Country Profile: Micronesia (Federated States Of)

Region: Oceania

Last Updated: 7 May 2017

Identified policies and legal sources related to abortion:
- Reproductive Health Act
- General Medical Health Act
- Constitution
- Criminal / Penal Code
- Civil Code
- Ministerial Order / Decree
- Case Law
- Health Regulation / Clinical Guidelines
- EML / Registered List
- Medical Ethics Code
- Document Relating to Funding
- Abortion Specific Law
- Law on Medical Practitioners
- Law on Health Care Services
- Other

Related Documents

From Criminal / Penal Code:
- Code of the Trust Territory of the Pacific Islands

From Case Law:
- Trust Territory v. Christina Tarkong, 1970

Concluding Observations:
- CEDAW

Persons who can be sanctioned:
- A woman or girl can be sanctioned
- Providers can be sanctioned
- A person who assists can be sanctioned

List of ratified human rights treaties:
- CERD
- CCPR
- Xist OP
- 2nd OP
- CESCR
- CESCR-OP
- CAT
- CAT-OP
- CEDAW
- CEDAW-OP
- CRC
- CRC:OPSC
- CRC:OPAC
- CRC:OPIC
- CMW
- CRPD *
- CRPD-OP
- CED **
- Maputo Protocol

Former ratified human rights treaties:
- Maputo Protocol

Abortion at the woman’s request

- No data

Legal Ground and Gestational Limit

- No data
**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

--- Source document: WHO Abortion Care Guideline (page 16)

**Additional notes**

The Code of the Trust Territory of the Pacific Islands states in Section 51: "Every person who shall unlawfully cause the miscarriage or premature delivery of a woman, with the intent to do so, shall be guilty of abortion and upon conviction thereof shall be imprisoned for a period of not more than five years."

In 1970, the Trial Division of the High Court, Yap District, considered the case of a woman charged with having unlawfully caused her own abortion. The court held that the section of the Trust Territory Code pertaining to abortion was so vague and indefinite that its attempted enforcement in the case in question constituted a denial of due process to the defendant and it was therefore invalid.

More generally, the court found that under the abortion section of this Code the persons liable are determinable by inference only and such indefiniteness and vagueness constitutes a denial of due process. It stated that criminal punishment was due only in cases where the intent to cause an abortion was present, precluding punishment for abortion by accident.

The court found that abortion statutes by their terms are applicable to the person causing the abortion and do not apply, without specific provision to the pregnant woman who is the victim of the act. Unless the abortion statute expressly makes the woman responsible, it is generally held, although the statute reads any "person," that she is not liable to any criminal prosecution, whether she solicits the act or performs it upon herself.

No law replacing Section 51 of the Code of the Trust Territory of the Pacific Islands could be found.

**Related documents:**
- Code of the Trust Territory of the Pacific Islands Title 11 Crimes and punishments (page 210)
- https://abortion-policies.srhr.org/documents/countries/

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is not viable. Grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers and leave women no choice but to continue with pregnancy. Being required to continue with a pregnancy that causes significant distress violates numerous human rights. Abortion Care Guideline § 2.2.2.

--- Source document: WHO Abortion Care Guideline (page 64)

**Additional notes**

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Rape

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Source document: WHO Abortion Care Guideline (page 64)

Additional notes

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Incest

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Additional Requirements to Access Safe Abortion

### Authorization of health professional(s)

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

Source document: WHO Abortion Care Guideline (page 81)

### WHO Guidance

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- **WHO Guidance**
  - Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available where the life and health of the woman, girl or other pregnant person is at risk. Abortion Care Guideline § 2.2.2.

Source document: WHO Abortion Care Guideline (page 64)

### Additional notes

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<table>
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<tr>
<th>Authorization in specially licensed facilities only</th>
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<tr>
<td>Judicial authorization for minors</td>
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<tr>
<td>Judicial authorization in cases of rape</td>
<td>Not applicable</td>
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<td>Police report required in case of rape</td>
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<td>Parental consent required for minors</td>
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<td>Spousal consent</td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) - and supported in the community - to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.

*Source document: WHO Abortion Care Guideline (page 52)*

The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

*Source document: WHO Abortion Care Guideline (page 81)*

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

*Source document: WHO-Safe-Abortion-Guidance-2012.pdf#page=104*

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*Source document: WHO Abortion Care Guideline (page 81)*

While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

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<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
<tr>
<td><strong>Ultrasound images or listen to foetal heartbeat required</strong></td>
<td>WHO Guidance</td>
</tr>
<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.</td>
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<tr>
<td><strong>Compulsory counselling</strong></td>
<td>WHO Guidance</td>
</tr>
<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality. Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements. The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual's situation and needs. Abortion Care Guideline § 3.2.2.</td>
<td></td>
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<tr>
<td><strong>Compulsory waiting period</strong></td>
<td>WHO Guidance</td>
</tr>
<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Mandatory waiting periods delay access to abortion, sometimes to the extent that women's access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.</td>
<td></td>
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<tr>
<td><strong>Mandatory HIV screening test</strong></td>
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<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Regulatory, policy and programmatic barriers - as well as barriers in practice - that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.</td>
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<td><strong>Other mandatory STI screening tests</strong></td>
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<tr>
<td><strong>Prohibition of sex-selective abortion</strong></td>
<td>WHO Guidance</td>
</tr>
<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. In situations where abortion is restricted for sex selection purposes, terminating a pregnancy for this reason is likely to involve an unsafe procedure carrying high risks. Any policies or guidelines on the use of technology in obstetric and fetal medicine should take into account the need to ensure women's access to safe abortion and other services - efforts to manage or limit sex selection should also not hamper or limit access to safe abortion services. Preventing gender-biased sex selection: an interagency statement.</td>
<td></td>
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<tr>
<td><strong>Restrictions on information provided to the public</strong></td>
<td>WHO Guidance</td>
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<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. Dissemination of misinformation, withholding of information and censorship should be prohibited. Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers. Abortion Care Guideline § 3.2.1.</td>
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*Source document:* WHO Abortion Care Guideline (page 77)
Clinical and Service-delivery Aspects of Abortion Care

<table>
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<tr>
<th>National guidelines for induced abortion</th>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. Safe Abortion Guidelines § 4.2.1.4.

*Source document: WHO-Safe-Abortion-Guidance-2012.pdf#page=103*

### Methods allowed

<table>
<thead>
<tr>
<th>Method</th>
<th>No data found</th>
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</table>

**Vacuum aspiration**

No data found

**Dilatation and evacuation**

No data found

**Combination mifepristone-misoprostol**

No data found

**Misoprostol only**

No data found

**Other (where provided)**

No data found

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

*Source document: WHO Abortion Care Guideline (page 50)*

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilatation and sharp curettage (D&Cs), including for sharp curette checks (i.e. to "complete" the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

*Source document: WHO Abortion Care Guideline (page 101)*

Dilation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

*Source document: WHO Abortion Care Guideline (page 103)*

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

*Source document: WHO Abortion Care Guideline (page 103)*

The Abortion Care Guideline recommends the use of misoprostol alone, with a regimen that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

*Source document: WHO Abortion Care Guideline (page 106)*
The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 μg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 μg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)

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Source document: WHO Abortion Care Guideline (page 55)

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

Source document: WHO Abortion Care Guideline (page 50)
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where can post abortion care services be provided</td>
<td>Primary health-care centres&lt;br&gt;No data found&lt;br&gt;Secondary (district-level) health-care facilities&lt;br&gt;No data found&lt;br&gt;Specialized abortion care public facilities&lt;br&gt;No data found&lt;br&gt;Private health-care centres or clinics&lt;br&gt;No data found&lt;br&gt;NGO health-care centres or clinics&lt;br&gt;No data found&lt;br&gt;Other (if applicable)</td>
</tr>
<tr>
<td>Contraception included in post-abortion care</td>
<td>No data found</td>
</tr>
<tr>
<td>Insurance to offset end user costs</td>
<td>Other (if applicable)</td>
</tr>
<tr>
<td>Who can provide abortion services</td>
<td>Nurse&lt;br&gt;No data found&lt;br&gt;Midwife/nurse-midwife&lt;br&gt;No data found&lt;br&gt;Doctor (specialty not specified)&lt;br&gt;No data found&lt;br&gt;Specialist doctor, including OB/GYN&lt;br&gt;No data found&lt;br&gt;Other (if applicable)</td>
</tr>
<tr>
<td>Extra facility/provider requirements for delivery of abortion services</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Referral linkages to a higher-level facility</strong></td>
<td></td>
</tr>
<tr>
<td>No data found</td>
<td></td>
</tr>
<tr>
<td><strong>Availability of a specialist doctor, including OB/GYN</strong></td>
<td></td>
</tr>
<tr>
<td>No data found</td>
<td></td>
</tr>
<tr>
<td><strong>Minimum number of beds</strong></td>
<td></td>
</tr>
<tr>
<td>No data found</td>
<td></td>
</tr>
<tr>
<td><strong>Other (if applicable)</strong></td>
<td></td>
</tr>
<tr>
<td>No data found</td>
<td></td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfills abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

---

**Conscientious Objection**

<table>
<thead>
<tr>
<th>Public sector providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data found</td>
</tr>
</tbody>
</table>

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---

<table>
<thead>
<tr>
<th>Private sector providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data found</td>
</tr>
</tbody>
</table>

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---

<table>
<thead>
<tr>
<th>Provider type not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data found</td>
</tr>
</tbody>
</table>

**WHO Guidance**

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---

<table>
<thead>
<tr>
<th>Neither Type of Provider Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data found</td>
</tr>
</tbody>
</table>

**WHO Guidance**

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---
<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Public facilities | **Indicators**

Country specific information related to sexual and reproductive health indications. As data for the Sustainable Development Goal (SDG) indicators related to sexual and reproductive health become available, these will be provided, through periodic updates.

### Goal 1. End poverty in all its forms everywhere

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)</td>
<td>No data</td>
</tr>
<tr>
<td>1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable</td>
<td>No data</td>
</tr>
<tr>
<td>1.4.2 Proportion of total government spending on essential services (education, health and social protection)</td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 3. Ensure healthy lives and promote well-being for all at all ages

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Maternal mortality ratio</td>
<td>BB (2017)</td>
</tr>
<tr>
<td>3.1.2 Proportion of births attended by skilled health personnel</td>
<td>No data</td>
</tr>
<tr>
<td>3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods</td>
<td>No data</td>
</tr>
<tr>
<td>3.7.2 Adolescent birth rate (aged 15-19 years) per 1,000 women in that age group</td>
<td>13.9 (2015-2020)</td>
</tr>
<tr>
<td>3.8.2 Number of people covered by health insurance or a public health system per 1,000 population</td>
<td>No data</td>
</tr>
</tbody>
</table>
### 3.c.1 Health worker density and distribution

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 5. Achieve gender equality and empower all women and girls

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex</td>
<td>No data</td>
</tr>
<tr>
<td>5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age</td>
<td>No data</td>
</tr>
<tr>
<td>5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence</td>
<td>No data</td>
</tr>
<tr>
<td>5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18</td>
<td>No data</td>
</tr>
<tr>
<td>5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age</td>
<td>No data</td>
</tr>
<tr>
<td>5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care</td>
<td>No data</td>
</tr>
<tr>
<td>5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education</td>
<td>No data</td>
</tr>
</tbody>
</table>

### 5.a.1 (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1 Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 6. Achieve gender equality and empower all women and girls

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education</td>
<td>No data</td>
</tr>
</tbody>
</table>

### 5.b.1 Proportion of individuals who own a mobile telephone, by sex

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.b.1 Proportion of individuals who own a mobile telephone, by sex</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5.2 Unemployment rate, by sex, age and persons with disabilities</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 10. Reduce inequality within and among countries

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2.1 Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities</td>
<td>No data</td>
</tr>
<tr>
<td>10.3.1 Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months</td>
<td>No data</td>
</tr>
<tr>
<td>16.2.2 Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation</td>
<td>No data</td>
</tr>
<tr>
<td>16.2.3 Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18</td>
<td>No data</td>
</tr>
<tr>
<td>16.3.1 Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms</td>
<td>No data</td>
</tr>
<tr>
<td>16.5.1 Proportion of persons who had at least one contact with a public official and who paid a bribe to a public official, or were asked for a bribe by those public officials, during the previous 12 months</td>
<td>No data</td>
</tr>
<tr>
<td>Indicator</td>
<td>Data</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>16.6.1 Primary government expenditures as a proportion of original approved budget, by sector (or by budget codes or similar)</td>
<td>No data</td>
</tr>
<tr>
<td>16.6.2 Proportion of the population satisfied with their last experience of public services</td>
<td>No data</td>
</tr>
<tr>
<td>16.7.1 Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions</td>
<td>No data</td>
</tr>
<tr>
<td>16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age</td>
<td>No data</td>
</tr>
<tr>
<td>16.10.1 Number of verified cases of killing, kidnapping, enforced disappearance, arbitrary detention and torture of journalists, associated media personnel, trade unionists and human rights advocates in the previous 12 months</td>
<td>No data</td>
</tr>
<tr>
<td>16.b.1 Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law</td>
<td>No data</td>
</tr>
</tbody>
</table>

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

17.8.1 Proportion of individuals using the Internet | No data |

### Additional Reproductive Health Indicators

- **Percentage of married women with unmet need for family planning** | No data |
- **Percentage of births attended by trained health professional** | 100 (2009) |
- **Percentage of women aged 20-24 who gave birth before age 18** | No data |
- **Total fertility rate** | 3.053 (2018) |
- **Legal marital age for women, with parental consent** | No data |
- **Legal marital age for women, without parental consent** | No data |
- **Gender Inequalities Index (Value)** | No data |
- **Gender Inequalities Index (Rank)** | No data |
- **Mandatory paid maternity leave** | no (2020) |
- **Median age** | 24.4 (2020) |
- **Population, urban (%)** | 22.703 (2018) |
- **Percentage of secondary school completion rate for girls** | No data |
- **Gender parity in secondary education** | 1.082 (2005) |
- **Percentage of women in non-agricultural employment** | No data |
- **Proportion of seats in parliament held by women** | 0 (2017) |
Sex ratio at birth (male to female births) 1.06 [2018]