# Women's Ability to Decide

Issue Brief on
**Indicator 5.6.1** of the
Sustainable Development Goals


## Analysis of data for policy and programming

Women's ability to make decisions reproductive health, contraceptive use and sexual relations is pivotal to gender equality and universal access to sexual and reproductive health and rights. Stocked shelves and trained staff must be in place, but access depends on autonomy. Too often women are not able to exercise their autonomy on these issues due to harmful and discriminatory social norms and practices and their lack of agency and financial resources.

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| **GOAL 5** | **Achieve gender equality and empower all women and girls** |
| **Target 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. |
| **Indicator 5.6.1** | Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health |

By the measure of Indicator 5.6.1, women who make their own decisions in all three of these areas—consensual sexual relations, contraceptive use and seeking reproductive health care for themselves—are considered empowered to exercise their reproductive rights.

Three questions are used in this composite indicator to assess women's autonomy:

1. **Reproductive health care:** Who usually makes decisions about health care for yourself?
2. **Contraceptive use:** Who usually makes the decision on whether or not you should use contraception?
3. **Sexual relations:** Can you say no to your husband/partner if you do not want to have sexual intercourse?

While the indicator has limitations[1], it is providing new insight and informing interventions to boost progress towards the Sustainable Development Goals, adopted in 2015 by all United Nations Member States as part of the 2030 Agenda for Sustainable Development. Indicator 5.6.1 is the only one of more than 200 indicators to quantify decision-making by women as a matter of agency and autonomy. This differs from an emphasis in the past on monitoring access to services, and offers new insight.

## Research findings and trend analysis

UNFPA commissioned a study on Indicator 5.6.1 conducted May to October 2019 using a mixed-method approach.[2] Research addressed changes and trends over time, influential factors, interventions with positive impact and corroboration of quantitative data by qualitative analysis, and a systematic literature review.

**What determines women's ability to decide on their sexual and reproductive health, and what is the relationship between this and other aspects of their lives?** The overall question is whether or not women are empowered and, if so, does this differ by indicator criteria and why. A study of 47 countries found that only 56 per cent of married women using contraception are empowered to make their own decisions on sexual and reproductive health, and of these women, most are likely to be educated and living in urban areas.[3] They are also likely to be experiencing better sexual and reproductive health and gender equality outcomes than women who do not meet all three criteria. Women from West and Central Africa are less likely to make decisions about their sexual and reproductive health compared with women from Latin America and the Caribbean, the Arab States and Asia. Furthermore, a small positive effect is attributed to getting married after age 18 and being exposed to media at least once a week.


**Does data analysis reveal similarities or differences across countries, and is the situation improving over time?** In-depth analysis based on Demographic and Health Survey (DHS) data across 22 countries finds that situations vary greatly. In Mali, for example, 6.5 per cent of married women are considered empowered in their decision-making compared with 75.6 per cent in Cambodia. Looking at more than one data point over time[4], trends are the most negative in Mali, Niger and Senegal where less than 10 per cent of women fulfil the indicator.

Nearly 60 per cent of countries show an overall positive trend, ranging from +1.8 per cent in Armenia to +14.3 per cent in Uganda. However, 41 per cent displayed a downward trend.

**When looking more closely at each of the three criteria—reproductive health, contraceptive use and sexual relations—do trends hold or are more questions raised?** A breakdown of the indicator into its three data points reveals even stronger variance. In many countries, the data points diverge in different directions over time. In Benin, women's ability to say "no" to sexual relations decreased by 24 per cent while results for the other two criteria remained the same. In Albania, while women's ability to say no to sexual relations and ability to make decision on health care increased by 13 per cent and 8 per cent respectively, their ability to decidie on the use of contraception declined by 4 percent. This suggests that the composite result can hide both positive and negative differences and that exploring *why* results differ requires more research.

Overall, analysis of DHS data across 22 countries concludes that decision-making on health care shows a positive trend towards progress (except in six countries affected by conflict), and the ability to say "no" to sexual relations shows a negative trend in more than half of countries.[5] Decision-making on contraceptives remains stable, but changes may be seen given a wider sample.

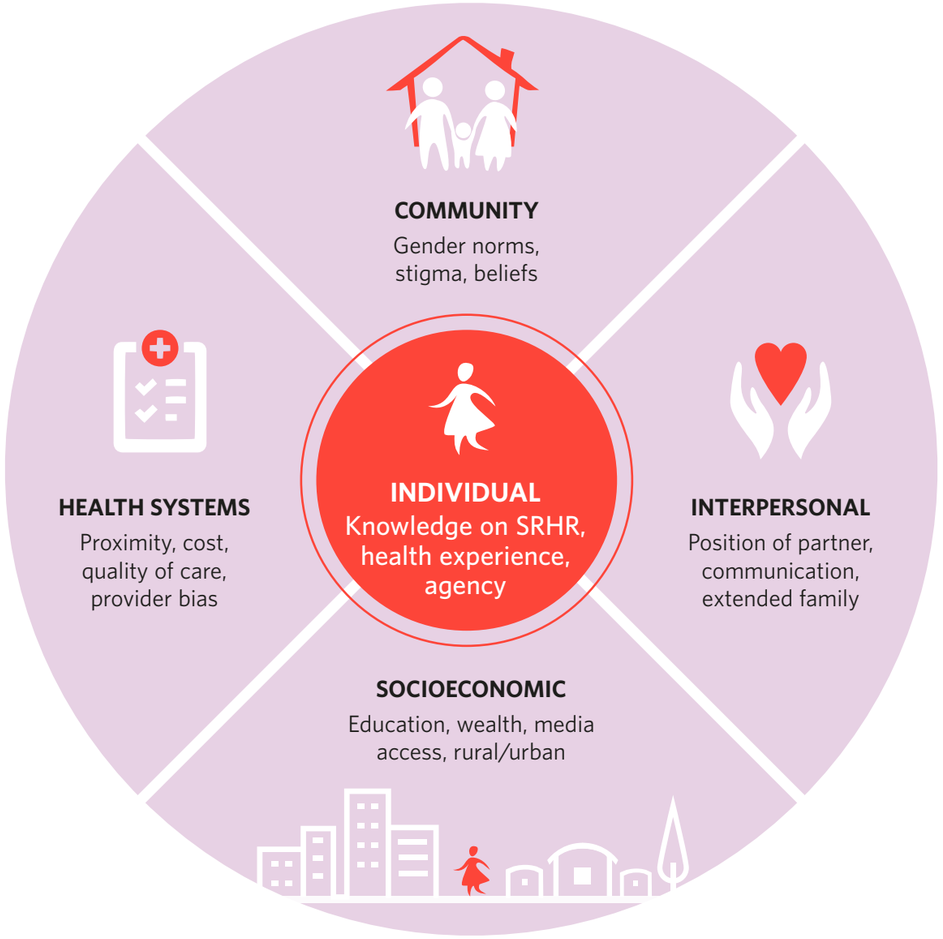


## Determining factors for women's ability to decide

Indicator 5.6.1 measures women's ability to make their own informed decisions about their sexual and reproductive health. "Informed" means based on sufficient knowledge. Answering questions about factors surrounding decision-making requires more than quantitative analysis. The research team triangulated data from quantitative and qualitative sources, including case studies and the systematic literature review and identified a number of determining factors:

- **Knowledge** related to sexual and reproductive health and reproductive rights is a key predictor for women's decision-making ability. Awareness, in contrast, is rarely fact-based and is prone to misconceptions, rumours and myths. The incidence of *awareness* on sexual relations, contraceptive use and reproductive health care is high in most settings whereas *knowledge* is strikingly low, in particular in rural settings. Access to quality information is either absent or communicated in inadequate ways so it is difficult to know whether women actually make informed decisions.
- The **position of the husband** or partner in the decision-making process is a key factor impacting on women's decision-making. Men's support makes access and use more likely. The position of the extended family, specifically of the mother-in-law in rural contexts, is also an important influence on the decision-making processes on contraceptive use and reproductive health care seeking.
- **Communication** between partners or spouses is a positive predictor for joint- or women's decision-making.
- **Gender norms** represent a significant deterrent for women's independent or joint decision-making. Women are expected to be submissive and passive in sexual relations, to fulfil reproductive obligations in wedlock and to obey their husbands' decisions regarding their own reproductive health.
- Contraceptive **side effects** influence women's decision-making. When women lack access to family planning services, the impact of side effects may result in decisions to discontinue use of contraceptives.
- Issues of **access, affordability and acceptability** of health services have an impact on decision-making. Barriers such as disrespectful treatment by health workers, inconvenient opening hours of facilities, informal costs, stock-outs, lack of method choice and, in some cases, lack of female health care providers play a role in the household's decision-making process.
- The likelihood is high that women in **rural areas** with low levels of education and agency will be subjected to unequal power relations and have little or rare communication with their husband/partner on matters related to sexual and reproductive health.
- The most significant demographic and social determinants across all areas of Indicator 5.6.1 are women's education level, education level of her husband/partner, household wealth status, urban residency and access to radio and television. The most influential determinants for individuals are adequate knowledge on sexual and reproductive health, previous health experiences or the health status of the woman, and a woman's autonomy and agency. The decision-making dynamic is influenced by the husband's or partner's position on the subject. Moreover, regarding the nature of **joint decision-making**, decisions that were reported as being taking "jointly" are likely to include a substantial percentage of decisions in which women were overruled by men.

**FIGURE 1:** Common determinants of women's informed decision-making




## Interventions with positive and sustainable impact for women's reproductive autonomy

Good programme models achieve change by tackling barriers at several levels—individual, interpersonal and institutional—and have an impact on both supply and demand.[6] Community outreach strategies, male engagement, information technologies for development (IT4D) and formative research at the initial stages of programming to understand context, show promising results. Engaging men in community mobilization activities and informal education has been linked to better reproductive health outcomes. Efforts to improve dialogue between couples and explore mutually supportive gender roles is another promising approach, both to increase joint decision-making and introduce non-violent communication skills.

In the area of health system strengthening, effective interventions include training health service providers on quality of care and gaps in competency, supervision of health facilities in partnership with local government health officials, and provision of contraceptives and other essential reproductive health supplies.

In the case studies, large improvements in women's decision-making on health care are often linked to a) removal of financial barriers due to health insurance coverage (Ghana, Rwanda); b) abolition of user fees (Uganda) and c) use of vouchers and/or conditional cash transfers (Uganda), coupled with improved levels of education, wealth, fewer people living in the household and media exposure.



## Who is being left behind?

Married, educated and wealthier women in urban areas are relatively well-positioned in terms of their decision-making on sexual and reproductive health, yet there are other groups of women who are more disadvantaged and vulnerable including:

- **Unmarried girls and women** with low education level in rural areas are often exposed to community sanctions and discrimination by health care providers and pharmacists.
- **Young adolescent girls aged** 10–14 have high vulnerability and low agency, yet are largely excluded from programmes and services offering much-needed information and support.
- **Girls and women belonging to marginalized groups** face exclusion and discrimination due to language, communication and cultural barriers. Such groups often include women with disabilities; women from indigenous, nomadic, refugee and internally displaced populations; and women who are illiterate.

Social and cultural norms are behind many of the barriers. Increasingly, efforts are focused on reaching adolescents and young people, populations in humanitarian crisis settings, and going the last mile to those most in need. Also, awareness is growing regarding the role of men, who are less knowledgeable and more prone to adhere to misconceptions and false information compared with women of the same age.

CASE STUDY **UGANDA**

### Uganda demonstrates consistent progress in women's decision-making ability in all three aspects of indicator 5.6.1.

The percentage increase in decision-making between 2006 and 2016 was +4.6 per cent on sexual relations, +2.6 per cent on contraceptive use and +12.6 per cent on reproductive health care. This trend was supported by better education and income levels as well as interventions such as abolishing user fees and introducing vouchers or conditional cash transfers. SASA! is a prevention programme on HIV and violence against women (VAW) designed by Raising Voices that has led to lower social acceptance of intimate partner violence and VAW and greater acceptance that a woman can refuse sex. Couples have improved their communication and levels of joint decision-making. SASA! Engages health workers and trains community activists who introduce door-to-door discussions, training, public events, films and soap opera groups.

## Recommendations

Based on the evidence obtained through this analysis, several areas of action are proposed:

1. **Address the root causes** that create barriers to women's ability to make decisions about their own sexual and reproductive health and provide technical and financial support to scale up and improve quality interventions in sexual and reproductive health and rights. This includes leaving no one behind with programmes and policies that reduce inequalities and strengthen women's agency and autonomy. A solution that encompasses social norms change for women's empowerment as well as access to essential supplies and services will include a) improving affordability of reproductive health services, b) increasing knowledge among women and men and challenging misconceptions, and c) initiating community-level activities on communication and mutual support.

2. **Close the research gap** by further analysing data trends, causal relations of policy changes and the quality of reported joint decision-making. Also, ensure that Indicator 5.6.1 is monitored in a disaggregated way, as well as complemented with data on unmarried women and girls and marginalized groups. In light of the context specific nature of norms, formative research at the initial stages of programming is needed to strengthen programme models and interventions, with a focus on sociocultural norms, use of technology for development to expand reach, and men's involvement in women's reproductive health.

3. **Support holistic gender-transformative programming approaches** and their evaluation, documentation and distribution. Such interventions promote gender equality and examine, question and change rigid gender norms and imbalances of power that give an advantage to boys and men over girls and women. Gender equality (the shared control of resources and decision-making) and women's empowerment are global priorities in the Sustainable Development Goals. By increasing the ability of women to make informed decisions on their sexual and reproductive health, countries are taking a transformational step towards Goal 5: Achieve gender equality and empower women and girls.

CASE STUDY **RWANDA**

**Rwanda reports consistent progress across all data points.**

The percentage increase in decision-making between 2010 and 2014 was +2.5 per cent on sexual relations, +1.7 per cent on contraceptive use and +9.7 per cent on reproductive health care. Improved affordability of services may be a contributing factor, given coverage by health insurance, as well as commitments to improve gender equality. The Bandebereho intervention by the Rwanda Men's Resource Center demonstrates positive models of fatherhood through 15 sessions on gender, communication, caregiving, non-violence and male engagement in reproductive and maternal health. Women report less physical and sexual violence, greater use of modern contraception and less decision-making by men only. The Indashyikirwa programme features a five-month curriculum to identify the causes and consequences of intimate partner violence (IPV), with both partners reporting positive changes.



## Endnotes

1 Note on limitations: The indicator captures results for married and in-union women and adolescent girls but not for those who are unmarried. The indicator creates an overall value from three data points that do not necessarily evolve in the same direction, which may mask changes and variance and does not allow for trend analysis (which must be done for each data point and which requires timely data). Broader data sources are needed. Current data on the indicator are derived from Demographic and Health Surveys (DHS) and efforts are being made to include MICS and other country-specific surveys. A wider sample is needed, and for DHS7 and later rounds, the survey questions will be extended to all married or in-union women aged 15-49, whether they are using contraception or not (currently, only those using contraction are included). Another limitation is that not all questions are asked on DHS in all countries. As of March 2019, a total of 51 countries, the majority in sub-Saharan Africa, have at least one survey with data on all three questions necessary for calculating Indicator 5.6.1.

2 Note on methodology: 1) Systematic review of factors associated with women's decision-making on sexual and reproductive health and reproductive rights (SRHR), including 345 peer reviewed articles out of 13,000 initially sourced. 2) Quantitative trend analysis of 98 data sets from the Demographic and Health Survey (DHS) of 22 countries with data for at least two of the three questions in this composite indicator; 3) Statistical analysis of 130,007 married women who use modern contraception from 47 countries; 4) Qualitative analysis involving four case studies in Ghana, Senegal, Uganda and Rwanda, and eight key informant interviews.

For the full UNFPA report of the Research on what determines women's ability to decide on their sexual and reproductive health and rights, please go to unfpa.org/sdg-5-6.

3 Among married and in-union women who use contraception in 47 countries (n=130,007).

4 DHS data on all three components were available for three different data points (2006, 2011 and 2016). The number of countries studied was too small for trend analysis in Eastern Europe and Central Asia and in Asia and the Pacific.

5 Women may "choose" to comply with sexual conditions imposed by husbands, as a way to negotiate autonomy in other aspects of their lives, and this may influence survey question response.

6 Findings of the systematic review and literature review of good practices.



**Source:** UNFPA and Hera (2019). *Research on what determines women's ability to decide on their SRHR and the relationship between this and other aspects of their lives.* Volumes 1 and 2: Final report, October 2019.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