 100
Proportion of demand satisfied by modern methods (%)

Access to four or more antenatal care visits

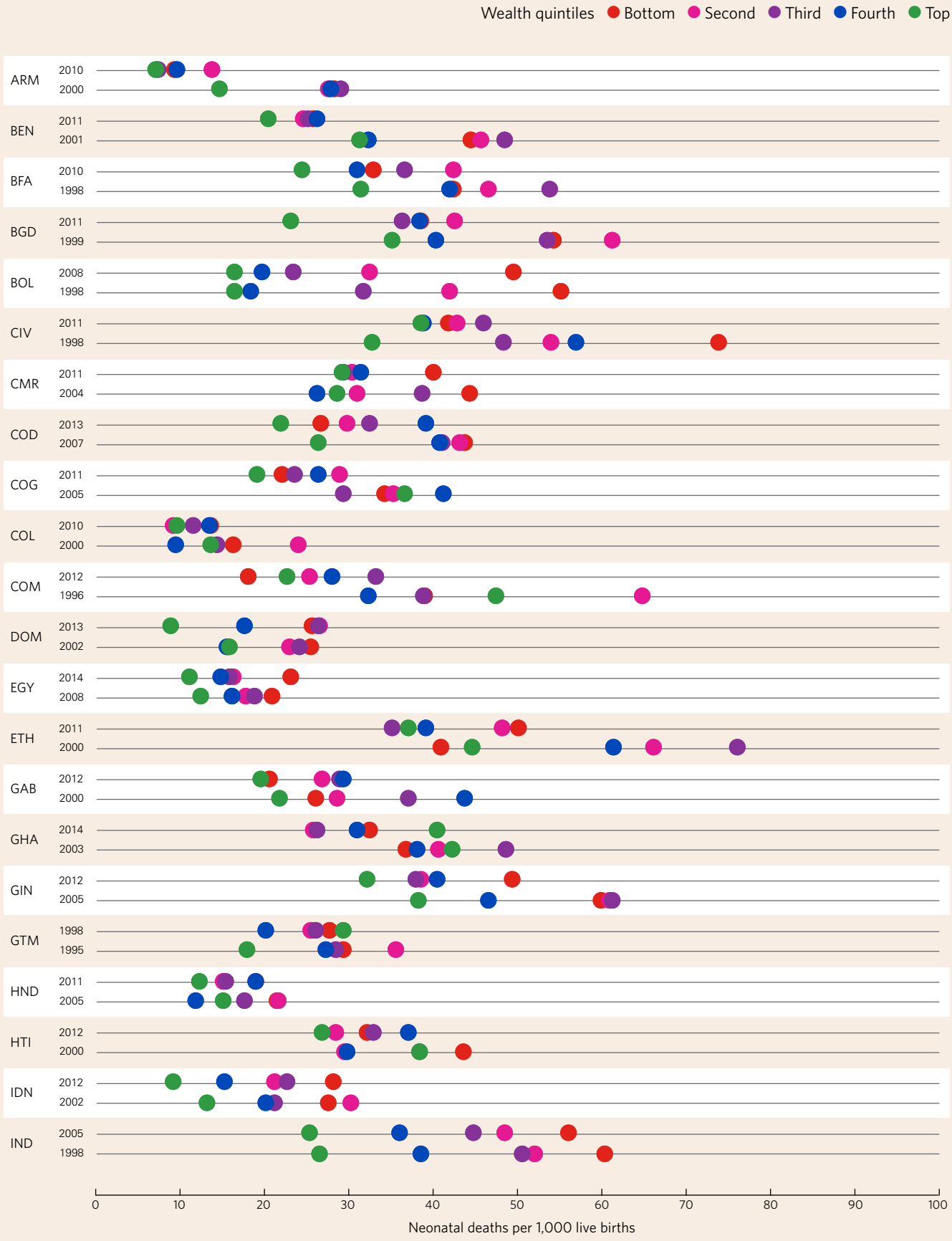



Wealth quintiles
Bottom
Second
Third
Fourth
Top
HTI 2012 2000
IDN 2012 2002
IND 2005 1998
JOR 2012 2002
KAZ 2010 1999
KEN 2008 1998
KGZ 2014 1997
KHM 2014 2005
LBR 2013 2007
LSO 2009 2004
MDA 2012 2005
MDG 2008 1997
MLI 2006 1995
MOZ 2011 2003
MWI 2013 2004
NAM 2013 2006
NER 2012 2006
NGA 2013 2003
NIC 2001 1998
NPL 2014 2006
PAK 2012 2006
PER 2012 2004
0
10
20
30
40
50
60
70
80
90
100
Percentage of women receiving four or more antenatal visits

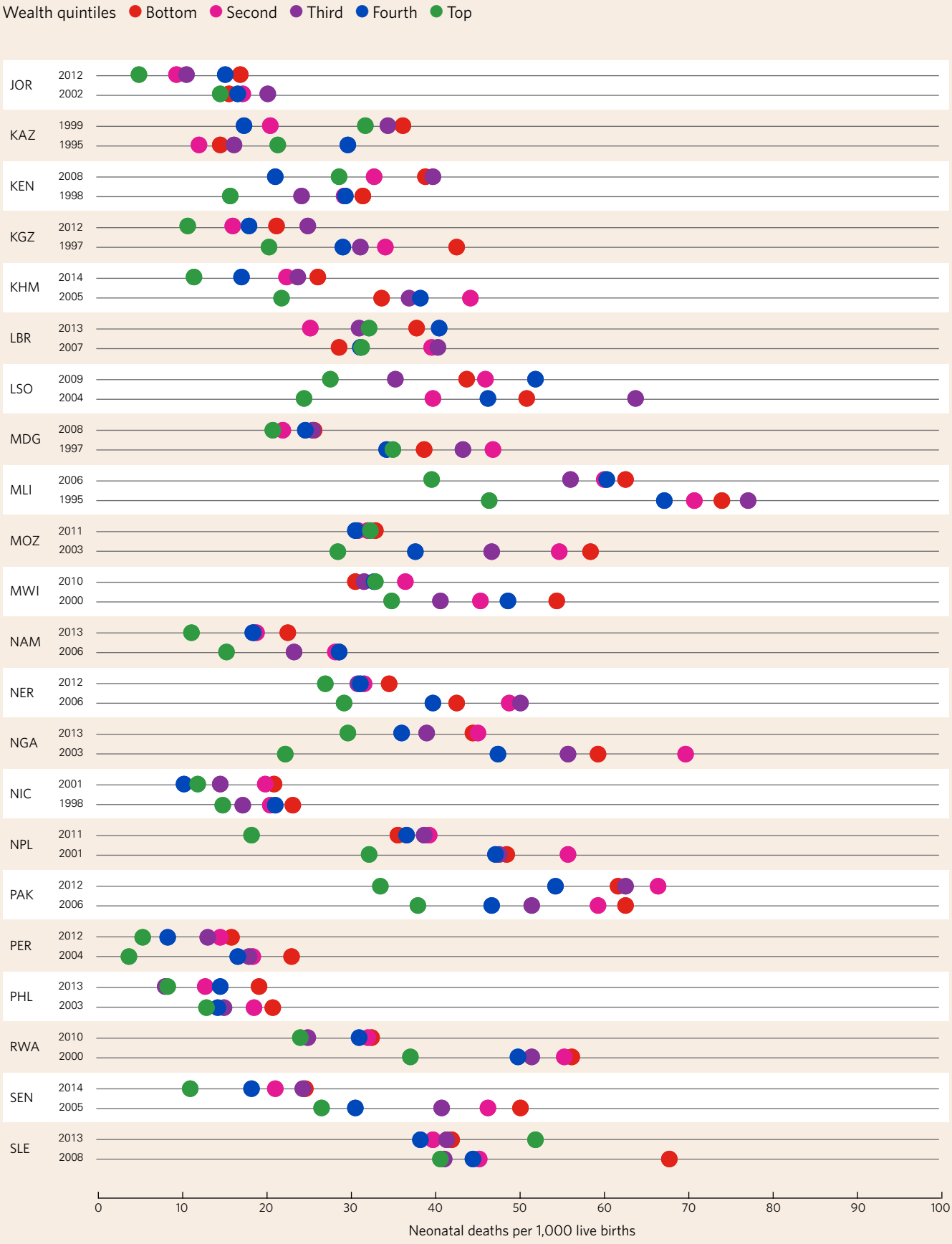
Access to four or more antenatal care visits (continued)



Neonatal mortality rate



Neonatal mortality rate (continued)




Wealth quintiles
Bottom
Second
Third
Fourth
Top
TCD
2004
1996
TGO
2013
1998
TUR
2003
1993
TZA
2010
1999
UGA
2011
2000
VNM
2002
1997
ZMB
2013
2001
ZWE
2010
1999
0
10
20
30
40
50
60
70
80
90
100
Neonatal deaths per 1,000 live births

Monitoring ICPD goals: selected indicators

Country, territory or other area	Sexual and reproductive health									Harmful practices		Education and employment						
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[§]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
	2015 estimate					2017		2017										
	2015	Lower	Upper	2006-2016	2006-2015	Any method[§]	Modern method[§]	Any method	Modern method	2008-2016	2004-2015	1999-2015 male	1999-2015 female	1999-2015	2000-2015 male	2000-2015 female	2000-2015	2010-2016
Afghanistan	396	253	620	51	78	25	23	51	46	35	–	–	–	–	62	35	0.57	–
Albania	29	16	46	99	20	63	22	82	28	10	–	97	95	0.99	86	85	0.98	33 [m]
Algeria	140	82	244	97	12	63	57	86	77	3	–	98	96	0.98	–	–	–	21
Angola	477	221	988	47	191	15	14	29	26	–	–	95	73	0.77	14	11	0.81	–
Antigua and Barbuda	–	–	–	100	–	64	62	83	80	–	–	87	85	0.98	78	81	1.04	–
Argentina	52	44	63	100	68	73	70	89	85	–	–	100	99	0.99	85	91	1.07	20 [n]
Armenia	25	21	31	100	23	59	29	82	41	7	–	89	98	1.10	79	91	1.15	36 [m]
Aruba	–	–	–	–	34	–	–	–	–	–	–	99	99	1.00	73	81	1.10	17
Australia	6	5	7	99	14	67	65	86	84	–	–	–	–	–	–	–	–	10
Austria	4	3	5	99	8	66	64	87	84	–	–	–	–	–	–	–	–	8
Azerbaijan	25	17	35	100	47	56	23	80	33	11	–	96	94	0.98	89	87	0.98	10
Bahamas	80	53	124	98	30	67	66	85	84	–	–	94	99	1.06	80	86	1.07	–
Bahrain	15	12	19	100	14	65	45	85	59	–	–	–	–	–	–	–	–	–
Bangladesh	176	125	280	42	113	64	57	85	75	59	–	93	97	1.04	50	55	1.09	32 [o]
Barbados	27	19	37	99	50	62	59	80	77	29	–	91	92	1.02	86	92	1.06	–
Belarus	4	3	6	100	22	67	57	87	75	3	–	94	94	1.00	96	96	1.01	12
Belgium	7	5	10	–	7	73	72	92	90	–	–	–	–	–	–	–	–	12
Belize	28	20	36	94	64	55	51	74	69	26	–	100	98	0.99	67	71	1.06	8
Benin	405	279	633	77	94	19	13	38	27	26	2	100	88	0.88	50	34	0.68	20
Bhutan	148	101	241	81	28	64	63	84	84	26	–	88	90	1.03	59	67	1.14	–
Bolivia (Plurinational State of)	206	140	351	85	88	63	44	78	54	22	–	95	95	1.00	75	76	1.01	–
Bosnia and Herzegovina	11	7	17	100	11	50	19	76	30	4	–	98	99	1.01	–	–	–	28 [m]
Botswana	129	102	172	100	39	59	57	81	79	–	–	91	92	1.01	59	67	1.13	–
Brazil	44	36	54	99	65	80	77	92	88	36	–	94	94	1.00	79	85	1.07	23
Brunei Darussalam	23	15	30	100	17	–	–	–	–	–	–	–	–	–	–	–	–	17 [o]
Bulgaria	11	8	14	100	41	68	50	84	61	–	–	96	97	1.01	89	87	0.97	19
Burkina Faso	371	257	509	66	132	24	24	48	46	52	58	70	66	0.95	23	20	0.87	–
Burundi	712	471	1,050	60	85	38	35	59	54	20	–	95	97	1.02	25	25	0.99	–
Cambodia	161	117	213	89	57	59	44	83	61	19	–	96	94	0.98	40	37	0.92	13 [o]
Cameroon, Republic of	596	440	881	65	119	33	22	61	41	31	0.4	100	90	0.90	46	40	0.87	11
Canada	7	5	9	100	13	75	73	91	89	–	–	–	–	–	–	–	–	10
Cape Verde	42	20	95	92	–	62	60	81	78	–	–	98	98	1.00	65	74	1.14	–
Central African Republic	882	508	1,500	40	229	25	19	52	40	68	18	79	62	0.79	18	9	0.52	–
Chad	856	560	1,350	20	203	7	6	23	20	67	32	95	74	0.78	16	5	0.33	–
Chile	22	18	26	100	52	66	65	83	82	–	–	93	93	1.00	87	90	1.04	12
China	27	22	32	100	6	83	83	96	95	–	–	–	–	–	–	–	–	–
China, Hong Kong SAR	–	–	–	–	3	76	73	92	88	–	–	–	–	–	–	–	–	7
China, Macao SAR	–	–	–	–	3	–	–	–	–	–	–	–	–	–	–	–	–	5 [m]
Colombia	64	56	81	99	84	78	72	90	83	23	–	92	92	1.00	76	82	1.08	21
Comoros	335	207	536	82	70	26	20	46	36	32	–	88	83	0.95	42	45	1.07	–

	Sexual and reproductive health									Harmful practices		Education and employment						
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[§]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
Country, territory or other area	2015	2015 estimate Lower	Upper	2006-2016	2006-2015	2017 Any method[§]	Modern method[§]	2017 Any method	Modern method	2008-2016	2004-2015	1999-2015 male	female	1999-2015	2000-2015 male	female	2000-2015	2010-2016
Congo, Democratic Republic of the	693	509	1,010	80	138	23	10	46	20	37	–	36	34	0.95	–	–	–	–
Congo, Republic of the	442	300	638	94	111	42	24	68	39	33	–	89	97	1.09	–	–	–	–
Costa Rica	25	20	29	99	61	80	77	93	90	21	–	96	96	1.00	76	80	1.05	21
Côte d'Ivoire	645	458	909	59	129	21	16	46	36	33	31	80	71	0.89	–	–	–	–
Croatia	8	6	11	100	12	66	47	86	61	–	–	–	–	–	–	–	–	19
Cuba	39	33	47	99	53	74	73	90	88	26	–	93	94	1.01	88	91	1.04	–
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	7	4	12	100	4	–	–	–	–	–	–	–	–	–	–	–	–	15
Czechia	4	3	6	100	11	77	70	91	83	–	–	–	–	–	–	–	–	8
Denmark	6	5	9	98	2	69	66	87	83	–	–	–	–	–	–	–	–	6
Djibouti	229	111	482	87	21	27	26	48	46	–	90	61	54	0.89	29	21	0.72	–
Dominica	–	–	–	100	47	–	–	–	–	–	–	96	99	1.03	76	82	1.07	–
Dominican Republic	92	77	111	98	90	71	69	87	84	37	–	86	85	0.99	61	70	1.14	21[m]
Ecuador	64	57	71	96	–	79	70	92	82	–	–	96	98	1.02	81	84	1.04	18
Egypt	33	26	39	92	56	61	59	84	81	17	70	99	99	1.01	81	82	1.01	27[m]
El Salvador	54	40	69	98	72	71	67	86	81	26	–	94	94	1.01	69	71	1.03	30
Equatorial Guinea	342	207	542	68	176	17	14	35	28	30	–	58	58	1.00	24	19	0.77	–
Eritrea	501	332	750	34	76	13	13	31	29	41	69	43	38	0.90	31	26	0.84	–
Estonia	9	6	14	99	16	66	60	85	78	–	–	–	–	–	–	–	–	11
Ethiopia	353	247	567	28	71	41	39	63	61	41	62	89	84	0.94	18	11	0.62	1[mn]
Fiji	30	23	41	100	28	49	45	72	67	–	–	96	98	1.03	79	88	1.11	–
Finland	3	2	3	100	7	74	73	90	88	–	–	–	–	–	–	–	–	11
France	8	7	10	98	6	80	78	95	92	–	–	–	–	–	–	–	–	12
French Guiana	–	–	–	–	87	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	40	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	291	197	442	89	114	35	24	58	40	22	–	–	–	–	–	–	–	–
Gambia	706	484	1,030	57	88	12	11	31	30	30	76	66	72	1.09	–	–	–	34[o]
Georgia	36	28	47	100	41	53	38	77	55	14	–	96	94	0.98	92	92	1.00	–
Germany	6	5	8	99	8	68	64	88	83	–	–	–	–	–	–	–	–	6
Ghana	319	216	458	71	65	31	26	52	45	21	2	92	92	1.01	58	57	0.98	–
Greece	3	2	4	–	8	69	47	88	60	–	–	–	–	–	–	–	–	17
Grenada	27	19	42	99	–	66	62	84	80	–	–	97	97	1.00	81	84	1.03	–
Guadeloupe	–	–	–	–	–	60	55	80	73	–	–	–	–	–	–	–	–	–
Guam	–	–	–	–	54	54	48	77	68	–	–	–	–	–	–	–	–	–
Guatemala	88	77	100	66	91	61	51	81	68	30	–	89	89	1.00	48	45	0.95	27
Guinea	679	504	927	45	146	8	7	24	22	52	94	84	72	0.86	38	25	0.66	–
Guinea–Bissau	549	273	1,090	45	106	17	16	44	42	24	42	71	68	0.95	10	6	0.56	–
Guyana	229	184	301	86	74	42	41	60	59	30	–	86	84	0.97	82	83	1.00	–
Haiti	359	236	601	49	66	41	37	57	51	18	–	–	–	–	–	–	–	–
Honduras	129	99	166	83	101	73	64	87	77	34	–	95	95	1.01	46	53	1.16	42[m]
Hungary	17	12	22	99	20	74	70	90	85	–	–	–	–	–	–	–	–	12[o]
Iceland	3	2	6	–	7	–	–	–	–	–	–	–	–	–	–	–	–	5

Monitoring ICPD goals: selected indicators

Country, territory or other area	Sexual and reproductive health									Harmful practices		Education and employment						
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[§]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
	2015 estimate					2017		2017										
	2015	Lower	Upper	2006-2016	2006-2015	Any method[§]	Modern method[§]	Any method	Modern method	2008-2016	2004-2015	1999-2015 male	female	1999-2015	2000-2015 male	female	2000-2015	2010-2016
India	174	139	217	81	28	56	50	82	73	27	–	97	98	1.01	61	62	1.01	28 [o]
Indonesia	126	93	179	87	48	62	60	84	81	14	–	93	92	0.99	75	75	0.99	25
Iran (Islamic Republic of)	25	21	31	96	38	76	63	92	77	17	–	99	100	1.01	80	81	1.01	34
Iraq	50	35	69	91	82	56	43	81	63	24	5	98	87	0.89	49	40	0.81	–
Ireland	8	6	11	100	9	67	62	86	80	–	–	–	–	–	–	–	–	14
Israel	5	4	6	–	10	71	57	89	72	–	–	–	–	–	–	–	–	16
Italy	4	3	5	100	6	67	53	86	68	–	–	–	–	–	–	–	–	21
Jamaica	89	70	115	99	46	71	68	87	83	8	–	93	94	1.01	64	70	1.09	–
Japan	5	4	7	100	4	48	45	71	66	–	–	–	–	–	–	–	–	4
Jordan	58	44	75	100	26	62	46	84	62	8	–	88	87	0.99	83	88	1.06	–
Kazakhstan	12	10	15	100	36	58	55	80	76	7	–	100	100	1.00	92	94	1.02	10 [m]
Kenya	510	344	754	62	96	64	61	81	78	23	11	84	88	1.04	57	56	0.97	–
Kiribati	90	51	152	98	49	28	24	51	44	20	–	–	–	–	66	73	1.11	–
Korea, Democratic People's Republic of	82	37	190	100	1	75	71	90	85	–	–	97	97	1.00	–	–	–	–
Korea, Republic of	11	9	13	100	2	79	70	93	83	–	–	–	–	–	–	–	–	–
Kuwait	4	3	6	99	7	56	49	78	68	–	–	–	–	–	–	–	–	–
Kyrgyzstan	76	59	96	98	42	44	41	72	68	12	–	98	98	0.99	80	80	1.00	21
Lao People's Democratic Republic	197	136	307	40	94	56	50	77	69	35	–	96	94	0.98	52	50	0.96	5 [o]
Latvia	18	13	26	98	15	67	61	85	77	–	–	–	–	–	–	–	–	11
Lebanon	15	10	22	–	–	62	46	83	61	6	–	92	86	0.94	65	65	1.00	21
Lesotho	487	310	871	78	94	61	60	78	77	17	–	79	82	1.04	27	42	1.57	–
Liberia	725	527	1,030	61	149	21	21	40	39	36	26 [l]	39	37	0.95	–	–	–	19 [o]
Libya	9	6	15	100	6	49	32	72	47	–	–	–	–	–	–	–	–	–
Lithuania	10	7	14	100	14	63	54	83	70	–	–	–	–	–	–	–	–	9
Luxembourg	10	7	16	100	6	–	–	–	–	–	–	–	–	–	–	–	–	6 [o]
Madagascar	353	256	484	44	145	47	40	72	61	41	–	77	78	1.00	31	32	1.04	4
Malawi	634	422	1,080	90	136	60	59	77	75	46	–	90	96	1.06	33	33	0.98	–
Malaysia	40	32	53	99	13	53	38	75	55	–	–	–	–	–	–	–	–	1
Maldives	68	45	108	96	14	44	37	65	55	4	–	97	96	0.98	45	51	1.14	56 [m]
Mali	587	448	823	49	172	14	14	36	35	60	90	67	60	0.90	39	30	0.76	14
Malta	9	6	15	100	13	81	63	94	73	–	–	–	–	–	–	–	–	10
Martinique	–	–	–	–	20	62	57	81	75	–	–	–	–	–	–	–	–	–
Mauritania	602	399	984	65	71	17	16	35	33	34	66	73	77	1.05	24	22	0.92	–
Mauritius	53	38	77	100	29	66	39	86	51	–	–	96	98	1.02	79	80	1.01	–
Mexico	38	34	42	96	83	73	69	87	83	26	–	97	98	1.01	66	69	1.04	20
Micronesia (Federated States of)	100	46	211	100	33	–	–	–	–	–	–	86	88	1.03	–	–	–	–
Moldova, Republic of	23	19	28	100	27	65	50	85	65	12	–	90	90	1.00	77	77	1.01	28
Mongolia	44	35	55	99	27	59	52	81	72	5	–	96	95	0.99	85	88	1.03	1
Montenegro	7	4	12	99	12	40	24	65	39	5	–	–	–	–	–	–	–	17
Morocco	121	93	142	74	32	68	61	87	78	13	–	99	99	1.00	59	53	0.90	–

Country, territory or other area	Sexual and reproductive health									Harmful practices		Education and employment						
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[S]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
	2015 estimate					2017		2017										
	2015	Lower	Upper	2006-2016	2006-2015	Any method[S]	Modern method[S]	Any method	Modern method	2008-2016	2004-2015	1999-2015 male	female	1999-2015	2000-2015 male	female	2000-2015	2010-2016
Mozambique	489	360	686	54	167	21	20	43	42	48	–	90	85	0.95	18	18	1.00	10
Myanmar	178	121	284	60	22	53	52	77	76	–	–	88	87	0.99	48	49	1.02	19 [o]
Namibia	265	172	423	88	82	59	58	78	78	7	–	89	92	1.03	45	57	1.27	31 [o]
Nepal	258	176	425	56	71	54	51	71	67	37	–	98	96	0.98	58	63	1.08	23 [o]
Netherlands	7	5	9	–	5	71	69	90	87	–	–	–	–	–	–	–	–	5
New Caledonia	–	–	–	–	23	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	11	9	14	97	19	70	68	88	85	–	–	–	–	–	–	–	–	12
Nicaragua	150	115	196	88	92	80	77	93	89	–	–	97	100	1.03	45	53	1.17	–
Niger	553	411	752	40	206	16	15	46	42	76	1	66	57	0.86	19	13	0.67	–
Nigeria	814	596	1,180	35	122	21	16	48	37	43	15	71	60	0.84	–	–	–	–
Norway	5	4	6	99	5	78	73	93	87	–	–	–	–	–	–	–	–	5
Oman	17	13	24	99	13	36	24	55	37	–	–	97	97	1.00	94	89	0.94	–
Pakistan	178	111	283	55	44	40	31	66	52	21	–	79	67	0.85	46	36	0.79	–
Palestine[1]	45	21	99	100	67	59	47	82	65	15	–	93	93	1.00	77	84	1.10	32
Panama	94	77	121	94	91	60	57	79	74	26	–	97	96	0.99	75	81	1.07	33
Papua New Guinea	215	98	457	53	–	37	31	60	50	–	–	90	84	0.92	–	–	–	–
Paraguay	132	107	163	96	63	75	67	91	81	17	–	89	89	1.00	67	66	1.00	13 [m]
Peru	68	54	80	90	65	74	54	89	65	19	–	95	96	1.01	77	79	1.03	22 [m]
Philippines	114	87	175	73	57	56	41	76	56	15	–	95	99	1.04	62	74	1.19	23
Poland	3	2	4	100	14	70	54	88	67	–	–	–	–	–	–	–	–	11
Portugal	10	9	13	99	10	74	68	91	84	–	–	–	–	–	–	–	–	11
Puerto Rico	14	10	18	–	36	76	69	92	83	–	–	–	–	–	–	–	–	–
Qatar	13	9	19	100	13	47	41	73	64	4	–	–	–	–	–	–	–	9
Reunion	–	–	–	–	–	73	71	90	87	–	–	–	–	–	–	–	–	29
Romania	31	22	44	99	39	68	57	88	73	–	–	92	91	0.99	86	86	1.00	18
Russian Federation	25	18	33	99	27	68	58	87	74	7	–	–	–	–	–	–	–	12
Rwanda	290	208	389	91	45	55	50	75	68	7	–	95	97	1.03	–	–	–	–
Saint Kitts and Nevis	–	–	–	100	–	–	–	–	–	–	–	80	83	1.04	81	85	1.04	–
Saint Lucia	48	32	72	99	–	59	57	79	76	24	–	95	93	0.97	80	81	1.01	–
Saint Vincent and the Grenadines	45	34	63	99	70	66	64	84	81	–	–	92	91	0.99	84	87	1.03	–
Samoa	51	24	115	83	39	28	27	39	38	11	–	97	98	1.02	75	84	1.12	41 [o]
San Marino	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–
São Tomé and Príncipe	156	83	268	93	92	42	40	57	54	35	–	97	95	0.98	44	51	1.15	–
Saudi Arabia	12	7	20	98	7	30	26	53	46	–	–	98	95	0.97	82	79	0.95	16
Senegal	315	214	468	53	80	23	21	47	44	32	21	70	76	1.09	23	18	0.77	–
Serbia	17	12	24	100	22	59	27	83	39	3	–	98	99	1.01	91	93	1.02	20
Seychelles	–	–	–	99	56	–	–	–	–	–	–	94	95	1.01	72	78	1.09	–
Sierra Leone	1,360	999	1,980	60	125	17	17	39	38	39	74	100	99	0.99	39	35	0.90	–
Singapore	10	6	17	100	3	66	60	86	77	–	–	–	–	–	–	–	–	11
Sint Maarten	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	6	4	7	99	21	72	62	89	77	–	–	–	–	–	–	–	–	14
Slovenia	9	6	14	100	5	74	65	90	80	–	–	–	–	–	–	–	–	10

Monitoring ICPD goals: selected indicators

Country, territory or other area	Sexual and reproductive health									Harmful practices		Education and employment							
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[S]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
	2015 estimate					2017		2017										
	2015	Lower	Upper	2006-2016	2006-2015	Any method[S]	Modern method[S]	Any method	Modern method	2008-2016	2004-2015	1999-2015 male	female	1999-2015	2000-2015 male	female	2000-2015	2010-2016
Solomon Islands	114	75	175	86	62	38	33	64	57	–	–	82	79	0.97	42	42	0.99	–
Somalia	732	361	1,390	9	–	28	28	50	48	–	97	–	–	–	–	–	–	–
South Africa	138	124	154	94	46	66	66	85	85	–	–	83	94	1.13	59	69	1.16	31
South Sudan	789	523	1150	19	158	7	6	18	16	52	–	47	34	0.71	–	–	–	–
Spain	5	4	6	–	8	68	64	85	81	–	–	–	–	–	–	–	–	16
Sri Lanka	30	26	38	99	20	72	59	91	74	–	–	98	96	0.98	84	87	1.04	28
Sudan	311	214	433	78	87	16	15	36	33	34	82	53	56	1.05	–	–	–	–
Suriname	155	110	220	90	65	53	53	74	73	19	–	91	92	1.01	49	60	1.21	–
Swaziland	389	251	627	88	87	65	63	81	80	5	–	79	78	0.99	31	38	1.24	–
Sweden	4	3	5	–	3	70	65	88	81	–	–	–	–	–	–	–	–	7
Switzerland	5	4	7	–	2	73	70	91	87	–	–	–	–	–	–	–	–	7
Syrian Arab Republic	68	48	97	96	54	58	44	80	61	–	–	72	70	0.98	47	46	0.99	–
Tajikistan	32	19	51	87	54	36	33	63	58	12	–	98	98	1.00	88	79	0.90	–
Tanzania, United Republic of	398	281	570	49	95	41	35	65	56	31	5	81	82	1.01	–	–	–	15[o]
Thailand	20	14	32	100	60	78	77	93	91	22	–	93	92	0.99	77	82	1.06	14
The former Yugoslav Republic of Macedonia	8	5	10	100	19	51	21	76	31	7	–	89	88	0.98	83	81	0.97	25
Timor-Leste, Democratic Republic of	215	150	300	29	51	31	28	55	50	19	–	96	99	1.03	48	56	1.16	–
Togo	368	255	518	45	85	22	20	40	36	22	2	96	90	0.93	32	15	0.48	12[o]
Tonga	124	57	270	96	30	35	32	55	51	6	–	99	99	1.00	71	80	1.12	–
Trinidad and Tobago	63	49	80	100	36	52	47	74	67	–	–	99	98	0.99	70	75	1.07	53
Tunisia	62	42	92	74	6	66	57	88	76	2	–	99	98	0.99	–	–	–	–
Turkey	16	12	21	97	29	74	50	92	61	15	–	94	93	0.99	88	85	0.97	24
Turkmenistan	42	20	73	100	21	56	52	79	75	6	–	–	–	–	–	–	–	–
Turks and Caicos Islands	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	93	42	–	–	–	–	–	–	95	98	1.03	62	78	1.26	–
Uganda	343	247	493	57	140	37	33	55	49	40	1	92	95	1.03	24	22	0.95	6[m]
Ukraine	24	19	32	99	27	67	55	87	71	9	–	96	98	1.02	88	89	1.01	18
United Arab Emirates	6	3	11	–	34	50	42	73	62	–	–	–	–	–	–	–	–	–
United Kingdom	9	8	11	–	19	80	80	93	93	–	–	–	–	–	–	–	–	11
United States of America	14	12	16	99	27	74	70	91	86	–	–	–	–	–	–	–	–	17[m]
United States Virgin Islands	–	–	–	–	43	71	66	87	82	–	–	–	–	–	–	–	–	–
Uruguay	15	11	19	100	64	78	75	91	88	25	–	100	99	1.00	72	79	1.10	19
Uzbekistan	36	20	65	100	30	70	66	89	85	–	–	93	91	0.97	–	–	–	–
Vanuatu	78	36	169	89	78	–	–	–	–	21	–	98	97	0.99	51	53	1.04	–
Venezuela (Bolivarian Republic of)	95	77	124	100	95	73	68	87	82	–	–	93	93	1.00	71	79	1.10	–
Viet Nam	54	41	74	94	36	77	65	92	78	11	–	–	–	–	–	–	–	11
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	385	274	582	45	67	40	34	61	51	32	16	92	78	0.85	50	33	0.67	–
Zambia	224	162	306	63	145	53	49	74	68	31	–	88	90	1.02	–	–	–	13
Zimbabwe	443	363	563	78	110	67	67	87	86	32	–	86	87	1.02	44	44	1.01	–

World and regional data

	Sexual and reproductive health									Harmful practices		Education and employment							
	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%)		Births attended by skilled health personnel, per cent[b]	Adolescent birth rate per 1,000 girls aged 15-19[b]	Contraceptive prevalence rate, women aged 15-49		Proportion of demand satisfied, women aged 15-49[§]		Child marriage by age 18, per cent	FGM prevalence among girls, aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent,		Gender parity index, primary education	Net enrolment rate, secondary education, per cent,		Gender parity index, secondary education	Share of youth not in education, employment or training (NEET), per cent
	2015 estimate					2017		2017										
	2015	Lower	Upper	2006-2016	2006-2015	Any method[§]	Modern method[§]	Any method	Modern method	2008-2016	2004-2015	1999-2015 male	female	1999-2015	2000-2015 male	female	2000-2015	2010-2016
Arab States	**162**	**138**	**212**	**79**	**52**	**53**	**47**	**77**	**68**	**19**	**55**	**86**	**83**	**0.96**	**64**	**58**	**0.92**	**–**
Asia and the Pacific	**127**	**114**	**151**	**82** [c]	**28** [c]	**67**	**63**	**87**	**82**	**26***	**–**	**95***	**95***	**0.99***	**65***	**66***	**1.02***	**–**
Eastern Europe and Central Asia	**25**	**22**	**31**	**98**	**–**	**66**	**49**	**87**	**65**	**11**	**–**	**94**	**94**	**0.99**	**88**	**87**	**0.99**	**21**
Latin America and the Caribbean	**68**	**64**	**77**	**94** [d]	**64** [h]	**75**	**70**	**89**	**83**	**29**	**–**	**94**	**94**	**1.00**	**74**	**78**	**1.06**	**22**
East and Southern Africa	**407**	**377**	**501**	**58**	**95**	**41**	**37**	**64**	**58**	**36**	**31**	**87**	**85**	**0.98**	**34**	**32**	**0.93**	**–**
West and Central Africa	**679**	**599**	**849**	**46**	**115**	**21**	**17**	**47**	**38**	**42**	**24**	**77**	**68**	**0.89**	**38**	**31**	**0.83**	**–**
More developed regions	**12**	**11**	**14**	**92** [e]	**16** [i]	**69**	**63**	**88**	**80**	**–**	**–**	**97**	**97**	**1.00**	**91**	**93**	**1.01**	**11**
Less developed regions	**238**	**228**	**274**	**75** [f]	**48** [j]	**62**	**57**	**84**	**78**	**28***	**–**	**91***	**90***	**0.98***	**62***	**61***	**0.99***	**–**
Least developed countries	**436**	**418**	**514**	**53** [g]	**91** [k]	**40**	**36**	**65**	**58**	**42**	**43**	**85**	**80**	**0.95**	**37**	**33**	**0.90**	**–**
World	**216**	**207**	**249**	**77**	**44**	**63**	**58**	**85**	**78**	**28***	**33 ****	**92***	**90***	**0.98***	**65***	**65***	**1.00***	**–**

NOTES

– Data not available.
§ Women currently married or in union.
a The maternal mortality ratio has been rounded according to the following scheme: <100, rounded to nearest 1; 100-999, rounded to nearest 1; and ≥1000, rounded to nearest 10.
b Includes surveys conducted between year 2006 and 2015.
c Excludes Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.
d Excludes Anguilla, Aruba, Bermuda, British Virgin Islands, Cayman Islands, Curacao, Montserrat, Sint Maarten, and Turks and Caicos Islands due to data availability.
e Excludes Andorra, Belgium, Bermuda, Faeroe Islands, Gibraltar, Greece, Greenland, Iceland, Liechtenstein, Netherlands, Portugal, San Marino, Spain, Sweden, Switzerland, and United Kingdom due to data availability.
f Excludes American Samoa, Anguilla, Aruba, British Virgin Islands, Cayman Islands, China, Hong Kong SAR, China, Macao SAR, Cook Islands, Curaçao, Dominica, French Guiana, French Polynesia, Guadeloupe, Guam, Israel, Martinique, Marshall Islands, Montserrat, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Puerto Rico, Reunion, Sint Maarten, Tokelau, Turks and Caicos Islands, Tuvalu, United States Virgin Islands, Wallis and Futuna Islands, and Western Sahara Islands due to data availability.
g Excludes Tuvalu due to data availability.
h Excludes Anguilla, Antigua and Barbuda, Bermuda, British Virgin Islands, Cayman Islands, Ecuador, Grenada, Montserrat, Sint Maarten, and Saint Kitts and Nevis due to data availability.
i Excludes Andorra, Bermuda, Faeroe Islands, Gibraltar, Greenland, Liechtenstein, and San Marino due to data availability.
j Excludes American Samoa, Anguilla, British Virgin Islands, Cayman Islands, Cook Islands, Dominica, Marshall Islands, Montserrat, Nauru, Niue, Northern Mariana Islands, Palau, Saint Kitts and Nevis, Tokelau, Turks and Caicos Islands, Tuvalu, Wallis and Futuna Islands, and Western Sahara Islands due to data availability.
k Excludes Tuvalu due to data availability.
l Percentage of girls aged 15-19 years who are members of the Sande society. Membership in Sande society is a proxy for female genital mutilation.
m Data based on age groups other than 15-24. Such data are not included in the calculation of regional and global averages.
n Data based on limited geographical coverage. Such data are not included in the calculation of regional and global averages.
o Data calculated using revised methodology. Such data are not included in the calculation of regional and global averages.
* Excludes China.
** Global average is based on countries where female genital mutilation is reported.
1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

Demographic indicators

Country, territory or other area	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 0-14, per cent	Population aged 10-24, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
Afghanistan	35.5	3.0	43	35	54	3	4.5	63	65
Albania	2.9	-0.1	17	22	69	13	1.7	77	81
Algeria	41.3	1.9	29	23	65	6	2.7	75	78
Angola	29.8	3.5	47	32	51	2	5.6	59	65
Antigua and Barbuda	0.1	1.1	24	25	69	7	2.0	74	79
Argentina	44.3	1.0	25	24	64	11	2.3	73	80
Armenia	2.9	0.3	20	19	69	11	1.6	71	78
Aruba	0.1	0.5	18	21	69	13	1.8	73	78
Australia[1]	24.5	1.4	19	19	65	16	1.8	81	85
Austria	8.7	0.5	14	16	67	19	1.5	79	84
Azerbaijan[2]	9.8	1.2	23	22	71	6	2.1	69	75
Bahamas	0.4	1.3	20	22	71	9	1.8	73	79
Bahrain	1.5	2.6	20	19	78	2	2.0	76	78
Bangladesh	164.7	1.1	28	29	67	5	2.1	71	75
Barbados	0.3	0.3	19	19	66	15	1.8	74	78
Belarus	9.5	0.0	17	15	68	15	1.7	68	78
Belgium	11.4	0.6	17	17	64	19	1.8	79	84
Belize	0.4	2.2	31	31	65	4	2.5	68	74
Benin	11.2	2.8	43	32	54	3	4.9	60	63
Bhutan	0.8	1.5	27	28	69	5	2.0	70	71
Bolivia (Plurinational State of)	11.1	1.5	32	29	62	7	2.8	67	72
Bosnia and Herzegovina	3.5	-0.9	14	18	69	17	1.4	75	80
Botswana	2.3	1.8	31	28	65	4	2.7	65	70
Brazil	209.3	0.9	22	24	70	9	1.7	72	79
Brunei Darussalam	0.4	1.4	23	24	72	5	1.9	76	79
Bulgaria	7.1	-0.6	14	14	65	21	1.6	71	78
Burkina Faso	19.2	3.0	45	33	52	2	5.3	60	61
Burundi	10.9	3.1	45	31	52	3	5.6	56	60
Cambodia	16.0	1.6	31	29	64	4	2.5	67	71
Cameroon, Republic of	24.1	2.7	43	32	54	3	4.6	57	60
Canada	36.6	1.0	16	17	67	17	1.6	81	84
Cape Verde	0.5	1.2	30	31	65	4	2.3	71	75
Central African Republic	4.7	0.7	43	34	53	4	4.8	51	55
Chad	14.9	3.2	47	34	50	2	5.8	52	54
Chile	18.1	0.9	20	22	69	11	1.8	77	82
China[3]	1,409.5	0.5	18	18	72	11	1.6	75	78
China, Hong Kong SAR[4]	7.4	0.7	11	14	72	16	1.3	81	87
China, Macao SAR[5]	0.6	2.1	13	14	77	10	1.3	81	87
Colombia	49.1	0.9	23	25	69	8	1.8	71	78
Comoros	0.8	2.4	40	31	57	3	4.3	62	66
Congo, Democratic Republic of the	81.3	3.3	46	32	51	3	6.0	59	62
Congo, Republic of the	5.3	2.6	42	30	54	3	4.6	63	67
Costa Rica	4.9	1.1	22	23	69	9	1.8	78	82
Côte d'Ivoire	24.3	2.5	42	33	55	3	4.8	53	56
Croatia	4.2	-0.5	15	16	66	20	1.5	75	81

Country, territory or other area	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 0-14, per cent	Population aged 10-24, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
Cuba	11.5	0.2	16	17	69	15	1.7	78	82
Curaçao	0.2	1.2	19	19	65	16	2.0	75	81
Cyprus[6]	1.2	0.8	17	20	70	13	1.3	79	83
Czechia	10.6	0.1	15	14	66	19	1.6	76	82
Denmark	5.7	0.5	16	19	64	20	1.8	79	83
Djibouti	1.0	1.7	31	30	65	4	2.8	61	64
Dominica	0.1	0.5	–	–	–	–	–	–	–
Dominican Republic	10.8	1.2	29	28	64	7	2.4	71	77
Ecuador	16.6	1.5	28	27	64	7	2.5	74	79
Egypt	97.6	2.1	33	26	61	5	3.2	69	74
El Salvador	6.4	0.5	27	29	64	8	2.1	69	78
Equatorial Guinea	1.3	4.1	37	29	60	3	4.6	57	59
Eritrea	5.1	2.1	42	32	55	4	4.1	63	68
Estonia	1.3	-0.2	16	15	64	19	1.6	73	82
Ethiopia	105.0	2.6	41	34	56	4	4.1	64	68
Fiji	0.9	0.7	28	26	65	6	2.5	68	74
Finland[7]	5.5	0.4	16	17	62	21	1.8	79	84
France	65.0	0.4	18	18	62	20	2.0	80	86
French Guiana	0.3	2.7	33	28	62	5	3.3	77	83
French Polynesia	0.3	0.8	23	24	69	8	2.0	75	79
Gabon	2.0	3.0	36	28	60	4	3.7	65	68
Gambia	2.1	3.1	45	33	52	2	5.4	60	63
Georgia[8]	3.9	-1.1	19	18	66	15	2.0	69	78
Germany	82.1	0.2	13	15	65	21	1.5	79	83
Ghana	28.8	2.3	39	31	58	3	3.9	62	64
Greece	11.2	-0.4	14	15	65	20	1.3	79	84
Grenada	0.1	0.4	26	26	66	7	2.1	71	76
Guadeloupe[9]	0.4	0.0	19	21	64	17	1.9	78	85
Guam	0.2	0.4	25	25	66	10	2.3	77	82
Guatemala	16.9	2.1	35	33	60	5	2.9	70	77
Guinea	12.7	2.3	42	32	55	3	4.8	60	61
Guinea–Bissau	1.9	2.6	41	32	56	3	4.6	56	60
Guyana	0.8	0.6	29	31	66	5	2.5	64	69
Haiti	11.0	1.3	33	31	62	5	2.9	61	66
Honduras	9.3	1.8	32	32	64	5	2.4	71	76
Hungary	9.7	-0.3	14	16	67	19	1.4	72	79
Iceland	0.3	0.6	20	20	65	14	1.9	81	84
India	1,339.2	1.2	28	28	66	6	2.3	67	70
Indonesia	264.0	1.2	27	26	67	5	2.3	67	72
Iran (Islamic Republic of)	81.2	1.2	24	21	71	5	1.6	75	77
Iraq	38.3	3.1	40	31	56	3	4.3	68	72
Ireland	4.8	0.4	22	18	64	14	2.0	80	84
Israel	8.3	1.6	28	23	60	12	2.9	81	84
Italy	59.4	-0.1	14	14	63	23	1.5	81	85
Jamaica	2.9	0.4	23	26	68	10	2.0	74	79

Demographic indicators

Country, territory or other area	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 0-14, per cent	Population aged 10-24, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
Japan	127.5	-0.1	13	14	60	27	1.5	81	87
Jordan	9.7	4.3	36	30	61	4	3.3	73	76
Kazakhstan	18.2	1.5	28	20	65	7	2.6	65	75
Kenya	49.7	2.6	40	33	57	3	3.8	65	70
Kiribati	0.1	1.8	35	29	61	4	3.6	63	70
Korea, Democratic People's Republic of	25.5	0.5	21	23	70	9	1.9	68	75
Korea, Republic of	51.0	0.4	13	17	73	14	1.3	79	85
Kuwait	4.1	4.6	21	18	77	2	2.0	74	76
Kyrgyzstan	6.0	1.6	32	25	64	4	3.0	67	75
Lao People's Democratic Republic	6.9	1.3	33	31	63	4	2.6	65	69
Latvia	1.9	-1.2	15	15	65	20	1.6	70	79
Lebanon	6.1	4.8	23	26	68	9	1.7	78	82
Lesotho	2.2	1.3	35	33	60	5	3.0	52	57
Liberia	4.7	2.6	42	32	55	3	4.5	62	64
Libya	6.4	0.5	28	26	67	4	2.2	69	75
Lithuania	2.9	-1.1	15	17	66	19	1.7	69	80
Luxembourg	0.6	2.0	16	18	69	14	1.6	80	84
Madagascar	25.6	2.7	41	33	56	3	4.1	65	68
Malawi	18.6	2.9	44	34	53	3	4.5	61	66
Malaysia[10]	31.6	1.7	24	27	69	6	2.0	73	78
Maldives	0.4	2.6	23	23	72	4	2.1	77	79
Mali	18.5	3.0	48	33	50	3	6.0	58	59
Malta	0.4	0.5	14	16	66	19	1.5	79	83
Martinique	0.4	-0.4	18	18	63	19	1.9	79	85
Mauritania	4.4	2.9	40	31	57	3	4.6	62	65
Mauritius[11]	1.3	0.2	18	23	71	11	1.4	71	78
Mexico	129.2	1.4	27	27	66	7	2.2	75	80
Micronesia (Federated States of)	0.1	0.3	33	35	62	5	3.1	68	71
Moldova, Republic of[12]	4.1	-0.1	16	18	73	11	1.2	67	76
Mongolia	3.1	1.8	30	23	66	4	2.7	65	74
Montenegro	0.6	0.1	18	19	67	15	1.7	75	80
Morocco	35.7	1.4	27	25	66	7	2.5	75	77
Mozambique	29.7	2.9	45	33	52	3	5.2	57	61
Myanmar	53.4	0.9	27	28	67	6	2.2	64	69
Namibia	2.5	2.2	37	32	60	4	3.4	62	68
Nepal	29.3	1.2	31	32	63	6	2.1	69	72
Netherlands	17.0	0.3	16	18	65	19	1.7	80	84
New Caledonia	0.3	1.4	23	23	68	10	2.2	75	80
New Zealand	4.7	1.1	20	20	65	15	2.0	80	84
Nicaragua	6.2	1.1	29	29	66	5	2.2	73	79
Niger	21.5	3.8	50	32	47	3	7.2	59	61
Nigeria	190.9	2.6	44	31	53	3	5.5	53	55
Norway[13]	5.3	1.2	18	19	65	17	1.8	80	84
Oman	4.6	6.0	22	20	76	2	2.6	76	80

Country, territory or other area	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 0-14, per cent	Population aged 10-24, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
Pakistan	197.0	2.1	35	30	61	4	3.4	66	68
Palestine[14]	4.9	2.7	40	33	57	3	3.9	72	76
Panama	4.1	1.7	27	25	65	8	2.5	75	81
Papua New Guinea	8.3	2.1	36	31	60	4	3.6	63	68
Paraguay	6.8	1.3	29	29	64	6	2.5	71	75
Peru	32.2	1.3	27	26	65	7	2.4	73	78
Philippines	104.9	1.6	32	29	63	5	2.9	66	73
Poland	38.2	-0.1	15	16	68	17	1.3	74	82
Portugal	10.3	-0.4	14	15	65	22	1.2	78	84
Puerto Rico	3.7	-0.2	18	21	67	15	1.5	76	84
Qatar	2.6	5.6	14	19	85	1	1.9	78	80
Reunion	0.9	0.8	24	23	65	11	2.3	77	84
Romania	19.7	-0.5	15	16	67	18	1.5	72	79
Russian Federation	144.0	0.1	18	15	68	14	1.8	66	77
Rwanda	12.2	2.5	40	31	57	3	3.8	65	70
Saint Kitts and Nevis	0.1	1.0	–	–	–	–	–	–	–
Saint Lucia	0.2	0.5	19	24	71	10	1.4	73	78
Saint Vincent and the Grenadines	0.1	0.1	24	25	68	8	1.9	71	76
Samoa	0.2	0.8	37	31	58	6	3.9	72	78
San Marino	0.0	1.0	–	–	–	–	–	–	–
São Tomé and Príncipe	0.2	2.2	43	33	54	3	4.4	65	69
Saudi Arabia	32.9	2.6	25	22	72	3	2.5	73	76
Senegal	15.9	2.9	43	32	54	3	4.7	65	69
Serbia[15]	8.8	-0.4	16	18	66	17	1.6	73	78
Seychelles	0.1	0.5	22	19	69	9	2.3	70	79
Sierra Leone	7.6	2.2	42	33	55	3	4.4	52	53
Singapore	5.7	1.7	15	18	72	13	1.3	81	85
Sint Maarten	0.0	2.7	–	–	–	–	–	–	–
Slovakia	5.4	0.1	15	16	70	15	1.5	73	80
Slovenia	2.1	0.2	15	14	66	19	1.6	78	84
Solomon Islands	0.6	2.1	39	32	58	4	3.8	70	73
Somalia	14.7	2.9	46	33	51	3	6.2	55	58
South Africa	56.7	1.4	29	27	66	5	2.4	60	67
South Sudan	12.6	3.2	42	33	55	3	4.8	56	58
Spain[16]	46.4	-0.1	15	14	66	19	1.4	81	86
Sri Lanka	20.9	0.5	24	23	66	10	2.0	72	79
Sudan	40.5	2.3	41	33	56	4	4.5	63	66
Suriname	0.6	1.0	26	26	67	7	2.3	68	75
Swaziland	1.4	1.8	37	33	60	3	3.0	55	61
Sweden	9.9	0.8	18	17	62	20	1.9	81	84
Switzerland	8.5	1.1	15	16	67	18	1.5	82	85
Syrian Arab Republic	18.3	-2.0	37	34	59	4	2.9	65	77
Tajikistan	8.9	2.2	35	29	61	3	3.3	68	74
Tanzania, United Republic of[17]	57.3	3.1	45	32	52	3	5.0	65	68
Thailand	69.0	0.4	17	20	71	11	1.5	72	79

Demographic indicators

Country, territory or other area	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 0-14, per cent	Population aged 10-24, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
The former Yugoslav Republic of Macedonia	2.1	0.1	17	19	70	13	1.5	74	78
Timor-Leste, Democratic Republic of	1.3	2.2	44	34	53	4	5.4	67	71
Togo	7.8	2.6	42	32	56	3	4.4	60	61
Tonga	0.1	0.5	36	32	58	6	3.6	70	76
Trinidad and Tobago	1.4	0.4	21	20	69	10	1.7	67	74
Tunisia	11.5	1.2	24	22	68	8	2.2	74	78
Turkey	80.7	1.6	25	25	67	8	2.0	73	79
Turkmenistan	5.8	1.8	31	26	65	4	2.8	65	71
Turks and Caicos Islands	0.0	1.9	–	–	–	–	–	–	–
Tuvalu	0.0	0.9	–	–	–	–	–	–	–
Uganda	42.9	3.3	48	34	50	2	5.5	58	62
Ukraine[18]	44.2	-0.5	15	15	68	16	1.6	67	77
United Arab Emirates	9.4	1.8	14	15	85	1	1.7	77	79
United Kingdom	66.2	0.6	18	17	64	19	1.9	80	83
United States of America	324.5	0.7	19	20	66	15	1.9	77	82
United States Virgin Islands	0.1	-0.2	20	20	61	19	2.2	78	82
Uruguay	3.5	0.3	21	22	64	15	2.0	74	81
Uzbekistan	31.9	1.6	28	26	68	4	2.3	69	74
Vanuatu	0.3	2.2	36	29	60	4	3.2	70	75
Venezuela (Bolivarian Republic of)	32.0	1.4	28	26	66	7	2.3	71	79
Viet Nam	95.5	1.1	23	23	70	7	2.0	72	81
Western Sahara	0.6	2.0	28	26	69	3	2.4	68	72
Yemen	28.3	2.6	40	33	57	3	3.9	64	67
Zambia	17.1	3.0	45	34	53	2	4.9	60	65
Zimbabwe	16.5	2.3	41	32	56	3	3.7	60	64

World and regional data

	Population								
	Total population in millions	Average annual rate of population change, per cent	Population aged 10-24, per cent	Population aged 0-14, per cent	Population aged 15-64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth (years), 2017	
	2017	2010-2017	2017	2017	2017	2017	2017	male	female
Arab States	**359**	**2.1**	**35**	**28**	**61**	**5**	**3.4**	**68**	**72**
Asia and the Pacific	**3,960**	**1.0**	**24** [a]	**24** [a]	**68** [a]	**8** [a]	**2.1** [a]	**70** [a]	**73** [a]
Eastern Europe and Central Asia	**243**	**0.9**	**23**	**22**	**67**	**10**	**2.1**	**70**	**77**
Latin America and the Caribbean	**641**	**1.1**	**25** [b]	**26** [b]	**67** [b]	**8** [b]	**2.0** [b]	**72** [b]	**79** [b]
East and Southern Africa	**581**	**2.7**	**42**	**32**	**55**	**3**	**4.5**	**61**	**65**
West and Central Africa	**424**	**2.7**	**44**	**32**	**53**	**3**	**5.2**	**56**	**58**
More developed regions	**1,260**	**0.3**	**16**	**17**	**65**	**18**	**1.7**	**76**	**82**
Less developed regions	**6,290**	**1.4**	**28**	**25**	**65**	**7**	**2.6**	**68**	**72**
Least developed countries	**1,002**	**2.4**	**40**	**32**	**57**	**4**	**4.0**	**63**	**66**
World	**7,550**	**1.2**	**26**	**24**	**65**	**9**	**2.5**	**70**	**74**

NOTES

— Data not available.

§ Due to rounding, dependency ratios may differ from numbers calculated based on percentage of population aged 0-14, aged 15-64 and aged 65 and older.

a Excludes Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

b Excludes Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Montserrat, Saint Kitts and Nevis, Sint Maarten, and Turks and Caicos Islands due to data availability.

1 Includes Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

2 Includes Nagorno-Karabakh.

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

4 As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

5 As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China.

6 Refers to the whole country.

7 Includes Åland Islands.

8 Includes Abkhazia and South Ossetia.

9 Includes Saint-Barthélemy and Sint-Martin (French part).

10 Includes Sabah and Sarawak.

11 Includes Agalega, Rodrigues and Saint Brandon.

12 Includes Transnistria.

13 Includes Svalbard and Jan Mayen Islands.

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

15 Includes Kosovo.

16 Includes Canary Islands, Ceuta and Melilla.

17 Includes Zanzibar.

18 Includes Crimea.

Technical notes for indicators
Data sources and definitions

The statistical tables in *The State of World Population 2017* include indicators that track progress toward the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD) beyond 2014, and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

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

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates, and inter-agency estimates. They also include the latest population estimates and projections from World Population Prospects: The 2017 revision, and Model-based Estimates and Projections of Family Planning Indicators 2017 (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources and notes. The statistical tables in *The State of World Population 2017* generally reflect information available as of June 2017.

Monitoring ICPD goals: selected indicators

Maternal and newborn health

Maternal mortality ratio (MMR), deaths per 100,000 live births and Range of MMR uncertainty (UI 80%), Lower and Upper estimates 2015. Source: United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG). This indicator presents the number of deaths of women from pregnancy-related causes per 100,000 live births. The estimates are produced by the Maternal Mortality Estimation Inter-agency Group (MMEIG) using data from vital registration systems, household surveys and population censuses. UNFPA, WHO, the World Bank, UNICEF, and United Nations Population Division are members of the MMEIG. Estimates and methodologies are reviewed regularly by MMEIG and other agencies and academic institutions and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel, per cent, 2006/2016. Source: Joint global database on skilled attendance at birth, 2017, United Nations Children's Fund (UNICEF) and World Health Organisation (WHO). Regional aggregates calculated by UNFPA based on data from the joint global database. Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a short training course, are not included.

Adolescent birth rate, per 1,000 girls aged 15-19, 2006/2015. Source: United Nations Population Division and UNFPA. The adolescent birth rate represents the risk of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

Sexual and reproductive health

The United Nations Population Division produces a systematic and comprehensive set of annual, model-based estimates and projections is provided for a range of family planning indicators for a 60-year time period. Indicators include contraceptive prevalence, unmet need for family planning, total demand for family planning and the percentage of demand for family planning that is satisfied among married or in-union women for the period from 1970 to 2030. A Bayesian hierarchical model combined with country-specific time trends was used to generate the estimates, projections and uncertainty assessments. The model advances prior work and accounts for differences by data source, sample population, and contraceptive methods included in measures of prevalence. More information on family planning model-based estimates, methodology and updates can be found at <http://www.un.org/en/development/desa/population>. The estimates are based on the country-specific data compiled in World Contraceptive Use 2017.

Contraceptive prevalence rate, women currently married/in-union aged 15-49, any method and any modern method, 2017. Source: United Nations Population Division. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, intrauterine devices, the pill, injectables, hormonal implants, condoms and female barrier methods.

Proportion of demand satisfied, any method and any modern method, women currently married/in-union aged 15-49, 2017. Source: United Nations Population Division. Percentage of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied and the percentage of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied by the use of modern contraception.

Proportion of demand satisfied with any methods (PDS) = Contraceptive prevalence rate for any methods (CPR) divided by total demand for family planning (TD).

Proportion of demand satisfied with modern methods (mPDS) = Contraceptive prevalence rate for modern methods (mCPR) divided by total demand for family planning (TD).

Where total demand = Contraceptive prevalence rate plus unmet need for contraception rate (UNR), that is

TD = CPR + UNR

Harmful practices

Child marriage by age 18, per cent, 2008/2016. Source: UNFPA. Proportion of women aged 20 to 24 years who were married or in a union before age 18.

Female genital mutilation (FGM) prevalence among girls aged 15-19, per cent, 2004/2015. Source: UNFPA. Proportion of girls aged 15 to 19 years who have undergone female genital mutilation.

Education

Male and female adjusted net enrolment rate, primary education, per cent, 1999/2015. Source: UNESCO Institute for Statistics (UIS). The adjusted primary school net enrolment rate indicates the percentage of children of the official primary age group who are enrolled in primary or secondary education.

Male and female net enrolment rate, secondary education, per cent, 2000/2015. Source: UNESCO Institute for Statistics (UIS). The secondary school net enrolment rate indicates the percentage of children of the official secondary age group who are enrolled in secondary education.

Gender parity index, primary education, 1999/2015. Source: UNESCO Institute for Statistics (UIS). The gender parity index (GPI) refers to the ratio of female to male values of adjusted primary school net enrolment ratio.

Gender parity index, secondary education, 2000/2015. Source: UNESCO Institute for Statistics (UIS). The gender parity index (GPI) refers to the ratio of female to male values of secondary school net enrolment ratio.

Share of youth not in education, employment or training (NEET), per cent, 2010/2016. Source: International Labour Organization. Percentage of youth who are not employed and not involved in further education or training. Youth are defined as 15 to 24 years unless indicated.

Demographic indicators

Total population, in millions, 2017. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from the United Nations Population Division. These indicators present the estimated size of national populations at mid-year.

Average annual rate of population change, per cent, 2010/2017. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from the United Nations Population Division. These figures refer to the average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population aged 0-14, per cent, 2017. Source: UNFPA calculation based on data from the United Nations Population Division. These indicators present the proportion of the population between age 0 and age 14.

Population aged 10-24, per cent, 2017. Source: UNFPA calculation based on data from the United Nations Population Division. These indicators present the proportion of the population between age 10 and age 24.

Population aged 15-64, per cent, 2017. Source: UNFPA calculation based on data from the United Nations Population Division. These indicators present the proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent, 2017. Source: UNFPA calculation based on data from the United Nations Population Division. These indicators present the proportion of the population aged 65 and older.

Total fertility rate, per woman, 2017. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from the United Nations Population Division. These indicators present the number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Male and female life expectancy at birth (years), 2017. Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from the United Nations Population Division. These indicators present the number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Regional classification

UNFPA averages presented at the end of the statistical tables are calculated using data from countries and areas as classified below. The regional classifications include only the countries where UNFPA works.

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

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

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

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

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

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

More developed regions comprise Europe, Northern America, Australia/New Zealand and Japan.

Less developed comprise all United Nations Population Division regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18) included 47 countries (as of June 2017): 33 in Africa, nine in Asia, four in Oceania and one in Latin America and the Caribbean - Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; Central African Republic; Chad; Comoros; Democratic Republic of the Congo; Djibouti; Eritrea; Ethiopia; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mozambique; Myanmar; Nepal; Niger; Rwanda; São Tomé and Príncipe; Senegal; Sierra Leone; Solomon Islands; Somalia; South Sudan; Sudan; Timor-Leste; Togo; Tuvalu; Uganda; United Republic of Tanzania; Vanuatu; Yemen and Zambia. These countries are also included in the less developed regions.

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Tel. +1 212 297 5000
www.unfpa.org
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