WE CARE.

Atlas of Maternal, Sexual, Reproductive, Child, and Adolescent Health

Member of ChildFund Alliance

WE CARE.
Atlas of Maternal, Sexual, Reproductive, Child, and Adolescent Health

Written by
Martina Albini, Eleonora Mattacchione, Elena Rebecca Cerri

Review and editing by
Maxwell Lacken

WeWorld Coordination
Andrea Comollo (Head of Comms., Italy and EU Programmes Dep.)
Anna Crescenti (Global Senior Technical Expert WASH)
Antilla Fürst (MEA and LAC Communications Focal Point)
Eleonora Mattacchione (Junior Advocacy Officer)
Elena Rebecca Cerri (Civil Service)
Erica Scigliuolo (Communications and Advocacy Specialist)
Greta Nicolini (Press Office Manager)
Ludovica Iaccino (Digital Content Specialist)
Martina Albini (National Advocacy and Study Centre Coordinator)
Maxwell Lacken (Project Manager for the Italian Programmes)
Rachele Ponzellini (EU and Global Communication Coordinator)
Tiziano Codazzi (Communications Specialist)

Graphics and layout Marco Binelli

Cover photo: Ilaria Quintas, from the photo collage project "What Women...", Mozambique, 2022

The publication is available to download from **www.weworld.it/en/what-we-do/publications**

Created by:
WeWorld
www.weworld.it

Sedi principali in Italia:
Milano, via Serio 6
Bologna, via F. Baracca 3

The publication was completed in September 2023.

Credits
Giulia Raggi, Technical Review

Table of Contents

Preface

More than three years have passed since the outbreak of the COVID-19 pandemic. As global health systems proved to be unprepared, the pandemic emergency pushed other health issues to the sidelines. Access to different health services, ranging from admissions to diagnostics, from checkups (and, more broadly, preventative medicine) to surgeries, has been severely restricted. **It has become increasingly clear that strengthening health systems, making them resilient and universally accessible, and adopting a holistic approach to health care interventions can no longer be postponed.**

In November 2022, **the world population reached 8 billion people**: an extraordinary result, the outcome of decades of remarkable achievements to ensure greater access to health care, adequate information and education, and poverty reduction. **This, however, should prompt us to consider the challenges and opportunities for further progress**. It has never been more important for people to exercise their rights and make informed choices than in this precise moment, which is characterised by poly-crises and profound changes. In this context, **there is a significant risk that people's sexual and reproductive rights will not be prioritised.**

To have good sexual and reproductive health means to experience complete physical, mental, and social well-being in all aspects of the reproductive system. Nonetheless, various vulnerable social groups are still denied this right and face daily discrimination. **Women, children, and adolescents are unquestionably among the groups most vulnerable to violations of human rights, particularly their sexual and reproductive rights**. Fully ensuring all individuals' sexual and reproductive rights could have beneficial effects on many other fundamental rights and freedoms. **Sexual and reproductive health, including family planning, is a prerequisite for empowering women and girls to fully enjoy their rights and achieve their aspirations**, as reaffirmed at the 2019 Nairobi Summit on Population and Development (ICPD+25).

Because the concept of sexual and reproductive health implies an overall state of well-being, it is easy to see how it relates to a multitude of other fundamental rights. For these reasons, **WeWorld's WE CARE Atlas emphasises the importance of a comprehensive approach to sexual and reproductive justice that includes guarantees of fundamental human rights including the right to life, health, privacy, education, information, freedom of expression, freedom from violence and discrimination, and freedom from torture, cruel, inhuman, and degrading treatment**.

The WE CARE Atlas collects various stories and best practices from the field to supplement the report's numerous facts and figures. WeWorld, which has been intervening in countries around the world for over 50 years, and currently operates in 27 countries, implements a multi-sectoral approach to ensuring the right to health, water, education, non-discrimination, and freedom from all forms of violence within the framework of the 2030 Agenda.

In recent years, for example, we have ensured equitable access to water through the provision of potable water resources and sanitation, resource management training, the fight against waste and exploitation of sources, and related policies. We have prioritised access to water and hygiene in schools, providing sanitation services and paying particular attention to the inclusion of girls, as we recognise the critical role that schools play as not only pivotal educational institutions but also as garrisons for the transmission of good practices between communities.

We have organised training courses and awareness-raising campaigns in all the countries we operate in to increase consciousness about the right to water and hygiene standards. We have also integrated health interventions with the fight against child and maternal malnutrition, training health personnel and ensuring health centre services.

The variety of contexts in which WeWorld operates demanded the development of solid guidelines and the promotion of a common standard. **The organisation has established two fundamental work modalities. WeWorld has adopted the WASH in Schools (WinS) method as part of its global intervention strategies in WASH (Water, Sanitation, and Hygiene) and Education**, which provides a strong synergy between these two sectors.

The WASH component is now required in all countries where WeWorld works on educational projects. **WeWorld has also adopted the Menstrual Hygiene Management (MHM) method as part of its global WASH (Water, Sanitation, and Hygiene) strategy, recognising how activities and programmes dedicated to health and menstrual hygiene are a starting point for raising broader issues** such as gender equality and women's empowerment, encompassing essential issues such as sex education, sexual and reproductive health and rights, child marriage, obstetric fistulas, female genital mutilation, and gender-based violence in general.

The MHM modality can help women and girls develop skills to overcome obstacles to their health, freedom, and development, as well as contribute to transformational processes that allow them to reach their full potential. **Such interventions clearly highlight the importance of a sexual and reproductive justice agenda to combat all violations of other rights, fundamental freedoms, and political, cultural, and economic inequalities that continue to prevent women, girls, boys, and adolescents from fully developing.**

Dina Taddia,
WeWorld CEO

Marco Chiesara,
WeWorld President

© Camilla Milani

Executive Summary

The right to health is a human right, and as such, it is not subject to discrimination or exclusion. Nonetheless, several vulnerable social groups are still denied this right and face daily discrimination. Among these are women, children, and adolescents, as well as the LGBTQIA+ community, people with disabilities, indigenous peoples, ethnic minorities, refugees, and people of migrant origin, among others). The Atlas of Maternal, Sexual, Reproductive, Child, and Adolescent Health was born from the need to evaluate the implementation and respect of sexual and reproductive rights around the world, in line with WeWorld's long history of interventions to promote the health of women, children, and adolescents and their communities.

THE MAIN REGULATORY REFERENCES

Today, there are various legislative tools to guide policies and prioritize government interventions in the field of sexual and reproductive health. As part of the Sustainable Development Goals (SDGs) and the United Nations Secretary-General's Global Strategy on Women's, Children's and Adolescent Health (2016-2030), all WHO member states have committed to improving the health of women, children and adolescents by accelerating coverage and improving the quality of health services. Achieving these goals requires adopting and implementing resilient policies that are informed about current challenges, focused on equity, and capable of ensuring the continuum of care for sexual, reproductive, maternal, newborn, child and adolescent health in a life-course approach.

However, the international journey on sexual and reproductive health rights began much earlier: precisely at the **1994 Cairo Conference on Population and Development (ICPD**), which **recognized sexual and reproductive health, including family planning, as a precondition for the empowerment of women and girls, for the full enjoyment of their rights and the achievement of gender equality**. In 2019, the United Nations Population Fund (UNFPA) and the Government of Kenya convened the **Nairobi Summit to mark the 25th anniversary of the Cairo Conference**. The outcome of the Summit gave light to the **Nairobi Declaration**, which translated the main issues addressed (universal access to sexual and reproductive health and rights; need for funding to complete the Cairo action programme; fight against gender-based violence and harmful practices; support for the right to sexual and reproductive health including in humanitarian settings) in **12 commitments and affirmed the need to establish a sexual and reproductive justice agenda.**

SEXUAL AND REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS: THE FRAMEWORK OF SEXUAL AND REPRODUCTIVE JUSTICE

Starting precisely from the framework of sexual and reproductive justice, **this Atlas affirms the link between sexual and reproductive rights and other human rights and fundamental freedoms**. Indeed, the framework of sexual and reproductive justice encompasses the broader spectrum of sexual and reproductive rights, which in turn refer to several human rights guarantees, including the rights to life, health, privacy, education, information, freedom of expression, freedom from violence and discrimination and freedom from torture, cruel, inhuman and degrading treatment. **The sexual and reproductive justice framework is central to strengthening the implementation and accountability of the Nairobi commitments and the Sustainable Development Goals.**

THE CENTRAL ROLE OF EDUCATION

The concept of sexual and reproductive justice is inextricably linked to education and its transformative power to generate change and knowledge transmission within communities, while also promoting paths of awareness, self-determination, and self-care. As has become universally recognised, good quality education is the foundation of health and well-being and is intrinsically linked to sexual and reproductive rights in a variety of direct and indirect ways. In this sense, education can be considered a development catalyst as well as a health intervention in and of itself. **This is especially true in emergency situations, where the school takes on an almost symbolic significance as a place that opens to the community, ensuring health and the transmission of knowledge and good practices between generations**. Ensuring education in such dramatic contexts has the potential to act broadly by limiting potential risks and dangerous situations to one's health.

THE SIX SECTIONS OF THE ATLAS

Beginning with these considerations, **the Atlas, divided into six thematic sections, investigates the major denials of rights and discrimination that women, children, and adolescents continue to face around the world.**

MATERNAL AND CHILD HEALTH

ANTENATAL CARE

- Globally, most women have access to quality antenatal care at least once before giving birth, yet only 66% receive four antenatal checks (UNICEF, 2022a).
- Antenatal care coverage increases with wealth, with women in the richest quintile being twice as likely to receive at least four checks as those in the poorest quintile: a gap of 34 percentage points (77% vs. 43%) (UNICEF, 2022a).

CHILDBIRTH

- Every two minutes, a woman dies needlessly from pregnancy-related causes (WHO, 2023a).
- In 2000, the global maternal mortality rate was 339 deaths every 100,000 live births. In 2020 it dropped to 223 (WHO, 2023a).
- The highest number of neonatal deaths is recorded in Central and Western Africa: more than 31 for every 1,000 live births (World Bank, 2023).

POSTNATAL CARE

- Approximately 1 in 5 women will experience a mental health problem during pregnancy or shortly after childbirth (UNFPA, 2022b).
- The first 1,000 days, or the time between conception and the first two years of a child's existence, are a period of great potential during which the foundations for long-term, optimal health and development are laid, but they are also a time of significant risk (UNICEF, 2017; Rice, 2022).

BODY POLITICS

FAMILY PLANNING

- In low-income regions, an estimated 257 million women who wish to avoid pregnancy do not use safe and effective contraceptive methods for a variety of reasons, ranging from a lack of access to information or services to a lack of support from their partners or community (UNFPA, 2023).
- Globally, 4 out of 10 women in a relationship do not use any form of contraception (United Nations, 2022).

SAFE ABORTION

- Unsafe abortion is a primary cause of maternal death and morbidity. Approximately 45% of all abortions performed globally are unsafe, with 97% occurring in low-income countries (WHO, 2021a).
- In 2022, 91 million women lived in one of the 23 countries where abortion is prohibited altogether (WALM, 2022).
- In countries with highly restrictive abortion regulations, the rate of unsafe abortions is much higher than in countries with less restrictive laws (Ganatra et al., 2017).

PRACTICES AFFECTING BODY INTEGRITY

- FGM is estimated to have affected 200 million girls worldwide (UNICEF, 2023b).
- FGM is still almost universal in some of these countries, with 90% of girls affected in Guinea, Mali, and Somalia (the latter case reaching 99%) (UNICEF, 2023b).

GENDER-BASED VIOLENCE

GENDER-BIASED SEX SELECTION

- When a couple or family prefers to have a son over a daughter, this is referred to as gender-biased sex selection. Gender-biased sex selection is a harmful practice that manifests violence and gender inequality and has a direct impact on the birth sex ratio of boys and girls (UNFPA, 2022b).
- Globally, 23.1 million "missing" female births were documented between the late 1990s and 2017 (Chao et al. 2019).

CHILD FORCED MARRIAGES

- Every year, 12 million girls get married before the age of 18: that's 23 every minute (UNICEF, 2022b).
- Over the last decade, increased education rates for girls, government investment in adolescent girls' rights, and increased public awareness of the dangers of child marriage have resulted in the prevention of 25 million child marriages worldwide (UNICEF, 2022b).

EARLY PREGNANCIES

- Every year, around 21 million girls aged 15-19 in low-income regions become pregnant and around 12 million of them give birth (UNDESA, 2022).
- Girls who marry before the age of 15 are 50% more likely than those who marry later to experience intimate partner violence (Girls Not Brides, 2021).

WASH AND SEXUAL AND REPRODUCTIVE RIGHTS

- To ensure sexual and reproductive health and gender equality, women, girls, and adolescents must have access to clean water, appropriate sanitation, and adequate hygiene (WASH). Access to water is integrally linked to women's and girls' sexual and reproductive health and rights.
- Due to inadequate WASH services, every day more than 700 children under the age of 5 die from diarrheal illnesses. They are about 20 times more likely to die from diarrheal illness in conflict zones than from the conflict itself (UNICEF, 2023c).
- 1 in 3 children without basic drinking water service in their school lives in the poorest countries, and

more than half in fragile settings (UNICEF/WHO, 2022).

MENSTRUAL HEALTH

- The concept of menstrual health extends beyond the simple management of the menstrual period to include the entire menstrual cycle as well as general health and well-being. Menstrual health is defined as a complete state of physical, mental, and social well-being during the menstrual cycle, rather than simply the absence of disease or infirmity (PERIOD, 2022).
- An estimated 1.8 billion people menstruate each month (WASH United, 2022)
- In Sub-Saharan Africa, 1 in 10 girls missed school during menstruation (UNESCO, 2014)
- More than 1 in 3 boys think periods should be kept secret (Plan International, 2021)
- Endometriosis affects approximately 10% of the female population (190 million women and girls) worldwide (WHO, 2021c)
- In terms of specialist visits, prescriptions, drugs, and so on, the menopause "business" would be worth approximately 600 billion dollars globally (Hinchliffe, 2020).

SEXUAL HEALTH AND WELL-BEING

SEXUALLY TRANSMITTED DISEASES (STDS)

- A woman living with HIV can transmit the infection to her child during pregnancy, childbirth, and breastfeeding (mother-to-child transmission, MTCT). The virus can pass through the placenta or, during delivery, through exposure to secretions, maternal blood, or, finally, breast milk (WHO, 2022f).
- Worldwide, 1.7 million children aged 0-14 are living with HIV (WHO, 2022f)
- Every day, over 1 million sexually transmitted diseases are contracted (ibid.). In 2020, the WHO estimated 374 million new infections, including chlamydia (129 million), gonorrhoea (82 million), syphilis (7.1 million), and trichomoniasis (156 million) (WHO, 2022f).

COMMON CANCER TYPES IN WOMEN

- Breast cancer is the most common type of cancer, accounting for 1 out of every 8 cancer diagnoses globally (International Agency for Research on Cancer, 2022).
- Cervical cancer is the fourth most common cancer type in women (after breast, colon, and lung cancer), accounting for 7% of all new cancer diagnoses in 2020 (WCRFI, 2022).

WE DO CARE. CONCLUSIONS AND RECOMMENDATIONS

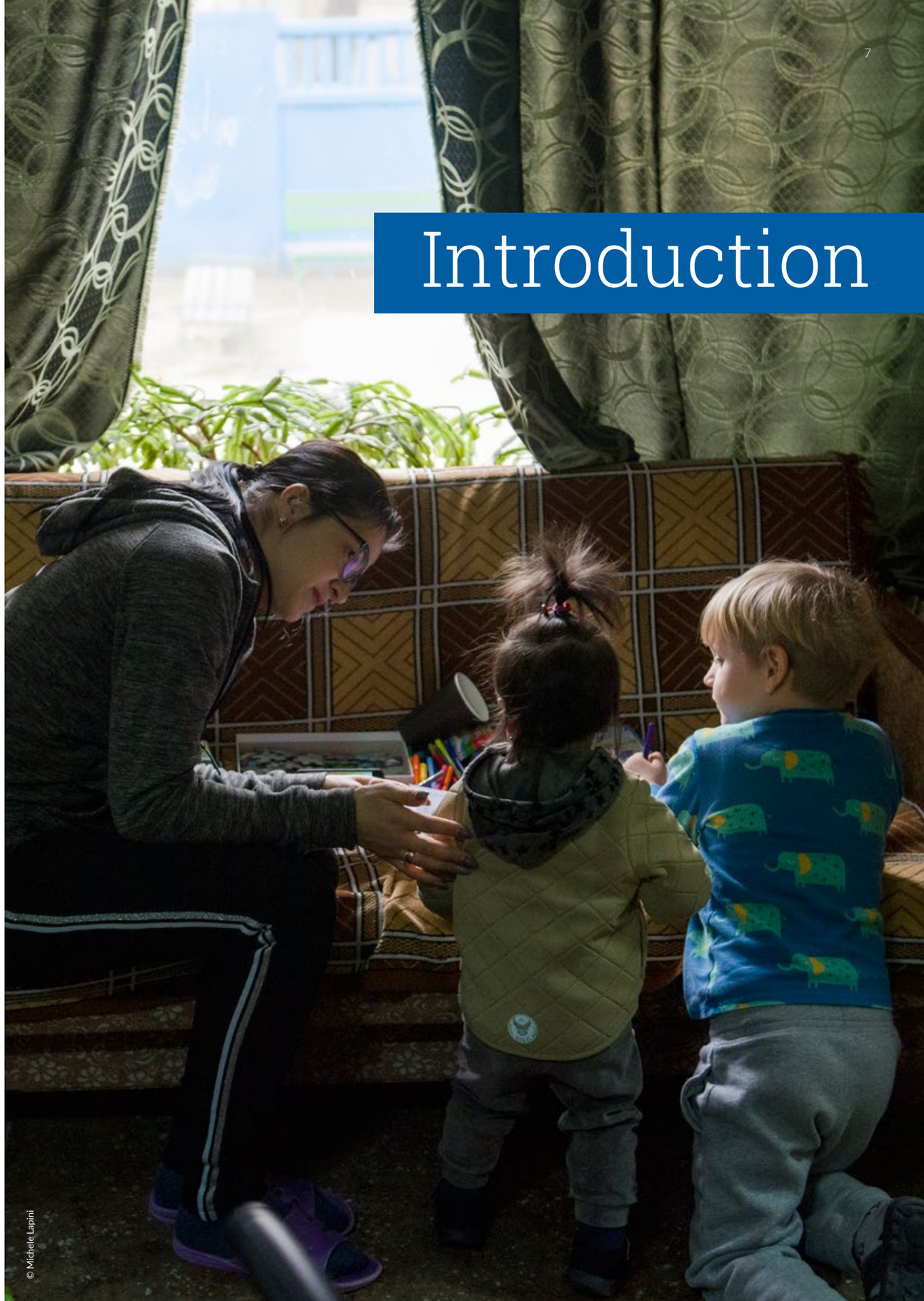
The COVID-19 pandemic has hindered progress made since the proclamation of the 2030 Agenda objectives and forecasts for improvements desired with the 12 Nairobi commitments. **Today, limitations on women's rights, as well as the persistence of conflict and protracted crises, jeopardise the revival of sexual and reproductive health and rights, bodily autonomy, and freedom from gender-based violence.**

The Atlas' six sections highlight major critical issues and gaps, not only in terms of universal access to care and health information but also from a regulatory standpoint, with several countries failing to guarantee citizens' bodily autonomy. **Women, girls, and children are once again paying the highest price in areas characterised by chronic poverty, conflicts, and inequalities, most notably Sub-Saharan Africa, followed by Central-Southern Asia, the Middle East, and Latin America.** As previously stated, this has implications not only for sexual and reproductive rights but also for a host of other fundamental human rights, including the right to education.

In this context, **emerging evidence suggests that providing sexual education programmes in schools for children and young people can have a positive impact on broader societal issues such as gender equality, human rights, and the well-being and safety of future generations. As a result, where adequate sexual education is lacking, there can be no talk of sexual and reproductive justice.**

The Nairobi Summit was held almost four years ago (2019), and the next International Conference on Population and Development (ICPD) is scheduled for 2024. Considering this critical appointment, it is necessary to emphasise the importance of a sexual and reproductive justice agenda as a vehicle for delivering on the commitments made in 2019, **not only to guarantee sexual and reproductive rights per se but also to combat all violations of other fundamental rights and freedoms, as well as social, political, cultural, and economic disparities.**

Introduction



© Michele Lapini

A reader's guide to the **Atlas**

The Atlas of Maternal, Sexual, Reproductive, Child, and Adolescent Health was born from a need to assess the application and enforcement of sexual and reproductive rights around the world, in line with WeWorld's 50-year history of intervening to improve the health of women, children, and their communities.

Starting from the framework of sexual and reproductive justice (as outlined in the Nairobi Declaration of 2019), **the report recognizes the connection between sexual and reproductive rights and a whole range of other human rights and fundamental freedoms**. In particular, the notion of sexual and reproductive justice is inextricably tied to education and its power to inspire change and the dissemination of knowledge within communities, as well as to support paths that encourage awareness, self-determination, and self-care.

Starting with these principles, **the Atlas investigates the major rights violations and discrimination that women, children, and adolescents still experience around the world**: the persistently high rates of maternal, newborn, and infant mortality, the spread of harmful practices like female genital mutilation (FGM), and restrictive and criminalizing abortion laws, which are just a few of the pressing issues that will be covered.
The report is divided into 6 thematic sections that group the main denials of rights that women and children suffer:

- MATERNAL AND CHILD HEALTH
- BODY POLITICS
- GENDER VIOLENCE
- WASH AND SEXUAL AND REPRODUCTIVE RIGHTS
- MENSTRUAL HEALTH
- SEXUAL HEALTH AND WELL-BEING

Maps and infographics that are based on data from reliable and updated secondary sources (such as the World Bank, UNFPA, UNICEF, etc.), as well as best practices, field stories, and testimonials that WeWord has gathered through its projects in 27 different countries around the world enrich each section. Following WeWorld's mission, the report considers the sexual and reproductive health of women, children, and adolescents and emphasizes the need to bring attention to other people, such as the trans community and the larger LGBTQIA+ community.

WHAT WE MEAN WHEN WE SAY "SEXUAL AND REPRODUCTIVE HEALTH"

Human rights do not permit discrimination or exclusion, and the right to health is no exception. Nevertheless, today, vulnerable social groups continue to be denied their rights and experience daily prejudice. These include women, children, and teenagers, as well as members of the LGBTQIA+ community, people of colour, people with disabilities, indigenous communities, and members of ethnic minorities, as well as refugees and those with migrant backgrounds.

Undoubtedly, among the groups most in danger of violating human rights, including the right to health, are women, children, and adolescents. They are prevented from growing and exercising their rights by a masculine and dominant cultural framework, in which gender and generational discrimination still exists, rather than because they are inherently more susceptible (see *WeWorld Index 2022*).

The World Health Organization (WHO) defines the concept of health as **"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"**[1], **underlining, therefore, how health must be considered in every facet while promoting a persistent state of well-being of people**. The recent COVID-19 pandemic has brought attention to the necessity of strengthening health systems, making them robust and accessible to all people, and adopting a comprehensive strategy for tackling health issues (see *WeWorld Index 2020* and *2021*). Paradoxically, the pandemic has overshadowed other health concerns due to the inadequacy of global health systems. **Consider the fact that there has been a decline of over 50% in cancer screenings globally** (Oakes et al., 2022). Access to other health services, such as hospitalizations, diagnoses, control exams (and more generally, preventative), and surgeries, has been severely restricted too.

The same issues have impacted sexual and reproductive health, an area that is still much too frequently disregarded and where the danger of going backwards is real (UNFPA, 2022a). **A condition of total physical, mental, and social well-being for all issues pertaining to the reproductive system is what refers to having good sexual and reproductive health, just like the more general definition of health given above.** This suggests that people can have pleasurable and risk-free sexual relationships, the capacity to procreate, and the autonomy to choose if, when, and how frequently to do so. People require access to accurate information and carefully chosen secure, effective, and inexpensive methods of contraception to be able to maintain their sexual and reproductive health. People must, among other things, be aware of sexually transmitted infections and be able to protect themselves from them, and when deciding whether to have children, women must have access to services and trained health professionals that can help them have a controlled pregnancy, a safe delivery, and a healthy baby (UNFPA, 2022a).

1 Quoted from the preamble to the Constitution of the World Health Organization, as adopted by the International Conference of Health, New York, June 19-22, 1946; signed on July 22, 1946, by representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on April 7, 1948.

Women's and children's rights are inextricably linked when it comes to sexual and reproductive health; the *WeWorld Index* series has long applied and continues to apply this approach. The discussion of complementarity and sequentiality between the main conventions dealing with women's and children's rights—respectively, the CEDAW (Convention on the Elimination of Discrimination Against Women) and the CRC (Convention on the Rights of the Child)—arose out of the need to protect women as adults as well as girls. According to Bosisio, Leonini, and Ronfani (2003), **"For women to fully exercise their rights, as women, it is, in fact, necessary that the little girls they had been had learned what their rights are as little girls, and to protect and claim them."** WeWorld has strengthened an integrated reading of the rights of women and children (and thus of the two Conventions) by measuring their inclusion jointly and considering some contextual factors that affect their quality of life with the international series of the *WeWorld Index*. For instance, children benefit from the social and economic progress of women in terms of health, education, involvement in public life, and employment. **The** WeWorld Index **lists health (including sexual and reproductive health) as one of the fundamental areas, or "building blocks" (the others being economy, education, and society), in which women and children must develop their capabilities to begin a positive cycle that can ensure well-being and full development**.

However, globally, the right to access quality sexual and reproductive health throughout life (life-course approach) is not always guaranteed. Looking at children's condition, for example, the first month of life, which is the precondition for future development, represents the riskiest period. Yet, **as many as 5 million children are estimated to have died before their fifth birthday in 2021, and an additional 2.1 million children and young people aged 5-24 years have lost their lives** (UNICEF, 2023a). It is also estimated that **1.9 million babies were stillborn during the same period**. In 2020, **an estimated 1 million adolescents died: many lack access to the information, services and protective environments**

As many as **5 million** children are estimated to have **died before their fifth birthday** in 2021

(UNICEF, 2023a)

they need to stay healthy and develop healthy lifestyles into adulthood (UNICEF, 2021a). With the onset of puberty, teenage girls are more vulnerable since **every year, almost 23 million girls become pregnant** (ibid.).

Overall, compared to adult women, fewer adolescent girls obtain prenatal care, skilled labour help, or postpartum care for themselves or their infants. **The fourth most frequent cancer in women is cervical cancer caused by human papillomavirus (HPV) infection acquired during adolescence, with 90% of new cases and fatalities in 2020 taking place in low- and middle-income countries** (ibid.).

Finally, despite a dramatic decline in maternal mortality, **the most recent data indicate that over 800 women still die every day from conditions connected to pregnancy and childbirth that could have been avoided** (ibid.). Tragically, with equitable access to and high-quality maternity, neonatal, adolescent, and child health care, many of these fatalities would have been avoided.

Every year,
almost **23 million girls**
become **pregnant**

(UNICEF, 2022)

THE MAIN NORMS OF REFERENCE

Different legislative tools are available today to guide policies and order government initiatives in this area. All WHO member states have committed to advancing access to and enhancing the quality of health services with the goal to improve the health of women, children, and adolescents as part of the Sustainable Development Goals (SDGs) and the United Nations Secretary-General's Global Strategy on the Health of Women, Children, and Adolescents[2] (2016-2030). The adoption and implementation of strong policies that are aware of contemporary issues committed to equity, and able to guarantee the continuum of care for sexual, reproductive, maternal, newborn, child, and adolescent health in a life-course approach are necessary for achieving these goals.

However, the global journey for sexual and reproductive health rights started much earlier, at the **Cairo International Conference on Population and Development (ICPD)** in 1994[3]. The Conference is crucial for sexual and reproductive health because it established an action plan that is still used as a benchmark in the field today. In fact, this has declared human rights the top priority for development, but even more significantly, **it has acknowledged sexual and reproductive health, including family planning, as a requirement for the empowerment of women and girls, for the full enjoyment of their rights, and for the achievement of gender equality.** The United Nations General Assembly then revised the Cairo action plan in 2010 before outlining an action framework for the ICPD follow-up in 2014[4]. The document urged nations to uphold the Cairo commitments and, in particular, to address the widening disparities and emerging difficulties in sexual and reproductive health. Finally, in 2019, **the Nairobi Summit, a meeting entitled "Accelerating the Promise,"** was organized by the United Nations Population Fund (UNFPA) and the Kenyan government to mark the 25th anniversary of the Cairo Conference and to identify strategies for implementing the commitments made at the first ICPD. The **Nairobi Declaration**[5], which gathered the Summit's conclusions, translated the major issues discussed (universal access to sexual and reproductive health and rights, the requirement for funding to complete the Cairo action plan, the fight against gender-based violence and harmful practices, and support for the right to sexual and reproductive health, including in humanitarian contexts) into **12 commitments**[6].

A High-Level Commission has been constituted to oversee the accomplishment of the Nairobi goals, and it annually prepares a report on how well each nation is doing in ensuring the rights to sexual and reproductive health[7]. **The Commission notes in its most recent report that people won't be able to exercise their agency (autonomy and self-determination) to make decisions about their bodies if sexual and reproductive rights are only partially realized**. In turn, this will impede society's overall ability to develop. The Commission asks for the creation of a **global agenda for sexual and reproductive justice**[8] **that focuses on removing all obstacles to achieving rights and bodily autonomy in view of the ongoing evidence of the denial of sexual and reproductive rights** (High-Level Commission on the Nairobi Summit, 2022).

The Commission wants to reiterate that the achievement of sexual and reproductive rights is based on the human rights of all individuals to respect their physical integrity, personal autonomy, and privacy regarding the concept of "bodily autonomy." **People must have the freedom to identify their sexuality, including their sexual orientation and gender identity and expression; choose whether and when to have sex; have safe and enjoyable sexual encounters; and make independent decisions on marriage and parenthood**. These rights rely on having access to and a choice of high-quality health and information services that are free from violence, coercion, and discrimination, appropriate for each stage of life, and adaptable to those stages. **Bodily autonomy, therefore, means having the power and agency to make informed choices about one's body and one's future, without violence or coercion, and having the necessary resources to make these choices** (ibid.).

WHY WE NEED TO TALK ABOUT SEXUAL AND REPRODUCTIVE JUSTICE

As previously said, **any intervention in sexual and reproductive health and rights must take place within a framework of justice and respect for human rights and fundamental freedoms that are universal, indivisible, interdependent, and interconnected.** This framework includes, among other things, the creation and use of accountability mechanisms by those who have the responsibility to guarantee rights (duty-bearers, including first and foremost the States), investment in right-holders seeking sexual and reproductive justice, and the strengthening and creation of new alliances.

These assumptions prompted the ICPD Commission to call for the establishment of a truly global agenda for sexual and reproductive justice. Such an agenda emphasizes justice as an essential component of attaining development, recognizing that development is both a right and a symbol of justice (High-Level Commission on the Nairobi Summit, 2021).

The framework of sexual and reproductive justice encompasses a broader spectrum of sexual and reproductive rights, which in turn refer to a

2 For more information https://www.salute.gov.it/imgs/C_17_pubblicazioni_1483_allegato.pdf

3 For more information https://www.unfpa.org/resources/cairo-declaration-population-development

4 For more information see https://www.unfpa.org/sites/default/files/pub-pdf/ICPD_beyond2014_EN.pdf

5 See https://www.nairobisummiticpd.org/content/icpd25-commitments

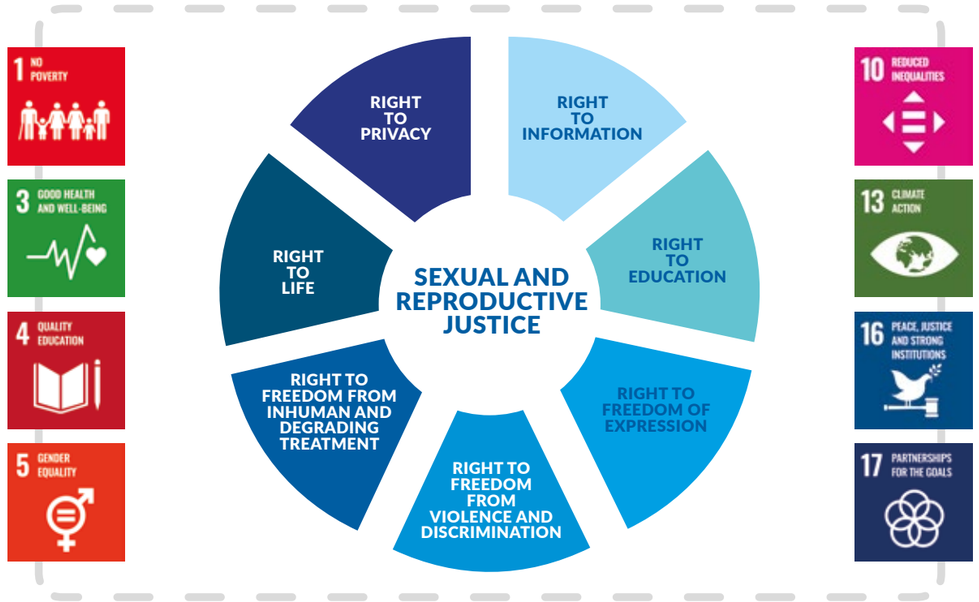
6 See https://www.nairobisummiticpd.org/commitments

7 The most recent Commission report, issued in 2022, recognizes progress, particularly in low- and middle-income countries, such as the development of national action plans to fulfil the Nairobi commitments. The document reports that sexual and reproductive justice is critical to achieving the 12 commitments, emphasizing the link with other relevant human rights issues, such as climate justice, economic justice, and the right to education, employing an intersectional approach. To see the report https://www.nairobisummiticpd.org/sites/default/files/NairobiHLC-ENGLISH_0.pdf and https://www.nairobisummiticpd.org/sites/default/files/HLC%20Report_11-01.pdf

8 The notion of "sexual and reproductive justice" dates back to 1994, when a collection of 12 Black feminists (Afro-descendant Women for Reproductive Justice) invented the term "reproductive justice." The expression was meant to shift the continuing discussion in the United States at the time, in which the "pro-life" against "pro-choice" division on abortion dominated reproductive, economic, and social concerns (Morison, 2021). The collective aimed to criticize how previous reproductive rights movements prioritized specific categories of women (essentially privileged, white, cisgender, and heterosexual women) while ignoring the lived realities of women who are black and other oppressed groups. While the term "reproductive justice" initially originated in the United States, the notion of sexual and reproductive justice has since spread worldwide. Many people have long acknowledged the significance of tackling many types of discrimination in order to achieve equitable sexual and reproductive justice while also achieving gender justice. As a result, the notion allows for a critical examination of reproductive rights as well as civil, economic, and social rights (ibid.).

THE FRAMEWORK OF SEXUAL AND REPRODUCTIVE JUSTICE

WeWorld's elaboration based on High-Level Commission on the Nairobi Summit, 2022



range of fundamental human rights guarantees, such as the rights to life, health, privacy, education, information, freedom of expression, freedom from violence and discrimination, and freedom from torture, cruel, inhuman, and degrading treatment (ibid.). These rights are enshrined in national laws and constitutions, as well as in basic and generally recognized human rights treaties. International and regional human rights treaties, interpretive declarations, and political consensus papers describe and expound on them as well. The sexual and reproductive justice framework is critical to strengthening implementation and accountability for the Nairobi commitments and the Sustainable Development Goals, specifically SDG 3 (good health and well-being) and SDG 5 (gender equality), as well as SDG 1 (zero poverty), SDG 4 (quality education), SDG 10 (reduced inequalities), SDG 13 (climate action), SDG 16 (peace, justice, and strong institutions), and SDG 17 (partnerships for the goals). **The framework is also committed to the 2030 Agenda's values of human rights, universality, and the basic premise of leaving no one behind on the path to greater inclusion.**

More specifically, sexual and reproductive justice underlines the following aspects:

- **INTERSECTIONAL:** Overcoming the structural impediments that people confront in fulfilling their rights and obtaining bodily autonomy throughout their lives is crucial to this strategy. **These obstacles might include a lack of health care, as well as discrimination and inequality based on gender, sexual orientation, ethnicity, disability, and other factors that trap people in poverty and social exclusion. In this sense, sexual and reproductive justice takes an intersectional approach** (see *WeWorld Index 2022*), acknowledging that various kinds of discrimination can overlap and combine. As a result, accumulated injustices for some persons and groups may be higher; remedies to these may necessitate, customized, and prioritized measures in accordance with human rights. **The Commission is adamant that such policies be influenced by what people identify as their needs and preferences. They should thus be founded on the awareness that individuals have the right to make decisions within conditions favourable to their execution** (High-Level Commission on the Nairobi Summit, 2021).

- **CULTURAL:** The cultural context is an important part of sexual and reproductive justice. Indeed, **achieving sexual and reproductive justice is heavily reliant on the abolition of discriminatory societal practices that restrict autonomy, agency, and physical rights**. These norms, for example, are to blame for the stigma associated with contraception or abortion, as well as the level of social acceptability of violence (see WeWorld (2021), *The culture of violence*). These norms, which frequently stem from repeated activities based on cultural or religious beliefs, are filtered through legislation and political decisions before being represented in healthcare organizations and procedures. **A sexual and reproductive justice agenda, therefore, must actively promote the removal of discriminatory norms, as well as reframe the policy decisions that follow them**. Where abortion is legal and safe, for example, maternal deaths tend to fall sharply while abortions remain stable. In contrast, when abortion is illegal, women turn to illegal procedures, frequently with fatal consequences. In this perspective, lowering maternal mortality entails not just improving service delivery but also promoting women's physical autonomy and decision-making.

- **CONTEXT-SPECIFIC:** Unlike the human rights-based approach to reproductive freedom, which affirms and protects the individual's right to access services such as contraception and maternal health care, the sexual and reproductive justice paradigm goes one step further. In fact, **it considers the concomitant social conditions that promote or impede the ability to enjoy sexual and reproductive freedom, and which are specific to the context in which women and children are inserted** (this type of context-specific approach is also used in the *WeWorld Index* series). Thus, reproductive autonomy concerns not just effective access to and choice of contraception, abortion, and prenatal and obstetric care, but also comprehending the obstacles women encounter when raising their children. **This context-specific approach recognizes that the degree of physical autonomy varies between groups of women and girls, even though they share a vulnerability related to gender and generational inequality**. As a result, it is evident that **discussing sexual and reproductive justice can have fundamentally different connotations in the Global North and the Global South**. Achieving sexual and reproductive justice requires tackling society's unequal allocation of power and seeking to restore people's dignity, a basic value that pervades a human rights-based approach.

However, the different features that constitute the framework of sexual and reproductive justice must be translated into acts and considered a crucial component of national health system interventions and international health policies. Indeed, the COVID-19 pandemic has once again exposed how sexual and reproductive health and rights are frequently overlooked in favour of other concerns. **Similar issues reoccur in humanitarian crisis contexts, where inadequate health systems, a lack of skilled health workers, depleted medical supplies, and restrictive and authoritarian political environments hinder the effective delivery of maternal, sexual, reproductive, and child health services, as well as adolescents**[9]. As a result, a framework for sexual and reproductive justice must be integrated into humanitarian operations and anchored in current humanitarian coordination and governance mechanisms. Intervening to guarantee the adoption of globally accepted norms, as well as encouraging health, cleanliness, and adequate educational nutrition initiatives, are critical actions to take in dealing with such difficulties.

9 Humanitarian crises, especially prolonged ones like Syria's, limit access to abortion, prenatal care, family planning, and other sexual and reproductive health treatments, as well as mental health services. Unwanted pregnancies, unsafe abortions, sexually transmitted diseases including HIV, pregnancy problems, miscarriage, PTSD, depression, suicide, intimate partner abuse, gender and sexuality, and maternal and infant mortality all rise as a result. Due to unmet contraceptive requirements, crisis-affected women and girls may have a greater rate of unintended births.

THE FUNDAMENTAL ROLE OF EDUCATION

Ultimately, ensuring the full realization of sexual and reproductive health and rights requires a focus on the provision of comprehensive and people-centred services and their diverse needs, which address the various aspects encompassed within the sexual and reproductive health framework and are reinforced by a supportive environment, quality health systems, and significant community involvement, including through education and awareness actions.

Indeed, an essential function is played by education, which is all too often denied precisely because of a lack of sexual and reproductive justice, but which is the key to protecting the rights of women and children, and therefore of their communities. As has been commonly acknowledged, excellent quality education is the cornerstone of health and well-being and is inextricably tied to sexual and reproductive rights in a variety of direct and indirect ways. People must have access to illness prevention knowledge to live healthy lives and fully develop. At the same time, to study, girls, boys, and adolescents must be well-nourished and healthy. Higher levels of education among mothers, as indicated by the *WeWorld Index* series, increase child nutrition and general health status while lowering avoidable child deaths, maternal mortality, and other communicable diseases, creating a virtuous cycle. **In this sense, we can say that education is both a development catalyst and a health intervention in and of itself.** In 2015, **with the Incheon Declaration[10], UNESCO reaffirmed that education develops the skills, values and attitudes that enable citizens to lead healthy and fulfilling lives, make informed decisions and respond to local and global challenges**. When unsafe, schools are places where some of the most worrying violations of sexual and reproductive rights can originate, such as sexual abuse, early pregnancy, the spread of HIV/AIDS and other sexually transmitted infections. **These phenomena tend to negatively affect students' academic performance, attendance rate and the quality of their educational experiences, leading in some cases to early leaving** (Hague et al., 2018). For example, teenage girls who become pregnant are more likely to have poorer educational achievement, owing in part to legislation in some nations that allow or requires the expulsion of pregnant girls. **However, schools play an important role in avoiding these occurrences as well as in educating children and teenagers on a variety of important subjects in their life, such as gender relations and sexuality**. As a result, whether a school provides sex education through a prescribed curriculum or not, **each school is involved in "educating" its children and young people through an informal and hidden curriculum, which enables its students to gain knowledge and understanding about sexuality and to negotiate sexuality with peers and teachers within the school community** (Hague et al., 2018).

This is especially true **in emergency situations, as the school takes on an almost symbolic value as a place that opens to the community, ensuring the health and the transmission of knowledge and good practices across generations**. Ensuring education in such dramatic contexts has the capacity to act broadly by minimizing potential hazards and dangerous conditions to one's health. In this perspective, **education is more than merely classroom lessons** since it includes transversal and complementary dimensions:

10 See https://unesdoc.unesco.org/ark:/48223/pf0000245656

EDUCATION IS A SAFE SPACE

A protected environment, such as a school, provides a variety of activities for boys' and girls' physical and psychological development, integrating classroom learning with recreational experiences such as play, sport, and socialization, and expanding its intervention boundaries beyond the building's walls.

EDUCATION MEANS STABILITY

Structured activities and daily commitment to lessons can restore a sense of continuity and normality not only for boys and girls but also for their families through psycho-social support and the peace of mind that comes from knowing that their children are safely participating in activities during school hours.

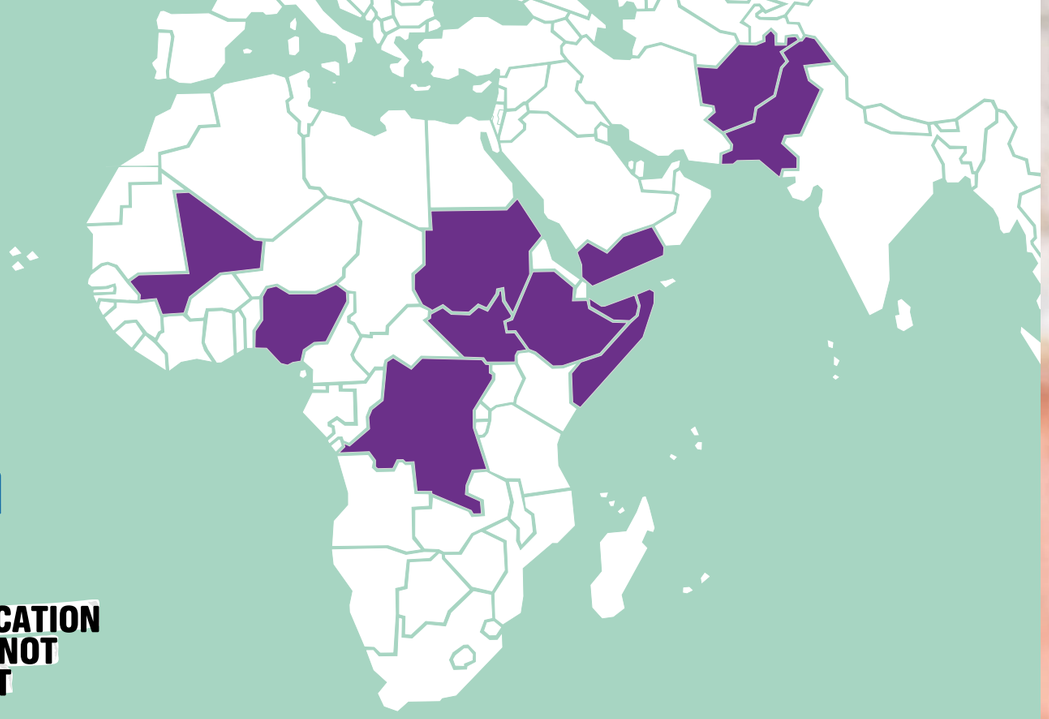
EDUCATION ACTS AS A FORM OF PREVENTION

By educating children about the hazards associated with crises, preventative measures may be taken.

EDUCATION PROVIDES PROTECTION

Concrete and everyday threats like female genital mutilation, early marriages and pregnancies, and forced labour can be opposed and prevented in schools through educating children and communities.

© PhotoAid



supports

EDUCATION CANNOT WAIT

The right to education is a basic human right that cannot be discriminated against or denied, and WeWorld has always been devoted to safeguarding and developing it, even in emergency situations and long-term crises. **Afghanistan, the Democratic Republic of the Congo, Ethiopia, Mali, Nigeria, Pakistan, Somalia, South Sudan, Sudan, and Yemen account for 84% of the boys, girls, and adolescents who do not attend school today.**

Starting from this, the coalition "Global Campaign for Education Italy"[11] of which WeWorld is a member, with the support of the networks it belongs to Link2007, CINI, AOI, and the NGOs AVSI and CISP, **asks the Italian Government to commit to protecting and promoting the right to education even in emergency situations and protracted crises, through an initial contribution of at least 15M€ total for the next four years to the global fund of the United Nations Education Cannot Wait (ECW)**[12].

We ask the Italian Government to promote the right to education in emergencies and protracted crises by contributing 15M € to Education Cannot Wait!

11 See https://www.gceitalia.org/

12 For more information you can check Education Cannot Wait latest report https://ejbn4fjvt9h.exactdn.com/uploads/2022/11/Educazione-in-Emergenza_GCE.pdf

Maternal and Child Health

Antenatal Care

Access to antenatal care and assistance is fundamental to protecting women's and children's health. **Through this form of preventive health care, women can learn from qualified health professionals about healthy pregnancy behaviours, better understand the warning signs during pregnancy and childbirth, and receive social, emotional and psychological support in this delicate phase of their life.**

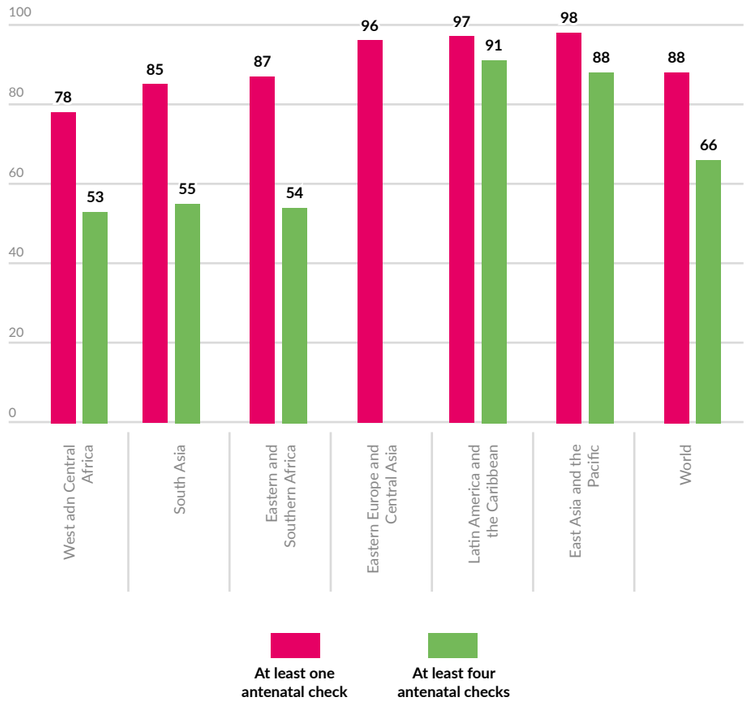
Antenatal care also enables women to access micronutrient supplements, hypertension treatment to prevent eclampsia[12], tetanus vaccination, HIV testing, and medications to prevent HIV mother-to-child transmission (UNICEF, 2022a), particularly in low-income nations without strong health systems and a **"culture of caring"**.

Globally, most women have access to quality **antenatal care at least once** before giving birth, yet **only 66%** receive **four antenatal checks**

(UNICEF, 2022a)

PERCENTAGE OF WOMEN AGED 15-49 WHO RECEIVED AT LEAST ONE OR AT LEAST FOUR ANTENATAL CHECKS (2015-2021)

Data updated to 2021. Source UNICEF, 2022.
The classification of the geographical areas responds to UNICEF global database.



Differences in accessing antenatal checks

Despite the progress made, there are still significant disparities in women's chances of receiving four antenatal checks, which is the number recommended by the WHO to ensure proper monitoring of the developing fetus and the woman's condition.
Also, not to be overlooked are the differences within the countries themselves: **women living in urban areas are more likely to receive at least four antenatal checks than those living in rural areas, with an urban-rural gap of 22 percentage points** (78% vs. 56%, respectively) (UNICEF, 2022a). Furthermore, **antenatal care coverage increases with wealth, with women in the richest quintile being twice as likely to receive at least four checks as those in the poorest quintile: a gap of 34 percentage points** (77% vs. 43%) (ibid.).

12 L'eclampsia è una grave patologia che può sorgere durante la gravidanza, caratterizzata da convulsioni, ed è potenzialmente letale.

Globally, **between 48 and 186 million** people are affected by **infertility**

(WHO, 2020a)

Infertility

Infertility is a condition of the male or female reproductive system defined by the inability to conceive after 12 to 24 months or more of targeted unprotected sex. Infertility affects one million people worldwide: estimates suggest that, globally, **between 48 and 186 million people are affected by this condition** (WHO, 2020a). **To talk about infertility means to talk about an essential human right:** indeed, every human being has the right to enjoy the highest physical and mental health standards. Everyone should be able to decide how many children to have and when, and infertility prevents one's fundamental right: the right to form a family.
Gender prejudice and infertility are frequently related. Although women may experience this condition just as much as men do, when a couple struggles to conceive, **there is a propensity to blame the woman, whether she is actually experiencing the issue or not.** Infertile couples, especially women, may experience circumstances of violence, divorce, stigma, emotional stress, depression, anxiety, and poor self-esteem as a result, which can have a particularly harmful societal impact (ibid.). The fear of not being fertile might deter men and women from using contraceptive techniques in some cultural contexts where the prospect of conceiving and having many children has a high social value. To identify what may be the cause of infertility in such cases, it is crucial to intervene with informative, public awareness, and educational initiatives and programmes.

© Michele Lapini

Childbirth

Every woman should have access to high-quality prenatal and postpartum care to ensure that any issues are detected and handled. Nonetheless, **every two minutes, a woman dies needlessly from pregnancy-related causes** (WHO, 2023a). Another 8 million or more women suffer long-term health problems as a result of pregnancy-related complications. **Every woman, regardless of economic status, has a 15% chance of having problems after labour, although in more developed locations, this seldom results in maternal fatalities** (ibid.). Simple reproductive health measures, such as the presence of experienced health staff during delivery, might save many women's lives in impoverished countries (WHO, 2018a).

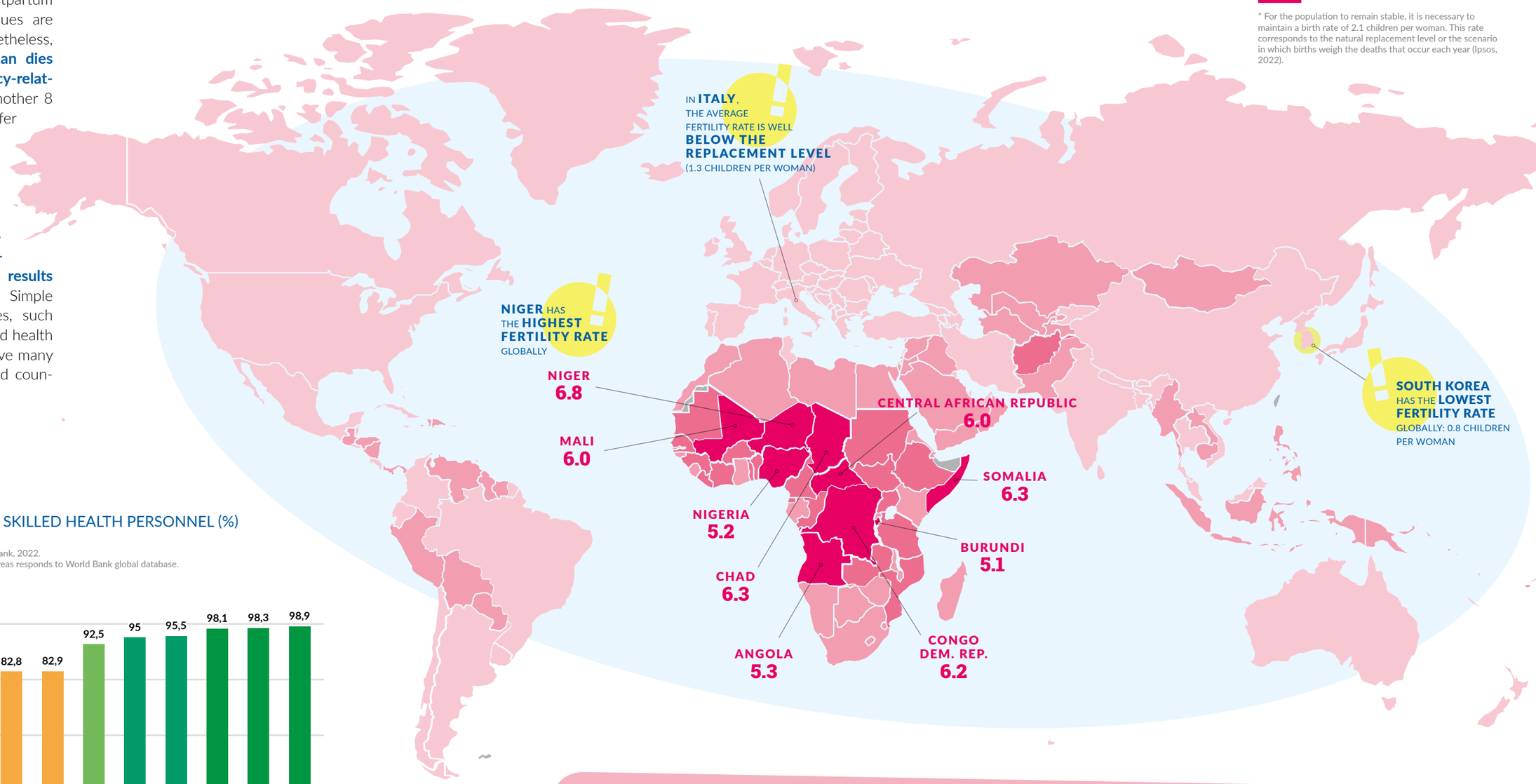
FERTILIY RATE (births per woman)

Data updated to 2021. Source World Bank, 2023.
The classification of the geographical areas responds to World Bank global database.

AVERAGE NUMBER OF CHILDREN PER WOMAN

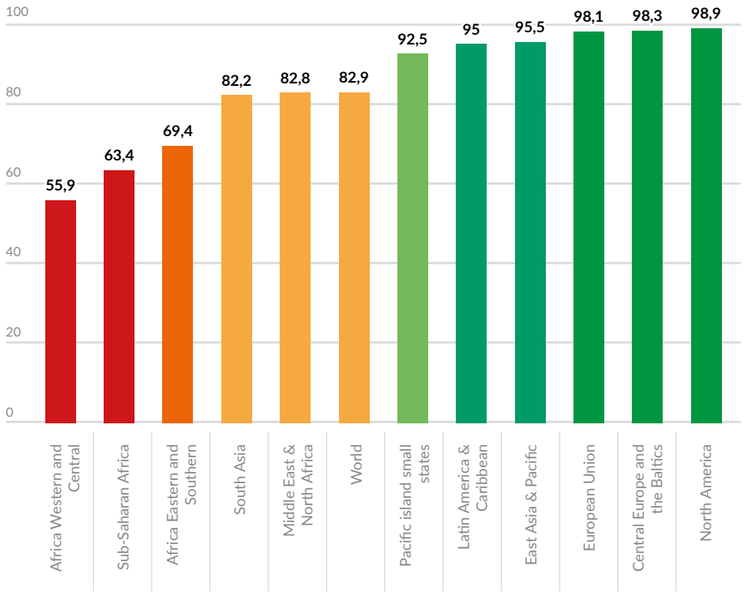
- Not available
- 2.1 or <2.1 (below the replacement level)*
- 2.2-4
- 4.1-5
- >5

* For the population to remain stable, it is necessary to maintain a birth rate of 2.1 children per woman. This rate corresponds to the natural replacement level or the scenario in which births weigh the deaths that occur each year (Ipsos, 2022).



BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL (%)

Data updated to 2019. Source World Bank, 2022.
The classification of the geographical areas responds to World Bank global database.



The risk of obstetric fistula

Obstetric fistula is one of the most serious birth injuries a woman can suffer. Injury between the vagina and the rectum, urethra, or bladder can result from protracted and difficult labour or a lack of early, high-quality medical treatment. Obstetric fistulas can cause urine, faeces, or both leaks, which can lead to persistent medical difficulties, despair, and social isolation (UNFPA, 2023). **The condition affects an estimated 2 million women and girls worldwide, with 50,000-100,000 new cases arising each year** (WHO, 2018b). Despite this, obstetric fistula is almost entirely avoidable. The fact that so many individuals are still victims indicates ongoing socioeconomic disparities and poor healthcare systems for the most vulnerable women and girls (UNFPA, 2023). Obesity and violence against women and girls are inextricably related. This lesion could be avoided by delaying the age of the first pregnancy (early pregnancies are almost always the result of early marriages), preventing girls from being subjected to harmful traditional practices such as FGM (female genital mutilation), and ensuring prompt and timely access to obstetric care (WHO, 2018b).

MATERNAL MORTALITY RATE

Data updated to 2020.
Source World Health Organization, 2023. The classification of the geographical areas responds to World Health Organization global database.

DEATHS PER 100,000 LIVE BIRTHS

- Not available
- <10
- 10-99
- 100-399
- 400-699
- 700 o >700

IN **HIGH-INCOME** COUNTRIES, THE MATERNAL MORTALITY RATE IS **12 DEATHS** FOR EVERY 100,000 LIVE BIRTHS. IN **LOW-INCOME** COUNTRIES, **429**: IS ALMOST 36 TIMES HIGHER.

SUB-SAHARAN AFRICA REMAINS THE REGION WITH THE **HIGHEST MATERNAL MORTALITY RATE** IN THE WORLD, WITH **535 DEATHS** FOR EVERY 100,000 LIVE BIRTHS

NIGERIA
1,047

CHAD
1,063

SOUTH SUDAN
1,223

CENTRAL AFRICAN REPUBLIC
835

In 2000, the global maternal mortality rate was **339 deaths** every 100,000 live births. In 2020 it dropped to **223**

(WHO, 2023a)

2000
339

2020
223

Every two minutes, a woman dies from causes related to **pregnancy or childbirth**

(WHO, 2023a)

Obstetric violence

The term obstetric violence refers to a series of behaviours adopted by healthcare structures and professionals working in the field of sexual and reproductive health that may be especially detrimental to women and their children[13]. These include, for example, an excess of unnecessary or non-consensual medical interventions, and neglect of women's mental health and self-determination. Childbirth is a significant experience, which many women define as transformative and foundational, and which every woman has the right to live according to their way of being and feeling. The term was first coined, and the phenomenon was recognized, in 2007 in Venezuela in a law on the right of women not to suffer violence. **In 2014, the World Health Organization (WHO) released a document reporting cases of disrespectful and abusive treatment suffered by women during childbirth[14]. In addition to possible physical damage, obstetric violence can also cause psychological damage whose effects can also negatively affect the mother-child relationship** (WHO, 2014). Labour and childbirth can be unpleasant experiences when intrusive procedures, lack of information, and disrespectful treatment are involved. As a result, the woman may feel undervalued and guilty for not being able to voice her rights.

In Italy, obstetric violence became a topic of conversation in 1972 as a result of the "Basta tacere" (Stop Silencing) campaign, which was supported by several feminist organizations in Ferrara. At that time, other women started to share their accounts of violence and maltreatment they had experienced during childbirth or pregnancy[15]. After the campaign was restarted in 2016, the Observatory on Obstetric Violence was established. **Out of 5 million women who gave birth between 2003 and 2017, according to a 2017 poll conducted by the same Observatory, almost a quarter reported having experienced obstetric violence[16]**. Following an incident at the Pertini hospital in Rome, when a three-day-old infant was discovered dead, the discussion resurfaced in January 2023. The theory is that once the mother fell asleep while nursing, the infant could have suffocated. The mother claimed that despite her repeated requests for the infant to be moved to the nursery so that she could recuperate following a protracted and challenging birth, the medical staff consistently refused to provide help. Obstetric violence in this particular instance would refer to the medical staff's unwillingness to provide the patient with the assistance she asked for. **The incident sparked a wave of protests that became known as the "Me Too of obstetric violence" as thousands of women shared their personal accounts online and launched a petition[17]**. The #Ancheame (it also happened to me)[18] movement against obstetric and gynaecological violence was subsequently founded by a group of experts, influencers, and maternity activists as a result. One of the goals of the campaign is to create and present a bill to political decision-makers on the issue.

13 More specifically, the WHO recommends that in the absence of precise medical instructions, the following should be avoided: enema; hair removal; rupture of membranes; imposing of body positions during labour and delivery; fasting and drinking prohibitions; episiotomy (cutting the perineum); pressing down on a woman's stomach (Kristaller manoeuvre); early cutting of the umbilical cord. WHO's Recommendations are available here: https://apps.who.int/iris/bitstream/handle/10665/352658/9789240045989-eng.pdf

14 For more information https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_ita.pdf;jsessionid=4419156F967A50EFD1D78625F57A1D39?sequence=17

15 For more information https://ovoitalia.wordpress.com/bastatacere/#:~:text=%E2%80%9CBasta%20tacere%3A%20le%20madri%20hanno,rispetto%20nell'assistenza%20alla%20nascita

16 To consult the survey see https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/

17 For more information https://www.repubblica.it/cronaca/2023/01/25/news/neonato_pertini_petizione_rooming_in_violenza_ostetrica-385071715/

18 For more information about the #Ancheame movement https://linktr.ee/ancheame

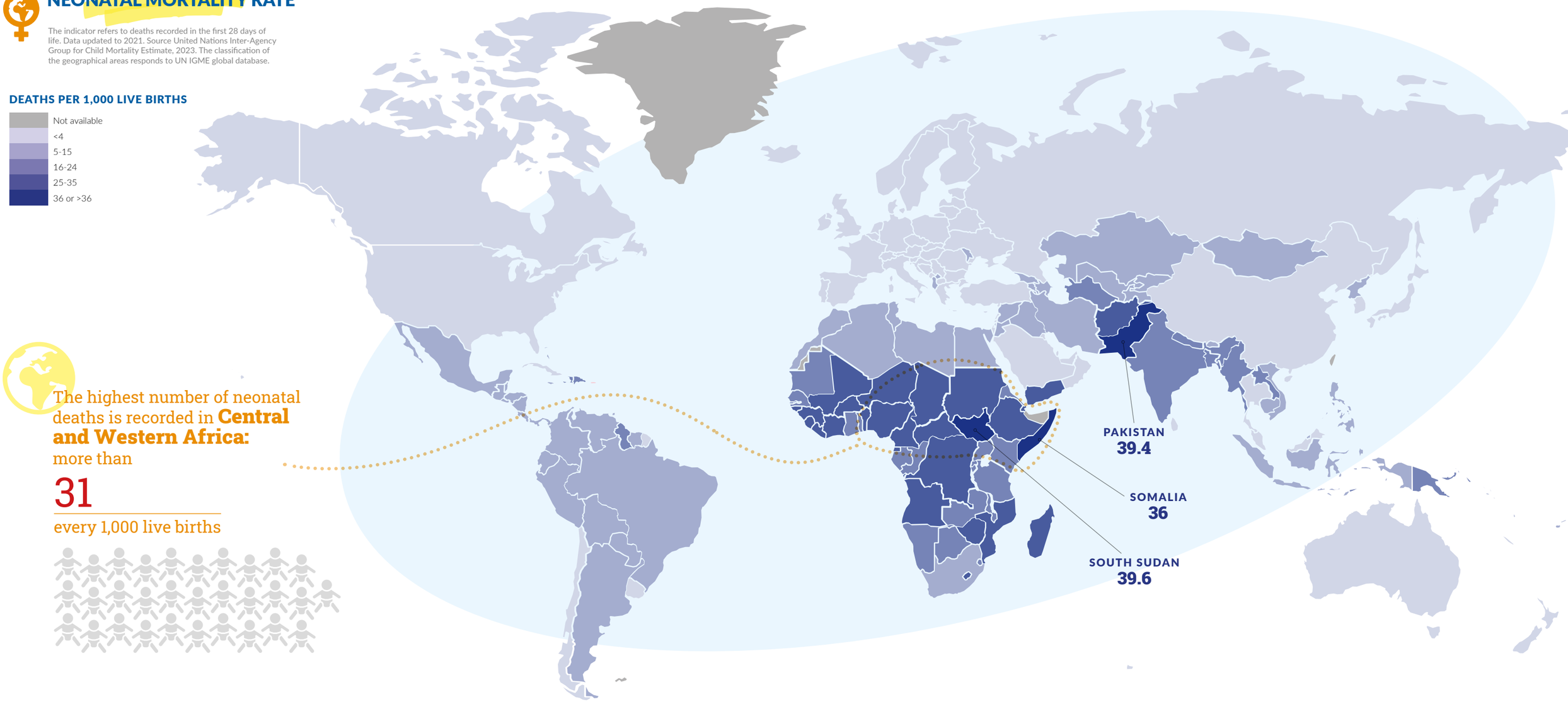
Postnatal Care

The postnatal period, i.e., the period between immediately following birth and finishing after the first six weeks of life (42 days), is a critical phase for women, newborns, parents, caregivers and families. Yet maternal and infant mortality and morbidity rates in this specific period are still too high (WHO, 2022a). More than 30% of maternal deaths occur after delivery (UNICEF, 2020). Newborns are at a higher risk of dying in their first month of life: **in 2021, the global average was 17.6 deaths per 1,000 live births** (UNIGME, 2023). Postnatal care services are critical to ensuring the continuum of care and are key to achieving the SDGs in reproductive, maternal and child health. However, the coverage and quality of these services are still low. **Different countries have different lengths of postpartum stays in healthcare facilities, and many women and children do not get enough postnatal care in the first 24 hours after they give birth** (Campbell et al., 2016)

Women and infants require constant monitoring and care after birth. **All babies should receive primary care that includes promoting and supporting early and exclusive breastfeeding (where feasible), keeping the baby warm, increasing handwashing frequency, and improving hygiene and skin grooming**. It is also critical to identify issues that may necessitate more care and to suggest when a newborn should visit a health institution. **Families should be counselled on how to recognize possible warning signs, understand the care that both the mother and the infant require, and access appropriate health treatments as necessary.** Promoting a healthy lifestyle through adequate nutrition, illness diagnosis and prevention, assisting women who may be victims of intimate partner abuse, and guaranteeing access to sexual and reproductive health, including postpartum family planning, are all critical components of comprehensive postnatal care.

NEONATAL MORTALITY RATE

The indicator refers to deaths recorded in the first 28 days of life. Data updated to 2021. Source United Nations Inter-Agency Group for Child Mortality Estimate, 2023. The classification of the geographical areas responds to UN IGME global database.



The highest number of neonatal deaths is recorded in **Central and Western Africa:** more than

31

every 1,000 live births

Approximately **1 in 5 women** will experience a **mental health problem during pregnancy or shortly after childbirth**

(UNFPA, 2022b)

Postpartum depression

Empirical research indicates that women and their families need and require a happy postnatal experience that will assist them in overcoming the physical and emotional problems that arise before, during, and especially after the delivery of their children. As a result, specialized postnatal services should include both physical and mental health care (UNFPA, 2022b).
Postpartum depression is the most prevalent mental healthcare condition that a woman might suffer after giving birth, and it may have a negative impact on not just the individual concerned, but also the entire family's cognitive and social health.

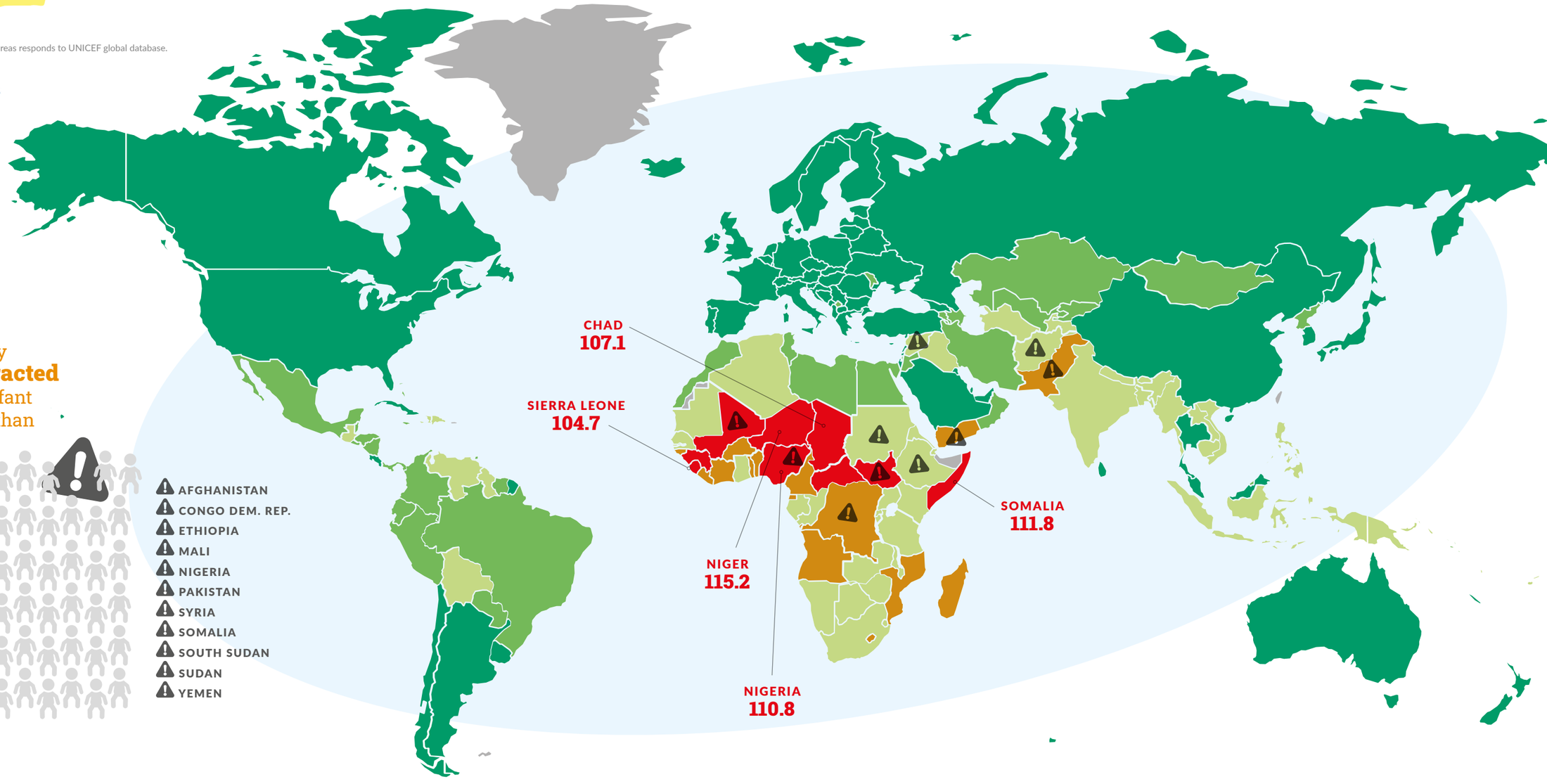
Postnatal depression is twice as often as at other periods in a woman's life, and it often goes unrecognized and untreated, causing havoc on spouses and the emotional and cognitive development of newborns and adolescents (Wang et al., 2021). Despair, melancholy, nausea, changes in sleeping and eating patterns, decreased libido, weeping spells, anxiety, impatience, feelings of isolation, mental load, thoughts of injuring yourself and/or the baby, and even suicide ideation are all frequent symptoms of this type of depression. Postpartum depression can strike at any point within the first year after giving birth and last for years. **This disorder affected 17.22% of the global population** (ibid.).
This type of depression has been connected to factors such as income and the development of the geographical location in which one lives. Contrary to popular belief, the problem does not simply affect industrialized countries: **the highest incidence rate (39.96%) was recorded in Southern Africa** (ibid.).

UNDER 5 MORTALITY RATE

Data updated to 2021.
Source UNICEF, 2023.
The classification of the geographical areas responds to UNICEF global database.

DEATHS PER 1,000 LIVE BIRTHS

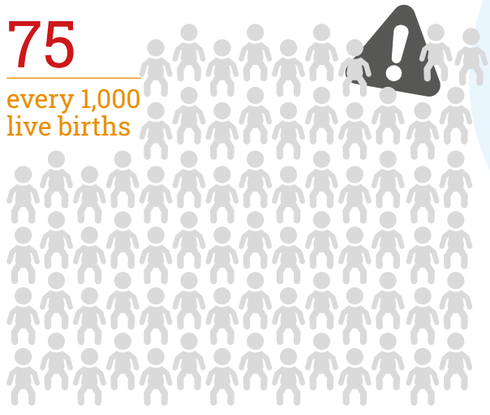
- Not available
- <10
- 10-20
- 20-60
- 60-90
- 90 or >90



In countries afflicted by **fragility and protracted crises**, the average infant mortality rate is more than

75

every 1,000 live births



- AFGHANISTAN
- CONGO DEM. REP.
- ETHIOPIA
- MALI
- NIGERIA
- PAKISTAN
- SYRIA
- SOMALIA
- SOUTH SUDAN
- SUDAN
- YEMEN

World Bank, 2023)

The first **1,000 days**

The first 1,000 days, or the time between conception and the first two years of a child's existence, are a period of great potential during which the foundations for long-term, optimal health and development are laid, but they are also a time of significant risk. During this period, a child's capacity to grow, learn, and develop completely depends heavily on the quality of care and nourishment provided to mothers and their children. **This is so that a child's brain may start to grow and develop as well as lay the groundwork for their long-term health throughout the first 1,000 days of life** (UNICEF, 2017; WHO, Nurturing Care Framework, 2020; Rice, 2022)

Research in the domains of neurology, biology, and early childhood development provides a plethora of information on how nutrition, interactions, and the environment in which one lives in the first 1,000 days impact future outcomes and living situations (Rice, 2022). **Nutrition, in particular, is critical to children's growth and, as a result, to the ability of their community and country to prosper.** Poor nutrition in the first 1,000 days can cause irreparable harm to a child's developing brain, affecting their capacity to function well in school and earn a wage and making it more difficult to escape poverty (UNICEF, 2017). Inadequate or inadequate nutrition can also create the groundwork for later obesity, diabetes, and other chronic disorders (see WeWorld Index 2017). Evidence suggests that avoiding vitamin deficits in the first place is far more beneficial than relying on replacement treatment after a deficiency has formed. **This necessitates, first and foremost, intervening with preventative measures, beginning with better nutrition for adolescents and young women before, during, and after pregnancy.** Other important measures include HIV-positive pregnant women and their children receiving vertical transmission prevention services (PMTCT) on time; tuberculosis screening and maintenance care; exclusive breastfeeding during the first six months of life; provision of nutritious, safe, and appropriate food to supplement breast milk as the child grows; availability of drinking water; best hygiene and sanitation practices; and regular monitoring of the child's growth and development.

The importance of breastfeeding cannot be overstated. Breastfeeding is a baby's first and greatest line of defence against illness and death, just like the first vaccination. High-impact public health measures that are well recognized to maximize infant survival include the promotion, support, and protection of exclusive breastfeeding for up to six months. These efforts must be backed up by frequent growth monitoring, the completion of the vaccine cycle, and proper nutrition (ibid.). **According to studies, failing to spend in the first 1,000 days results in billions of dollars being lost owing to decreased economic production and increased healthcare expenditures** (Rice, 2022).

© Camilla Milani

WeWorld in Burundi: promoting safe and equitable maternal and child health

Following the COVID-19 epidemic, living circumstances for some of the world's most vulnerable populations have become intolerable, such as in Burundi, one of the world's poorest countries where famine kills thousands of people each year, especially children. **Mothers are unable to give birth safely due to a shortage of food, clean drinking water, and hygienic facilities.** Hospitals with gynaecological and paediatric departments are mostly concentrated in a few big urban centres that are entirely shut off from the villages, and rural health centres (a type of community clinic) are severely under-equipped. A mother may have to drive tens of kilometres on mountainous, treacherous roads to reach a hospital and seek at least a very expensive gynaecological checkup with ultrasound before giving birth. **If a mother is fortunate enough to give birth in a hospital, the setting may not always be sanitary (due to a shortage of medications and disinfectants), and power may not always be available.** As a result, she may be obliged to give birth at night, utilising the flashlight of the nearest available cell phone.

However, in this context, one of the gravest risks concerns malnutrition, which can create malformations in the fetus and, post-partum, compromise breastfeeding. In the first years of the child's life, the scarcity of checks prevents timely intervention in the most severe forms of malnutrition, which often leads to death. In Burundi, **65% of children under 5 suffer from chronic malnutrition, and the mortality rate in the same age group is 53 deaths for every 1,000 live births** (World Bank, 2023). While malnutrition is not the only cause of infant mortality, it certainly is a determining factor. This situation, mainly due to inadequate food consumption and exacerbated by morbidity, derives from a set of underlying causes such as the structural insufficiency of the health system and sanitation services; a weak agricultural economy; micronutrient deficiencies resulting from soil infertility that is exacerbated by climate change.

WeWorld has been present in Burundi since 1994, working to improve the health service and access to it, especially in the maternity sector, to develop an efficient and sustainable agricultural economy and to respond to the specific health needs of the population affected by natural disasters, epidemics and persistent malnutrition.

WeWorld wants to guarantee protection, safety and means of independent growth to mothers and their children, whose lives are already endangered at birth due to lack of adequate health services. Victims of malnutrition, Burundian women and children must be supported to break the chain of hunger and poverty and to lay the foundations and start a process of improving individual and community well-being. The project addresses the problem of malnutrition in all its dimensions and causes and supports the recipient women and their children in two fundamental paths: motherhood (pregnancy, childbirth, breastfeeding and raising children), and independence, i.e. the strengthening of women as persons with equal rights as men, capable

of receiving an income, having a voice, actively participating in the economic and political life of the community. To contribute sustainably to improving food and nutrition security for women, boys, girls and the entire population, and the common general well-being for a more dignified and equal life in terms of rights, WeWorld is committed to a program aimed at responding to basic needs.

The women and children reached by the programme

WeWorld's programme is active in 41 municipalities in 7 provinces, reaching many mothers, girls, children and their communities.

DIRECT RECIPIENTS:

- **314,000** people can use the services of 20 community health centres equipped with autonomous systems for the supply of energy, water, disinfectants.
- **25,000** women can benefit from an ultrasound in their community health centre.
- **118,038** pregnant and lactating women and their children are supported with distributions of nutritious foods and protein meals.
- **9,821** women with children aged between 5 and 6 diagnosed as malnourished – meaning **15,109 children** – are supported with distributions of nutritious foods and protein meals.
- **1,004** *Mamans Lumière* receive training on food to support and guide the whole community towards the elimination of malnutrition.
- **1,300** artisans, of which more than half are women are strengthened through training on entrepreneurship, production and sale of *foyers ameliorés* and the concrete opportunity to start and grow their own business through a credit.

TOTAL RECIPIENTS:

- About **3.5 million** people living in the 41 municipalities of the 7 provinces of Bujumbura, Cibitoke, Bubanza, Rumonge, Ruyigi, Rutana and Cankuzo where the project is implemented.

Body Politics

© Camilla Miliani

Family **Planning**

The term "family planning" refers to the availability and use of tools (mainly contraceptive methods and fertility treatment) **and knowledge that allow people to have the desired number of children or none, and to determine the spacing between pregnancies** (UNFPA, 2023b). Access to safe and voluntary family planning, including contraceptive knowledge, is a fundamental human right.
Proper family planning not only allows for postponing pregnancies in adolescent girls, who face major health risks when exposed to early pregnancy but also for preventing them in adult women. **In this sense, family planning is a critical instrument for ensuring gender equality and women's empowerment, as well as an essential tool in poverty reduction. Indeed, by lowering the number of undesired pregnancies, family planning can improve girls' education and generate chances for women to participate more actively in society and enhance their employment opportunities.**

However, **in low-income regions, an estimated 257 million women who wish to avoid pregnancy do not use safe and effective contraceptive methods for a variety of reasons, ranging from a lack of access to information or services to a lack of support from their partners or community** (UNFPA, 2023). Over the last two decades, the number of women seeking family planning has increased dramatically, **from 900 million in 2000 to almost 1.1 billion in 2020** (WHO, 2020b).

Globally, **4 out of 10 women** in a relationship **do not use any form of contraception**

(United Nations, 2022)

© Fabio Lovino

Contraceptive methods

According to the 2030 Agenda[12], contraceptive prevalence and unmet family planning needs are crucial indicators for monitoring progress in reproductive health access. **Oral contraceptive tablets, implants, injectables, patches, vaginal rings, intrauterine devices, condoms, and male and female sterilization are all modern contraceptive options. Then there are the so-called "natural methods," such as using the fertility calendar, abstinence, or the amenorrhea phase during breastfeeding** (UN, 2022).

All techniques have sanitary and practical contraindications, as well as different methods of action and effectiveness in preventing unintended pregnancies. Effectiveness of methods is measured by the number of pregnancies per 100 women using the method per year. **Methods are classified by their effectiveness as commonly used into: Very effective (0–0.9 pregnancies per 100 women); Effective (1-9 pregnancies per 100 women); Moderately effective (10-19 pregnancies per 100 women); Less effective (20 or more pregnancies per 100 women)** (ibid.).

12 More precisely according to Goal 3.7 "By 2020, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes".

Mechanisms of action and effectiveness of contraceptive methods*

*WeWorld's reproduction of World Contraception Use, UN 2022

Method	How it works	EFFECTIVENESS: pregnancies per 100 women per year with consistent and correct use	EFFECTIVENESS: pregnancies per 100 women per year as commonly used
Combined oral contraceptives (COCs) or "the pill"	Prevents the release of eggs from the ovaries (ovulation)	0.3	7
Progestogen-only pills (POPs) or "the minipill"	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	0.3	7
Implants	Thickens cervical mucous to blocks sperm and egg from meeting and prevents ovulation	0.1	0.1
Progestogen only injectables	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	0.2	4
Monthly injectables or combined injectable contraceptives (CIC)	Prevents the release of eggs from the ovaries (ovulation)	0.05	3
Combined contraceptive patch and combined contraceptive vaginal ring (CVR)	Prevents the release of eggs from the ovaries (ovulation)	0.3 (for patch) 0.3 (for vaginal ring)	7 (for patch) 7 (for contraceptive vaginal ring)
Intrauterine device (IUD): copper containing	Copper component damages sperm and prevents it from meeting the egg	0.6	0.8
Intrauterine device (IUD) levonorgestrel	Thickens cervical mucous to block sperm and egg from meeting	0.5	0.7
Male condoms	Forms a barrier to prevent sperm and egg from meeting	2	13
Female condoms	Forms a barrier to prevent sperm and egg from meeting	5	21
Male sterilization (Vasectomy)	Keeps sperm out of ejaculated semen	0.1	0.15
Female sterilization (tubal ligation)	Eggs are blocked from meeting sperm	0.5	0.5
Lactational amenorrhea method (LAM)	Prevents the release of eggs from the ovaries (ovulation)	0.9 (in six months)	2 (in six months)
Standard Days Method or SDM	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days.	5	12
Basal Body Temperature (BBT) Method	Prevents pregnancy by avoiding unprotected vaginal sex during fertile days	Reliable effectiveness rates are not available	
TwoDay Method	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days	4	14
Sympto-thermal Method	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile	<1	2
Emergency contraception pills (ulipristal acetate 30 mg or levonorgestrel 1.5 mg)	Prevents or delays the release of eggs from the ovaries. Pills taken to prevent pregnancy up to 5 days after unprotected sex	< 1 for ulipristal acetate ECPs 1 for progestin only ECPs 2 for combined estrogen and progestin ECPs	
Calendar method or rhythm method	The couple prevents pregnancy by avoiding unprotected vaginal sex during the 1st and last estimated fertile days, by abstaining or using a condom	Reliable effectiveness rates are not available	15
Withdrawal (coitus interruptus)	Tries to keep sperm out of the woman's body, preventing fertilization	4	20

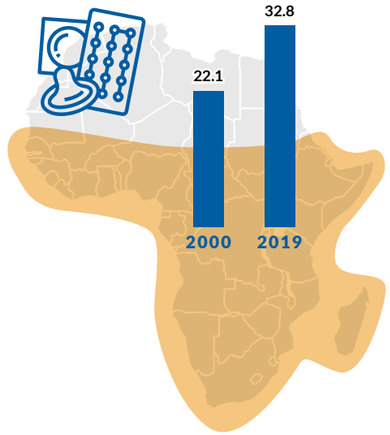
The proportion of women of reproductive age whose family planning requirements are covered by modern contraceptive techniques has gradually increased over the last decades, **going from 73.6% in 2000 to 76.8% in 2020** (ibid).

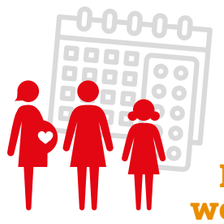
Reasons for this slow increase include a limited number of available methods; limited access to services, particularly among younger and poorer people; fear or experience with side effects; cultural or religious opposition; poor quality of available services; user and supplier prejudices against certain methods; and gender barriers in accessing services.

In 2019, it was estimated that **between 1.1 and 1.9 billion women of reproductive age (15-49 years) globally needed access to family planning services; of these, 842 million used contraceptive methods, while 270 million had an unmet need for contraception** (ibid.).

PERCENTAGE OF WOMEN OF REPRODUCTIVE AGE (15-49 YEARS) IN A RELATIONSHIP WHO USE ANY CONTRACEPTIVE METHODS IN SUB-SAHARAN AFRICA

Data updated to 2019. Source World Bank, 2022. The classification of the geographical areas responds to World Bank global database.





Between 1.1 and 1.9 billion women of reproductive age (15-49 years) globally **needed access to family planning services**

(UN, 2022)

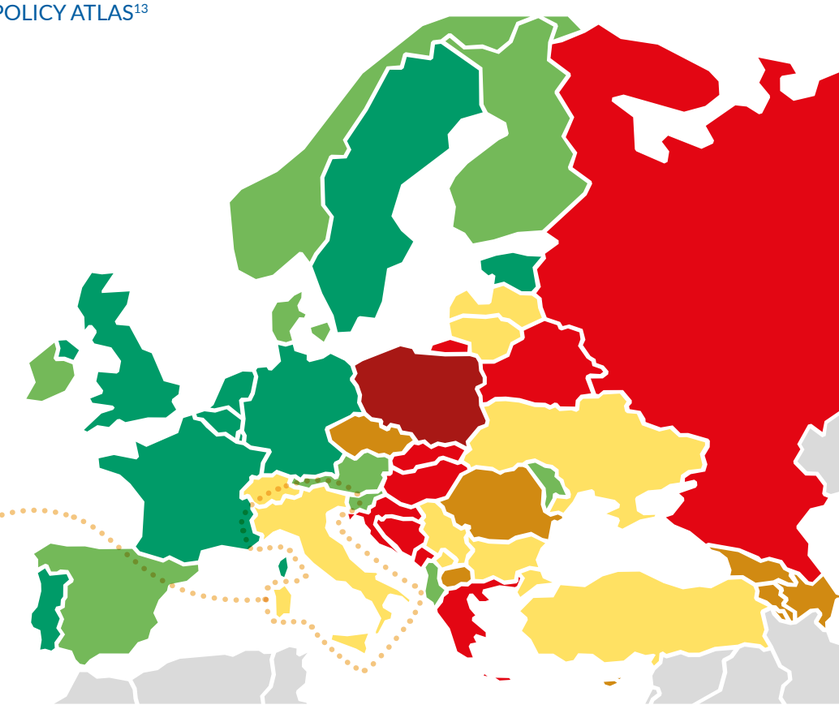
EUROPEAN CONTRACEPTION POLICY ATLAS[13]

Data updated to 2021. WeWorld's reproduction

PERCENTAGE SCORES REGARDING ACCESS TO CONTRACEPTION

- 75% - 90%
- 60% - 75%
- 55% - 60%
- 50% - 55%
- 40% - 50%
- 0% - 40%

ITALY IS STILL **LAGGING BEHIND** IN TERMS OF ACCESS TO CONTRACEPTION, **RANKING 22ND** IN EUROPE



13 The European Contraception Policy Atlas is a map displaying contemporary contraceptive levels for 45 nations across Europe. The rankings are determined by access to contraception, counselling, and online information. More information can be found at https://www.epfweb.org/sites/default/files/2022-02/CCeptionInfoA3_EN%202022%20v10.pdf

© Camilla Miliani

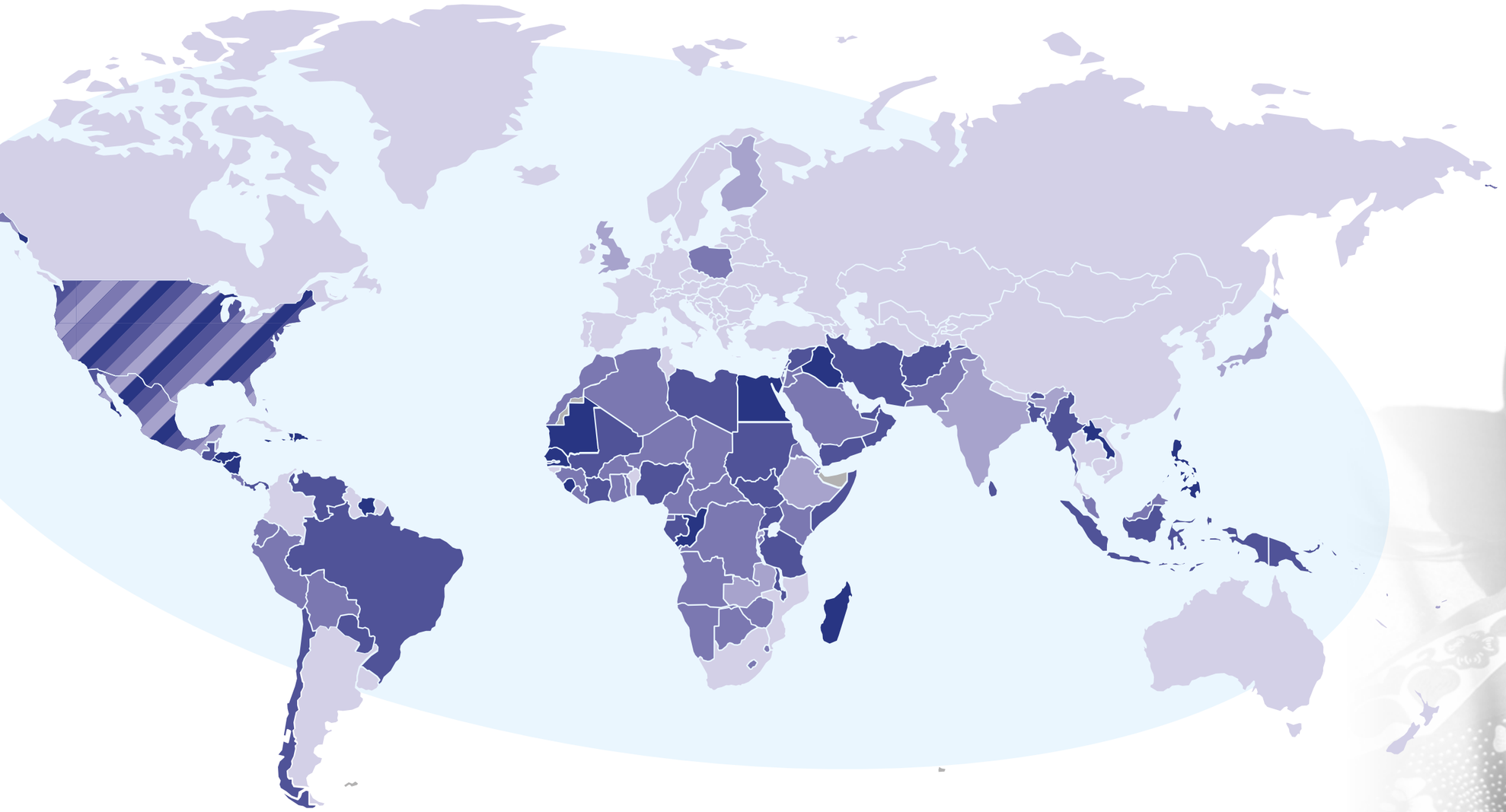
Safe Abortion

ABORTION LAWS AROUND THE WORLD*

Data updated to 2021. Source WALM, 2022

LEGEND

- Prohibited altogether
- To save the woman's life
- To preserve health
- Broad social or economic grounds
- On request (gestational limits vary)*
- Data not available



In 2022, **91 million women** lived in one of the **23 countries** where **abortion is prohibited** altogether

(WALM, 2022)

© Camilla Miliani

* Gestational limits differ widely between countries. In the case of Mexico and the United States, abortion laws vary at the state level from the 2nd category (to save the woman's life) to the 5th (abortion on request but with gestational limits). For more information see https://reproductiverights.org/maps/worlds-abortion-laws/

SPECIAL CIRCUMSTANCES THAT ALLOW FOR VOLUNTARY ABORTION

Information updated to 2022. Source Center for Reproductive Rights, 2023

Abortion permitted in cases of rape	Brazil; Chile; Ivory Coast; Gabon; Mali; Panama; Sudan; Angola; Bolivia; Botswana; Burkina Faso; Cameroon; Central African Republic; Chad; Democratic Republic of Congo; Ecuador; ESwatini; Ghana; Guinea; Israel; Lesotho; Liberia; Liechtenstein; Mauritius; Monk; Namibia; Nauru; Poland; Saint Lucia; Seychelles; Togo; Zimbabwe; Barbados; Ethiopia; Fiji; Finland; Hong Kong; India; Japan; Rwanda; Saint Vincent & the Grenadines; Taiwan
Abortion permitted in cases of incest	Bhutan; Gabon; Mali; Angola; Bolivia; Botswana; Burkina Faso; Central African Republic; Chad; Democratic Republic of Congo; Eritrea; ESwatini; Ghana; Guinea; Israel; Lesotho; Liberia; Mauritius; Monk; Namibia; Nauru; Poland; Saint Lucia; Seychelles; Togo; Zimbabwe; Barbados; Ethiopia; Fiji; Hong Kong; India; Rwanda; Saint Vincent & the Grenadines; Taiwan
Abortion permitted in cases of fetal impairment	Gabon; Gambia; Iran; United Arab Emirates; Angola; Botswana; Burkina Faso; Central African Republic; Chad; Democratic Republic of Congo; ESwatini; Ghana; Guinea; Israel; Kuwait; Lesotho; Liberia; Mauritius; Monk; Namibia; Nauru; Niger; Qatar; Seychelles; Togo; Zimbabwe; Barbados; Belize; Fiji; Great Britain; Hong Kong; India; Rwanda; Saint Vincent & the Grenadines; Taiwan; Zambia
Spousal authorization required	Indonesia; Syria; United Arab Emirates; Yemen; Central African Republic; Equatorial Guinea; Kuwait; Morocco; Saudi Arabia; Japan; Taiwan; Türkiye
Parental authorization/notification required	Panama; Syria; Timor-Leste; United Arab Emirates; Angola; Equatorial Guinea; Kuwait; Liechtenstein; Mauritius; Poland; Saudi Arabia; Barbados; Fiji; India; Rwanda; Taiwan; Albania; Armenia; Bosnia Herzegovina; Cambodia; Croatia; Cuba; Czech Republic; Denmark; Georgia; Greece; Kosovo; Lithuania; Latvia; Moldova; Montenegro; Norway; Portugal; Republic of North Macedonia; San Marino; Serbia; Slovak Republic; Slovenia; Spain; Türkiye; Uruguay
Abortion permitted on additional enumerated grounds relating to such factors such as the woman's age or capacity to care for a child	Bhutan; Brazil; Ecuador; Eritrea; Gabon; Ghana; Israel; Liechtenstein; Nauru; Seychelles; Finland
Sex-selective abortion prohibited	China; Kosovo; Montenegro; Nepal
Legislation explicitly permits abortion only to protect the physical health of the woman	Monaco; Zimbabwe
Law unclear	Palau; Marshall Islands; Micronesia
Federal system in which abortion law is determined at state level; classification reflects legal status of abortion for largest group of people	United States of America; Mexico

WHY IS IT CRITICAL TO ENSURE SAFE ABORTION ACCESS?

Abortion is a medical intervention that can be efficiently administered by a wide range of health providers using medication or a surgical procedure. A medical abortion can be safely self-administered by the pregnant woman outside of a health facility (for example, at home) within the first 12 weeks of pregnancy. This requires the woman to have access to correct information, high-quality medications, and the support of a qualified healthcare practitioner (if she needs or wishes it during the process).

Comprehensive abortion treatment was added to WHO's list of essential health services in 2020[14]**. Access to correct information throughout the process, procedure management, and post-abortion care should all be part of comprehensive abortion care.** Miscarriage, induced abortion (the intentional termination of an existing pregnancy by medical or surgical means), incomplete abortion, and stillbirth should all be covered.

6 out of every 10 undesired pregnancies result in **induced abortion** (voluntary termination of pregnancy)

(WHO, 2021a)

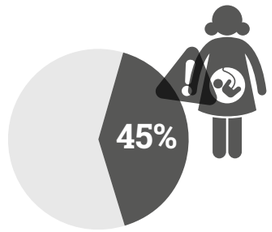
14 See https://www.who.int/emergencies/diseases/novel-coronavirus-2019/related-health-issues

Unsafe abortion is a primary cause of maternal death and morbidity, yet it is preventable. It can cause physical and mental health problems, as well as social and financial costs to women, communities, and healthcare systems. Approximately **45% of all abortions performed globally are unsafe, with 97% occurring in low-income countries** (WHO, 2021a). Asia, particularly South and Central Asia, accounts for more than half of all unsafe abortions. **In Latin America and Africa, about three out of every four abortions are performed in dangerous conditions** (ibid.). **The stigma associated with abortion, as well as the lack of access to safe, inexpensive, timely care that respects the dignity of the pregnant woman, pose substantial risks to women's physical and mental well-being. According to estimates, unsafe abortions cause between 4.7% and 13.2% of maternal deaths each year** (ibid.).

Physical health risks associated with unsafe abortion include but are not limited to:

- Incomplete abortion (failure to remove or push all of the pregnancy tissue out of the uterus)
- Haemorrhage (heavy bleeding)
- Infection
- Uterine perforation (which occurs when the uterus is punctured with a sharp object)
- Damage to the genital tract and internal organs as a result of inserting dangerous objects into the vagina or anus.

However, there are also significant repercussions for women's mental health, which are frequently linked to stigma and social pressure from family, community, and even health professionals themselves. Several pieces of scientific evidence suggest that **having a safe abortion procedure does not have any harmful effects on mental health; on the contrary, negative outcomes are associated with restrictions or denials of abortion access** (Abrams, 2022).



Approximately **45%** of all abortions performed globally are **unsafe**, with **97%** occurring **in low-income countries**

(WHO, 2021a)

Furthermore, being able to undergo a safe abortion has significant social implications. **This is related to women's education, labour-force participation, and positive contributions to GDP growth.** Because women's and children's rights are inextricably linked, the legal status of abortion can have an impact on children's educational achievements and labour-market wages later in life. **Empirical research suggests that legalizing abortion, by reducing the number of undesired pregnancies, is associated with increased parental investment in children, notably in girls' education** (Rodgers et al., 2021).

In higher-income regions, an estimated **30 women die for every 100,000** unsafe abortions. In lower-income regions, the ratio rises to **220 deaths for every 100,000** unsafe abortions

(WHO, 2021).

ABORTION RIGHTS WITHIN THE FRAMEWORK OF SEXUAL AND REPRODUCTIVE JUSTICE

Evidence acquired over years of research shows that restricting access to safe abortion does not diminish their number (Bearak et al., 2020) **but it does influence their safety and dignity. In countries with highly restrictive abortion regulations, the rate of unsafe abortions is much higher than in countries with less restrictive laws** (Ganatra et al., 2017).

Access to safe and legal abortion is a human rights issue. According to official interpretations of international human rights law[15] **denying pregnant women, girls, and others access to abortion is a form of discrimination and violates multiple fundamental human rights.** The supervisory bodies of the different UN human rights treaties routinely request that governments legalize abortion in all circumstances, or at the very least guarantee it in specific circumstances (such as rape or incest).

Many women's and girls' human rights **are directly violated by the inaccessibility of safe, quality abortion care or its outright denial, including the right to life; the right to the highest attainable standard of physical and mental health; the right to benefit from scientific progress and its implementation; the right to freely and responsibly decide how many children to have, when and at what distance; and the right to freedom from torture, cruel, inhuman, and degrading treatment.** Countries must respect, preserve, and fulfil human rights, particularly those relating to sexual and reproductive health, as well as ensure everyone's bodily autonomy is guaranteed.

15 These rights are established, among other things, in the Universal Declaration of Human Rights and are reaffirmed and protected in numerous international treaties, such as the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention Against Torture (CAT), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC), as well as in regional treaties in Africa, Americas and Europe.

© Vincenzo Montefinese

The right to abortion in Italy

In Italy, access to voluntary abortion is regulated by **Law 194/1978**, which, while recognizing the right to life of the embryo and foetus, also protects women's physical or mental health if it is jeopardized by the continuation of pregnancy, childbirth, or maternity (Luca Coscioni Association, 2022). Prior to the adoption of Law 194, **contraception was deemed illegal, and the voluntary termination of an undesired pregnancy constituted a felony under Italian law.** According to the Rocco Code, the latter was penalized as a "crime against the integrity of the lineage" (Quaglia, 2022).

To date, the law's implementation is fraught with difficulties, particularly around conscientious objection. The contents of Law 194 are the result of a compromise between very different requests and sensitivities, as evidenced by the inclusion in the law's text of the possibility for healthcare personnel and those performing auxiliary activities to refuse to practice or participate in voluntary abortion interventions due to conscientious objection (article 9).

According to the report to Parliament on the application of the Law 194[16] in 2020, **the number of abortions was 66,413, a 9.3% decrease over 2019** (Ministry of Health, 2022). Since 1983, when the maximum number of voluntary terminations of pregnancy were documented in Italy (234,801 instances), there has been a steady decrease (Luca Coscioni Association, 2022). As previously stated, more than forty years after the law's introduction, it is still partially implemented, a picture well described by the ***MaiDati***[17] journalistic investigative project, curated by Chiara Lalli and Sonia Montegiove, which intends to monitor the application of Law 194 through a data collection carried out hospital by hospital. Lalli and Montegiove criticize the Ministry of Health's report for providing aggregated and insufficiently updated data, making true restitution of the country's situation difficult.

According to the ministerial report, in 2020, more than half of gynaecologists (64.6%), 44.6% of anaesthesiologists, and 36.2% of non-medical personnel expressed a conscientious objection at the national level (Ministry of Health, 2022). Even though conscientious objection is a legal right, the MaiDati project highlights how the report's data may be misleading. The investigation revealed that **there are sanitary structures where 100% of the staff exercise conscientious objection, even though Law 194 clearly states that hospitals and authorized nursing homes must provide abortion services and that regional authorities must ensure implementation.**

Several organizations, including the Luca Coscioni Association, continue to condemn the flaws in the current system while also emphasizing the flaws in the law's text. The Association specifically requests that the parts of the law that have demonstrated the most critical issues[18] including specifically article 9, be amended.

16 See https://www.salute.gov.it/imgs/C_17_pubblicazioni_3236_allegato.pdf

17 The name of the project, which can be translated as "Never Given (Data)" alludes to insufficient data playing with the Italian words "dati" that mean both data and given https://www.maidati.it/

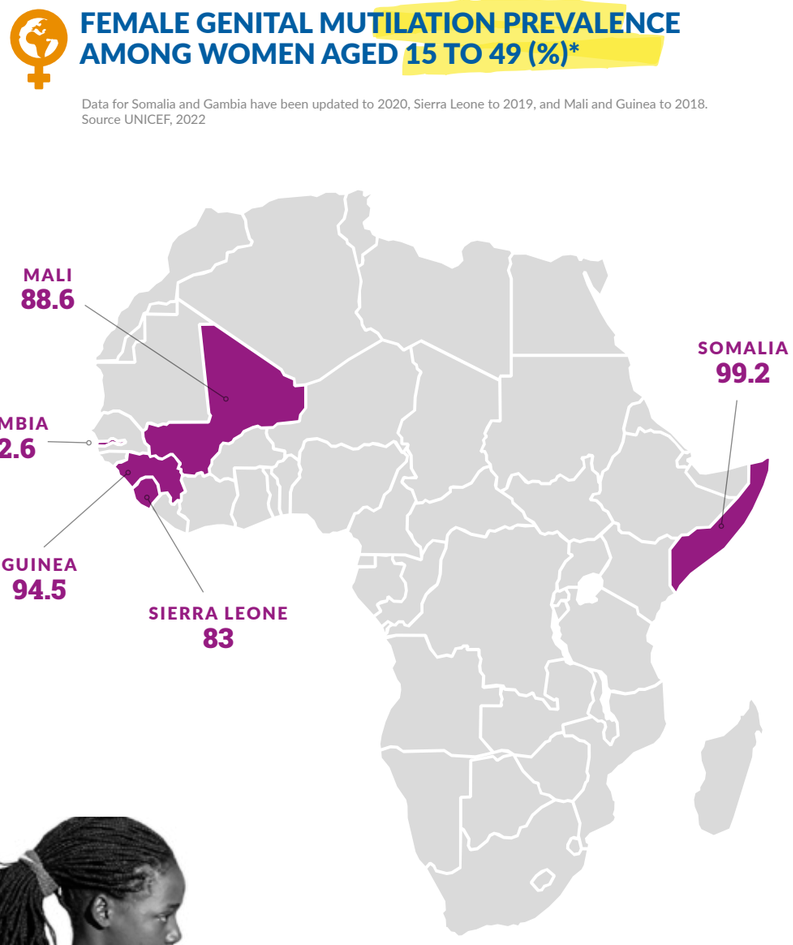
18 The other articles considered more critical are article 4, which establishes the 90-day limit for abortion on request, based on the woman's independent assessment; article 5, which establishes the obligation of the document or certificate issued by the doctor, and which provides for a "reflection" 7 days; articles 6 and 7, which regulate the so-called therapeutic voluntary abortion. For more information, see https://www.associazionelucacoscioni.it/cosa-facciamo/aborto-e-contraccezione/aborto

Practices affecting bodily integrity

In a framework of sexual and reproductive justice that seeks to guarantee people's bodily autonomy, **it is vital to monitor respect for the rights to physical and psychological integrity, as well as freedom from cruel, inhuman, and degrading treatment.** Despite this, far too many women are still subjected to practices that jeopardize their physical integrity, and thus their dignity, autonomy, and decision-making capacity, such as female genital mutilation and virginity tests.

FGM is estimated to have affected **200 million girls worldwide**

(UNICEF, 2023b)



FEMALE GENITAL MUTILATION PREVALENCE AMONG WOMEN AGED 15 TO 49 (%)*

Data for Somalia and Gambia have been updated to 2020, Sierra Leone to 2019, and Mali and Guinea to 2018.
Source UNICEF, 2022

© Camilla Miliani

FEMALE GENITAL MUTILATION (FGM)

In 1996, the World Health Organization defined "female genital mutilation" (FGM) as **any procedure that involves the partial or total removal of the external female genitalia for cultural, religious, or other non-therapeutic reasons.** The practices are classified into four categories based on the severity of the woman's injuries[19].

These interventions are true medical-surgical acts, which are often carried out by inexperienced and unqualified personnel: members of the local community, traditional midwives, or other elderly women from the village they belong to perform FGM in inadequate (or non-existent) hygienic-sanitary conditions, without the use of anaesthetics, antibiotics, or sterile material, putting the woman at risk of infection or death from bleeding. **Female genital mutilation has no positive impact on the health of women and girls. On the contrary, it creates immediate risks and complications for their physical, mental, and sexual health, as well as their overall well-being throughout their lives.**

FGM is estimated to have affected 200 million girls worldwide (UNICEF, 2023b). Current trends also indicate that **30 million girls are at risk of facing it within the next ten years** (ibid.). Today, the phenomenon is still extremely common and practised, with children and adolescents being its primary target (WHO, 2022b). The western, eastern, and northeastern regions of Africa, as well as some countries in the Middle East, Asia, and Latin America, have the highest concentration. **FGM is still almost universal in some of these countries, with 90% of girls affected in Guinea, Mali, and Somalia (the latter case reaching 99%)** (ibid.).

Although there is no explicit reference to FGM[20], the interpretation of numerous international human rights instruments[21] allows these practices to be classified as frontal violations. In this sense, **FGM is a real violation of the right to life and bodily integrity: the main issue with these practices (which are neither eliminated nor reduced by medicalization) is the harm done to women's health.** FGM, which involves the removal and damage of healthy and normal tissues, interferes with the normal functions of a woman's body and thus violates her fundamental human rights (UNICEF, 2023b).

This harmful practice is frequently supported by victims: estimates imply that 23% of women who have had it want the procedure to continue (ibid.). In fact, in some cultures, performing FGM on girls serves as **an initiation ceremony, validating their future identity as women and therefore preparing them for adulthood and married life** (WHO, 2022b).

19 Type 1: Foreskin excision, with or without partial or total removal of the clitoris. Type 2: Excision of the clitoris with partial or total removal of the labia minora. Type 3: Excision of a portion or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Type 4: Unclassified residual operations include perforation, penetration, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by the burn of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or vaginal incision; introduction of corrosive substances into the vagina to cause bleeding or tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation (WHO, 1996).

20 The case of regional agreements and conventions is different: article 38 of the Istanbul Convention of 2011, for example, specifically states that female genital mutilation must be prosecuted under criminal law as harmful acts, regardless of the arguments offered in support.

21 These include the Universal Declaration of Human Rights, CEDAW and the CRC.

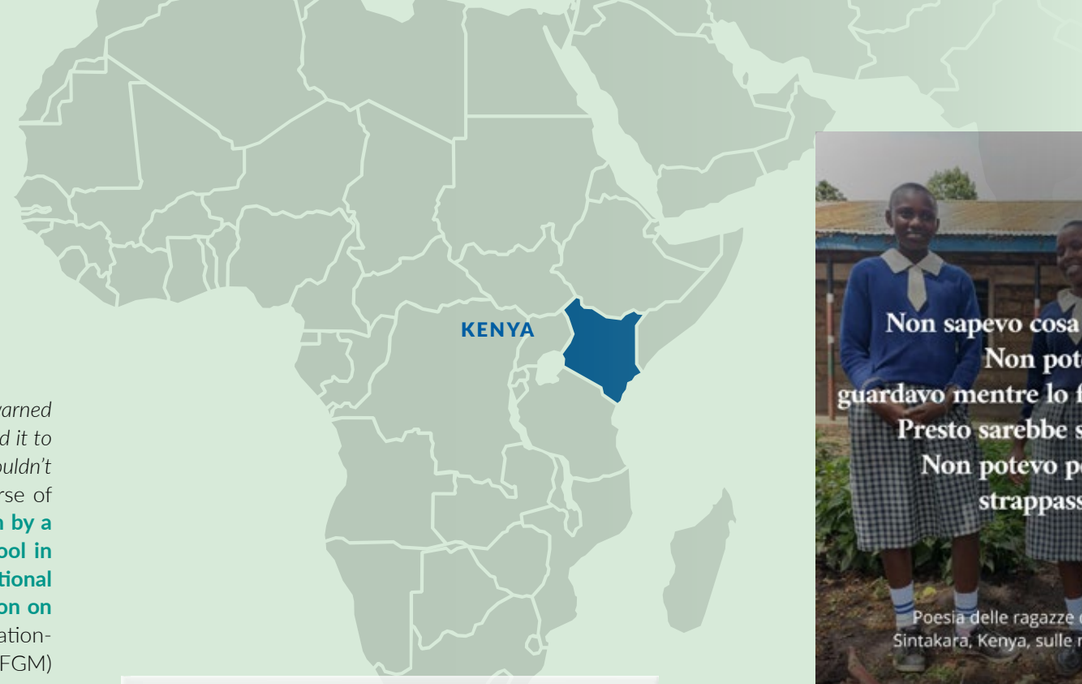
The current situation in Italy

As migration has increased in recent decades, **the number of women and girls in Europe, Australia, and North America who have suffered or are at risk of suffering FGM has increased too.** Indeed, FGM is a global issue rather than a phenomenon isolated to specific regions.

In 2018, **87,600 people living in Italy had been subjected to FGM (including 7,600 minors)**, with a higher prevalence among migrants from Mali, Somalia, Sudan, and Burkina Faso (Farina et al., 2020).

Despite the importance of these data, what happens in the country is mostly hidden, rarely known, especially in courtrooms, and widely ignored.

However, it is significant to remember that FGM was criminalized with Law 7/2006, and the specific reference to the "crime of practices of mutilation of female genital organs" was added to Art. 583 bis of the Penal Code.



WeWorld in Kenya: education has a critical role in preventing and combating FGM

"I didn't know what was happening, but my conscience warned me of a danger. I couldn't talk, I just watched as they did it to my sister. It will soon be my turn, I couldn't wait. I couldn't allow them to pluck off my body". This is the first verse of the poem **FGM, a wild practice, which was written by a group of young girls at Sintakara Elementary School in Kenya and released on the occasion of the International Day of Zero Tolerance for Female Genital Mutilation on February 6.** The institute participates in WeWorld's national campaign to eradicate female genital mutilation (FGM) and child marriage through activities that raise awareness and empower female students beginning in primary school. In fact, even though **FGM has been illegal in Kenya since 2011, it is estimated that 21% of girls and women aged 15 to 49 have been subjected to the practice, particularly in Somali, Maasai, and Kisii communities** (prevalent in Narok, Migori, and Isiolo counties, where WeWorld operates). A statistic that is not just unchanged from past years but is expected to worsen due to the pandemic.

"We are afraid that we are only seeing the tip of the iceberg," says **Annarita Spagnuolo**, WeWorld's country representative in Kenya. *"The problem not only persists but has gotten worse during the pandemic. Schools, which serve as our initial control point and a focal point for raising awareness, were closed for many months in 2020. The absence of such an important educational centre had an effect: the country focused on fighting the pandemic, and the guard was lifted on other issues, such as abuse and violence against girls and women, which instead escalated."* The potential risks of FGM are considerably more well-understood among younger generations. Girls can, in fact, suffer from a variety of side effects before and after the procedure, including excessive bleeding, anaemia, and difficulties with urinating. **The practice is strongly related to education: after the cut is completed, the girls are deemed ready to marry, which frequently leads to early marriage and the abandoning of studies.**

"I was not subjected to female genital mutilation because my father, after attending an awareness course, understood the risks I was taking and opposed it," says **Purity, who is now a WeWorld activist in Kenya.** *"Because of him, I am also working hard to promote awareness in my community, to inform young girls about the health risks of this practice, and to go beyond. If this practice was abolished, females may continue their studies and finish their education without having to worry about marriages, early pregnancies, or health concerns."*

The poem
FGM, A WILD PRACTICE

I didn't know what was happening,
but my conscience warned me of a danger.
I couldn't talk, I just watched as they did it to my sister,
It will soon be my turn, I couldn't wait.
I couldn't allow them to pluck off my body,
FGM is a ruthless act, not for this generation.

I watched them jump, jump and ululate, so happy with themselves
No, no, no this will not befall me, over my dead body
I promise myself, my mom, my aunt, please grandma, save me
FGM is a ruthless act, not for this generation.

My legs grew light, very light, I fled and vanished in the thin air, like a gazelle chased by a lion
I ran and ran and run in pursuit of my dignity, they didn't get me,
I know they are still hoping to get me, but no, no, not me I will remain a complete woman
FGM is a ruthless act, not for this generation.

I didn't know what was happening
I couldn't talk,
I just watched as they did it to my sister,
It will soon be my turn
I couldn't allow them to pluck off my body

A poem on FGM by some girls attending Sintakara primary school in Kenya

I was lucky. My father opposed it
and I wasn't subjected to female genital mutilation

Purity, Activist against FGM
Testimonial collected by WeWorld

Why climate change is, first and foremost, a gender issue. Female Genital Mutilation on the rise in Kenya

For some time now, it has been clear that the climate issue is not "gender neutral" (see *WeWorld Index 2021* and *2022*). Climate change disproportionately impacts women, girls, and boys, exacerbating gender discrimination in areas such as health, education, the economy, and safety. In this context, an increasing number of studies are emphasizing the connection between climate change and an increase in violence against women and girls (Barnfonden, 2022). The changes we are witnessing, in particular, have an impact on two related phenomena: early marriages and female genital mutilation. Kenya serves as an example in this regard. The relationship between climate change and female genital mutilation (sometimes a direct result of early marriages) has long been investigated in this country (Esho et al., 2021).

In Kenya, it is believed that approximately two out of every ten women aged 15 to 49 have been submitted to FGM. The frequency is especially high in the most marginalized populations, such as Somalis (96%), Kisii (93%), and Maasai (77%), where FGM is considered as a true rite of passage into adulthood, a time of transition from a child to a woman. **In Maasai communities, for example, FGM symbolizes better self-realization and femininity, as well as more marriage opportunities.**

Today, however, climate change is having a negative impact on the Maasai tribes' living situations, increasing the chances for women and girls of being subjected to harmful traditional practices. Kenya is suffering from increasingly protracted droughts, and temperatures are rapidly rising. This has an impact on community livelihoods by, among other things, producing water and food instability and expanding pockets of poverty. **Poverty-stricken families are frequently forced to resort to early weddings to minimize the burden of family expenses.** It is reported that **47% of females in Kaijado County, where Maasai communities reside, were married before the age of 18** (ibid). The rise of underage marriage and FGM frequently go hand in hand. In reality, "uncut" girls (those who have not undergone the procedure) are not regarded as acceptable for marriage in the communities. **This creates a vicious spiral in which climate change affects people's livelihoods, forcing them into poverty. Families resort to adaptation methods such as early marriages of sons and daughters to escape poverty. To marry, the latter must adhere to the practice of FGM.**

THE VIRGINITY TEST

The "virginity test" entails inspecting the female genitalia to establish if the woman or girl in question has previously engaged in sexual activity (Olson and Moreno, 2017). **Such a method is used in certain communities to identify whether women or girls are still considered "virgins." In rare cases, the exam is also used to assess the sexual assault of rape survivors.** The visual inspection of the hymen or the so-called "two-finger method," in which the examiner inserts two fingers into the girl's vagina to check whether the hymen is still intact, are the two most commonly used procedures for the "virginity test".

This happens because, from ancient times, virginity and, by extension, a woman's "purity" and "innocence" have been linked with the hymen's integrity (ISSM, 2018). This belief was (or is) prominent not just in weakly secularized countries: until a few decades ago, placing the wedding night sheet in the window to show the blood stain, a sign of a woman's virginity pre-nuptial, was a highly popular practice in Italy (Il Post, 2020).

Several scientific studies have found that this type of test does not produce accurate results because the integrity and characteristics of the hymen vary from woman to woman and the membrane can rupture or stretch during daily activities unrelated to sexual intercourse (ISSM, 2018). This practice has been documented in Afghanistan, Bangladesh, Egypt, India, Indonesia, Iran, Jordan, Palestine, South Africa, Sri Lanka, Swaziland, Türkiye, and Uganda, but it has also been observed in countries in the Global North within their diaspora communities (Olson and Moreno, 2017). In any case, virginity tests have never been historically connected with specific locations or monotheistic religions.

In 2018, the United Nations High Commissioner for Human Rights, the World Health Organization, and UN Women published a joint statement[22] indicating that the virginity test has no scientific or clinical validity. No test can establish that a girl or woman has had sexual intercourse, and the integrity of a girl or woman's hymen cannot prove whether she has had sexual intercourse or is sexually active or not. **Virginity tests have been widely condemned as a breach of human rights, particularly the right to be free of harsh, inhuman, or degrading treatment. Although tests have been technically prohibited in several nations around the world, they are nonetheless still required and performed** (ibid.).

Virginity tests can have both short and long-term consequences, such as:

- **PHYSICAL INJURY:**
  Virginity tests can inflict physical harm to the women and girls who are tested, even increasing pre-existing injuries in the case of sexual abuse survivors. Damage can also be caused by relatives who, upon a "failed" test, may injure or murder the woman or girl for the sake of "family honour." Self-harm and suicide attempts have also been reported as a result of virginity testing (WHO, 2022c).

- **PSYCHOLOGICAL DAMAGE:**
  Women and girls who endured virginity tests describe intense dread and anxiety prior to the screening, as well as yelling, sobbing, and fainting during the test. Long-term repercussions include low self-esteem, depression, a sense of invasion of privacy, and re-victimization (for sexual assault survivors) (ibid.).

- **SOCIAL HARM:**
  Virginity testing is commonly associated with harmful traditional and cultural standards that subject women and girls to stigma, shame, and dishonour towards themselves, their families, and their communities. Women and girls may be abducted or even killed if they have (or are suspected of having) sexual encounters outside society's standards. In some communities, early marriage is used as a "preventive" technique to avert shame and dishonour (ibid.).

22 See https://www.who.int/news/item/17-10-2018-interagency-statement-calls-for-the-elimination-of-virginity-testing

Gender-based **Violence**

WHEN THERE IS VIOLENCE, THERE CANNOT BE SEXUAL AND REPRODUCTIVE JUSTICE

Gender affects people's experiences with and access to health care: the way health systems are organized and delivered may restrict or allow a person's access to information, support, and health services, as well as influence check-ups results (WHO, 2023). **In this situation, the disparities and prejudice that women and girls must confront daily endanger their health and well-being.**

Women and girls frequently encounter barriers to information and health care. These barriers include mobility restrictions; lack of access to decision-making power; lower literacy rates than men; discriminatory claims of communities and health professionals; and lack of training and awareness of women's and girls' specific needs among health professionals and systems (WHO, 2023). Women and girls also face high levels of violence rooted in gender inequality and are at high risk of being subjected to harmful practices such as FGM and forced marriage, which is frequently followed by pregnancies. **According to WHO data, approximately one in every three women worldwide has experienced physical and/or sexual violence by a partner or by others in their lifetime** (ibid.).

Violence against women and girls is a growing public health concern and a serious violation of human rights, with negative consequences for physical, mental, and psychosocial health, as well as sexual and reproductive health. **Sexual violence can result in unintended pregnancies, induced abortions, gynaecological issues, and sexually transmitted diseases such as HIV. Intimate partner violence during pregnancy increases the chances of miscarriage, stillbirth, premature birth, as well as babies with low birthweight (LBW)** (ibid.). Conflict and post-conflict situations, including displacement, can aggravate violence against women and girls and increase the risk of new forms of violence (see WeWorld Index 2021 and 2022). **All forms of violence against women and girls must be prevented and opposed within a framework of sexual and reproductive justice.**

© PhotoAid

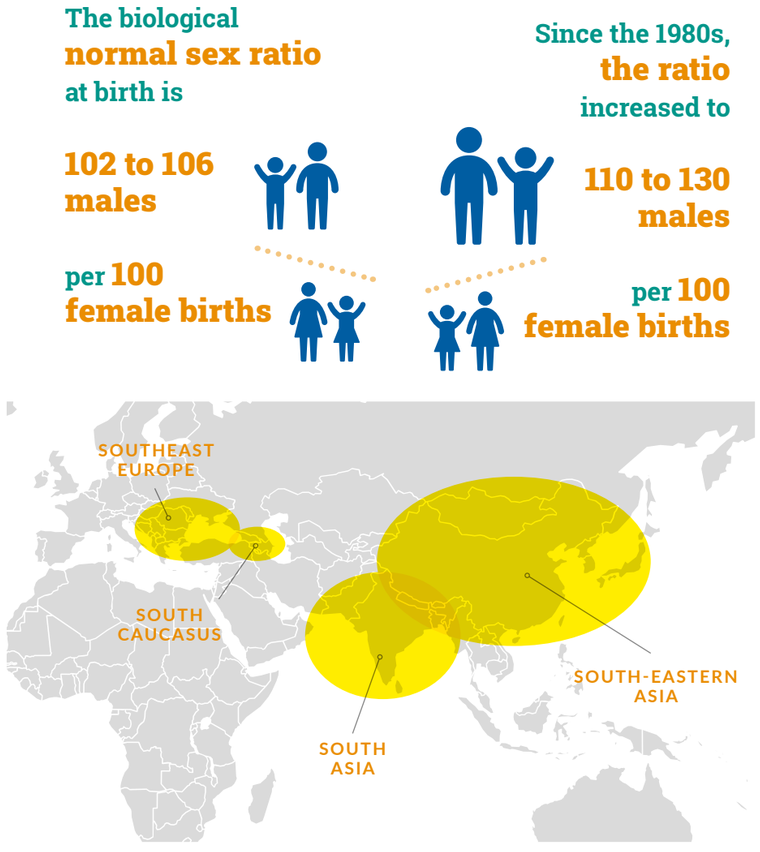
Gender-biased **sex selection**

When a couple or family prefers to have a son over a daughter, this is referred to as gender-biased sex selection[23]. Gender-biased sex selection is a harmful practice that manifests violence and gender inequality and has a direct impact on the birth sex ratio of boys and girls (UNFPA, 2022b). Such selection can take place before birth[24] , by choosing the sex of the child before conception or deciding to terminate the pregnancy, or after birth, by infanticide or differential treatment in maternal nutrition and childcare[25] (ibid.).

Globally, 23.1 million "missing" female births were documented between the late 1990s and 2017 (Chao et al. 2019), resulting in an imbalance in the sex ratio at birth. **India alone accounts for nearly half of the world's missing women** (ibid.). Estimates (UNFPA, 2022b) suggest that this figure could be much higher, leading to the belief that **140 million women are "missing" worldwide**[26]. Some geographic areas have had up to 25% more male births than female births since the 1990s.

HOW DO WE KNOW GENDER-BIASED SEX SELECTION IS TAKING PLACE?

WeWorld's elaboration on UNFPA, 2022b.



At birth, the normal sex ratio ranges from 102 to 106 boys for every 100 girls. However, much higher than normal ratios, sometimes as high as 130 boys born to 100 girls, have been observed, particularly in countries with deeply entrenched gender inequalities and patriarchal family values (ibid.).

Gender ratios (male and female population shares) may vary. **In 2020, women accounted for under 50% of the global population** (UNFPA, 2022b). **In the absence of selective abortion practices, having a boy is slightly more likely than having a girl** (Ritchie and Roser, 2019).

Nonetheless, today (though trends have also been observed in the past) the sex ratio at birth in some countries is too skewed to be explained solely by biological differences.
A recent study (Chao et al., 2019) remodelled birth sex ratios around the world using data from censuses and household surveys, among other sources. **Albania, Armenia, Azerbaijan, China, Georgia, Hong Kong, India,**

23 Sex constitutes an element of our genetic makeup. It is the set of biological, physical, and anatomical characteristics that distinguish males and females. Gender, on the other hand, refers to the socially and culturally constructed distinctions between female and male identities, which are typically based on physical and biological differences. Gender is a cultural construct that represents, defines, and rewards behaviours that cover the biological endowment and give life to the male/female binary status. As a result, it is a process that converts biological differences into social differences. As a result, gender varies across cultures, geographical areas, and historical periods; it is thus a learned trait rather than an innate one. It is dynamic and relative because each society determines which values to assign to various gender identities, as well as what it means to be a man or a woman: as a result, the concepts of masculinity and femininity are also relative.

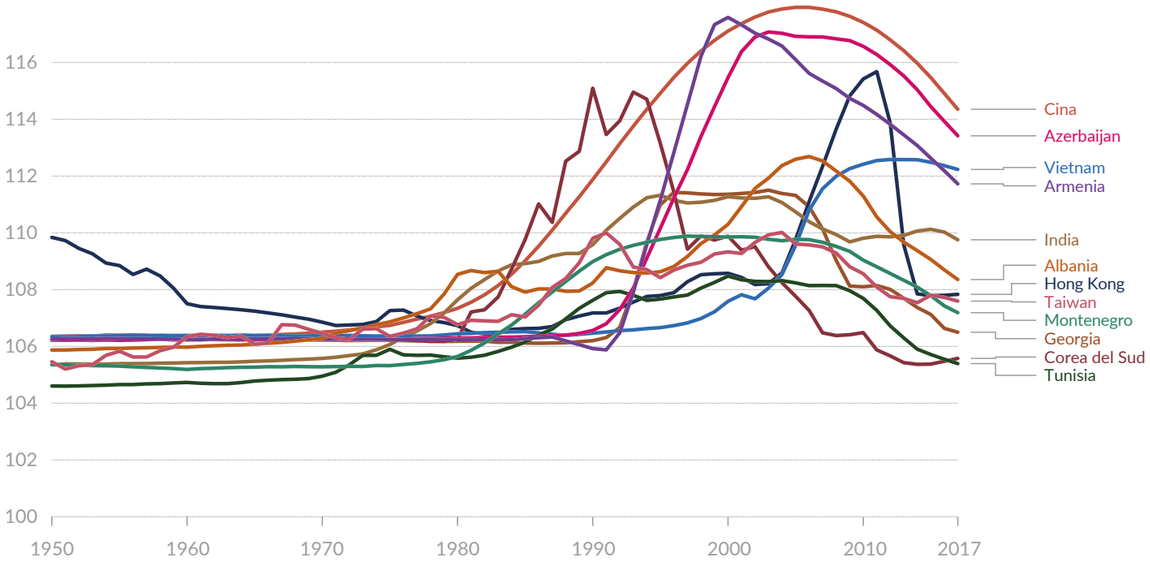
24 Through the screen embryo. See https://www.unfpa.org/sites/default/files/resource-pdf/Preventing_gender-biased_sex_selection.pdf

25 In this section, we will only deal with the subject of gender-biased sex selection taking place before birth but, for more information on the phenomenon after birth, see https://ourworldindata.org/gender-ratio

26 In the 1990s, the first to bring attention to the topic was Amartya Sen, with his article "More than 100 million Women are Missing", published in The New York Review of Books. See https://web.archive.org/web/20130504072819/http://ucatlas.ucsc.edu/gender/Sen100M.html

MALE/FEMALE RATIO AT BIRTH FROM 1950 TO 2017 IN COUNTRIES MOST AFFECTED BY GENDER-BIASED SEX SELECTION

WeWorld elaboration on Our World in Data, 2019



Montenegro, South Korea, Taiwan, Tunisia, and Vietnam were identified as having strong statistical evidence of a skewed gender ratio.

Several countries now have strong evidence of selective abortion and discrimination against girls (ibid.). Not only the availability of technologies for prenatal sex determination coincides with the gender bias in favour of males, but there is also clear evidence from studies investigating the use and promotion of such methods (Ritchie and Roser, 2019). **Son preference is more prevalent in East and South Asian countries, but it can also be found in Middle East and North Africa.**

Although these countries have significant cultural, economic, and social differences, there are several parallels that explain the strong preference for sons. **What these countries share is a strong logic of "patrilineality": the logic by which productive goods move through the male line within the family** (Das Gupta, 2003). **Men are the focal points in these societies, and women are the moving points: when a daughter marries, she leaves her current family to join a new one.**

In these contexts, having a son rather than a daughter can result in social and economic benefits such as:

- **THE FAMILY NAME:** Within a family, lineage is found in the male line. You can pass on the family name if you have a son.
- **DOWRY:** A major economic concern associated with the birth of a daughter is the transfer of property or money from the bride's family to the groom's family (the dowry). Several studies in India have found that dowry is the most common reason for not wanting a girl (Diamond-Smith et al, 2008).
- **LABOUR OPPORTUNITIES:** Males are thought to provide better economic opportunities for their families. This may be due to real gender differences in economic opportunity, but it is often due to undervaluing women's work (Das Gupta et al., 2003).
- **SUPPORT IN OLD AGE:** In some communities, sons are often responsible for caring for their parents in their old age and sickness (Hesketh, 2011). Elderly parents frequently live with married children, particularly sons, from whom they expect greater economic resources and, thus, the possibility of long-term care. For these reasons, it is uncommon for parents in Taiwan, for instance, to live with a married daughter (ibid.).
- **FAMILY AND SOCIAL PRESSURE:** In some countries, family members and communities exert consistent pressure. When women do not have a child or are pregnant with a girl, they frequently report pressure from in-laws and husbands, as well as verbal and physical abuse (Puri et al., 2011).
- **RELIGION:** Some communities believe that only a son can light the funeral pyre and perform death rites and rituals required for salvation (ibid.).

Addressing a complex and often invisible phenomenon like gender-biased sex selection requires a multi-sectoral approach as well as extensive cultural work to change people's perceptions of the worth of daughters. Promoting female empowerment paths from childhood, as well as ensuring that girls and boys receive a high-quality education, increases their chances of entering the labour force and fully participating in social and political life, thus becoming positive role models (UNFPA, 2022b).

Child forced marriages

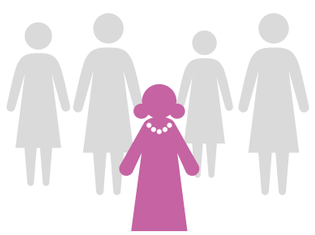
Every year,
12 million girls
get married
before the age of 18:
that's **23 every minute**

(UNICEF, 2022b)

Child forced marriage (CFM) is a violation of human rights and a harmful practice that disproportionately affects women and girls worldwide.

Child marriage endangers the lives and futures of girls and women all over the world, **robbing them of their right to self-determination, disrupting their education, making them more vulnerable to violence, discrimination, and abuse, and preventing full economic, political, and social participation** (UNICEF, 2022b).

Child forced marriages are frequently followed by early pregnancy and childbirth, resulting in higher-than-average maternal morbidity and mortality (ibid.).

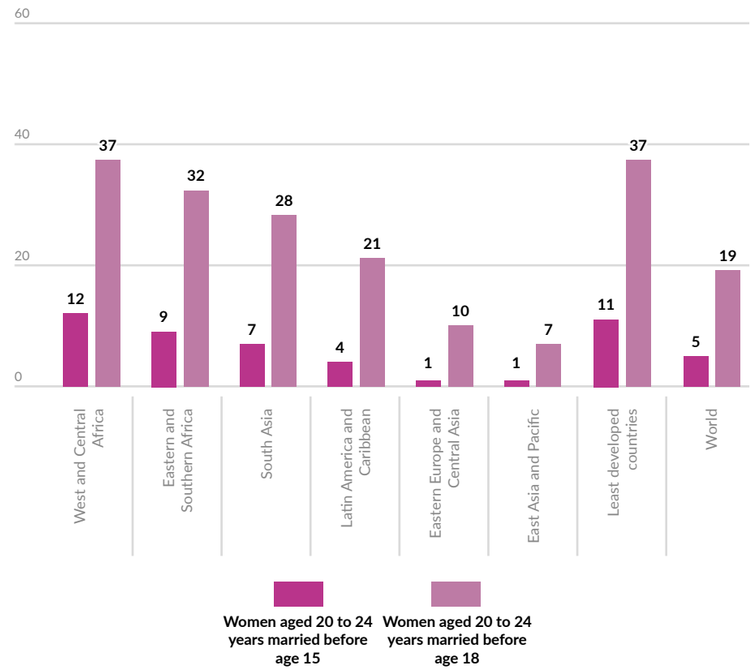


Worldwide,
1 in 5 women
got **married**
before the age of 18

(UNICEF, 2022)

PREVALENCE OF CHILD AND FORCED MARRIAGE PER GEOGRAPHICAL AREA (%)

The data, updated to 2020, refer to the percentage of girls between the ages of 20 and 24 who got married before the age of 15 and before the age of 18.
Source UNICEF, 2022.
The classification of geographical areas follows that established by UNICEF.



Today, it is estimated that more than **650 million women were married as children** (ibid.). Over the last decade, increased education rates for girls, government investment in adolescent girls' rights, and increased public awareness of the dangers of child marriage have resulted **in the prevention of 25 million child marriages worldwide** (ibid.). Despite this, the prevalence of child forced marriages remains high, especially in some regions (see the graph above).

The 2030 Agenda's goal of ending child marriage in all countries is currently not being met by any region. Progress needs to be significantly accelerated and maintained in order to put an end to the practice globally. **By 2030, more than 120 million more girls will be married before the age of 18 if current trends continue** (UNICEF, 2022b).

Numerous factors, such as economic shocks, school closures, and challenges in obtaining social and medical services, can raise the risk of child marriage. For instance, **it is now widely recognized how economic insecurity leads families to turn to early marriage as a means of financial relief. In this sense, early marriage serves as a coping mechanism for precarious and uncertain situations, such as armed conflicts, food shortages, and natural disasters** (UNICEF, 2021b). It is also well known that having access to a secure and high-quality education can help prevent early marriage. In some situations, families do in fact tend to decide on a girl's education and marriage concurrently (ibid.).

The phenomenon has been particularly impacted by school closures, such as those brought on by the COVID-19 pandemic, which pushed many girls and boys to get married because continuing their education was no longer an option (ibid.). **The pandemic has increased inequality in areas already plagued by protracted crises and persistent poverty, limiting opportunities for many children and adolescents** (see *WeWorld Index 2020* and *2021*). Additionally, during the pandemic emergency, many services deemed "non-essential" were suspended, including those for sexual and reproductive health, which are crucial for preventing violent situations like early marriages and subsequent pregnancies. Furthermore, COVID-19 has also halted an important sociocultural project: **the reduction of community dialogues and awareness campaigns on the negative effects of child marriages has left a dangerous gap** (UNICEF, 2021b).

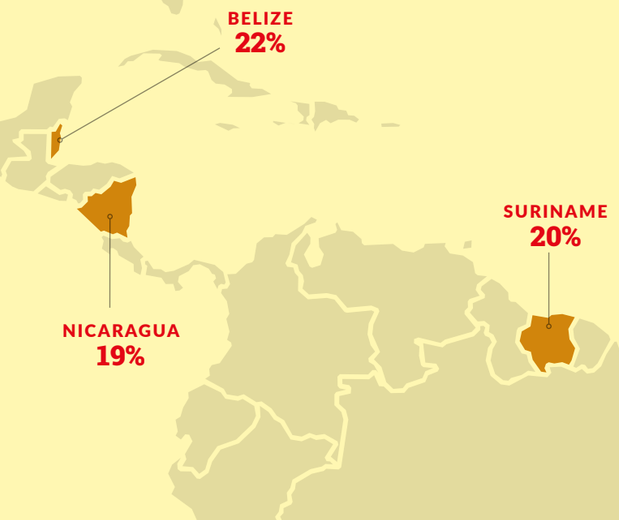
Finally, climate change and other environmental crises are creating contexts that expose millions of boys and girls worldwide to an increased risk of early marriage (UNFPA, 2022c). **Many of the areas with the highest rates of child marriage are also suffering the most from the effects of climate change.** The practice is more common in communities with limited access to resources and low income, particularly in rural areas where people rely on the local environment for a living (ibid.).

Male child and forced marriages

Globally, **115 million boys and men married before reaching the age of 18** (UNICEF, 2022b). Even though boys and girls forced into marriage as children do not face the same risks and consequences due to biological and social differences, **the practice still constitutes a violation of fundamental human rights.** Child grooms, like child brides, are forced to assume adult responsibilities for which they may be unprepared. **Early marriage can lead to early fatherhood and put a strain on the family's finances; it can also limit the boy's access to education and job opportunities** (ibid.).

THE THREE COUNTRIES WITH THE HIGHEST PREVALENCE OF MALE CHILD AND FORCED MARRIAGES (%)

The data, updated to 2020, refer to the percentage of men between the ages of 20 and 24 who got married before 18. Source UNICEF, 2022.



EDUCATION AS A PREVENTATIVE MEASURE

Many teenage girls face a choice between staying in school and marrying at some point in their lives. Despite significant progress in recent decades, support for girls' quality education remains limited in many areas.

Girls may drop out due to a lack of nearby educational facilities, either because schools are simply too far away or because walking long distances places them at risk of harassment (World Bank, 2017). Poor quality education is also a deterrent, and some communities believe that if teenage girls attend public schools, they will be harassed.

Finally, the cost of education makes it difficult for many girls to continue their studies, particularly at the secondary level. **Early marriage reduces girls' educational opportunities, while better educational opportunities may reduce the likelihood of early marriage. The literature and evidence on the subject suggest that keeping girls in school is one of the best ways to postpone marriage** (ibid.).

WeWorld in Afghanistan
The daily reality of single mothers: the story of Morwarid

The Taliban's return to power has resulted in the reintroduction of severe restrictions and discrimination against women. Women today are not allowed to leave their homes unless accompanied by a male family member. **More than 2 million women have become widows as a result of the high rate of male deaths in recent conflicts as well as the effects of the pandemic and other widespread diseases.** Consequently, their chances of finding work are almost non-existent. They are not only denied autonomy and economic independence but their survival conditions and access to food are also jeopardized.

To cope with these circumstances, many boys and girls are forced to drop out of school to work or beg on the streets, with all the psychological, developmental, and physical risks that entail. **With nearly 8 million girls and boys in urgent need of humanitarian assistance, and at least half of them out of school, safe access to quality education has become a rarity rather than the right it should be. In the Afghan context, especially for girls, the ability to attend school is critical as a tool to combat the traditional and widespread use of forced marriages for economic reasons.**

Since the end of 2021, WeWorld has been implementing a Cash for Food project in the rural areas of Robat E Sangi, specifically to support women who have found themselves in charge of their own families. The program assisted 180 households in the first year of operation. Prior to the start of the distributions, 95.5% of the recipients had been suffering from hunger, with 71.1% suffering from acute hunger; some even lived on bread and tea for weeks. A second Cash for Food project in the same area started assisting 240 new families in August 2022.

Morwarid's family

Morwarid, a mother of six, found herself alone with her children after her opioid-addicted husband abandoned them. This condition is quite common in rural Afghanistan, where those who work in the opium fields end up using it to avoid fatigue and hunger.

Within two or three days, the mother and her children raise the equivalent of about one dollar's worth of roots, the main crop of the area in which they live. They spend their earnings on sugar, tea, and rice, as well as the fare for shared cars to get to the points of sale. If they don't have enough money, they ride a donkey or walk there. However, Morwarid's family survives mostly on dry bread and tea while sitting in the one room of their earthen dwelling. They search daily for flour or something to eat.

Previously, families in the area who relied on grain sales and consumption would give a third of their harvest to needy neighbours. They are now struggling every day to provide food and heat their homes. **Morwarid's eldest daughter, now 17, moved out four years ago after being married off because her mother couldn't pay back a loan. The other children are 13, 9, 5, and 3 years old. Ahmad, the sixth child, died of a cold when he was six years old.**

After years of conflict, epidemics linked to hygiene and food shortages, and the COVID-19 health crisis, the national health system is severely underfunded and understaffed. These flaws have resulted in the spread of corrupt practices, where medical services are frequently conditional on obtaining benefits. **In this system, a prescription costs more than $10, plus the cost of travelling to the nearest health centre. A medical visit represents, at best, a month's work in the fields for Morwarid's family. When Ahmad became ill, his mother asked neighbours for help in getting him to the nearest medical centre, which was about 20 kilometres away. However, no one had enough money to help her.**

Early Pregnancies

Early pregnancy (also known as adolescent pregnancy) is a worldwide phenomenon with well-known causes and serious health, social, and economic consequences. Although the global teenage birth rate has decreased, rates remain uneven across regions of the world (WHO, 2022c).

There are also huge variations within countries: teenage pregnancy is more common among people with a lower level of education or a lower economic status (ibid.). Adolescents are prevented from avoiding unwanted pregnancies in several countries due to barriers to obtaining and using contraception. While adolescents may have access to contraceptives because they are available in their immediate surroundings, they may lack the financial resources to pay for them as well as the knowledge of where to obtain them and how to use them correctly.

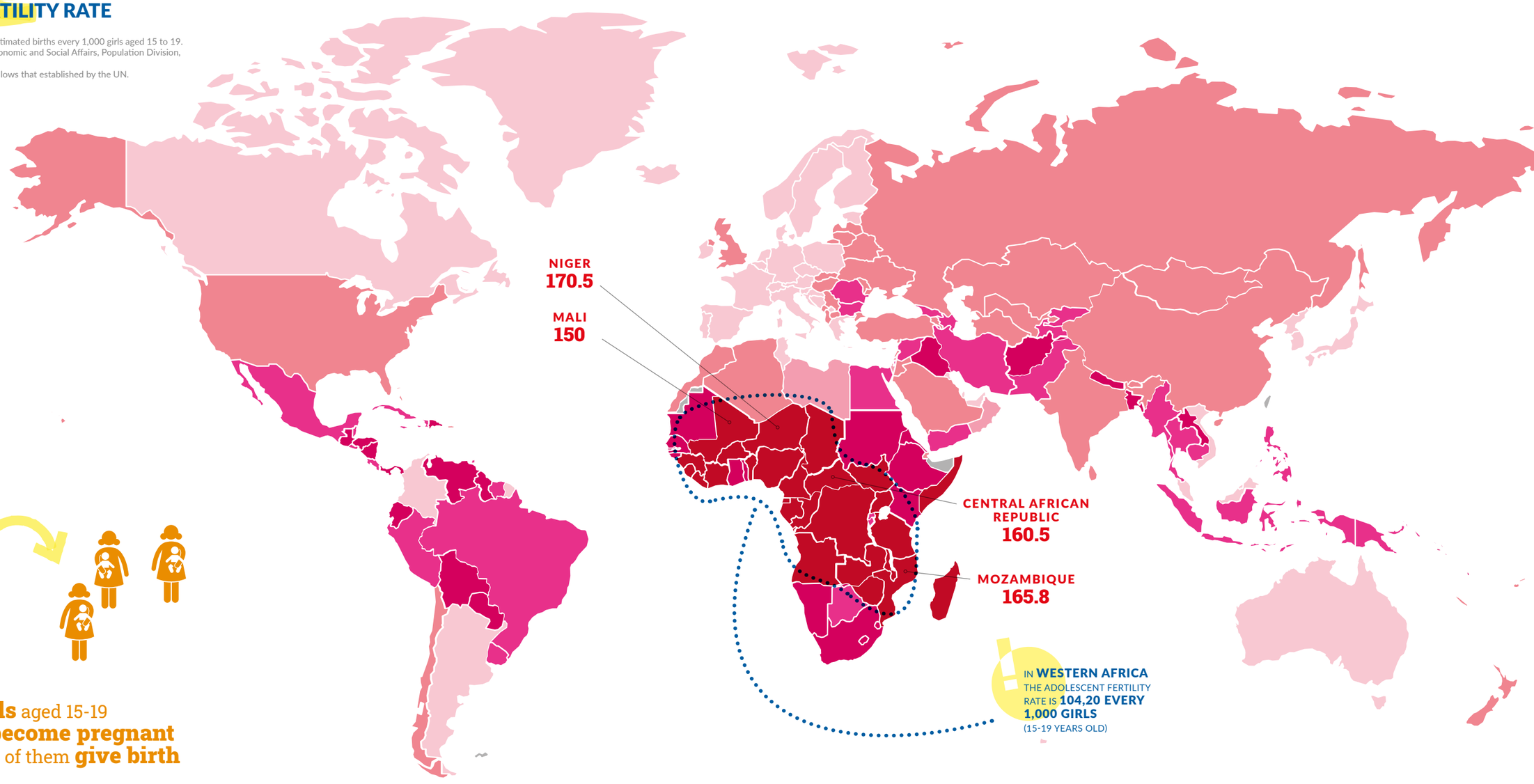
Restrictive laws and policies on contraceptive provision based on age or marital status are significant barriers to contraceptive provision and use among adolescents. This is frequently combined with professional bias and/or an unwillingness to recognize adolescent sexual health needs (ibid.).

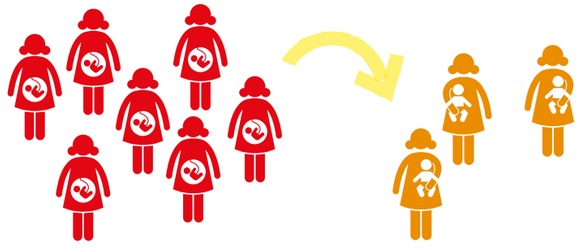
Globally, the adolescent fertility rate is **42 births every 1,000 girls** aged 15-19

(World Bank, 2022).

ADOLESCENT FERTILITY RATE

The data, updated to 2021, refer to the estimated births every 1,000 girls aged 15 to 19.
Source United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects 2022.
The classification of geographical areas follows that established by the UN.





Every year, around **21 million girls** aged 15-19 in low-income regions **become pregnant** and around **12 million** of them **give birth**

(UNDESA, 2022)

THE CONNECTION BETWEEN CHILD AND FORCED MARRIAGES AND EARLY PREGNANCIES AND THEIR CONSEQUENCES

Girls who marry before the age of 15 are 50% more likely than those who marry later to experience intimate partner violence (Girls Not Brides, 2021). Child marriages, and the potential for violence that results from them, put girls at a higher risk of pregnancy because **when they marry very young, they typically have limited autonomy in influencing decisions about pregnancy delay and contraceptive use.**

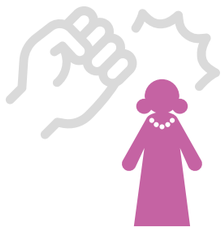
Furthermore, in some cases, girls choose to become pregnant because their educational and employment opportunities are limited. Motherhood is often valued in such societies, and marriage and pregnancy may be the best of the few options available to adolescent girls (World Bank, 2017).

Child marriage is likely to be the cause of at least 84% of childbirths among mothers under the age of 18, with serious consequences for sexual, reproductive, maternal, and child health (UNDESA, 2020). Under-five mortality increases by 3.5% when born to a mother under the age of 18 (UNDESA, 2021). **Early births are directly responsible for three out of every hundred deaths among children under the age of five** (ibid.).

Interventions to limit early marriage and pregnancies could reduce fertility and population growth by about a tenth in countries where these practices are prevalent (ibid.). **It is estimated that, globally, the benefits from reduced population growth could total more than $500 billion per year by 2030** (ibid.). The risks of dying before the age of five or suffering from physical developmental delays would be reduced for children of mothers who give birth at a young age. **Reduced under-five mortality and malnutrition are expected to save more than $90 billion globally by 2030** (ibid.).

In general, evidence from various countries around the world has shown that keeping girls in school for as long as possible, ensuring fair, safe, non-judgmental access to sex education appropriate for different stages of life, and providing comprehensive relationship care are among the best tools for combatting early marriage and pregnancies (UNFPA, 2015).

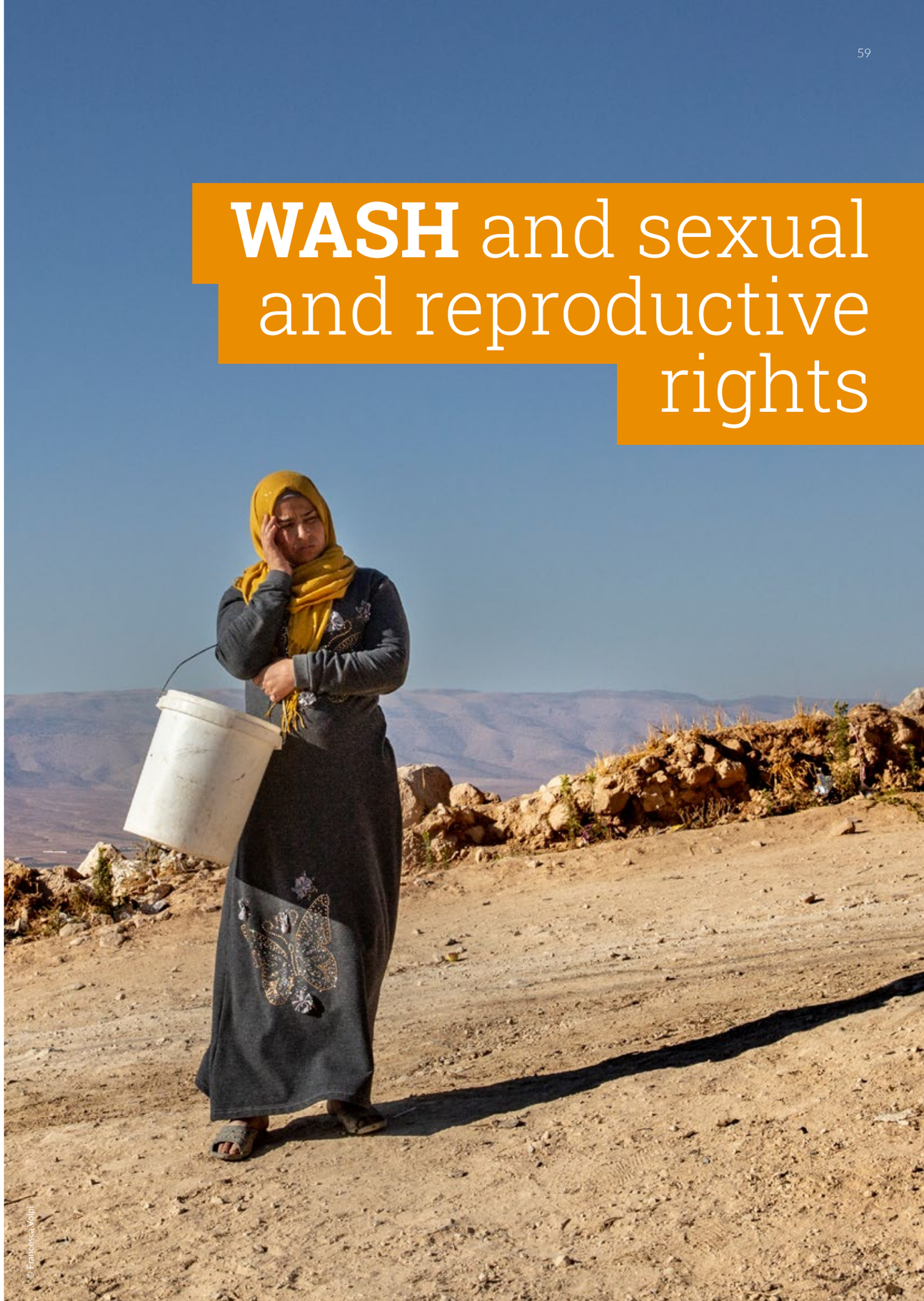
Group educational interventions in schools can successfully influence young people's attitudes, particularly boys' attitudes, toward rethinking gender roles and lead to healthier relationships. Programs that worked directly with girls and boys to provide them with information, skills, and resources yielded the best results (ibid.). In a framework of sexual and reproductive justice, interventions aimed at adolescents are required to address issues of socialisation, equality, and gender-based violence while also ensuring long-term educational paths.



Girls who marry **before the age of 15** are **50% more likely** than those who marry later **to experience intimate partner violence**

(Girls not Brides, 2021).

WASH and sexual and reproductive rights



© Francesca Volpi

WASH
(WAter, Sanitation and Hygiene)

To ensure sexual and reproductive health and gender equality, women, girls, and adolescents must have access to clean water, appropriate sanitation, and adequate hygiene (WASH). **Access to water is integrally linked to women's and girls' sexual and reproductive health and rights.**

When safe sources of clean water are difficult to reach, **women frequently find themselves travelling great distances to access it.** They also must carry the weight of the water themselves, **which increases the risk of stress, musculoskeletal issues, and uterine prolapse, among other health problems.** While travelling to and from a water collection point, **women and girls can also face harassment, violence, and even rape** (UN Women, 2018). Women and girls are at risk for diseases when they are denied access to safe sanitation facilities at home, and they also run the risk of harassment and violence when using public toilets. Similarly, **women's freedom of movement and access to opportunities to participate in community life are constrained by the absence of safe sanitation in public spaces** (IWHC, 2020).

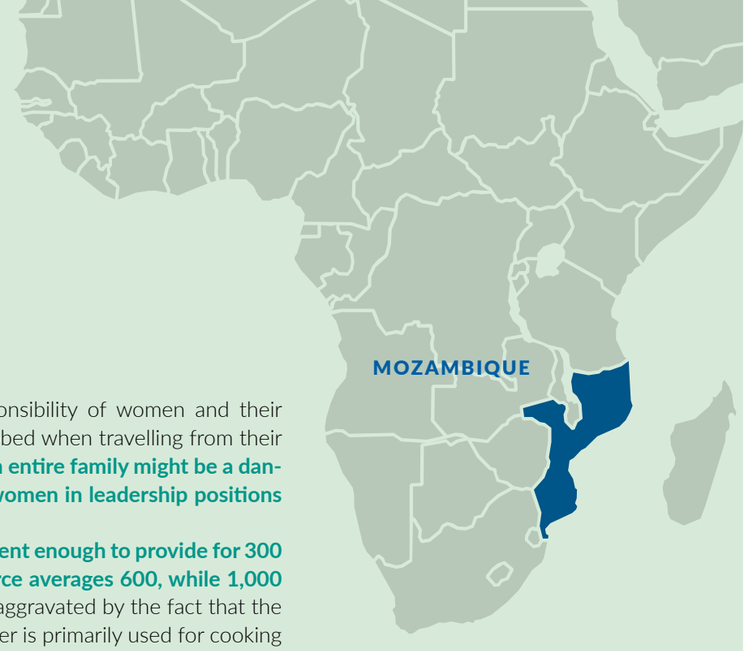
Despite significant regional and national differences, similar problems persist around the world, with women, children, and adolescents frequently enduring most of this. **It is crucial to include women in local water, sanitation, and hygiene committees and in all decision-making processes relating to the placement, design, and administration of water points and toilets, especially in areas where access to WASH services is still severely limited.**

The link between WASH and sexual and reproductive justice within the 2030 Agenda framework

WeWorld's elaboration on WaterAid, 2019[27]

WASH	Sexual and reproductive justice and the SDGs' targets
Safe water, sanitation and hygiene in healthcare settings are essential to ensure infection prevention and control (IPC) and quality health care. Sepsis and other infections are the leading causes of maternal and newborn disease and mortality. Improving WASH and IPC in healthcare settings and households reduces the risks for mothers and newborns. People with HIV suffer disproportionately from the adverse effects of inadequate WASH services and are more likely to suffer and die from diarrheal disease. Babies born to mothers with HIV are more dependent on complementary foods, which require access to safe water. Prevention and treatment of non-communicable diseases, such as cervical cancer, require care in quality facilities and IPCs. Access to contraceptives, safe childbirth and abortion, as well as management of sexual health, can be hampered by inadequate WASH services and facilities, staff shortages, and gaps in IPC education. Menstrual health should be covered in comprehensive sexual education curricula as it can act as an entry point for discussions on sexual and reproductive health in general. Adequate access to water and sanitation at home and in the community are the cornerstones of universal health coverage.	3 GOOD HEALTH AND WELL-BEING **3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births **3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births **3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases **3.4** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being **3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes **3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
6 CLEAN WATER AND SANITATION **6.1** By 2030, achieve universal and equitable access to safe and affordable drinking water for all **6.2** By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations **6.b** Support and strengthen the participation of local communities in improving water and sanitation management	Women's and girls' access to water and sanitation is at risk because of period taboos. Their mobility may be restricted during their period, just as they might not be allowed access to bathrooms, kitchens, or water. People living with HIV may be denied access to safe water and sanitation due to stigma against them and a lack of knowledge about HIV transmission. Violence against women and girls in WASH-related issues frequently results from their exclusion from decision-making processes by governments and by men. People are empowered and can take part more actively in community life when their sexual and reproductive rights are realised.
The lack of safe water collection points and adequate sanitation facilities restricts the movement of women and raises the possibility of sexual assault. Adolescent girls' access to education and achievement of positive health outcomes are impacted by poor hygiene practices, inadequate menstrual health facilities, and a lack of information, education, and appropriate sanitary products. Comprehensive menstrual health approaches can aid in ending harmful customs and ideas like child marriage. Health and safety risks exist for nurses, midwives, and the entire community of health workers in healthcare facilities without clean water, adequate sanitation, and good hygiene practices. In healthcare facilities, women have the right to receive high-quality care, dignity, and privacy for matters pertaining to their health.	5 GENDER EQUALITY **5.1** End all forms of discrimination against all women and girls everywhere **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation **5.3** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation **5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences **5.c** Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels

27 See https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/2019-08/a-shared-agenda-exploring-links-between-water-sanitation-hygiene-and-sexual-and-reproductive-health-and-rights-in-sustainable-development.pdf



WeWorld in Mozambique
Women and water: a story of female empowerment

Water supply in Mozambique is largely the responsibility of women and their daughters, who risk being raped, harassed, and robbed when travelling from their homes to the water source. **Collecting water for an entire family might be a dangerous endeavour because there aren't enough women in leadership positions on water management committees.**

One well in Mozambique is estimated to be sufficient enough to provide for 300 families but, in the Guro district, each water source averages 600, while 1,000 families are supplied in Tambara. This situation is aggravated by the fact that the wells draw from small aquifers; as a result, that water is primarily used for cooking and drinking, while women use water collected from riverbanks for other needs like washing and bathing, which could have serious consequences due to possible contamination.

Water management committees made up of 12 persons (including six women and six men) have been established by the government to ensure the upkeep, repair, and management of water supplies. Despite that, a female presence is never guaranteed. For instance, the 22 water committees in the three villages of Tambara have 264 members overall, with 56 women and 208 men. Therefore, only 21% of water committee members are women. Only one woman chairs a water committee; the other twenty-one are led by men, making up the remaining 4.5% of those in power. Only two women possess the hand pump's key. The situation is somewhat better in the Guro district, where women make up 50% of the membership on management committees and make up 38.6% of the committee chairs. **These committees typically have limited female leadership, which means that choices made do not adequately consider the objectives and concerns of women.**

In Mozambique, WeWorld works to promote female empowerment and make women leaders in the management of water resources. It does so by adopting a systemic approach aimed at bridging the gender gap in well-managed roles, intervening in the barriers preventing women and adolescents from accessing and managing resources, and raising female awareness. This is done not only to advance the status of women in the centres of society, politics, and the economy, but also to boost self-esteem and develop skills and competencies.

Maria Jessinao, who oversees hygiene and makes sure the well and its surroundings are in good shape, is one of the many women who participate in the empowering process that WeWorld carries out every day in the field. *"I shift with three other members to make sure everything always functions"*, she explains. *"Although it's a new duty for me, I feel incredibly helpful to my community".*

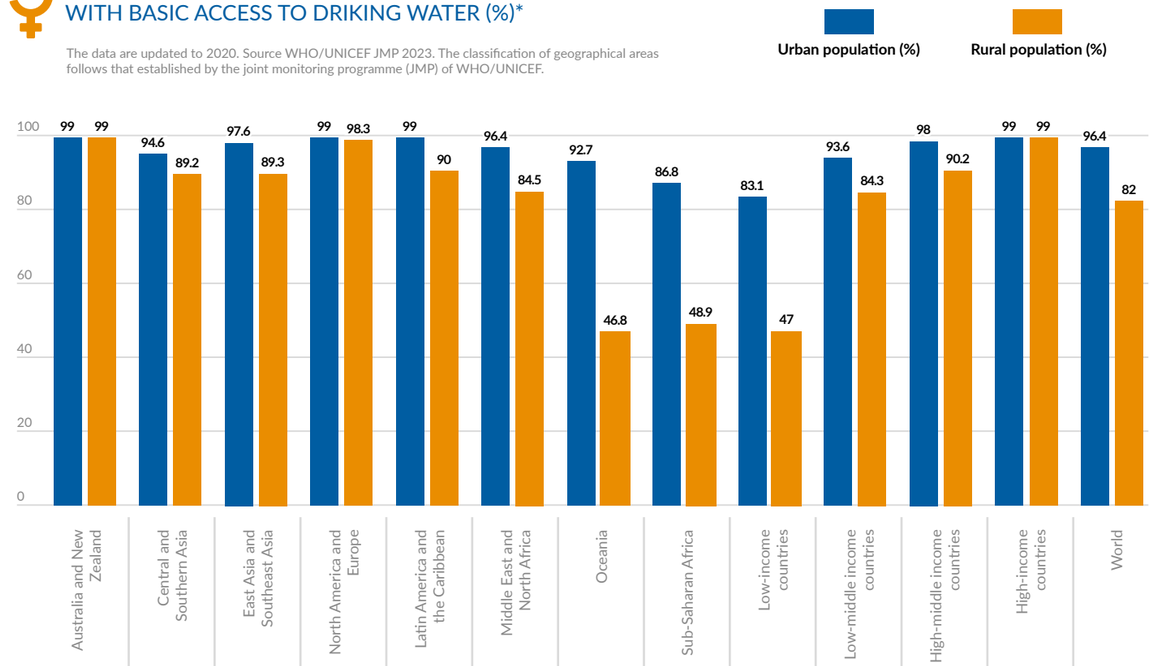
As **a mechanic, Deliessi Mastala** oversees the pump's upkeep. *"We are always talking about potential difficulties and how to handle them because of the committee. Our way of working in groups is incredibly effective. I am appreciative of the training I am receiving, and I am overjoyed because I believe I can act as a role model for other women in the community".*

"I have no prior expertise in this area, but I'm quite passionate," **Graça Tomas** says in closing. *"This is my first time serving on a committee".*

ACCESS TO WATER

RURAL AND URBAN POPULATION WITH BASIC ACCESS TO DRIKING WATER (%)*

The data are updated to 2020. Source WHO/UNICEF JMP 2023. The classification of geographical areas follows that established by the joint monitoring programme (JMP) of WHO/UNICEF.



ENSURING A SAFE ACCESS

Everyone has the right to access safe drinking water sources: this applies both in situations of stability and crisis, in urban and rural contexts, and in every country in the world. **When people lack access to clean water, there are negative impacts on their health, nutrition, education and every other aspect of their lives. However, water availability itself is not enough to keep people healthy: water must also be safe, accessible and affordable.** This means it must come from a reliable source such as a well, faucet or hand pump; free from faecal and chemical contamination; readily available for at least 12 hours a day; and located within the premises of the house or a reasonable distance (WHO, 2022d).

Due to insufficient sewage systems or a lack of cleanliness, **millions of people still rely on water sources that are highly or moderately susceptible to faecal contamination today** (ibid.). If it is not treated, transported, stored, and handled appropriately, water that is safe at its source could nevertheless become contaminated. **Worldwide, millions of people consume water contaminated by chemicals at levels considered unsafe based on WHO guidelines. These chemicals are naturally present in groundwater but are not removed by treatment facilities, putting people at risk** (ibid.).

Given the precarious condition of water supply systems in low-income countries, **30 to 40% of rural water sources do not ensure the safety of water** for human use, placing communities at considerable health risk

(WHO, 2022d)

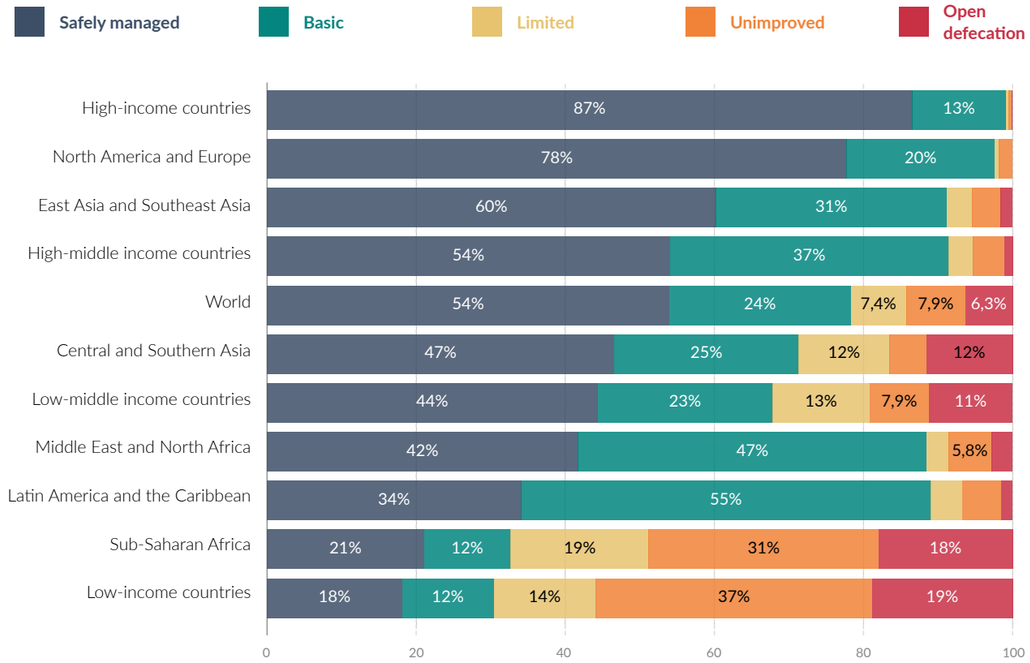
The effects of climate change on WASH*

Source WaterAid, 2022

Climate change effects	Impact on WASH
Reduced rainfalls	• Reduction of the availability of drinking water for supply • Reduced flow in rivers • Less dilution/increase in the concentration of pollutants in the water • Threat to hygiene practices
Flooding	• Pollution and flooding of wells • Inaccessibility of water sources • Flooding of latrines • Damage to infrastructure • Landslides around water sources • Sedimentation and turbidity • Threat to the sustainability of sanitation behaviours • Increase in epidemics and diseases related to contaminated water (waterborne diseases)
Droughts	• Decrease in river outflow • Reduction of infiltrations • Lowering of natural aquifers • Conflicts for the management of natural resources • Increase in diseases related to lack of water (shigella, typhoid fever, diarrhoea, etc.)
Rising temperatures	• Damage to infrastructure • Increased pathogens in the water resulting in an increased risk of disease • Changes in the seasonality of river flow result in a reduction in water availability in the dry season
Rising sea levels: flooding and saline intrusion into freshwater	• Reduction in the availability of drinking water, with strong impacts on its quality

POPULATION WITH ACCESS TO SANITATION FACILITIES (%)

The data are updated to 2020. Source WHO/UNICEF JMP 2021. The classification of geographical areas follows that established by the joint monitoring programme (JMP) of WHO/UNICEF.



SANITATION SERVICES

Unsafe sanitation causes 775,000 deaths annually, making it one of the biggest health and environmental issues in the world, especially for the poorest (Ritchie and Roser, 2021). Infectious diseases like cholera, diarrhoea, dysentery, hepatitis A, typhoid, and polio are greatly increased by the inability to access sufficient sanitation. Additionally, it exacerbates malnutrition and is particularly associated with child stunting (ibid.).

The number of deaths brought on by inadequate sanitation varies greatly by country, reaching a peak in low-income nations, especially in sub-Saharan Africa and Asia. In the Central African Republic and Chad, incidence can reach 120 deaths per 100,000 people; rates here are frequently higher than 50 deaths per 100,000. On the other hand, in Europe, the rates are less than 0.1 per 100,000 people (ibid.). **The lack of appropriate and safe sanitation is generally restricted to low- and middle-income countries and is therefore a symptom of substantial inequalities, much like the challenges in accessing safe drinking water.**

As of today, **3.6 billion people use inadequate toilets**, which has an impact on both their health and the environment in which they live (World Toilet Day, 2022). Faecal contamination of already limited water resources occurs because of insufficient sanitation systems. Such contamination is found in rivers, lakes, and soil. This makes it crucial to **invest resources in ensuring everyone has safe access to purportedly "improved" sanitation.**

Facilities that provide the hygienic separation of human waste from human touch and water sources are referred to as "improved" sanitation facilities. It must be emphasised, nevertheless, that having access to better sanitation systems does not always imply a safe environment. Using an improved sanitation facility that is not shared with other households and where waste is carefully disposed of on-site or is transported and handled off-site is referred to as **safe or safely managed sanitation.**

The following are descriptions of the other types of sanitation facilities:

- **Basic service:** an improved private facility that separates excreta from human contact.
- **Limited service:** an improved facility shared with other families.
- **Unimproved service:** Unimproved facility that does not separate excrement from human contact.
- **No service:** open defecation

About **6% of the world's population** has no sanitation at all and must practice **open defecation** instead.
In **low-income** countries, the figure rises to **19%**

(World Toilet Day, 2022)

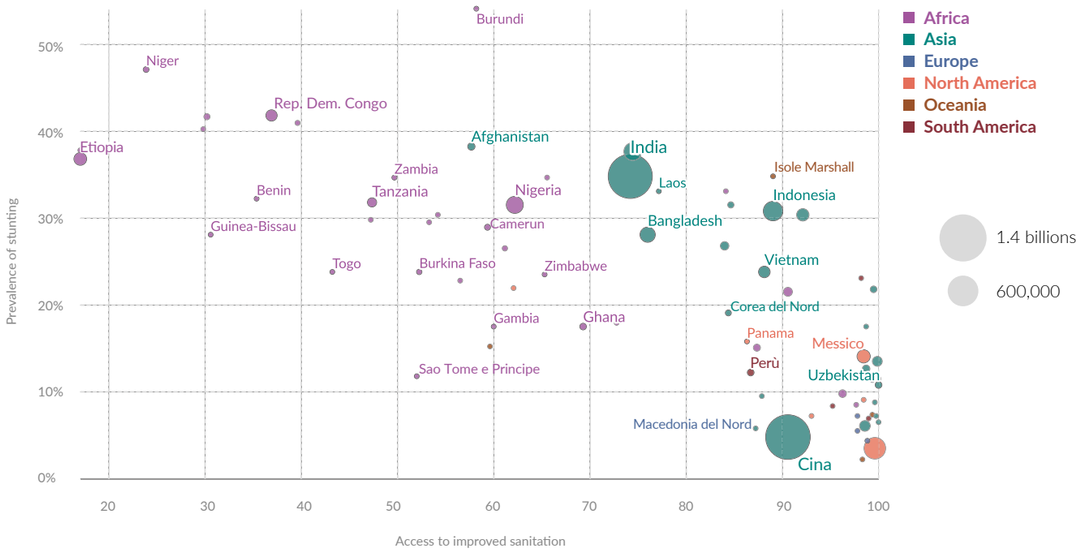
THE LINK BETWEEN STUNTING AND INADEQUATE ACCESS TO WASH SERVICES

The WHO defines stunting as the process whereby the height of a boy or girl is less than the average height for child growth standards for the reference age[28]. Stunting tends to be a sign of chronic malnutrition, but it is also linked to several combined factors, including infectious diseases, childhood diarrhoea and poor hygiene.

The graph below shows the prevalence of stunting compared to the share of the population with access to improved sanitation: **child stunting rates are typically higher in countries with lower access to improved sanitation services.**

PREVALENCE OF STUNTING VS. IMPROVED SANITATION FACILITIES

The data are updated to 2020. Source WHO/UNICEF JMP 2022. The classification of geographical areas follows that established by the joint monitoring programme (JMP) of WHO/UNICEF

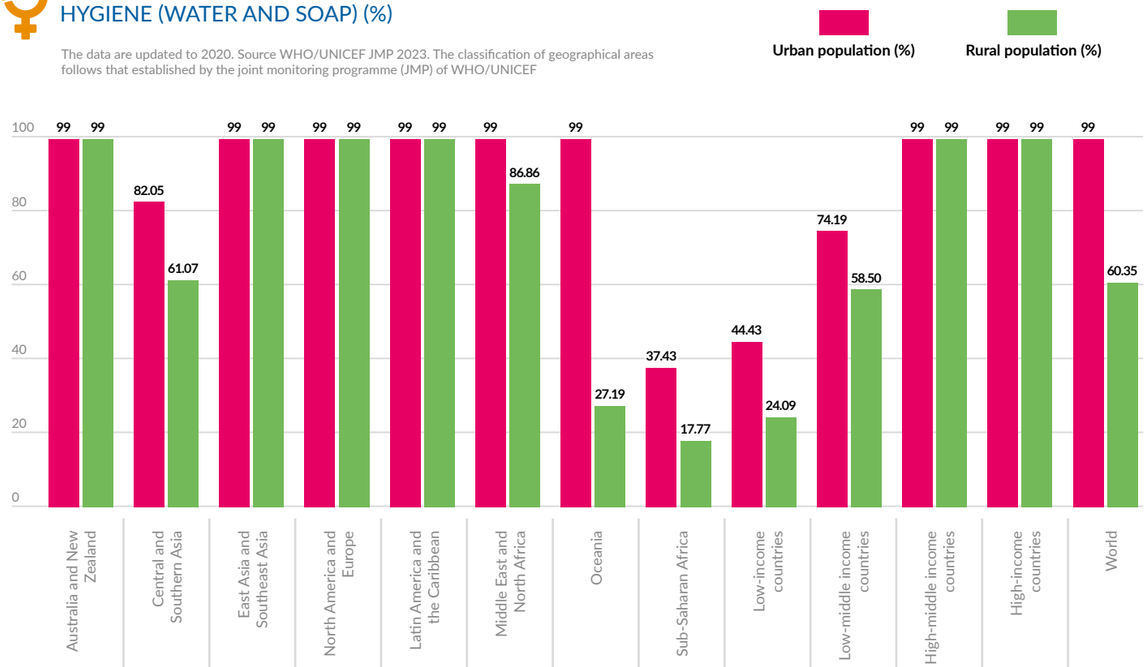


28 The prevalence of stunting is measured as the proportion of children under 5 reporting more than two standard deviations below the mean established by the WHO Child Growth Standards. See https://www.who.int/news/item/19-11-2015-stunting-in-a-nutshell

HYGIENE

RURAL AND URBAN POPULATION WITH BASIC ACCESS TO HYGIENE (WATER AND SOAP) (%)

The data are updated to 2020. Source WHO/UNICEF JMP 2023. The classification of geographical areas follows that established by the joint monitoring programme (JMP) of WHO/UNICEF



Although COVID-19 has highlighted the importance of hand hygiene to prevent the spread of the disease, **three billion people worldwide, including hundreds of millions of schoolchildren, lack access to wash their hands with soap.** People living in rural areas, urban slums, disaster-prone areas and low-income countries are the most vulnerable and hardest hit (UNICEF, 2023c).

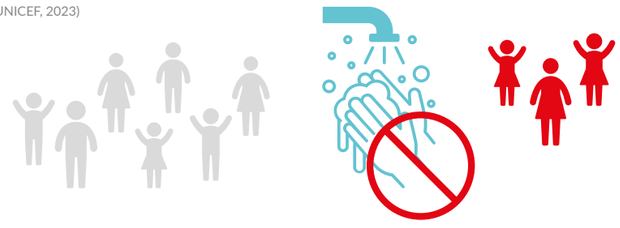
THE IMPORTANCE OF SCHOOLS IN ENSURING ADEQUATE WASH SERVICES AND PRACTICES

The presence of adequate and safe WASH services in schools contributes positively to the health, education and overall well-being of girls and boys. **Children spend a significant amount of time in schools, making them the best places to learn and experience good WASH practices. Providing clean water in schools is a highly effective practice for increasing access to education and learning outcomes** (UNICEF/WHO, 2022). In addition to the need for water to maintain personal and environmental hygiene, **reduced student dehydration in schools has been associated with improved cognitive abilities.**

The benefits, however, go beyond the classroom: **learning correct WASH practices at school contributes not only to the health of future generations, but also to that of the communities in which they live and, therefore, to the development of society.** As agents of change, girls and boys can positively influence the behaviour of their families and community members.

Approximately **3 in 10 people** worldwide
lack access to soap and water

(WHO/UNICEF, 2023)



Education and Health
WeWorld and the *WASH in Schools* modality

Access to clean water, adequate sanitation and hygiene (WASH) outside the home, and particularly in the school environment, is critical to the health and education of children. Indeed, they spend a significant part of their day at school, where **WASH services can enhance educational opportunities, and reduce the potential for disease transmission, as well as address issues of personal dignity, particularly for girls.**

The importance of ensuring adequate WASH services in schools has been recognized globally under the SDGs (particularly at goals 4.a, 6.1, 6.2): here they are considered as key components of a safe, non-violent, inclusive and effective. Specifically, SDG 4.A.1 aims to ensure that all boys and girls attend schools that guarantee access to basic WASH in Schools (WinS) services, consisting of:

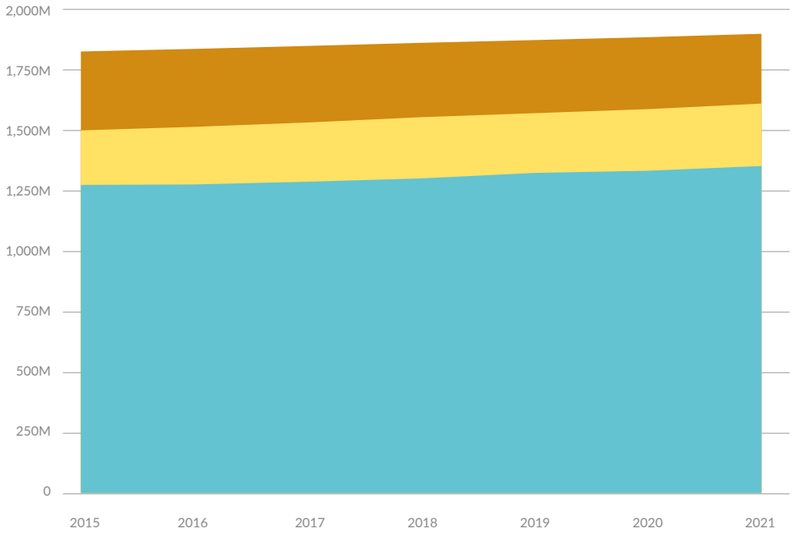
a) **drinking water at school from an improved water source**
b) **improved toilet facilities, divided by gender and usable (available, functional, private)**
c) **hand washing facilities, equipped with soap and water**

As part of the global intervention strategies in WASH and Education, WeWorld has adopted the WASH in Schools (WinS) method, which provides for a strong synergy between these two sectors.

In all countries where WeWorld intervenes with educational projects the WASH component is now essential.

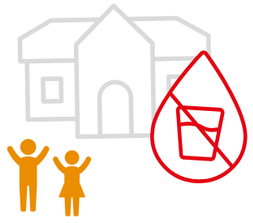
CHILDREN WITH ACCESS TO DRINKING WATER SERVICES AT SCHOOL

The data refer to the period between 2015-2021. Source WHO/UNICEF JMP 2023. The classification of geographical areas follows that established by the joint monitoring programme (JMP) of WHO/UNICEF



LEGEND

NO SERVICE	Drinking water from an improved source and water is available at the school at the time of the survey
LIMITED	Drinking water from an improved source but water is unavailable at the school at the time of the survey
BASIC	Drinking water from an unimproved source or no water source at the school



546 million children lack basic drinking water service in their school

(WHO/UNICEF, 2023)

In 2021, **539 million children lacked basic sanitation** in their schools

(UNICEF/WHO, 2022).

DRINKING WATER: In 2021, **71% of schools had basic drinking water service** (improved drinking-water source available at the time of the survey), **14% had limited service** (improved drinking-water source unavailable), **and 15% had no service** (unimproved drinking-water source or no source). Coverage of basic drinking water services ranged from 46% in low-income countries to 100% in high-income countries (UNICEF/WHO, 2022).

In 2021, **802 million boys and girls lacked basic sanitation** in their schools

(UNICEF/WHO, 2022).

HYGIENE: In 2021, **58% of schools had basic hygiene services** (hand washing facilities with soap and water available at the time of the survey), **17% had limited services** (hand washing facilities with water but no soap available), and **25% had no service at all** (no facilities or lack of water in school). This translates into **802 million boys and girls who lacked basic sanitation in their schools.** In this case, the **inequalities between countries are even more striking: coverage of basic sanitation ranged from 23% in low-income countries to more than 99% in high-income countries. Notably, nearly two-thirds of schools (63%) in Sub-Saharan Africa had no sanitation at all.**

SANITATION: In 2021, **72% of schools had basic sanitation** (improved facilities with gender-segregated toilets usable at the time of the survey), **16% had limited sanitation** (improved facilities not gender-segregated or were not usable), and **13% had no services** (facility not improved or none). This translates into **539 million children lacking basic sanitation in their schools** (UNICEF/WHO, 2022). Coverage of basic sanitation ranged from 47% in low-income countries to 100% in high-income countries. Looking at the differences between different school levels, 2 out of 3 primary schools (68%) and 3 out of 4 secondary schools (75%) had basic sanitation but there was insufficient data to generate global estimates for preschools. Although national definitions and indicators vary, in all countries with available data, **significantly fewer schools had toilet facilities considered accessible to boys and girls with disabilities** (ibid.).

Girls and boys living in **low-income countries** or **protracted crises** find it even **harder to access WASH services:**

1 in 3 children lacking **basic sanitation at their school** lived in the poorest countries, and **3 out of 5** lived in fragile settings

(UNICEF/WHO, 2022)

1 in 3 children without basic sanitation lived in the poorest countries, and **more than half** lived in fragile settings

(UNICEF/WHO, 2022)

1 in 3 children without basic drinking water service in their school lives in the poorest countries, and **more than half** in fragile settings

(UNICEF/WHO, 2022)

WeWorld in the Gaza Strip: the right to health in emergency contexts

More than 15 years of conflict in the Gaza Strip have limited access to sufficient and adequate WASH services in the territory's health facilities, endangering the health conditions of more than 2 million Palestinians living under siege. WeWorld is helping to ensure high-quality WASH standards are achieved in healthcare facilities in the Gaza Strip through integrated WASH in Health interventions, notably by supporting Al-Shifa Hospital, the largest healthcare facility in Gaza **providing services to over 45% of the total population each year.** The fieldwork conducted by WeWorld has institutionalized thanks to the definition of **WASH in Health protocols in agreement with the Ministry of Health, which were then adopted throughout Palestine.** Moreover, to oversee the implementation of the protocols and the adoption of appropriate practices and interventions, **WeWorld plays the role of subgroup leader of WASH in Health (a thematic subgroup of the WASH Cluster and Heath Cluster) in the area.**

"WeWorld has taken action to improve water and sanitation services in Al-Shifa Hospital, including rehabilitation of drinking water facilities, improvement of the sewage system and construction of a medical wastewater treatment plant. Through this locally built and innovative treatment plant, the contaminated wastewater is treated and disposed of safely without harming the community and the environment surrounding the Al-Shifa Medical Complex," said **Eng Baha'Kilani, Physician at Al-Shifa Hospital.**

WeWorld's healthcare projects in the area adopt **a gender-sensitive approach, including assessing the specific needs of women and providing technical solutions based on these identified needs**. This includes the provision of separate toilet facilities which offer adequate security and privacy for women. In addition, **1,000 hygiene kits were provided to households in the surrounding community during community hygiene promotion sessions, including essential items needed by women (such as menstrual health items).**

© WeWorld

Our emergency intervention in the West Bank

WeWorld takes action to protect the right to health throughout the West Bank, with a focus on the governorates of Hebron, Bethlehem, and Ramallah.

With a multi-sectoral approach (WASH, education, health, and protection), the implemented projects here aim to prevent internal forced displacement and improve access to inclusive and quality essential services in six Palestinian communities at risk. Again, a gender-sensitive approach cuts across all project components in the evaluation, planning and implementation phases.

The intervention included the construction of **two schools and a primary health clinic that were furnished with gender-sensitive WASH services.** In fact, having gender-sensitive (and, therefore, divided by sex) toilets is essential for the welfare and dignity of girls and boys. In all impacted communities, WeWorld held a hygiene awareness event. Each of the components of the hygiene and training kits that were distributed was created with the active participation of community members, including marginalised and vulnerable groups.

Menstrual Health

© Camilla Miliani

Promoting **gender equality** through menstrual health

The obstacles that people might encounter in managing their menstrual health jeopardise their ability to access education and fully enjoy other aspects of life and basic rights. The term "people" is used within this context for a reason. Although this Atlas focuses on women and girls[29], it is vital to note that not all people who menstruate are female: indeed, transgender and intersex people may also menstruate. As a result, when it comes to menstrual health, the debate should be broadened to include aspects such as discrimination experienced by more vulnerable groups, such as the LGBTQIA+ community, that go beyond female biology.

An estimated 1.8 billion people menstruate each month, but access to adequate sanitation infrastructure, including safe, private, and accessible sanitation equipped with soap and water, where people can change clothes and clean or dispose of menstrual hygiene products, remains a major need (WASH United, 2022). **It is becoming increasingly clear that the inability to change menstrual pads or use reusable menstrual clothes that have not been thoroughly washed can result in dangerous infections** (WHO, 2021).

It is also critical that people have access to a variety of menstrual products and are educated on how to use them (see box on menstrual product types). Promoting or distributing only one type of product, such as disposable tampons or pads, ignores the fact that menstruating people are not a homogeneous group, and their needs and preferences vary. Tampons and menstrual cups, for example, may not be culturally acceptable in some settings, putting people at risk of infection if they are not adequately informed about how to insert them, when to change these products, or what hygiene practices to follow.

Even today, many people lack true control over the products they use and are unable to properly dispose of or clean these products, with personal, environmental, and cultural consequences (PERIOD, 2022).

An estimated **1.8 billion** people **menstruate each month**

(WASH United, 2022)

29 Throughout this document, the term 'girls and women' is often used as a stand in for all menstruators regardless of gender identity. This shorthand is used to increase readability. As part of WeWorld's commitment to equality and human rights mandate, programmes should be inclusive of transgender and non-binary persons who have menstrual health and hygiene needs.

What is meant by menstrual health?

Menstrual hygiene and menstrual health are frequently used interchangeably. However, in the strictest sense, menstrual hygiene refers only to the types of hygiene products used to deal with menstruation or the daily process of menstrual hygiene management. Furthermore, the term has a negative connotation, which reinforces the stigma that menstruation is dirty or impure (PERIOD, 2022). **Significant efforts have been made in the context of sexual and reproductive justice to shift from the concept of "menstrual hygiene" to that of "menstrual health," which extends beyond the simple management of the menstrual period to include the entire menstrual cycle as well as general health and well-being. Menstrual health is defined as a complete state of physical, mental, and social well-being during the menstrual cycle, rather than simply the absence of disease or infirmity** (PERIOD, 2022). Achieving menstrual health means that women, girls, and anyone else who has a menstrual cycle can:

- Access **accurate, timely, and age-appropriate information** about the menstrual cycle, menstruation, and changes experienced throughout life, as well as related self-care and hygiene practices.
- **Take care of their body** during their period in a way that supports their hygiene, comfort, privacy, and safety preferences. This includes having access to and using effective and affordable menstrual products, as well as having supportive facilities and services available, such as clean water, accessible sanitation, body and hand washing facilities, the ability to change menstrual products, and clean and/or dispose of used materials.
- Access to **appropriate health services**, as well as timely diagnosis, treatment, and care for menstrual cycle discomforts and disorders.
- Live in **a positive and menstrual-friendly environment** free of stigma and psychological distress, where they can get the help they need to take care of their bodies and make informed decisions.
- Decide **whether and how to participate in all aspects of life**, including civil, cultural, economic, social, and political participation, during all phases of the menstrual cycle, without exclusion, restriction, discrimination, coercion, and/or violence.

Menstrual products and methods

"Menstrual products" are internal or external physical products that are used to absorb or collect menstrual blood and effluents. Menstrual products can be both reusable and disposable. Using words like "hygiene products" or "sanitary products" can reinforce negative stereotypes such as the period being inherently dirty or the vagina needing to be sanitised. This language also implies that the proper use of menstrual products (such as pads, tampons, and menstrual cups) is the quick fix to the "unsanitary problem" of menstruation, without taking menstrual health as a broader social issue into account (PERIOD, 2022). The main menstrual products and methods used are:

- **DISPOSABLE PRODUCTS.** These are menstrual flow management products that can only be used once and then discarded. Disposable menstrual pads and tampons are the most common examples. Choosing a specific type of product to manage menstruation is highly personal and influenced by lifestyle, needs, culture, and socioeconomic status. However, it is worth noting that single-use menstrual products, such as tampons and sanitary pads, have become a significant contributor to global single-use plastic waste (Blair et al., 2022).
- **REUSABLE PRODUCTS**. Cloth pads, menstrual cups and menstrual underwear are examples of products that can be used repeatedly to collect or absorb menstrual flow. A reusable product is intended to be used more than once and can last anywhere from one menstrual cycle to ten years (PERIOD, 2022). Reusable menstrual products are typically a more environmentally sustainable option than disposable menstrual products, and their use is frequent and must be linked to access to adequate water and sanitation (ibid.).
- **FREE BLEEDING**. Free bleeding is the practice of not using any menstrual materials or products to absorb or collect menstrual flow. This habit can be viewed as a free and conscious choice for those who choose to bleed without the use of menstrual products, as well as a compulsion dictated by necessity for those who do not have access to these products. Women used to bleed freely into the earth as part of ritual traditions during new moons, but in modern times the practice has often been associated with acts of rebellion (feminist and anti-patriarchal) or defiance against the menstrual products industry (ibid.).
- **SUSTAINABLE MENSTRUAL PRODUCTS.** This term refers to environmentally conscious behaviours and the use of menstrual products that reduce waste, and pollution, or are made with minimal or no chemicals or plastics. In 2018, the Women's Environmental Network (WEN) in the United Kingdom launched the Environmenstrual Week, an entire week of events dedicated to the promotion of environmentally friendly menstrual products (in fact, the initiative gets its name from the combination of the words environment and menstrual). Since then, the week has been celebrated in October[30].

Regardless of the type of product used consciously, the individual's informed choice should always be the foundation of proper menstrual health. An informed choice is one that is made after considering all available information about health alternatives to guide the final decision and is consistent with the person's values. **All menstruating people should have access to menstrual products that are safe, and comfortable, and promote sustainable production and use.**

30 See https://www.wen.org.uk/environmenstrualweek/

© WeWorld

Menstrual Hygiene Management (MHM) modality: WeWorld's approach to menstrual health

Menstrual Hygiene Management (MHM) is a working method that WeWorld has incorporated into its global WASH (Water, Sanitation, and Hygiene) strategy.

The MHM concept implies that *"Women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials. They understand the basic facts linked to the menstrual cycle and how to manage it with dignity and without dis- comfort or fear"* (WHO/UNICEF, 2019).

The broader spectrum of menstrual health and hygiene (MHH) complements the definition of MHM, including *"broader systemic factors that link menstruation with health like the well-being, gender equality, education, equity, empowerment, and rights. These systematic factors have been summarized by UNESCO as accurate and timely knowledge, available, safe, and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy"*[31] (ibid.).

In this way, **menstrual health and hygiene-related activities and programmes serve as a starting point for addressing more significant issues like gender equality and women's empowerment, including crucial issues like sex education, sexual and reproductive health and rights, child marriage, obstetric fistulas, female genital mutilation, and violence in general.** The MHM modality can promote transformative processes so that women and girls can realise their full potential. In fact, these programmes can assist women in learning how to deal with challenges to their development, freedom, and health. Adolescent girls, the women they will become, and the communities in which they live—which can gain from their active and equitable participation—all benefit from investments in their well-being. **Primary and secondary schools, formal and informal education centres, women's protection centres, shelter and relief centres, child health centres, hospitals, and nutrition centres are a few examples of locations and facilities ideal for the implementation of MHM activities.**

WeWorld employs this method of operation in its initiatives, for instance, in Kenya, Tanzania, Mozambique, Haiti, Syria, Lebanon, Libya, and Nicaragua.
.

31 In this document we will refer to MHM, thus including also MHH.

WeWorld in Nicaragua
Health, Education, Empowerment: how to break the taboos around menstruation

WeWorld has worked in Nicaragua since 1984 to combat gender-based violence and advance the emancipation of girls and women by promoting a shift in the cultural norms and social structures that support violent and discriminatory behaviour. The country has been experiencing a severe economic downturn for some time, which, while affecting the whole population, has an especially negative effect on women and youths. In terms of demographics, Nicaragua has a highly young population (45% of the population is under 25). **It is estimated that 40% of women between the ages of 15 and 49 have experienced psychological, physical, or sexual abuse and that at least 25% of women, particularly the younger ones, have been raped.** These statistics show a rise in violence and femicides over the past few years. In Central America and the Caribbean, Nicaragua is tied for fourth place with Guatemala in terms of the prevalence of early pregnancies. When it comes to the prevalence of child marriage, Nicaragua substantially outperforms the regional average, with 35% of women having a sexual relationship before the age of 18 (see WeWorld Index 2022).

WeWorld's operations across the country are divided into three primary areas: awareness, economic empowerment, and preventive and direct help. Through aid, survivors of violence and their children are given access to medical and legal support. Women's rights education and training programmes are examples of interventions. Awareness campaigns raise public awareness of gender issues through events and the publication of content on social media and in local media. Economic empowerment enables women to engage in individual or group productive activities that provide opportunities for them to achieve self-emancipation and break the cycle of abuse. **WeWorld supports the "Red de Albergues" (a Women's Shelters Network) in Nicaragua, a hub for women's organisations that provide shelter, safety, and free assistance to women who have been victims of violence and their children.**

The **#WithHer project**, which specifically strives to establish avenues of empowerment and escape from abuse, while also shattering the taboos surrounding menstruation, which are still quite powerful in this country, provides a synthesis of these three intervention components. According to Tiziana Rossetti, WeWorld country representative in Nicaragua, *"In indigenous Miskite culture, women cannot touch water sources or cultivate the land during menstruation because they are considered dirty and are thought to be able to transmit diseases."*

Millions of women and girls today experience shame, exclusion, and discrimination simply because they have periods. The lack of infrastructure and accessible menstrual products exacerbates an already difficult situation. This is why, thanks to funding from private donors, the European Community, and thanks to the technical support of Cotonella, **WeWorld has opened an Atelier to produce menstrual underwear as part of the #WithHer project: a tailoring laboratory for producing an item of clothing still considered "luxury" today, to be washed without shame.**

"The women we encounter in Nicaragua's rural communities frequently cannot afford sanitary pads because of their high cost", says Rossetti. *"Then, the women use patches created from old clothes. Many people wash them inside their homes after wearing them instead of hanging them outside in the sun out of embarrassment. They are occasionally washed in dirty water or with excessive chlorine. When the patches are not properly cleansed, they can cause infections and irritability".*

Menstrual cycle management also has a direct impact on women and girls' access to education and their sense of dignity. According to Rossetti, *"Girls very frequently stay home from school because they are bullied and afraid of getting dirty because of poor infrastructure: the lack of water and clean, safe, and separate toilets make menstruation really difficult to manage outside the home."*

WeWorld is promoting a WASH (WAter, Sanitation, and Hygiene) approach in schools with an intersectional gender focus specifically for these reasons: **the advantages associated with good menstrual health practises (availability of menstrual products, clean and safe toilets, understanding and protective school staff, correct information on menstrual hygiene) lead to greater participation, self-esteem, and ultimately can have a positive impact.**

"For my family, paying 20 pesos for a pad was beyond our budget's reach. So, I started machete-chopping old clothes, washing them in the river, and saving them for later use", explains **Angelica**, whom we met in the brand-new WeWorld Atelier. *"I started having periods soon after turning 15. My family had never explained menstruation to me. My sister, who had given me some clothing to wear, was the first person I told. Last year, my 13-year-old daughter started having periods. Since I've been here, I buy her menstrual products because I experienced embarrassment".*

"Girls should not worry about menstruation because it is natural, and they need to learn how to protect themselves, how to care for themselves, and how to clean themselves," says **Vittoria.** *"Although I was unaware of panties-pads, I believe they can put girls at ease by removing their worry about mishaps. The new undergarments will make plenty of women feel more at ease".*

"We are incredibly proud of this new business. Women believe they are an essential part of the project that will empower about 240 survivors of violence to create a different and more affordable product that will increase awareness of menstrual health issues and make women's health safer overall, including from an environmental standpoint", concludes Rossetti. *"The first goal is to give women staying in shelters a path that will enable them to take better care of themselves and their children through increased awareness of gender rights and menstrual health, reuse skills for their own economic independence, and involve the rest of the community for a cultural change".*

DIFFERENCES IN THE MENSTRUAL HEALTH PRACTICES BETWEEN WOMEN LIVING IN URBAN AND RURAL AREAS (%)

Data are referred to the period between 2016 and 2020. Source WHO/UNICEF JMP 2023

	RURAL POPULATION					URBAN POPULATION				
	Proportion of women and girls age 15-49 who have menstruated in the previous year					Proportion of women and girls age 15-49 who have menstruated in the previous year				
COUNTRY	Private place to wash and change	Participation in activities during menstruation	Use of menstrual materials	Use of reusable materials	Use of single-use materials	Private place to wash and change	Participation in activities during menstruation	Use of menstrual materials	Use of reusable materials	Use of single-use materials
Algeria	88	77	94	7	87	91	74	95	3	91
Bangladesh	97		98	71	25	97		98	51	47
Burkina Faso	72	82	85	63	22	79	82	92	16	76
Central African Republic	92	66	96	77	19	92	72	94	39	55
Chad	94	66	95	87	8	92	69	93	55	38
Costa Rica	99	92	99	2	96	99	94	99	2	96
Côte d'Ivoire	80	68	100	72	28	80	81	99	38	61
Cuba	97	67	98	4	94	94	74	97	2	95
Dem. People's Republic of Korea	99	99	99	74	25	99	98	99	43	55
Democratic Republic of the Congo	89	85	93	78	15	92	86	96	35	61
Ethiopia	80		78	55	23	80		96	25	71
Gambia	98	83	99	79	21	95	79	98	50	47
Ghana	93	80	98	18	80	95	82	98	7	91
Indonesia	90		97	17	79	96		99	9	91
Iraq	87	88	96	17	79	89	90	96	8	87
Kenya	89		99	16	83	89		99	6	94
Kiribati	91	85	98	24	74	94	83	98	11	87
Kyrgyzstan	93	94	97	25	72	94	91	97	8	89
Lao People's Democratic Republic	74	88	75	3	72	93	88	94	2	92
Lesotho	94	86	98	12	85	95	88	98	3	96
Madagascar	91	92	93	79	14	90	90	97	58	39
Mongolia	90	96	91	5	86	89	97	92	2	90
Montenegro	98	94	97	4	93	97	93	97	4	93
Nepal	82	0	93	71	21	89	0	94	54	41
Niger	47		83	73	10	61		94	35	58
Nigeria	67	79	95	43	51	90	74	96	11	85
North Macedonia	97	92	98	1	97	98	94	99	1	98
Sao Tome and Principe	93	87	100	96	4	95	90	99	97	2
Serbia	99	89	98	0	98	99	92	98	1	98
Sierra Leone	90	80	97	88	9	96	80	97	48	50
State of Palestine	83	89		2	92	80	86		2	94
Suriname	96	82	87	6	81	96	83	95	3	92
Togo	90	87	96	76	20	93	88	97	39	58
Tonga	94	84		1	94	94	87		1	90
Tunisia	56	87	96	6	90	56	90	96	3	93
Turkmenistan	99	99	99	1	99	99	99	99	1	98
Uganda	85		98	46	52	92		98	24	74
Zimbabwe	96	83	97	29	68	97	84	99	11	88

Period poverty

Period poverty can result from a lack of access to menstrual products or menstrual health education due to financial restrictions or unfavourable socio-cultural stigmas linked with menstruation. In menstrual health, the term is often used to call attention to the confluence between appropriate and educated access to menstruation products and socioeconomic status, as well as to mobilise political and social activities around menstrual health.

In this regard, **the Tampon Tax (tax on menstruation products) has sparked intense debate and mobilisation.** These items are frequently categorised as non-essential goods in many countries all over the world since they are not subject to a single or special tax. In recent years, we have seen the establishment of numerous initiatives to repeal or provide tax breaks for period products. Some federal states in the US have no sales tax, while others exempt menstruation items from the tax. period products are exempt from VAT in Kenya, Canada, Scotland, and Ireland, however in other countries, efforts to remove or lower taxes on period products are still underway or have not been successful (Global Citizen, 2021). **All these initiatives were inspired by the concept of period equity, which was created by US activist Jennifer Weiss-Wolf to promote legislative efforts to eliminate taxes on menstrual products.**

However, it is crucial to highlight that, while period poverty can be a captivating narrative for engaging, attracting, or activating people on the problem, the word can frequently appear to be an understatement because it equates an inability to manage a period only with financial constraints. **The danger is that by insisting on the link between poverty and the menstrual cycle as the biological reason why women, girls, and other menstruators experience poverty, we risk ignoring how menstrual management is linked to broader motivations and challenges related to health, well-being, and sexuality.** Menstrual poverty is unquestionably a helpful and mobilising tool for activism associated with the most economically disadvantaged populations; yet it is not always appropriate to represent the efforts of the entire menstrual movement (PERIOD, 2022).

Menstrual poverty is thus not "the problem," but rather one of several barriers to normalising menstrual health. Tackling period poverty thus entails addressing a wide range of factors that keep menstruating people poor, such as a lack of access to water, affordable and high-quality products, insufficient space and facilities for menstruation management, a lack of information, and the stigma that still surrounds the topic.

WeWorld's campaign: #StopTheTamponTax

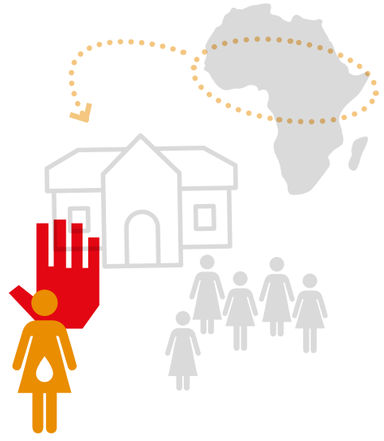
In the last months of 2020, WeWorld launched a campaign aimed at reducing the taxation on menstrual products, starting from the consideration that the COVID-19 pandemic had significantly worsened women's economic condition and that the lowering of VAT on these products could no longer be postponed. **The campaign had an excellent response: within a few weeks, over 600,000 signatures were collected thanks to a petition launched together with the OndeRosa collective (Pink Waves) and several parliamentarians who supported WeWorld, presenting amendments to the 2021 Budget Law.** The Tampon Tax was then reduced to 10% in the 2022 Budget Law, up to a further reduction to 5% of all absorbent products (including those for childhood) in the 2023 Budget Law.

THE LINK BETWEEN EDUCATION AND MENSTRUAL HEALTH

The first menstruation is referred to as menarche. The age at which menarche occurs is affected by genetic and environmental variables, and it normally happens between the ages of 10 and 16 years. This time varies greatly between regions and people, but in general, in recent decades, there has been a decrease in the average age of the first menstruation (Khan, 2022), which usually coincides with the onset of puberty leading to those biological changes that allow reproduction.

In various societies (as seen in previous sections), menarche has a social value, sanctioning the transition from childhood to adulthood (connecting to phenomena such as MGF, weddings, and early pregnancies), with an array of consequences in terms of access to social life, and especially to education.

This represents a great paradox, especially if one considers that schools could represent privileged places for the menstrual health of millions of girls and boys, places in which to receive safe menstrual products and learn good personal hygiene practices.



In Sub-Saharan Africa,
1 in 10 girls missed school
during menstruation

(UNESCO, 2014)

Menstruation, on the other hand, continues to have a significant impact on girls' access to and participation in education around the world. **In Ethiopia, for example, menstruation causes 50% of girls to miss one to four days of school each month** (Khan, 2022). **In Kenya, it is projected that girls skip an average of four school days per month, resulting in 165 fewer learning days over the course of four years** (ibid.). This urgency, however, is not limited to the countries of the global South. According to a Plan International (2021) research conducted in the United Kingdom, **64% of girls aged 14-21 lost part or a full day of school due to menstruation, and 13% of girls missed a full day of school at least once a month. Menstruation can also affect adolescent girls dropping out of school, a major challenge for many countries.**

To raise awareness of the need for adequate and effective management of menstrual health starting from schools and to counter the taboos and stigma that still surround menstruation, **Menstrual Hygiene Day** was launched, which is celebrated every year on the **28th of May.** The date of May 28 is linked to the duration of the menstrual cycle, which on average lasts 28 days, and to the fact that people tend to menstruate for five days each month (and May is precisely the fifth month of the year).

The Day was created above all to promote WASH good practices: in fact, as seen in the previous section, within the framework of sexual and reproductive justice, menstrual hygiene management is intrinsically linked to WASH good practices and services. Yet, in many countries, schools still face significant challenges in ensuring adequate

1 in 5 girls in India
drop out of school
after their periods

(Khan, 2022)

facilities are available for girls (see box on the link between education and WASH in the previous section).

Studies (World Bank, 2017) **have reaffirmed the fundamental intersection between water and gender, underlining, however, how the existence of a separate bathroom is insufficient to guarantee its use by women and girls. In this sense, investing in privacy, cleanliness, safety, and availability of water resources represents a crucial intervention.**

WASH in Schools and MHM: WeWorld's work in schools

In the broader framework of WASH in Schools (WinS), menstrual hygiene management (MHM) also plays a key role in achieving several SDGs, including the 3, 4, 5 and 6 (see box on the link between WASH to sexual and reproductive rights in the previous section).

It is now universally recognized that the education field has a leading role to play in promoting non-discriminatory gender roles, as well as cross-sector collaboration with the health and water sectors, to make MHM access a universal service available to all girls.

WeWorld conducts activities to ensure menstrual health for women and girls as part of its WASH in Schools strategy, including:

- Teacher and educational staff training and capacity building.
- Activities to raise awareness (including waste disposal and management).
- Integration of menstrual hygiene sessions into formal or non-formal curricula.
- Distribution of "dignity kits," which are kits of basic products needed to ensure personal and menstrual hygiene. These kits are designed with local culture, customs, item availability, and WASH strategy guidelines in mind.

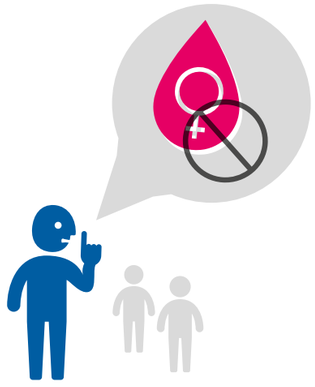
Even when male and female students have separate toilets, they must have running water and soap, which is not always the case. Ensuring that toilet latrines have doors that close properly and can be locked gives girls more privacy. Furthermore, to ensure adequate menstrual health practises, these services should be equipped with functional and effective menstrual product disposal facilities, which are often lacking. In Kenya, for example, a survey of 62 primary schools in rural areas discovered that while 84% of schools had separate latrines for girls, 77% lacked a lock and only 13% had water in or near the latrine. Furthermore, only 10% of schools said they always provide menstrual products to their students. Most of the schools involved in the study did not have adequate methods for disposing of used pads (ibid.).

Promoting good hygiene practices in schools can result in higher enrolment rates, fewer absences, and greater gender equality in the classroom. An additional source of water, private latrines, and adequate sanitation provide incentives for parents to send their daughters to school, as well as relieve the burden of responsibility for collecting water, given that, in most cases, women and girls are responsible for reaching water sources, which are often very far from their homes (Khan, 2022). **Access to safe water sources, adequate sanitation, and menstrual products can thus start a virtuous cycle that allows girls to overcome educational barriers, especially those living in poverty. Another essential measure is the promotion of sexual health education courses, specifically puberty and menstruation education. Sexual and reproductive health is frequently not addressed in schools (if at all) until girls reach menarche. This is a missed opportunity:** it is critical to begin laying the groundwork for proper sexual and reproductive health at a young age, involving both male and female students.

In a survey of 4,127 girls and boys from four countries – Brazil, Indonesia, the Netherlands, and Uganda – the most common reason given for avoiding the topic was that menstruation is a 'private matter' for girls and women. **Respondents aged 16 to 25 also admitted that they often associate menstruation with words like "dirty" (55%), "embarrassing" (31%) and "disgusting" (38%)** (PERIOD, 2022). Education about puberty and menstruation, provided to both girls and boys as part of a comprehensive sexuality education curriculum, can help them better understand physical changes, become more aware of socially constructed myths around menstruation, and reduce the stigma against menstruation and gender discrimination, which is still particularly prevalent (Plan International, 2021).

More than 1 in 3 boys think **periods** should be kept **secret**

(Plan International, 2021)



MENSTRUATION, STEREOTYPES AND GENDER DISCRIMINATION

For centuries, menstruating women have been characterised as impure, and menstruation has been described as a disabling phenomenon for women's participation in various spheres of life, justifying their exclusion from areas such as education, work, and politics (Siviero, 2021). Religious traditions have a fundamental responsibility in prescribing a set of behaviours for menstruating women to follow to protect the integrity of what they come into contact with. According to the book of Leviticus, *"When a woman has a flow of blood, that is, flow in her body, her uncleanness will last seven days; whoever touches it will be unclean until evening"* (ibid.).

This view of menstruation and the consequences of contact with a menstruating woman has been perpetrated also by philosophers, writers, and medical practitioners. Menstruation was a symptom of an unstable balance inherent in women, as well as an indicator of the "female disease" in Hippocratic writings and the first studies of ancient "gynaecology." **Throughout the centuries, and until the Enlightenment, the prevalent belief was that menstrual blood was impure blood, full of negativity, poison, and danger.** Beginning in the eighteenth century, medical professionals began to treat the subject differently, for example, by observing the average length of menstruation or the age of menarche, but the idea behind these studies was still to link the presence of ovaries to the supposed tendency of women to hysteria, sensitivity, and indiscipline. All these beliefs have long been rooted in popular superstitions, such as menstruating women causing mayonnaise to curdle or preventing bread from rising (ibid.).

Writer Jane McChrystal pointed out in an article on the history of menstrual studies (2021) how the stigmatisation of menstruation and the gender gap in medicine has resulted in a significant delay in the collection of data and specific knowledge about menstruation. Only with the first female doctors did things begin to change gradually: the presence of women at university, particularly in medical studies, made it possible to change the approach to health and the medical and collective imagination of menstruation. However, **the knowledge gap has not been completely closed, and there are still substantial disparities between what doctors know about men's bodies and what they know about women's bodies, with serious implications for the latter's health.**

Despite undeniable progress in the medical field, and even though some beliefs have been largely superseded in various countries around the world, **there is still a certain taboo surrounding the topic, even in the global North** (McChrystal, 2021). Consider the difficulties in naming menstruation: in Italy, the rules, the Marquis, the red army, the red baron, the Landing of the English, or *"le mie cose"* (literally, my things) are all alternative names for menstruation. **In addition to centuries of prejudice and false beliefs, this inability to speak calmly about the subject is due to a lack (if not non-existence) of adequate sex education. Menstruating women continue to be judged as hysterical, irascible and hypersensitive, fuelling the belief that "in those days" it is better not to deal with women or to entrust them with too demanding tasks** (Falcone, 2018).

Advertisements aimed at promoting positive models frequently depict menstrual blood as a **blue liquid**, rather than red, **which stains only a central and limited area** of the pad

(Lino, 2016)

The image of a menstruating woman in advertisements for menstrual products is quite different. Women are free from all the restrictions associated with menstruation here: they engage in extreme sports, go out with friends, work, dance, and cartwheel, demonstrating that menstruation is not a disabling disease at all. However, advertisements aimed at promoting positive models frequently depict menstrual blood as a blue liquid, rather than red, which stains only a central and limited area of the pad (Lino, 2016). As a result, the road to complete normalisation, even narration, of menstruation is still long, and that this must pass from correct sexual education not only across genders but across generations.

MDCDS AND THE DEBATE ON MENSTRUAL LEAVE

The need to strengthen and increase knowledge and collect more data on sexual and reproductive health, and more specifically on menstrual health is also evidenced by the emerging attention on the so-called menstrual discomforts, conditions and disorders (MDCD). It is an umbrella term for all the discomforts, pains, conditions and diseases related to the menstrual cycle that a person may experience. Many different types of MDCD vary based on the pain experienced during menstruation, whether there is heavy menstrual bleeding, blood clots, or emotional upheaval. Some MCDCs include polycystic ovary syndrome (PCOS), dysmenorrhea (uterine pain

Endometriosis affects approximately **10% of the female population** (190 million women and girls) worldwide

(WHO, 2021b)

that occurs during menstruation), premenstrual dysphoric disorder (PMDD), endometriosis, or uterine fibroids. **Not all MDCDs are diagnosable or treatable, but they refer to the full range of distressing physical, mental, or emotional symptoms a person may experience about their menstrual cycle.**

Endometriosis is a chronic and progressive condition that has long been ignored. It is a disease characterized by the presence of tissue similar to the endometrium (the inner lining of the uterus) on the outside of the uterus (WHO, 2021b). Endometriosis causes a chronic inflammatory reaction that can lead to the formation of scar tissue (adhesions, fibrosis) within the pelvis and other parts of the body. Endometriosis can also cause infertility due to likely effects on the pelvic cavity, ovaries, fallopian tubes or uterus (ibid.). **Often, endometriosis is mistaken for other conditions that cause pelvic pain, including ovarian cysts, leading to delays in diagnosis: on average, an endometriosis diagnosis takes eight years** (PERIOD, 2022).

Endometriosis has significant social, public health, and economic implications. It can reduce the quality of life due to severe pain, fatigue, depression, anxiety and infertility. Some people with endometriosis experience such debilitating pain that they cannot get to work or school (WHO, 2021b). Furthermore, the pain experienced during sexual intercourse due to this condition can lead to interrupting or totally avoiding sexual intercourse, with significant repercussions on the sexual health of the affected persons and/or their partners (ibid.). **Adequately addressing endometriosis, with prevention and early diagnosis policies, could ensure the empowerment of those affected while simultaneously supporting their right to work, education and the highest standard of sexual and reproductive health, quality of life and general well-being.**

In the context of the MDCDs, there is also a debate about **menstrual leave**, which is a type of leave that allows a person with menstruation to take holidays or extra paid sick days from their job and/or work flexibly (PERIOD, 2022). Menstrual leave policies vary widely around the world and can be implemented at the national, state, or local levels. Looking at national systems, there are still a few countries (such as Japan, South Korea, Taiwan, Indonesia, and Spain) that have incorporated menstrual leave into their labour codes, both nationally and in industry agreements (Euronews, 2023). The most recent and notable case in Europe is that of Spain, which approved a law on paid menstrual leave in February 2023, becoming the first European country to do so (Politico, 2023).

Today, however, **the subject is extremely divisive**. On the one hand, opponents of menstrual leave argue that it would undermine efforts to achieve greater gender equality by widening the pay gap and deepening inequalities by portraying women as more expensive or less reliable workers (PERIOD, 2022).

On average, an **endometriosis diagnosis** takes **eight years**

(PERIOD, 2022)

Proponents of menstrual leave, on the other hand, argue that it ensures gender-sensitive workplaces that recognise the diverse needs and experiences of all employees.

An additional perspective then enters the debate, referring to the concept of the **gender pain gap**. This notion encompasses the **series of inequalities observed and experienced by men and women in the health system, particularly the prejudice against women's expressions of pain, which has a negative impact on the diagnosis and treatment of their health conditions when compared to those of men** (ibid.). This bias is rooted in pain stereotypes passed down through centuries of medical discourse about female bodies (see box 'Menstruation, stereotypes, and gender discrimination'). In fact, research into the gender pain gap and the biases that support it is relatively new. **Several studies have found that women's pain is more likely to be minimised or ignored by healthcare providers than men's** (WHO, 2021b). **Women of colour, including Black, Asian, indigenous, and other historically marginalised communities, are much more likely to face discrimination, and their pain is frequently underestimated and taken for granted due to false beliefs about racial differences and pain sensitivity** (PERIOD, 2022). In this context, menstrual leave is viewed as a normalisation of pain rather than an active attempt to alleviate the discomforts experienced by menstruating people. Finally, it's worth noting that the period-leave debate has raised important questions about how to promote inclusiveness in the workplace for menstruating people. **Whether the menstrual leave is planned or not, it is critical to take concrete steps to provide adequate answers and tools for employees who menstruate.**

*Several studies have found that **women's pain is more likely to be minimised or ignored** by healthcare providers than men's*

(WHO, 2021b)

MENOPAUSE IS PART OF THE MENSTRUAL HEALTH CONTINUUM

Menopause is one of the milestones in a woman's life that marks the end of her reproductive period (WHO, 2022e). Except in rare cases where specialised fertility treatments are used, a woman cannot become pregnant after menopause. **Menopause occurs after premenopause and is diagnosed after the menstruating person has been without a period for 12 months. The global median age at menopause onset is 51 years** (ibid.). Although there are associations between age at menopause and certain demographic, health, and genetic factors, it is impossible to predict when a woman will experience menopause. It can also be induced by surgical procedures that remove both ovaries or medical interventions that cause the ovarian function to cease (for example, radiotherapy or chemotherapy).

Many women who have had specific surgical procedures (hysterectomy or surgical removal of the uterine lining) and those who use certain hormonal contraceptives and other drugs that cause infrequent or no periods, stop having periods before menopause. They may, however, experience other menopausal-related changes such as sleep-wake rhythm changes, hot flashes, vaginal dryness, and so on.

The global population of postmenopausal women is increasing. Women aged 50 and up will account for 26% of all women and girls worldwide in 2021. This percentage has increased by 22% in the last decade, reflecting the fact that women are living longer lives (WHO, 2022e).

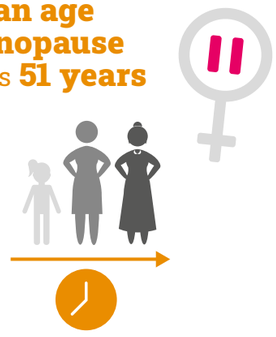
It is critical to look at menopause as a point on the life continuum rather than a final destination and to pay close attention to the pre-and post-menopausal stages. A woman's health status as she enters premenopause will be largely determined by her previous reproductive and health history, as well as lifestyle and environmental factors. P**re- and post-menopausal symptoms can be detrimental to personal and professional life, and menopausal changes will have an impact on a woman's health as she ages.**

As a result, appropriate and informed pre-menopausal care is critical to promoting healthy ageing and a higher quality of life in general. Premenopausal women require quality health care and rely on communities and systems to help them. **Unfortunately, in most countries, both stakeholder awareness and access to menopause-related information and services remain significant challenges.** The topic of menopause is frequently avoided in families, communities, workplaces, and even healthcare settings. Women may also experience menopause-related symptoms without realising that there are counselling and treatment options available to help them (ibid.). As a result of the lack of discussion about menopause, people are less likely to seek help or draw attention to their own experiences.

Furthermore, **it is not uncommon for healthcare professionals to be untrained in recognising pre- and post-menopausal symptoms and, as a result, to advise patients on treatment options and the importance of maintaining good health before, during, and after the menopausal transition. Menopause is currently given little attention in many health professional training programmes, and the sexual well-being of menopausal women is neglected in many countries** (WHO, 2022e).

*It is critical to look at menopause as **a point on the life continuum** rather than a final destination and to pay close attention to the pre-and post-menopausal stages.*

The global **median age** at **menopause** onset is **51 years**



This means that common gynaecological effects of menopause, such as vaginal dryness and pain during intercourse, may be overlooked. Similarly, older women may not consider themselves to be at risk for STIs, such as HIV, and may not be advised to practise safe sex or get tested. Many governments do not have health policies or funding in place to include menopause-related diagnosis, counselling, and treatment services as routinely available services. **Menopause-related services are particularly difficult to fund in settings where other urgent and competing priorities for health funding exist, such as in countries experiencing protracted crises and emergencies** (WHO, 2022e).

Finally, menopause can be viewed as a significant social as well as biological transition. Indeed, gender norms and family and sociocultural factors, such as how the female ageing process and menopausal transition are viewed in the culture in which she is embedded, can influence a woman's experience of menopause on a societal level. As a result, **women must be given the**

opportunity to positively experience this important transition, which allows them to re-evaluate their health, lifestyle, and relationship with their bodies (WHO, 2022e).

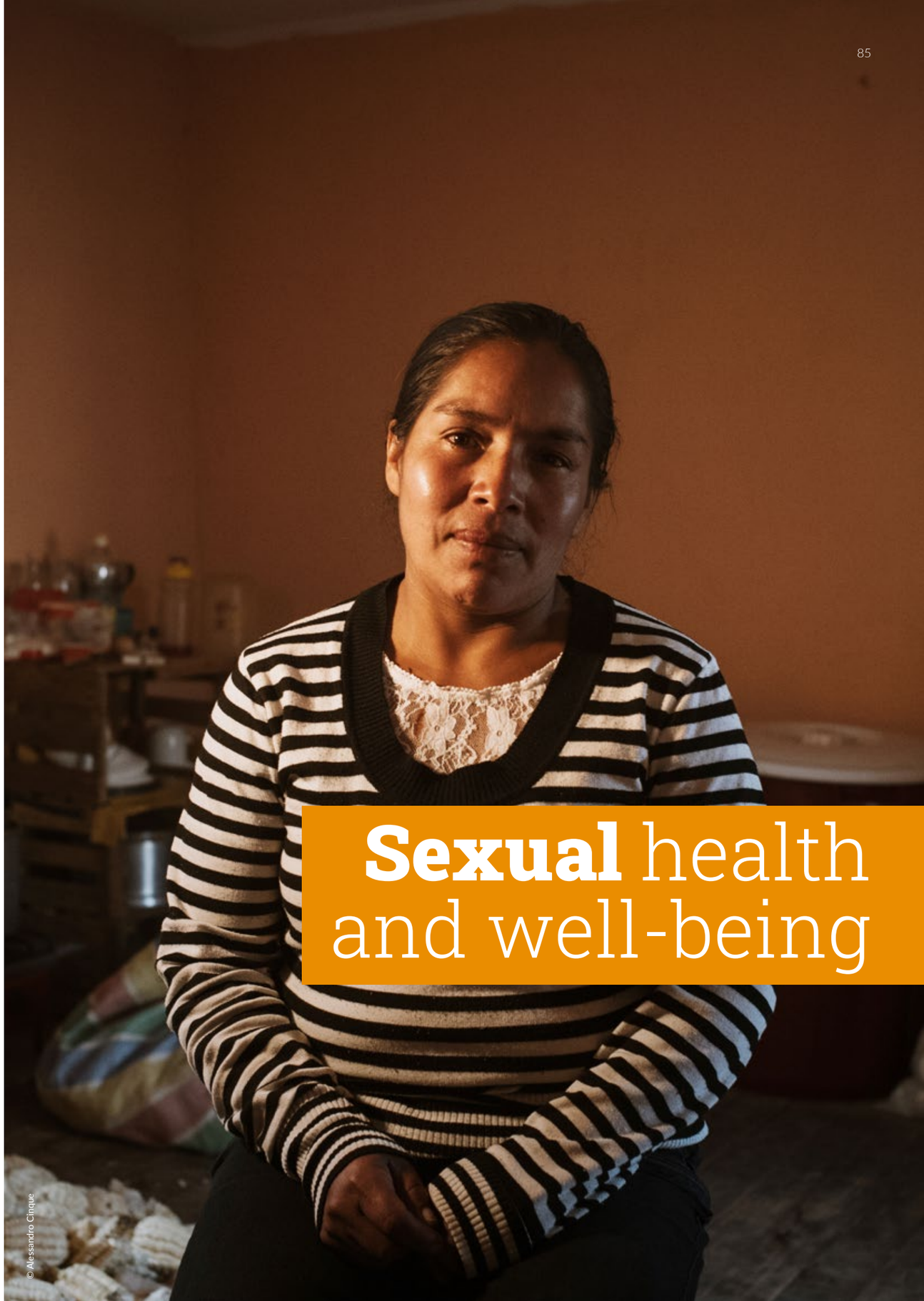
Failure to act in this manner can have serious consequences for women's lives and, as a result, for the societies in which they live, to the point where an international debate on the so-called "menopause economy" has recently begun (Ladynomics, 2022). **Several studies have found that menopause can be expensive for women who need medical and pharmacological interventions. In terms of specialist visits, prescriptions, drugs, and so on, the menopause "business" would be worth approximately 600 billion dollars globally** (Hinchliffe, 2020).

Furthermore, menopausal women have higher levels of anxiety and depression, incur higher healthcare costs, and are frequently forced to miss work due to symptoms and discomfort (Keshishian et al., 2015). According to a study conducted in the United Kingdom, **approximately one-third of working women aged 50 to 64 require time off work to relieve menopausal symptoms** (Ladynomics, 2022). In this case, corporate inclusion and welfare policies, including training and awareness-raising activities, could make a difference in supporting their employees during such a difficult time.

The issue is not the menopause itself, but the economic, work, and social context that ignores gender and generational differences, promoting a linear standard work model with a male imprint that does not allow for interruptions (see WeWorld (2022), *Papà, non mammo*).

In terms of specialist visits, prescriptions, drugs, and so on, **the menopause "business"** would be worth approximately **600 billion dollars globally**

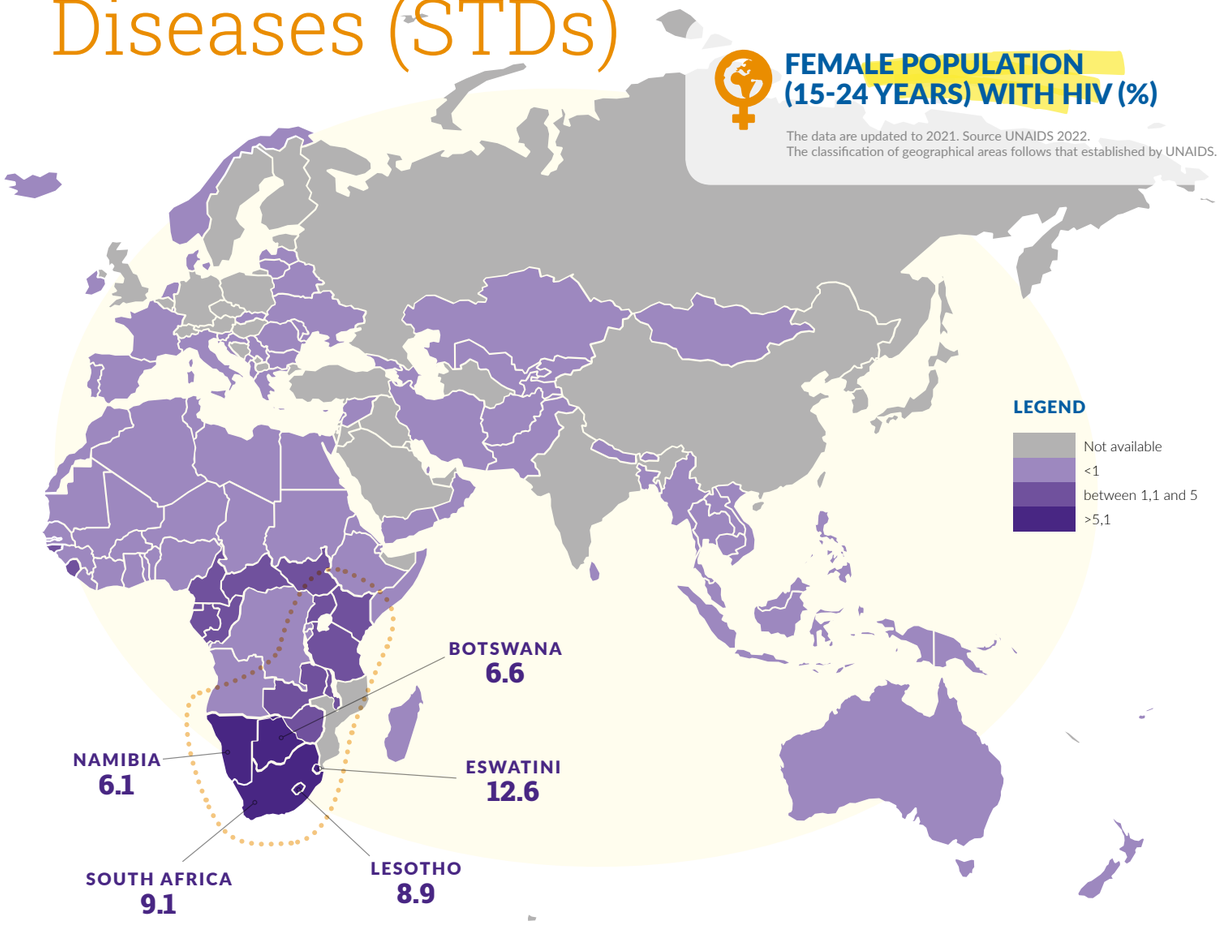
(Hinchliffe, 2020)



Sexual health and well-being

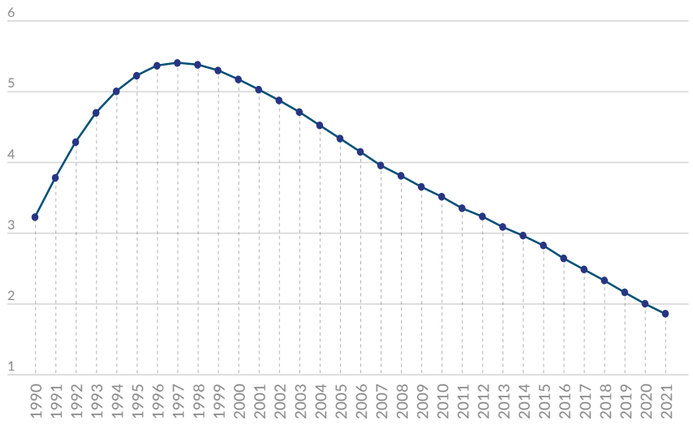
© Alessandro Cinque

Sexually Transmitted Diseases (STDs)



THE HIGHEST INCIDENCE OF HIV AMONG YOUNG WOMEN (15-24 YEARS) IS RECORDED IN EASTERN AND SOUTHERN AFRICA

Data updated to 2021. Source UNAIDS 2022



WeWorld in Burundi: World AIDS Day

Since 1994, WeWorld has been present in Burundi with projects related to water, nutrition, socio-economic development and health. **In 2017, a program aimed at strengthening health services was activated in five refugee camps for people from the Democratic Republic of the Congo, guaranteeing health care for over 17,000 people: some living with HIV/AIDS**[33].

"It is a complex issue, which still carries with it its stigma and prejudices", says **Dr Happy Pauliane Mwete, head of the health centre of the Musasa refugee camp and WeWorld manager for the Muyinga and Ngozi area, in Burundi.**

"There have been many instances of discrimination in refugee camps in the past, and many refugees demanded that people living with HIV/AIDS live isolated and apart from their communities. I have once seen a parent forbid their child to play with that of an HIV/AIDS patient. One day the little ones escaped from parental control and spent time together. Alarmed, the family went to the Health Centre asking us to test the child to verify that he was not sick.

It is in these cases that we take the time to intervene with adequate training. The refugees participated in numerous awareness sessions in which they learned about the different ways of contagion, the methods of prevention, and the treatments available and got to know what it means to live with the disease through the testimonials of other people. ***Today, with the passing of time and thanks to regular awareness campaigns, we register few cases of discrimination in the camps; many refugees have increased their knowledge about HIV/AIDS and thanks to the fieldwork of all partners, people living with HIV have been integrated into different professional and cultural activities, improving their inclusion and reducing stigmatisation.***

The community today is generally attentive and supportive. However, it happens that the first not to accept the disease for fear of stigma are the patients themselves. These people sometimes refuse medical treatment at the Health Centre and prefer to be treated in clinics outside the camps. Still, the camps' health centres are functioning and have the necessary medical equipment for screening, treatment and prevention. We also do HIV viral load tests for control. Within the health centre it is possible to provide all medical care according to the recommendations and protocol of the Ministry of Health. We must continue to work to eliminate stigma and spread the message that there is life after an HIV diagnosis".

33 AIDS (acquired immune deficiency syndrome) is an infectious disease caused by HIV and identifies an advanced clinical stage of the virus.

COVERAGE OF ANTIRETROVIRAL THERAPY FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT) (%)

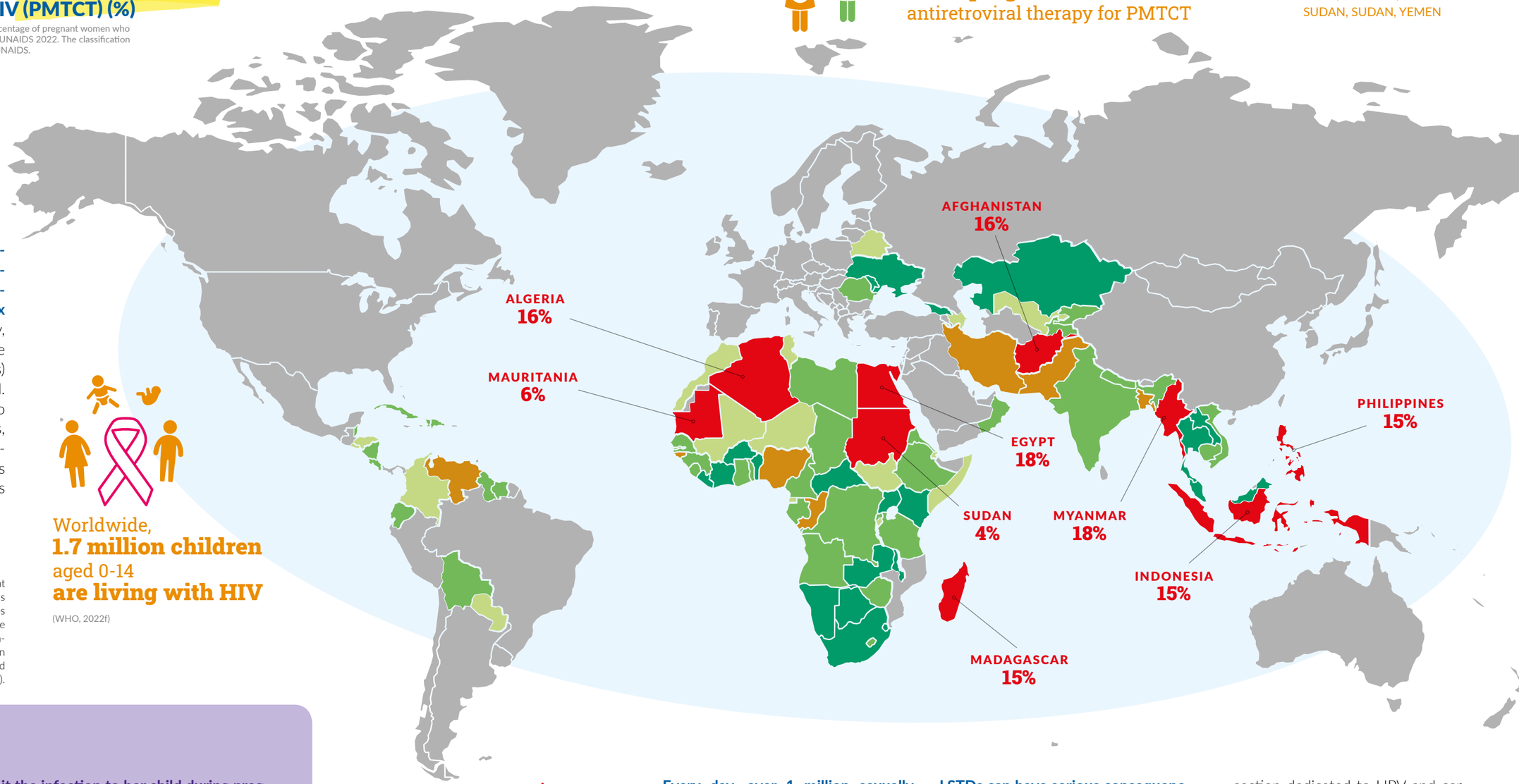
The data are updated to 2021 and refer to the percentage of pregnant women who received antiretroviral therapy for PMTCT. Source UNAIDS 2022. The classification of geographical areas follows that established by UNAIDS.

LEGEND

- Not available
- >90
- Between 60 and 90
- Between 40 and 60
- Between 20 and 40
- <20

In **fragile and conflicts afflicted countries**, just over **1 in 2 pregnant women** receive antiretroviral therapy for PMTCT

AFGHANISTAN, CONGO DEM. REP., ETHIOPIA, MALI, NIGERIA, PAKISTAN, SYRIA, SOMALIA, SOUTH SUDAN, SUDAN, YEMEN



More than 30 different bacteria, viruses, and parasites can be transmitted through sexual contact, including vaginal, anal, and oral sex (WHO, 2022f). During pregnancy, childbirth, and breastfeeding, some sexually transmitted diseases (STDs) can be passed from mother to child. Eight pathogens have been linked to an increase in STD incidence: syphilis, gonorrhoea, chlamydia, trichomoniasis, hepatitis B, herpes simplex virus (HSV), HIV, and human papillomavirus (HPV) are all examples of viruses[34].

34 Furthermore, outbreaks of new infections that can be transmitted through sexual contacts, such as monkeypox, Shigella Sonnei, Neisseria meningitides (meningococcus), Ebola and Zika are emerging, as is the re-emergence of neglected STIs such as lymphogranuloma venereum. These herald growing challenges in providing adequate services for the prevention and control of sexually transmitted diseases (WHO, 2022f).

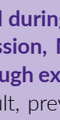
Worldwide,
1.7 million children
aged 0-14
are living with HIV

(WHO, 2022f)

Pregnancy and HIV

A woman living with HIV can transmit the infection to her child during pregnancy, childbirth, and breastfeeding (mother-to-child transmission, MTCT). The virus can pass through the placenta or, during delivery, through exposure to secretions, maternal blood, or, finally, breast milk. As a result, preventing virus transmission from mother to child (PMTCT) is critical.

The main preventive measure is to get an HIV test before or during pregnancy so that therapeutic measures can be implemented to prevent or limit virus transmission if infected. Currently, available therapies (antiretrovirals) involve taking oral combinations of drugs with different mechanisms of action to suppress HIV replication and reduce viral load. This therapy should be strengthened during childbirth when children are most vulnerable to contagion (WHO, 2022f).



In 2020, the WHO estimated **374 million new infections**, including chlamydia (129 million), gonorrhoea (82 million), syphilis (7.1 million), and trichomoniasis (156 million)

Every day, over 1 million sexually transmitted diseases are contracted (ibid.). In 2020, **the WHO estimated 374 million new infections, including chlamydia (129 million), gonorrhoea (82 million), syphilis (7.1 million), and trichomoniasis (156 million)**[35].

35 Research to develop genital herpes and HIV vaccines is advanced, with several vaccine candidates in early clinical development. There is mounting evidence to suggest that the vaccine prevents meningitis (MenB) and provides cross-protection against gonorrhoea. More research is needed on vaccines for chlamydia, gonorrhoea, syphilis and trichomoniasis (WHO, 2020).

LSTDs can have serious consequences beyond the immediate impact of the infection itself:

- Diseases such as herpes, gonorrhoea and syphilis can increase the risk of acquiring HIV.
- Mother-to-child transmission of STDs can lead to stillbirth, neonatal death, low birth weight and premature birth, sepsis, neonatal conjunctivitis, congenital deformities, blindness, and deafness.
- HPV infection can cause cervical and other types of cancer (see the section dedicated to HPV and cervical cancer).
- Hepatitis B caused about 820,000 deaths in 2019 (WHO, 2022f), mainly from cirrhosis and hepatocellular carcinoma. STIs such as gonorrhoea and chlamydia are major causes of pelvic inflammatory disease and infertility in women (see also section on natal health).

Common **Cancer Types** in Women

Breast cancer

Breast cancer is not a contagious or infectious disease. Unlike some cancers that are caused by infections, such as human papillomavirus (HPV) infection and cervical cancer, no viral or bacterial infections have been linked to the development of breast cancer. **About half of all breast cancers occur in women who have no other risk factors for the disease other than their gender (female) and age (over 40).** However, some factors, such as increasing age, obesity, harmful alcohol use, family history of breast cancer, radiation exposure, reproductive history (such as age at onset of menstruation and age of first pregnancy), tobacco use, and postmenopausal hormone therapy, can increase the risk of breast cancer (WHO, 2021c).

Breast cancer is the most common type of cancer, accounting for **1 out of every 8 cancer diagnoses** globally

(International Agency for Research on Cancer, 2022)

In 2020, there were approximately 2.3 million new cases of breast cancer worldwide and approximately 685,000 deaths, with large geographic variations observed between regions and countries around the world. Breast cancer **incidence rates are highest in the Global North** (where prevention systems are more robust and widespread) **while Global South countries account for a disproportionate share of breast cancer deaths** (International Agency for Research on Cancer, 2022). Several studies show that while breast cancer mortality rates in most high-income countries have decreased over time, they remain high and are increasing in many lower-middle-income and low-income countries (Lima et al., 2021).

Breast cancer treatment can be very effective, especially when the disease is detected early. However, there are significant disparities around the world in terms of who can access cancer services, including screening and treatment. In some regions, this is due to a lack of infrastructure to provide such services, while in others, the services are prohibitively expensive (WCRFI, 2023). **If such screening services are unavailable or inaccessible, the cancer will most likely be detected at a later stage, decreasing the person's chances of survival.** The same is true for cancer treatments: if people cannot access them, they are unlikely to live a long life once diagnosed (ibid.).

In 2020, approximately **2.3 million new cases** of breast cancer and **685,000 deaths** were recorded worldwide

(International Agency for Research on Cancer, 2022)

COVID-19 Effect

The COVID-19 pandemic has resulted in a suspension or reduction of cancer screening and diagnosis appointments. Simultaneously, people eligible for cancer screening may have been hesitant to attend their appointments due to concerns about being exposed to COVID-19 in a hospital, clinic, or doctor's office (WCRFI, 2022). Reduced cancer screening and treatment during the pandemic pose a public health issue: **while cancer incidence is likely to have remained constant, fewer cases have been diagnosed promptly.** This means that cancer mortality may rise in the future as more people are diagnosed with the disease and begin treatment at a later stage.

Cervical cancer is the **fourth most common** cancer type in women

(WCRFI, 2022)

WeWorld in Latin America: the telemedicine service in Bolivia and Peru

The suspension or reduction of health services because of the COVID-19 pandemic has had a global impact. However, it has made it even more difficult for people living in areas where health systems are absent or fragile, or where proximity medicine networks are not widespread, to obtain treatment, screening, and consultations.

The rural populations of Apurmac in Peru and La Paz and Pando in Bolivia do not have access to quality health care. This is due to a lack of professional human resources and limited government financial resources invested in healthcare on the one hand, and a lack of infrastructure and roads in geographically inaccessible areas on the other.

The binational project **"Health and Telemedicine: Consolidating and Strengthening Access to Basic Health Care in Peru and Bolivia"** aims to improve access to health services by utilising telemedicine.

WeWorld has been in Bolivia since 1987 and Peru since 2002. The project operates in all of Peru's Apurmac provinces (Abancay, Andahuaylas, Antabamba, Aymaraes, Chincheros Cotobambas, and Grau) and Bolivia's La Paz and Pando regions, **establishing an integrated health system capable of ensuring efficient and effective responses to the needs of the most vulnerable population, which has been exacerbated by the pandemic.**

The initiative, which focuses on the primary challenges of public health systems, aspires towards four concrete outcomes: **strengthening health systems** in the reference context through technological innovations and health personnel training; **improving access to health care services** delivered through telemedicine for the most vulnerable population of Apurmace of La Paz and Pando; **disseminating a correct health and prevention culture and raising awareness of healthy lifestyles** in the community. WeWorld will strengthen the Telemedicine system in Bolivia by supporting the National Telemedicine Programme of the National Ministry of Health.

Cervical cancer

Cervical cancer is a type of gynaecological cancer[36] **that develops in the cervix of a woman (also known as the "neck of the womb"). Cervical cancer is the fourth most common cancer type in women (after breast, colon, and lung cancer), accounting for 7% of all new cancer diagnoses in 2020** (WCRFI, 2022). In addition, 604,127 women were diagnosed with cervical cancer worldwide in 2020, with 341,831 dying from the disease (ibid.).

Nearly all cases of cervical cancer (99%) are caused by human papillomavirus (HPV) infection, which is spread through sexual contact (WHO, 2022g). Although most HPV infections resolve on their own with no symptoms, persistent infection in women can lead to cervical cancer.

Cervical cancer is one of the most avoidable types of cancer. Most cases of cervical cancer are prevented by effective primary (HPV vaccination) and secondary (screening and treatment of precancerous lesions and HPV) prevention strategies. In many countries, a global strategy based on human papillomavirus (HPV) vaccination and HPV-based screening has proven to be the most cost-effective measure (De Martel, 2017). **However, progress towards increased prevention is frequently slow, with relatively low vaccine access and limited use of cervical cancer screening, particularly in countries in the Global South** (ibid.).

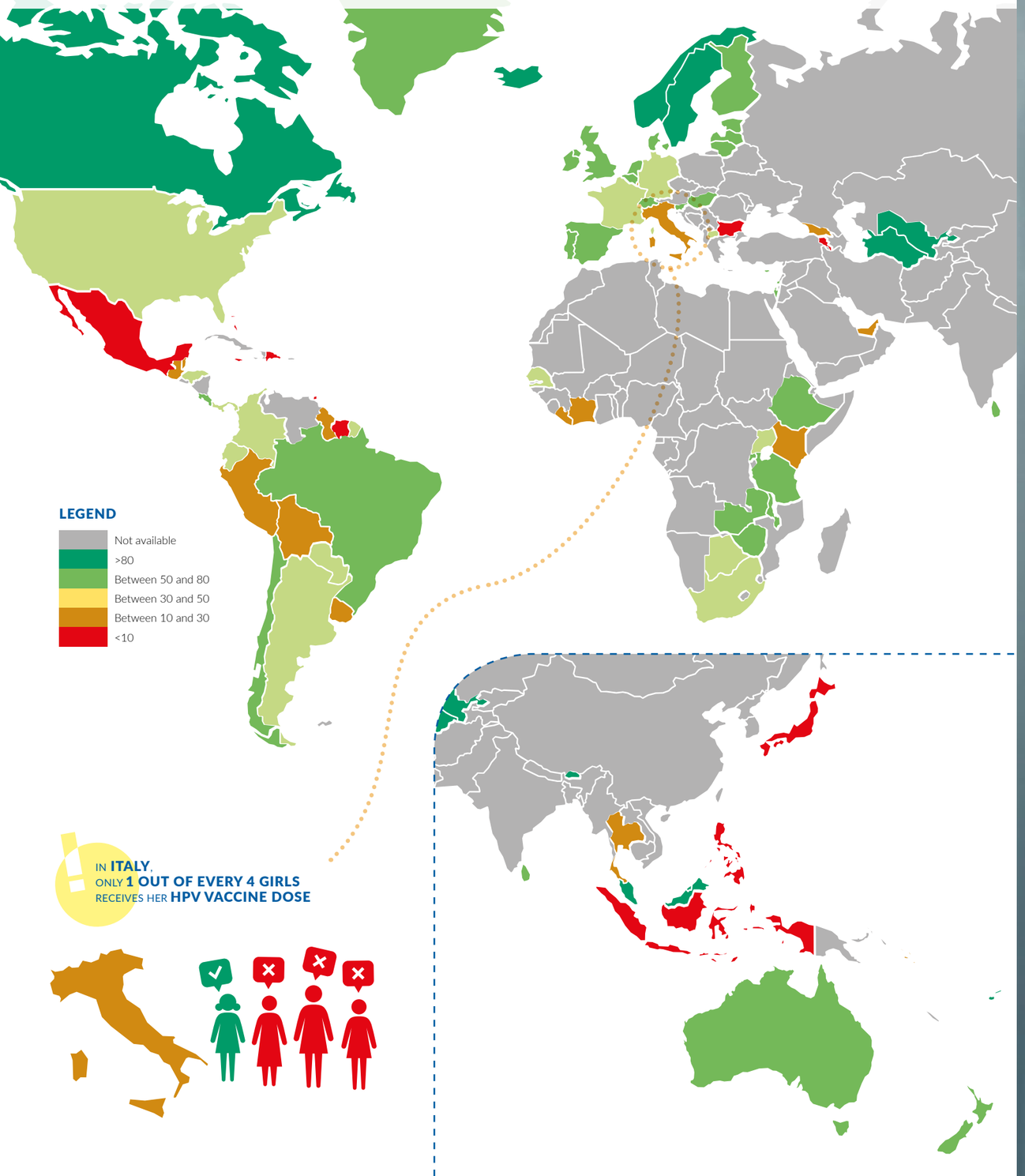
The global incidence of HPV is estimated to be 12%, with significant regional differences. Sub-Saharan Africa had the highest incidence (24%), followed by Latin America and the Caribbean (16%), Eastern Europe (14%), and Southeast Asia (14%). Furthermore, **HPV is more prevalent in groups under the age of 25** (22%), highlighting the **importance of anti-HPV vaccination campaigns among adolescents** (De Martel, 2017).

Cervical cancer is one of the most successfully treatable cancer types when detected early and managed effectively. Cancers that have progressed to an advanced stage can also be managed with appropriate treatment and palliative care. **Cervical cancer could be eradicated within a generation if a comprehensive approach to prevention, screening, and treatment is implemented** (WHO, 2022g).

36 Gynaecological cancer is defined as any cancer that originates from a woman's reproductive organs. Gynaecological cancers can develop in different places within a woman's pelvis, which is the abdomen area below the navel and between the pelvic bones. Types of gynaecological cancer: the (lower case) cervical cancer starts from the cervix, which is the narrow, lower end of the uterus; Ovarian cancer originates in the ovaries, which are on each side of the uterus. Some ovarian cancers can also start in the fallopian tubes or peritoneum; uterine cancer begins in the uterus; vaginal cancer originates in the vagina, which is the hollow, tube-like canal between the fundus of the uterus and the outside of the body; Vulvar cancer originates in the vulva, the external part of the female genital organs (WCRFI, 2022).

GIRLS AGED 15 RECEIVING THE RECOMMENDED DOSE OF HPV VACCINE (%)

The data are updated to 2020. Source WHO 2022. The classification of geographical areas follows that established by the WHO.



IN **ITALY**, ONLY **1 OUT OF EVERY 4 GIRLS** RECEIVES HER **HPV VACCINE DOSE**

Conclusions and Recommendations

WE DO CARE. Conclusions and Recommendations

The world's population peaked at 8 billion people in November 2022, an extraordinary achievement that reflects, among other things, decades of remarkable accomplishments to ensure greater access to health care, information, and education, as well as to reduce poverty (UNFPA, 2023). However, such a result should prompt us to reflect on the challenges and opportunities for future progress. People have never needed to exercise their rights and be able to make informed choices more than at this precise moment, which is marked by multiple crises and profound changes.

While the COVID-19 pandemic has passed its peak, its side effects are far from over. The war in Ukraine has sent shockwaves around the world, threatening food security and raising living costs. In February 2023, the earthquakes in Syria and Turkey highlighted the extreme vulnerability to which people living in long-term crises and conflict are exposed. Climate change threatens our planet's very existence, and growing inequalities, combined with increasing social and political polarization, undermine hopes for sustainable development. In this context, there is a significant risk that people's sexual and reproductive rights will not be prioritised.

The Nairobi Summit was held almost four years ago (2019), and the next International Conference on Population and Development (ICPD) is scheduled for 2024. Given the significance of this international appointment, it is necessary to emphasise the importance of a sexual and reproductive justice agenda as a vehicle for delivering on 2019 commitments, not only to guarantee sexual and reproductive rights per se, but also to combat all violations of other rights, fundamental freedoms, and social, political, cultural, and economic inequalities.

Since 2019, **at least 77 countries**[37] **have developed national action plans to incorporate the Nairobi commitments into their national or sectoral policies and/or develop systems to track progress.** However, as this Atlas shows, **there are still many gaps between the global North and global South**. The COVID-19 pandemic has hindered progress made since the proclamation of the 2030 Agenda objectives and forecasts for improvements desired with the 12 Nairobi commitments.

Furthermore, today's revival of rights and sexual and reproductive health, bodily autonomy, and freedom from gender-based violence is jeopardised by restrictions on women's rights as well as the persistence of conflict and protracted crises. Consider Afghanistan, where the Taliban banned the sale of contraceptives, claiming that their use by women resulted from a Western conspiracy to control the Muslim population (The Guardian, 2023). **Access to health care and sexual and reproductive health care is hampered, if not directly impeded in these countries, where resources have been depleted to unsustainable and unacceptable levels.**

The Atlas' six sections (Natal health, Body policies, Gender-based violence, WASH and sexual and reproductive rights, Menstrual health, and Sexual health and well-being) **highlight major critical issues and gaps not only in terms of universal access to care and information on one's health but also in terms of regulations, with several countries failing to guarantee citizens' bodily autonomy. Women, children and adolescents are once again paying the highest price** in regions that struggle with chronic poverty, conflicts, and inequalities, most notably in **Sub-Saharan Africa, followed by Central-Southern Asia, the Middle East, and Latin America.** As previously stated, this has implications not only for sexual and reproductive rights but also for a series of other fundamental human rights, including the right to education.

37 Albania, Angola, Argentina, Bangladesh, Benin, Bolivia, Burkina Faso, Cambodia, Cameroon, Central African Republic, Chad, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Ivory Coast, Cuba, Democratic Republic of Congo, Djibouti, Dominican Republic, Ecuador, Egypt, Federated States of Micronesia, Fiji, Georgia, Ghana, Guinea, Guinea Bissau, Haiti, India, Iraq, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Mexico, Morocco, Myanmar, Nepal, Nicaragua, Nigeria, North Macedonia, Pakistan, Paraguay, Peru, Philippines, Rwanda, Samoa, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Syria, Thailand, Tonga, Tunisia, Turkey, Turkmenistan, Uganda, United Republic of Tanzania, Vanuatu, Vietnam and Zimbabwe. See https://www.nairobisummiticpd.org/sites/default/files/HLC%20Report_11-01.pdf

The Nairobi Statement: 12 Global Commitments

The 2019 Nairobi Summit galvanised global momentum, resulting in over 1,300 pledges from a variety of stakeholders, including governments. The Summit was also followed by widespread support for the Nairobi Declaration, which outlines the global commitment to achieving the ICPD's goals. The Declaration's 12 global commitments are critical to ensuring the full, effective, and expedited implementation of the ICPD Programme of Action (established in Cairo in 1994) and achieving the goals of the 2030 Agenda.

In this sense, the plan is to:

1 NAIROBI GLOBAL COMMITMENT

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

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

2 NAIROBI GLOBAL COMMITMENT

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

3 NAIROBI GLOBAL COMMITMENT

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

4 NAIROBI GLOBAL COMMITMENT

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

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

5 NAIROBI GLOBAL COMMITMENT

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

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

6 NAIROBI GLOBAL COMMITMENT

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

7 NAIROBI GLOBAL COMMITMENT

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

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

8 NAIROBI GLOBAL COMMITMENT

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

9 NAIROBI GLOBAL COMMITMENT

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

10 NAIROBI GLOBAL COMMITMENT

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

11 NAIROBI GLOBAL COMMITMENT

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

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

12 NAIROBI GLOBAL COMMITMENT

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

The fundamental role of comprehensive sexual education

People will not develop the agency to make informed decisions about their bodies and the rest of their lives if their sexual and reproductive rights are not fully realised. Awareness of one's sexual and reproductive rights, as now universally recognised, must pass through quality sexual education that is complete and inclusive of all cognitive, emotional, physical, and social aspects of sexuality (**comprehensive sexual education**).

Such education aims to provide girls, boys, and young people with the knowledge, skills, attitudes, and values that will enable them to realise their right to health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their own and others' well-being; and understand and ensure the protection of their rights for life (PERIOD, 2022). **As a result, where there is no proper sexual education, it is impossible to affirm sexual and reproductive justice.**

Teaching about the cognitive, emotional, social, and physical aspects of sexuality has been increasingly recognised and demonstrated in recent decades to have a positive impact on the sexual and reproductive health of girls and young people (UNESCO, 2018). **Emerging evidence also suggests that providing sexual education programmes in schools for children and young people can have a positive impact on broader societal issues like gender equality, human rights, and the well-being and safety of future generations**. Sexual education programmes that include a focus on gender rights, for example, have been linked to outcomes such as reduced risk of child sexual abuse (ibid.).

Many instruments, treaties and international agreements reaffirm the importance of sex education[38]. In particular, the **UNESCO guidelines** on the subject, published for the first time in 2009 and updated in 2018[39], indicate **8 key concepts** around which quality sex education curricula should be built:

- RELATIONSHIPS
- VALUES, RIGHTS, CULTURE AND SEXUALITY
- UNDERSTANDING GENDER
- VIOLENCE AND STAYING SAFE
- SKILLS FOR HEALTH AND WELL-BEING
- THE HUMAN BODY AND DEVELOPMENT
- SEXUALITY AND SEXUAL BEHAVIOUR
- SEXUAL AND REPRODUCTIVE HEALTH

38 Among these: the Convention on the Rights of the Child (CRC) of 1989, with specific reference to article 19; the European Regional Strategy on sexual and reproductive health of 2001; the 2003 General Comment of the Committee on the Rights of the Child; the 2009 ICPD Resolution 2009/1; the 2010 WHO Standards for Sex Education in Europe; ICPD Resolution 2012/1 on young people and adolescents of 2012; the 2013 General Comment of the Committee on the Rights of the Child; targets included in objectives 3,4 and 5 of the 2030 Agenda of 2015; the 2016 General Comment of the Committee on the Rights of the Child; the UNESCO International Guidelines, first published in 2009 and updated in 2018.

39 See https://unesdoc.unesco.org/ark:/48223/pf0000260770

WeWorld's proposal for Italy: sexual education in schools

Since 1975, when the first bill for compulsory sexual education in schools was presented, 16 laws have been proposed in Italy, but none have been passed. The most recent attempt to introduce it was in 2015, when the then-Minister of Health, Beatrice Lorenzin, established a commission for implementing the WHO guidelines on sexual education, which had already been introduced in most European countries, in Italy.

Despite the lack of a unified policy on the subject, sexual education is compulsory in the majority of EU Member States, except for Bulgaria, Cyprus, Italy, Lithuania, Poland, and Romania (Lo Moro et al., 2023). In Italy, the underlying motivations are different: on the one hand, there is an ongoing debate within the Catholic Church between those who openly oppose all forms of sex education and those who, instead, have taken positions more open to addressing the issue of affective education (ibid.). On the other hand, in recent years, a vocal minority of pro-life activists and organisations has carried out a number of campaigns and mobilisations in the media and on the streets aimed at undermining the importance of sexual education, while also appealing to some political groups and the attitudes of a sizable portion of the public, which tend to promote traditionalist and conservative ideas (Prearo, 2022; Siviero, 2016). As a result, **sexual education in Italy remains optional and subject to wide variation in teaching methods**. Although some schools provide sexual education, this is dependent on the school administration's willingness. Furthermore, teachings tend to focus solely on biological aspects, rather than the broader psychological, social, or emotional aspects advocated by WHO and UNESCO (ibid.). In this context, several studies conducted among Italian adolescents to assess their sexual knowledge have revealed an urgent need for sexual education[40].

A 2016 survey (Drago et al., 2016) revealed that most male and female students enrolled believe that the school must play a central role in this educational process. Despite this awareness, the same male and female **students rated their school's sexual education as poor or absent** (Drago et al., 2016). A study conducted in 2022 (Lo Moro et al., 2023) explored the various Italian regional initiatives that took place between 2006 and 2021 to assess potential gaps in sexual education teaching in our country. Twelve of the twenty Italian regions had at least one sex education programme, for a total of 39 projects.

Overall, almost all of the UNESCO-identified themes were addressed, with notable differences between Northern, Central, and Southern Italy. The main themes (in 92% of the regions) were contraception, love, marriage, cohabitation, and family. Pregnancy and childbirth were mentioned in only 25% of the regions. The least discussed topic (17%) was disability. **Local initiatives funded by local health authorities and the Regions can only compensate for some of these shortcomings and territorial differences.** However, a review of the various initiatives revealed that significant improvements were made following sexual education interventions, reconfirming their significance (Lo Moro et al., 2023).

Increasing the supply of sexual education teachings, achieving adequate educational standards, and lowering existing differences not only between the various Italian regions, but also between Italy and other European countries, are **interventions that can no longer be postponed if future generations are to be provided with adequate knowledge and information on sex and sexuality and, as a result, ensure their well-being.**


© Claudio Majorana

40 See Bergamini et al., 2013; Bogani et al., 2015; Borraccino et al., 2020; Drago et al., 2016; Orlando et al., 2019; Smorti et al., 2019.

A framework of true sexual and reproductive justice is required for the realisation of the global promises and goals promoted by the 2030 Agenda, the ICPD Programme of Action, and the Nairobi commitments, as proven by the data and evidence reported in this Atlas. This concept refers to a broad range of rights underlying the principle of bodily autonomy, using an intersectional approach to reach out to groups of people who face multiple forms of discrimination and violations of their rights.

According to this viewpoint, full realisation of sexual and reproductive rights includes not only access to health care, but also to quality education, information, decent work, a safe and healthy environment, freedom from all forms of marginalisation and violence, and the ability to participate in decision-making processes (High-Level Commission on the Nairobi Summit, 2022). In essence, **sexual and reproductive justice should become the key to unleashing the full potential of all human beings to create a more equitable, secure, and sustainable future.**

For this reason, as also reaffirmed by the high-level Commission on the progress of the ICPD Action Plan, by 2030, it will be essential to:

- **MAKE SEXUAL AND REPRODUCTIVE JUSTICE THE GOAL:**
  Conduct all work on sexual and reproductive health and rights under a justice framework. This must consider human rights and fundamental freedoms as universal, indivisible, interdependent and interrelated. This approach entails developing and implementing accountability mechanisms, actively engaging civil society movements advocating for sexual and reproductive justice and forging new alliances. National governments' more concrete commitment should translate into the promotion of laws and budget choices that promote sexual and reproductive justice and gender equality (ibid.).

- **PUT RIGHTS AND DEVELOPMENT AT THE CORE:**
  Develop universal health coverage with comprehensive sexual and reproductive health and rights as essential services. National recovery plans for the COVID-19 pandemic should be used to implement life-course universal health coverage. Putting users' needs first, and listening to their requests and experiences will aid in the defence of their rights and the quality of assistance. (ibid.).

- **THINK DIFFERENTLY:**
  Pursue recent innovations in health-care service delivery to accelerate sexual and reproductive justice and support people's agency and bodily autonomy. A good place to start would be to explore the potential of self-managed care or telehealth, which could be especially useful in reaching out to some marginalised groups (ibid.).

- **REACH FURTHER:**
  Prioritize groups facing the worst disparities in sexual and reproductive justice. In this sense, closing gaps in humanitarian action is an urgent priority, as is putting a greater emphasis on reducing risks to sexual and reproductive health and rights in future disaster risk reduction plans (ibid.)

- **SHOW THE MONEY:**
  Increase domestic and international finance for sexual and reproductive health and rights at levels sufficient to achieve sexual and reproductive justice. Dedicated expenditures in national health budgets must be identifiable and measurable, and donor contributions must be considered. Comprehensive, free sexual and reproductive health and rights services should be implemented (ibid.).

- **TELL A NEW STORY:**
  Create new narratives around sexual and reproductive justice that are accurate and powerful enough to counter ongoing opposition. This necessitates the development of more robust data collection and use systems, which must be updated and disaggregated to capture critical aspects of sexual and reproductive health and rights, including gender equality and intersectionality. Sexual and reproductive justice must become a compass that can re-energize and inspire action to galvanise broader support (ibid.).

Bibliography

Abrams Z. (2022), The facts about abortion and mental health, https://www.apa.org/monitor/2022/09/news-facts-abortion-mental-health, accessed in July 2023

Arnold M., Morgan E., Rumgay H., Mafra A., Singh D., Laversanne M., Vignat J., Gralow J.R., Cardoso F., Siesling S., Soerjomataram I. (2022), Current and future burden of breast cancer: Global statistics for 2020 and 2040, https://www.thebreastonline.com/article/S0960-9776(22)00144-8/fulltext, accessed in July 2023

Arnsenault C. et al. (2022), COVID-19 and resilience of healthcare systems in ten countries, https://www.nature.com/articles/s41591-022-01750-1 , accessed in July 2023

Associazione Luca Coscioni (2022), Aborto, https://www.associazionelucacoscioni.it/cosa-facciamo/aborto-e-contraccezione/aborto , accessed in July 2023

Badalassi G., Gentile F. (2022), Ebbene sì, esiste pure l'economia della menopausa, https://www.ladynomics.it/ebbene-si-esiste-pure-leconomia-della-menopausa-%EF%BF%BC/ , accessed in July 2023

Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C et al. (2020), Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30315-6/fulltext, accessed in July 2023

Bello C., Llach L. (2023), Painful periods? Spain just passed Europe's first paid 'menstrual leave' law, https://www.euronews.com/next/2023/02/16/spain-set-to-become-the-first-european-country-to-introduce-a-3-day-menstrual-leave-for-wo#:~:text=Worldwide%2C%20menstrual%20leave%20is%20currently,Indonesia%2C%20South%20Korea%20and%20Zambia, accessed in July 2023

Bergamini M. et al. (2013), Risk perception of sexually transmitted diseases and teenage sexual behavior: Attitudes towards in a sample of Italian adolescents, https://pubmed.ncbi.nlm.nih.gov/24396993/, accessed in July 2023

Blair L.A.G., Bajòn-Fernandèz Y., Villa R. (2022), An exploratory study of the impact and potential of menstrual hygiene management waste in the UK, https://www.sciencedirect.com/science/article/pii/S2666790822000404, accessed in July 2023

Bogani G. Cromi A., Serati M., Monti Z., Apolloni C., Nardelli F., Di Naro E., Ghezzi, F. (2015), Impact of school-based educational programs on sexual behaviors among adolescents in northern Italy, https://www.tandfonline.com/doi/abs/10.1080/0092623X.2014.958791 , accessed in July 2023

Borraccino A., Moro G. L., Dalmasso P., et al. (2020), Sexual behaviour in 15-year-old adolescents: Insights into the role of family, peer, teacher, and classmate support, https://annali.iss.it/index.php/anna/article/view/1136/668 , accessed in July 2023

Campbell O. M. R., Cegolon L., Macleod D., Benova L. (2016), Length of stay after childbirth in 92 countries and associated factors in 30 low- and middleincome countries: compilation of reported data and a cross-sectional analysis from nationally representative surveys., https://pubmed.ncbi.nlm.nih.gov/26954561/, accessed in July 2023

Camut C. (2023), Spain approves paid menstrual leave, first country in Europe to do so, https://www.politico.eu/article/bill-europe-spain-parliament-creates-first-menstrual-leave-in-europe/, accessed in July 2023

Center for Reproductive Rights (2022), The World's Abortion Laws, https://reproductiverights.org/maps/worlds-abortion-laws/ , accessed in July 2023

Chao F., Gerland P., Cook A.R., Alkema L. (2019), Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels, https://www.pnas.org/doi/10.1073/pnas.1812593116, accessed in July 2023

Commissione Europea (2022), Sexuality education across the European Union, https://op.europa.eu/it/publication-detail/-/publication/5724b7d8-764f-11eb-9ac9-01aa75ed71a1, accessed in July 2023

Das Gupta M., Zhenghua J., Bohua L., Zhenming X., Chung W., Hwa Ok B. (2010), Why is Son preference so persistent in East and South Asia? a cross-country study of China, India and the Republic of Korea, https://www.tandfonline.com/doi/abs/10.1080/00220380412331293807, accessed in July 2023

Diamond-Smith N., Luke N., & McGarvey S. (2008), Too many girls, too much dowry': son preference and daughter aversion in rural Tamil Nadu, India, https://www.tandfonline.com/doi/abs/10.1080/13691050802061665?journalCode=tchs20, accessed in July 2023

Drago F., Ciccarese G., Zangrillo F., Gasparini G., Cogorno L., Riva S., Parodi A. (2016), A survey of current knowledge on sexually transmitted diseases and sexual behaviour in Italian adolescents, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4847084/ , accessed in July 2023

Education Cannot Wait (2022), ECW's Strategic Plan 2023–2026 Achieving Results: A New Way of Working, https://www.educationcannotwait.org/resource-library/ecws-strategic-plan-2023-2026-achieving-results-new-way-working, accessed in July 2023

Esho T., Komba E., Richard F., Shell-Duncan B. (2021), Intersections between climate change and female genital mutilation among the Maasai of Kajiado County, Kenya, https://jogh.org/documents/2021/jogh-11-04033.pdf , accessed in July 2023

European Parlamentary Forum for Sexual & Reproductive Rights (2022), Contraception Policy Atlas in Europe, https://www.epfweb.org/sites/default/files/2022-02/CCeptionInfoA3_EN%202022%20v10.pdf, accessed in July 2023

Falcone A. (2018), Educazione sessuale e affettiva a scuola: perché renderla obbligatoria, https://annalisafalcone.it/2018/01/16/educazione-sessuale-a-scuola-perche-renderla-obbligatoria/, accessed in July 2023

Farina P., Ortensi L.E., Pettinato T. (2020) Le mutilazioni genitali femminili in Italia: un aggiornamento, https://boa.unimib.it/retrieve/handle/10281/280487/411349/mpdf.pdf , accessed in July 2023

Ganatra B., Gerdts C., Rossier C., Johnson Jr B. R., Tuncalp Ö., Assifi A. et al. (2017), Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext, accessed in July 2023

Girls not brides (2021), Child marriage and health, https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/ , accessed in July 2023

Global Citizen (2021), The Tampon Tax: Everything You Need to Know, https://www.globalcitizen.org/en/content/tampon-tax-explained-definition-facts-statistics/, accessed in July 2023

Hague F., Miedema E., Le Mat M. (2018), Understanding the 'Comprehensive' in Comprehensive Sexuality Education. A literature Review, https://www.researchgate.net/publication/324080732_Understanding_the_'Comprehensive'_in_Comprehensive_Sexuality_Education_A_literature_Review , accessed in July 2023

Hesketh T., Lu L., Xing Z. W. (2011), The consequences of son preference and sex-selective abortion in China and other Asian countries, https://www.cmaj.ca/content/183/12/1374, accessed in July 2023

High Level Commission on the Nairobi Summit on ICPD25 Follow-up (2021), Sexual and reproductive justice as the vehicle, https://www.nairobisummiticpd.org/sites/default/files/HLC%20Report_11-01.pdf, accessed in July 2023

High Level Commission on the Nairobi Summit on ICPD25 Follow-up (2022), No exceptions, No Exclusions. Realizing sexual and reproductive health, rights and justice for all, https://www.nairobisummiticpd.org/sites/default/files/files/Nairobi%20HLC-ExSumm-English%20(1).pdf , accessed in July 2023

Hinchliffe E. (2020), Menopause is a $600 billion opportunity, report finds, https://fortune.com/2020/10/26/menopause-startups-female-founders-fund-report/, accesso marzo 2023

https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/virginity_testing_eng.pd11f , accessed in July 2023

Il Post (2020), In Francia si discute di certificati di verginità, https://www.ilpost.it/2020/09/18/francia-certificati-verginita/, accessed in July 2023

Il Post (2022), San Marino ha depenalizzato l'aborto, https://www.ilpost.it/2022/09/01/san-marino-aborto/

International Agency for Research on Cancer (2022), Current and future burden of breast cancer: global statistics for 2020 and 2040, https://www.iarc.who.int/news-events/current-and-future-burden-of-breast-cancer-global-statistics-for-2020-and-2040/, accessed in July 2023

International Women's Health Coalition (2020), Integrating sexual and reproductive health in WASH, https://canwach.ca/wp-content/uploads/2020/10/SRHR-WASH-Fact-Sheet_WebFinal.pdf, accessed in July 2023

International Women's Empowerment Network (2021), Hygiene Empowerment Resource (H.E.R) Program, https://www.iwenetwork.org/programs-1, accessed in July 2023

Ipsos (2022), 8 miliardi di abitanti nel mondo: un trend di crescita destinato a proseguire?, https://www.ipsos.com/it-it/diminuzione-popolazione-mondiale-principali-fattori-impatto-covid#:~:text=Affinch%C3%A9%20l'umanit%C3%A0%20si%20mantenga,che%20si%20hanno%20ogni%20anno, accessed in July 2023

ISSM (2018), What is virginity testing? Why is it used, and what are its potential effects?, https://www.issm.info/sexual-health-qa/what-is-virginity-testing-why-is-it-used-and-what-are-its-potential-effects/, accessed in July 2023

Khan M. M. (2022), Menstrual health and hygiene: What role can schools play?, https://blogs.worldbank.org/education/menstrual-health-and-hygiene-what-role-can-schools-play, accessed in July 2023

Lima S. et al. (2021), Global breast cancer incidence and mortality trends by region, age-groups, and fertility patterns, https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00265-0/fulltext, accessed in July 2023

Lino C. (2016), Cosa sono davvero le mestruazioni, https://www.ilpost.it/2016/01/22/mestruazioni-assorbenti/, accessed in July 2023

Lo Moro G. et al. (2023), Sex Education in Italy: An Overview of 15 Years of Projects in Primary and Secondary School, https://link.springer.com/article/10.1007/s10508-023-02541-6 , accessed in July 2023

Maitreyi Bordia D. (2017), The RISING TIDE. A new look at water and gender, https://openknowledge.worldbank.org/bitstream/handle/10986/27949/W17068.pdf?sequence=4&isAllowed=y, accessed in July 2023

McChrystal J. (2021), No Girl Left Behind. While science and medicine advance, myths around menstruation persist, https://www.historytoday.com/archive/history-matters/no-girl-left-behind, accessed in July 2023

Ministero della Salute (2022), Relazione Ministro Salute attuazione Legge 194/78 tutela sociale maternità e interruzione volontaria di gravidanza - dati definitivi 2020, https://www.salute.gov.it/portale/documentazione/p6_2_2_1.jsp?lingua=italiano&id=3236 , accessed in July 2023

Morison T. (2021), Reproductive justice: A radical framework for researching sexual and reproductive issues in psychology, https://compass.onlinelibrary.wiley.com/doi/full/10.1111/spc3.12605 , accessed in July 2023

Oakes A.H., Boyce C., Patton C. et al. (2022), Rates of Routine Cancer Screening and Diagnosis Before vs After the COVID-19 Pandemic, https://jamanetwork.com/journals/jamaoncology/fullarticle/2798851 , accessed in July 2023

OHCHR (2020), Information series on sexual and reproductive health and rights. Abortion, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf , accessed in July 2023

OHCHR (2023), Child and forced marriage, including in humanitarian settings, https://www.ohchr.org/en/women/child-and-forced-marriage-including-humanitarian-settings#:~:text=Worldwide%2C%20more%20than%20650%20million,union%2C%20before%20reaching%20age%2018, accessed in July 2023

Olson R., Moreno C. (2017), Virginity testing: a systematic review, https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0319-0 , accessed in July 2023

Orlando G., Campaniello M., Iatosti S., Grisdale, P. J. (2019), Impact of training conferences on high-school students' knowledge of sexually transmitted infections (STIs), https://www.jpmh.org/index.php/jpmh/article/view/1072, accessed in July 2023

Our World in Data (2021), Sanitation, https://ourworldindata.org/sanitation, accessed in July 2023

OVOItalia (2017), Indagine Doxa-OVOItalia , https://ovoitalia.wordpress.com/indagine-doxa-ovoitalia/, accessed in July 2023

PERIOD (2022), Glossary for the Global Mestrual Movement, https://period.org/uploads/Global-Glossary-for-the-Menstrual-Movement-v1.3.pdf, accessed in July 2023

Plan International (2021), New survey shows 'deep-rooted' taboos around periods, https://plan-international.org/news/2022/05/25/new-survey-shows-deep-rooted-taboos-around-periods/, accessed in July 2023

Prearo M. (2022), Il fronte 'anti-gender' all'attacco in nome della pseudoscienza, https://www.valigiablu.it/carriera-alias-scuola/, accessed in July 2023

Puri S., Adams V., Ivey S., Nachtigall R. D. (2011), There is such a thing as too many daughters, but not too many sons: A qualitative study of son preference and fetal sex selection among Indian immigrants in the United States, https://www.sciencedirect.com/science/article/abs/pii/S0277953611000700, accessed in July 2023

Quaglia V. (2022), Abortire in Italia: un diritto a rischio?, https://www.rivistailmulino.it/a/abortire-in-italia-un-diritto-a-rischio, accessed in July 2023

Rice S. (2022), Nutrition in the 1000-Day Window: Biden–Harris Administration Setting the Foundation for the Health of Our Nation, https://ajph.aphapublications.org/doi/10.2105/AJPH.2022.307137 B. Chalmers (1992), WHO appropriate technology for birth revisited , https://pubmed.ncbi.nlm.nih.gov/1420006/, accessed in July 2023

Richie H., Roser M. (2019), Gender ration, https://ourworldindata.org/gender-ratio, accessed in July 2023

Ritchie H., Roser M. (2021), Clean Water, https://ourworldindata.org/water-access, accessed in July 20233

Rodgers YVM, Coast E, Lattof SR, Poss C, Moore B. (2021), The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250692 , accessed in July 2023

Siviero G. (2016), I movimenti no-gender, spiegati bene, https://www.ilpost.it/giuliasiviero/2016/02/22/i-movimenti-no-gender-spiegati-bene/ , accessed in July 2023

Siviero G. (2021), Furono le mediche a farci cambiare approccio alle mestruazioni , https://www.ilpost.it/2021/10/15/furono-le-mediche-a-farci-cambiare-approccio-alle-mestruazioni/, accessed in July 2023

Smorti M., Milone A., Gonzalez J., Vitali Rosati G. (2019). Adolescent selfie: An Italian Society of Paediatrics Survey of the Lifestyle of Teenagers, https://ijponline.biomedcentral.com/articles/10.1186/s13052-019-0653-7 , accessed in July 2023

The Guardian (2023), Taliban fighters stop chemists selling contraception, https://www.theguardian.com/global-development/2023/feb/17/taliban-ban-contraception-western-conspiracy , accessed in July 2023

UN (2020), Fertility among young adolescents aged 10 to 14 years, https://www.un.org/en/development/desa/population/publications/pdf/fertility/Fertility-young-adolescents2020.pdf, accessed in July 20233

UN (2022), World Contraceptive Use, https://www.un.org/development/desa/pd/data/world-contraceptive-use, accessed in July 2023

UN Women (2018), Gender Equality in the 2030 Agenda: Gender-Responsive Water and Sanitation Systems, https://www.unwomen.org/en/digital-library/publications/2018/6/issue-brief-gender-responsive-water-and-sanitation-systems , accessed in July 2023

UNAIDS/WHO (1999), World Health Organization Communicable Disease Surveillance and Response, https://www.unaids.org/sites/default/files/media_asset/jc240-sextransminfsurv_en_0.pdf, accessed in July 2023

UNDESA (2019), World Population prospects 2022. Age-specific fertility rates by region, subregion and country, 1950-2100 (births per 1,000 women) Estimates. Online Edition, https://population.un.org/wpp/Download/Standard/Fertility/, accessed in July 2023

UNDESA (2022), World Population Prospects 2022. Age-specific fertility rates by region, subregion and country, 1950-2100 (births per 1,000 women) Estimates., https://population.un.org/wpp/Download/Standard/Fertility/, accessed in July 2023

UNESCO (2014), Puberty education & menstrual hygiene management, https://unesdoc.unesco.org/ark:/48223/pf0000226792, accessed in July 2023

UNESCO (2018), International technical guidance on sexuality education: an evidence-informed approach, https://unesdoc.unesco.org/ark:/48223/pf0000260770 , accessed in July 2023

UNFPA (2015), Girlhood, Not Motherhood, https://www.unfpa.org/publications/girlhood-not-motherhood, accessed in July 2023

UNFPA (2022a), My body, My life, My world Operational Guidance, https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA-MBMLMW_OperationalGuidance-EN.pdf , accessed in July 2023

UNFPA (2022b), Gender-biased sex selection, https://www.unfpa.org/sites/default/files/resource-pdf/3_Infographic_Macro_factsheet_web.pdf, accessed in July 2023

UNFPA (2022c), World Mental Health Day, https://www.unfpa.org/events/world-mental-health-day, accessed in July 2023

UNFPA (2022c), Climate justice requires ending climate crisis-related child marriages, https://esaro.unfpa.org/en/news/climate-justice-requires-ending-climate-crisis-related-child-marriages, accessed in July 2023

UNFPA (2023a), Family planning, https://www.unfpa.org/family-planning , accessed in July 2023

UNFPA (2023b), Obstetric fistula, https://www.unfpa.org/obstetric-fistula, accessed in July 2023

UNICEF (2017), First 1,000 days, https://www.unicef.org/southafrica/media/551/file/ZAF-First-1000-days-brief-2017.pdf, accessed in July 2023

UNICEF (2018), Drinking water, sanitation and hygiene in schools: Global baseline report 2018, https://data.unicef.org/resources/wash-in-schools/, accessed in July 2023

UNICEF (2020), Levels and trends in child mortality 2020. Estimates developed by the UN Inter-agency group for child mortality estimation, https://www.unicef.org/reports/levels-and-trends-child-mortality-report-2020, accessed in July 2023

UNICEF (2021), COVID-19: A threat to progress against child marriage, https://data.unicef.org/resources/covid-19-a-threat-to-progress-against-child-marriage/, accessed in July 2023

UNICEF (2021a), Healt Results 2021. Maternal, Newborn and adolescent health, https://www.unicef.org/media/123406/file/Health_Results_2021_Maternal_Newborn_Adolescent_Health.pdf, accessed in July 2023

UNICEF (2022a), Antenatal care, https://data.unicef.org/topic/maternal-health/antenatal-care/, accessed in July 2023

UNICEF (2022b), Child marriage, https://data.unicef.org/topic/child-protection/child-marriage/ accessed in July 2023

UNICEF (2023), Water, Sanitation and Hygiene (WASH). Safe water, toilets and good hygiene keep children alive and healthy, https://www.unicef.org/wash, accessed in July 2023

UNICEF (2023a), A child or youth died once every 4.4 seconds in 2021 – UN report, https://www.unicef.org/press-releases/child-or-youth-died-once-every-44-seconds-2021-un-report , accessed in July 2023

UNICEF (2023b), Female Genital Mutilation (FGM), https://data.unicef.org/topic/child-protection/female-genital-mutilation/ , accessed in July 2023

UNICEF (2023c), Water. Ensuring an adequate and safe water supply for the survival and growth of children, https://www.unicef.org/wash/water, accessed in July 2023

UNICEF/WHO (2019), Guidance on menstrual health and hygiene, https://www.unicef.org/media/91341/file/UNICEF-Guidance-menstrual-health-hygiene-2019.pdf, accessed in July 2023

UNICEF/WHO (2022), Progress on drinking water, sanitation and hygiene in schools: 2000-2021 data update, https://washdata.org/sites/default/files/2022-10/jmp-2022-wins-data-update.pdf , accessed in July 2023

VAWnet (2017), Reproductive Justice & Violence Against Women: Understanding the Intersections, https://vawnet.org/sc/reproductive-justice-violence-against-women-understanding-intersections, accessed in July 2023

Wang Z., Liu J., Shuai H. et al. (2021), Mapping global prevalence of depression among postpartum women, https://www.nature.com/articles/s41398-021-01663-6 , accessed in July 2023

Water Aid (2022a), No climate resilience without WASH: a call to action, https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/no-climate-resilience-without-wash-a-call-to-action.pdf, accessed in July 2023

Water Aid (2022b), The role of water, sanitation and hygiene in sexual and reproductive health rights, https://washmatters.wateraid.org/publications/the-role-of-water-sanitation-and-hygiene-in-sexual-and-reproductive-health-rights, accessed in July 2023

WHO (2014), La Prevenzione ed eliminazione dell'abuso e della mancanza di rispetto durante l'assistenza al parto presso le strutture ospedaliere, https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_ita.pdf;jsessionid=4419156F967A50EFD1D78625F57A1D39?sequence=17, accessed in July 2023

WHO (2018a), Births attended by skilled health personnel, https://www.who.int/data/nutrition/nlis/info/births-attended-by-skilled-health-personnel, accessed in July 2023

WHO (2018b), Obstetric fistula, https://www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula, accessed in July 2023

WHO (2020a), Infertility, https://www.who.int/news-room/fact-sheets/detail/infertility, accessed in July 2023

WHO (2020b), Family planning/contraception methods, https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception , accessed in July 2023

WHO (2021a), Abortion, https://www.who.int/health-topics/abortion#tab=tab_1, , accessed in July 2023

WHO (2021b), Endometriosis, https://www.who.int/news-room/fact-sheets/detail/endometriosis#:~:text=Endometriosis%20is%20a%20disease%20characterized,other%20parts%20of%20the%20body, accessed in July 2023

WHO (2021c), Breast cancer, https://www.who.int/news-room/fact-sheets/detail/breast-cancer, accessed in July 2023

WHO (2022), WHO urges quality care for women and newborns in critical first weeks after childbirth, https://www.who.int/news/item/30-03-2022-who-urges-quality-care-for-women-and-newborns-in-critical-first-weeks-after-childbirth, accessed in July 2023

WHO (2022a), WHO urges quality care for women and newborns in critical first weeks after childbirth,

WHO (2022b), Health risks of female genital mutilation (FGM), https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation, accessed in July 2023

WHO (2022c), Adolescent pregnancy, https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy, accessed in July 2023

WHO (2022d), Water, sanitation and hygiene (WASH),https://www.who.int/health-topics/water-sanitation-and-hygiene-wash#tab=tab_1, accessed in July 2023

WHO (2022e), Menopause, https://www.who.int/news-room/fact-sheets/detail/menopause , accessed in July 2023

WHO (2022f), Sexually Trasmitted Infections (STIs), https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis), accessed in July 2023

WHO (2022g), Cervical cancer, https://www.who.int/news-room/fact-sheets/detail/cervical-cancer, accessed in July 2023

WHO (2023), Gender and health, https://www.who.int/health-topics/gender#tab=tab_1, accessed in July 2023

WHO (2023a), Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division, https://www.who.int/publications/i/item/9789240068759, accessed in July 2023

WHO Regional Office for Europe and BZgA (2010), Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists, https://www.bzga-whocc.de/fileadmin/user_upload/ WHO_BZgA_Standards_English.pdf , accessed in July 2023

World Bank (2017), Educating girls, Ending Child Marriage, https://www.worldbank.org/en/news/immersive-story/2017/08/22/educating-girls-ending-child-marriage, accessed in July 2023

World Bank/ICRW (2017) Economic impacts of child-marriage: global synthesis report, https://documents1.worldbank.org/curated/en/530891498511398503/pdf/116829-WP-P151842-PUBLIC-, accessed in July 2023

World Cancer Research Fund International (2022), The impact of COVID-19 on cancer screening and treatment, https://www.wcrf.org/impact-covid-19-cancer-screening-treatment/, accessed in July 2023

World Cancer Research Fund International (2023), Differences in cancer incidence and mortality across the globe, https://www.wcrf.org/differences-in-cancer-incidence-and-mortality-across-the-globe/, accessed in July 2023

World Toilet Day (2022), Making the Invisible Visible, https://www-worldtoiletday-info.translate.goog/?_x_tr_sl=en&_x_tr_tl=it&_x_tr_hl=it&_x_tr_pto=sc, accessed in July 2023

9 788832 154191

WeWorld is an independent organization working in development cooperation and humanitarian aid for over 50 years, active today in 27 countries.

WeWorld works in **165 projects** reaching over **10 million direct beneficiaries** and **54 million indirect beneficiaries**.

We operate in: **Italy, Syria, Lebanon, Palestine, Libya, Tunisia, Afghanistan, Burkina Faso, Benin, Democratic Republic of Congo, Burundi, Kenya, Tanzania, Mozambique, Mali, Niger, Bolivia, Brazil, Nicaragua, Ecuador, Haiti, Cuba, Peru, India, Nepal, Thailand, Cambodia, Ukraine, Moldova.**

Children, women and youth, actors of change in every community, are the protagonists of WeWorld projects and campaigns in the following fields of intervention: **human rights** (gender equality, prevention and contrast of violence against women and children, migrations), **humanitarian aid** (prevention, aid and rehabilitation), **food security, water and sanitation, health, education and learning, socio-economic development, environmental protection, global citizenship education and international volunteering**.

Mission

We work for girls, boys, women and youth, actors of change in every community for a fairer and more inclusive world. We support people overcoming emergencies and we guarantee a life with dignity, opportunities and a better future through human and economic development programs (in the framework of the 2030 Agenda).

Vision

We strive for a better world where everyone, especially women and children, must have equal opportunities and rights, access to resources, to health, to education and to decent work.

A world in which the environment is a common good to be respected and preserved; in which war, violence and exploitation are banned. A world where nobody is left behind.

WEWORLD

VIA SERIO 6,
20139 MILANO - IT
T. +39 02 55231193
F. +39 02 56816484

VIA BARACCA 3,
40133 BOLOGNA - IT
T. +39 051 585604
F. +39 051 582225

www.weworld.it