
A pregnant woman wearing a floral headscarf and denim overalls, smiling and holding her belly, standing in front of a purple wall with a poster in the background.

Tracking women's decision-making for sexual and reproductive health and reproductive rights



**SUSTAINABLE DEVELOPMENT
GOAL **INDICATOR 5.6.1****



The Sustainable Development Goals mark tremendous progress in addressing women's sexual and reproductive health and reproductive rights. For the first time, an international development framework includes not only targets on services (Targets 3.1 and 3.7), but also targets that address the barriers and human rights-based dimensions (Target 5.6). Target 5.6 on universal access is measured by two indicators designed to complement each other (Indicators 5.6.1 and 5.6.2).



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 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

INDICATOR 5.6.2: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education¹.

Combined, they provide a comprehensive picture of key dimensions of sexual and reproductive health and reproductive rights, measuring women's ability to make her own decisions on contraceptive use, reproductive health care and sexual relations, as well as the legal and regulatory environment. This allows a complementary examination of whether a country has a positive enabling legal and normative framework, and whether its provisions go the last mile to empower all women and girls.



Only women who assert that they make their own decisions in three key areas are considered to have autonomy in reproductive health decision-making and empowered to exercise their reproductive rights. Three questions are used in this composite indicator to assess women’s autonomy:

 Reproductive health care	 Contraceptive use	 Sexual relations
Who usually makes decisions about health care for yourself?	Who usually makes the decision on whether or not you should use contraception?	Can you say no to your husband/partner if you do not want to have sexual intercourse?
<ul style="list-style-type: none">• You• Your husband/partner• You and your husband/partner jointly• Someone else	<ul style="list-style-type: none">• Mainly respondent• Mainly husband/partner• Joint decision• Other, specify	<ul style="list-style-type: none">• Yes• No• Depends/not sure

Until recently, the indicator captured results for married and in-union women and adolescent girls of reproductive age (15–49 years old) who are using any type of contraception. In the next phase of the national Demographic and Health Survey (DHS–7) and later rounds, the questionnaire will be extended to respondents whether they are using contraception or not. One limitation of the data is that unmarried women and girls are not included.

As of early 2020, a total of 57 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. Broader data sources are needed and efforts to increase data coverage are underway. Current data on the indicator are derived from the DHS and efforts are being made to include the Multiple Indicator Cluster Surveys (MICS), the Generation and Gender Survey (GGG) and other country-specific surveys.



Levels in women’s decision-making regarding sexual and reproductive health

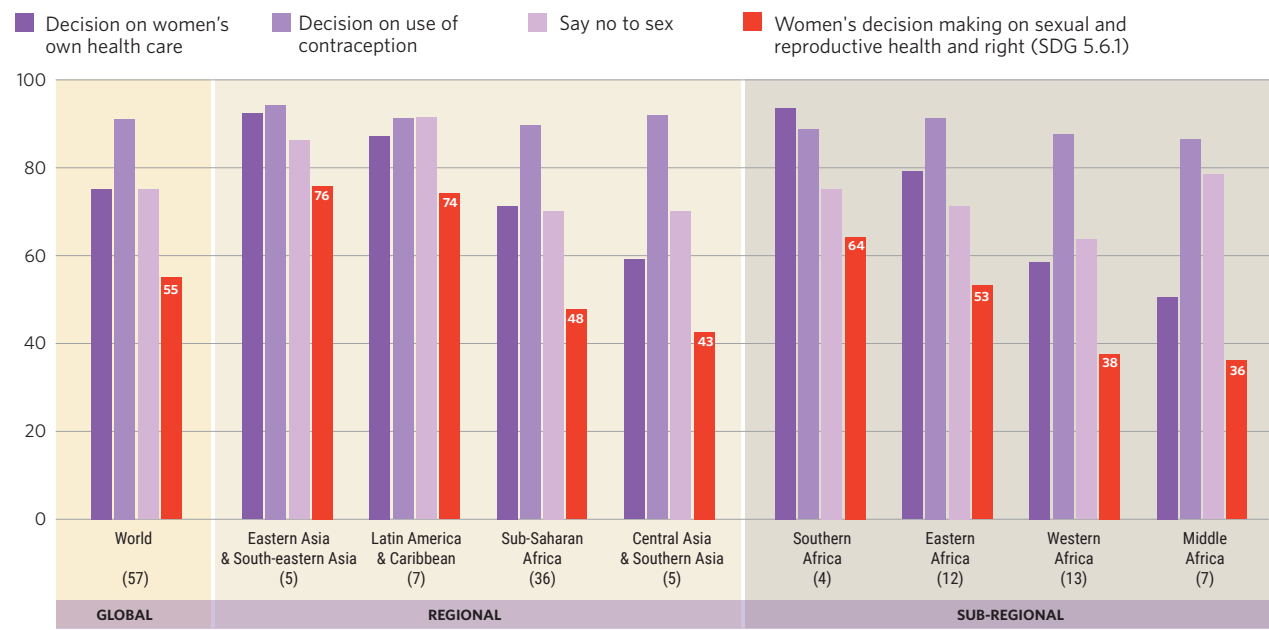
Only 55 per cent of married or in-union women aged 15 to 49 make their own decisions regarding sexual and reproductive health and rights, based on data from 57 countries. Data thus far reveal large disparities among regions², from less than 40 per cent empowered in Middle Africa and Western Africa to nearly 80 per cent in some countries in Europe, South-eastern Asia, and Latin America and the Caribbean. Analysis of the three sub-indicators shows that while women seem to have the most autonomy in deciding to use contraception, with 91 per cent empowered, only three in four women can decide on their own health care or say no to sex.

Dynamics in sexual and reproductive health decision-making vary substantially across regions. In Southern Africa, 92 per cent of married or in-union women make decisions on their health care and 75 per cent can say no to sex. In comparison, in Middle

Africa, 50 per cent of women make decisions of their health care, and close to 80 per cent can say no to sex. Although In Eastern Asia and South-eastern Asia, and Latin America and the Caribbean over 85 per cent of women are able to make at least one of the three types of decisions, only three in four can make decisions for all of them. In summary, gaps still exist in women’s autonomy, even where high levels of individual decision-making are observed in some dimensions.

The levels in women’s decision-making regarding sexual and reproductive health care greatly varied across countries. Among the 57 countries with data, Ecuador has the highest level, at 87 per cent, followed by the Philippines and Ukraine where 81 per cent of married or in-union women decide on sexual and reproductive health care for themselves. Mali, Niger and Senegal are among the countries with the lowest levels, where less than 10 per cent of married or in-union women participate in the decisions on sexual and reproductive health care (figure 2).

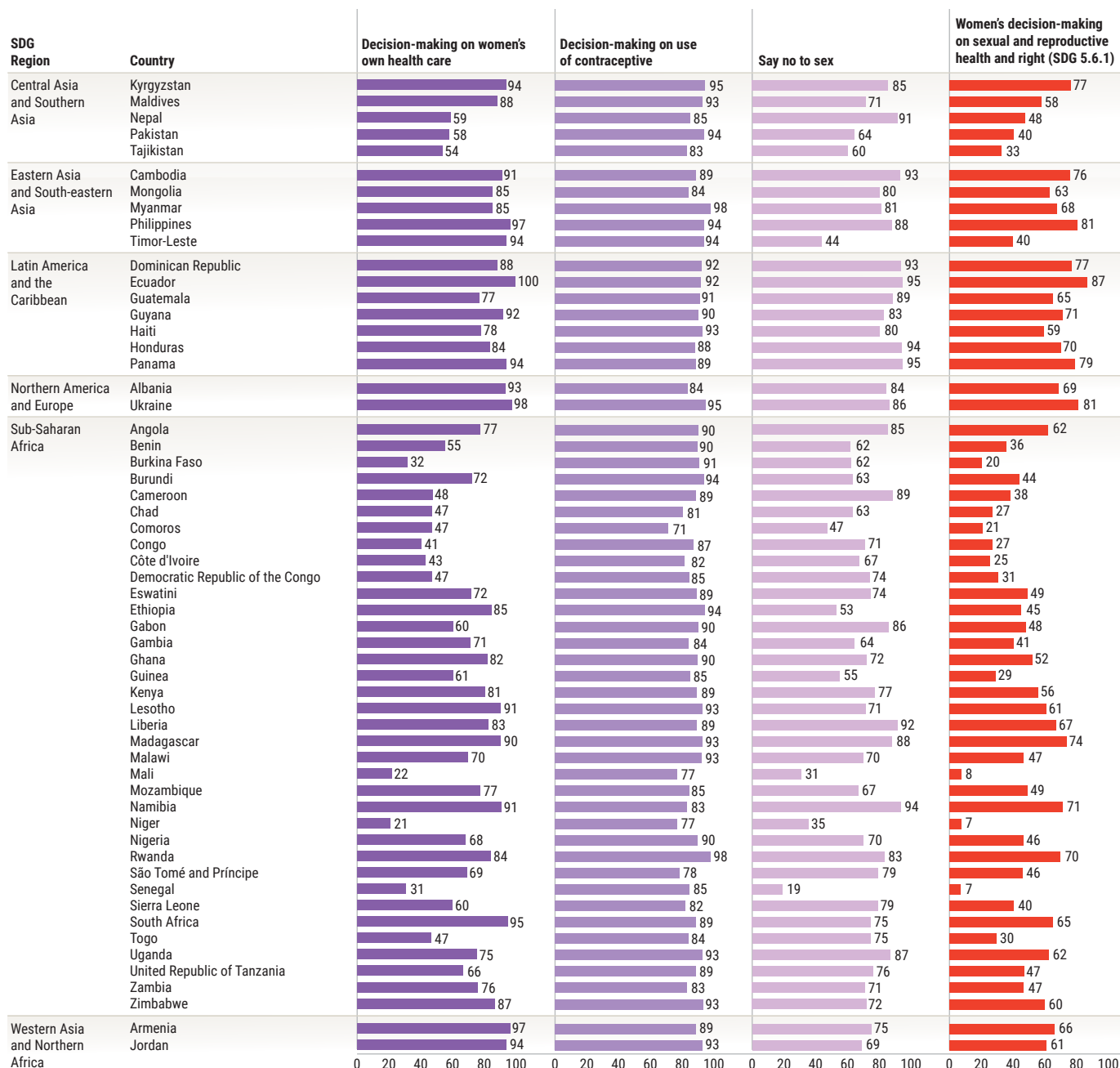
Figure 1. Proportion of women aged 15-49 years who make their own decisions regarding sexual and reproductive health and rights (including deciding on their own health care, deciding on the use of contraception; and can say no to sex); by SDG region, most recent data 2007-2018.



Notes: The number of countries with comparable survey data included in the regional aggregations is presented in parentheses.

Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

Figure 2. Proportion of women aged 15-49 years who make their own decisions regarding sexual and reproductive health and rights (including deciding on their own health care, deciding on the use of contraception; and can say no to sex); by country, most recent data 2007-2018.



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

Leaving no one behind

The 2030 Agenda for Sustainable Development elevates as a core principle the objective to “leave no one behind.” Leaving no one behind will require the use of disaggregated data, to allow an in-depth look at trends across different population groups. Overall, older women, more educated women, women living in urban areas, and women living in the wealthier households are more likely to make their own decisions.³

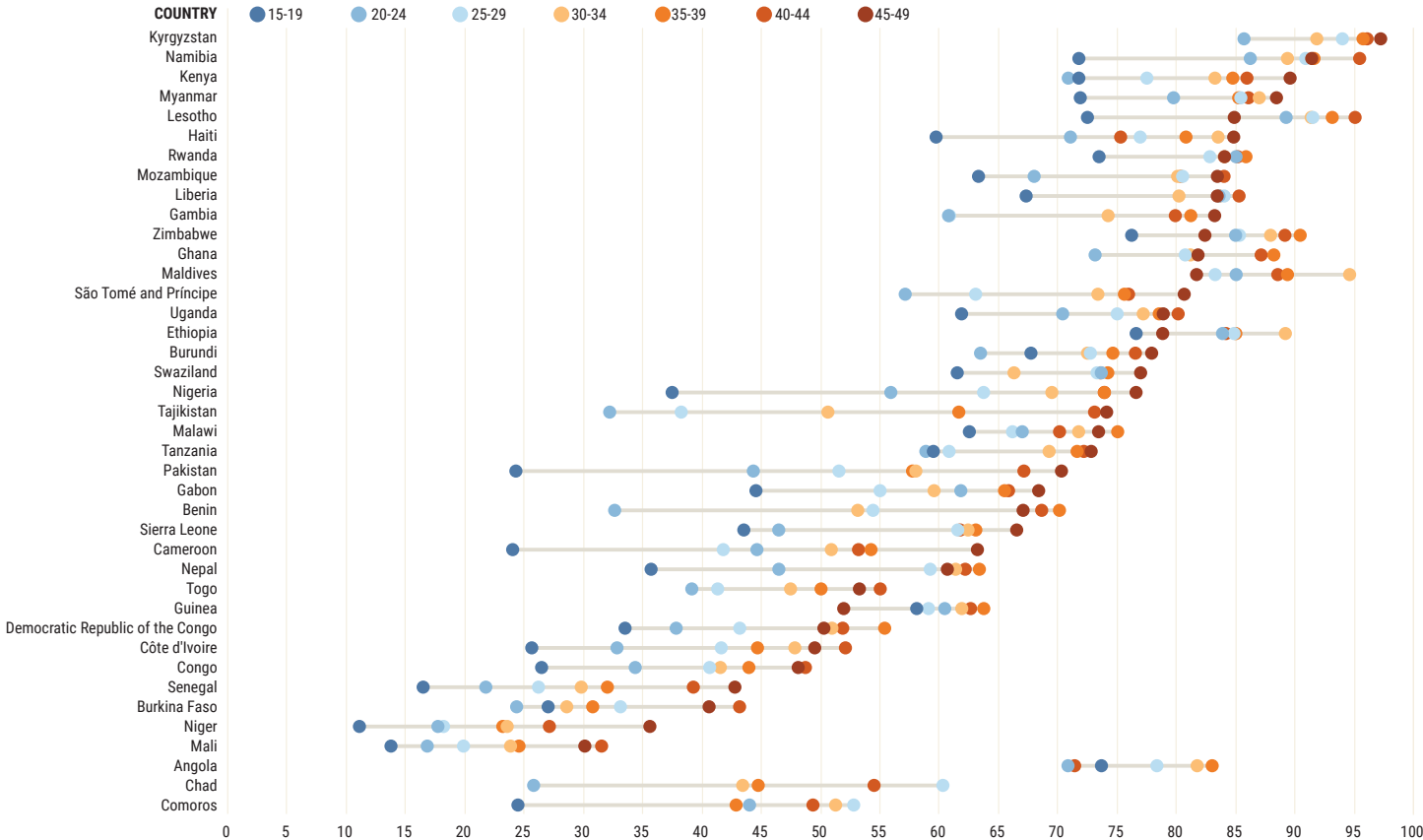
Variations are found at the national level for each type of decision. In some countries such as Jordan, Tajikistan and Zimbabwe, older women are more likely to have the ability

to say no to sex; while in other countries such as Comoros, Ethiopia and Guinea, older women are less likely to have the ability say no to sex (figure 3.a). In contrast, older women are more likely to make their own decisions on their health care in almost all of the countries with data available (figure 3.c). More consistent disadvantages among less educated women, women living in poorer households, and women living in rural areas are found in the vast majority of the countries across all three components of the indicator.

To leave no one behind, it is important to know if the situation of the most vulnerable is improving, regardless of where they

FIGURE 3 – AGE GROUP

Figure 3.a Decision-making on women’s own health care, by age, select countries, per cent



live. Substantial variations at the sub-national level are observed in a number of countries. In Pakistan, over half married or in-union women living in the province of Sindh and Islamabad Capital Territory (ICT) make their own decisions on health care, compared with approximately 10 per cent of their peers living in FATA and Balochistan. Similarly, in Mozambique, over 70 per cent women living in Maputo and Inhambane have autonomy in health care decision-making, compared with less than 10 per cent of women living in Tete (figure 7.a).

Data on each core element reflect the enormous heterogeneity of access to sexual and reproductive health education and services, and to reproductive rights. To achieve the Goal by 2030, unnecessary legal, medical, clinical and regulatory barriers to the utilization of sexual and reproductive health services must be removed, and changes in social norms and government policies that allow women and girls to fully exercise their reproductive rights must be prioritized.

FIGURE 3 - AGE GROUP (CONTINUED)

Figure 3.b Decision-making on contraception use, by age, select countries, per cent

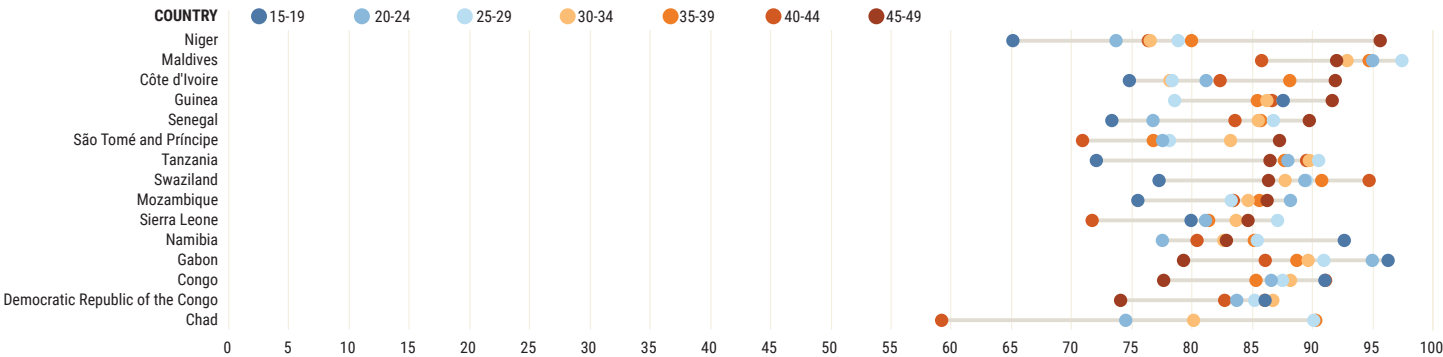
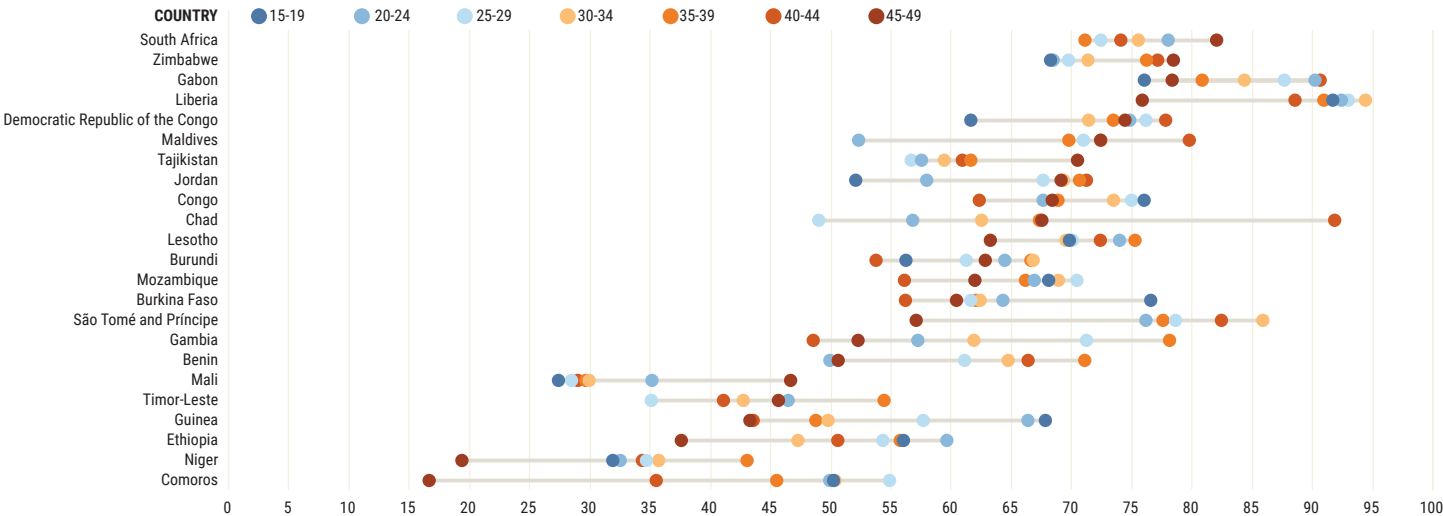


Figure 3.c Say no to sex, by age group, select countries, per cent



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

FIGURE 4 – HIGHEST LEVEL OF EDUCATION

Figure 4.a Decision-making on women’s own health care, by women’s level of education, select countries, per cent

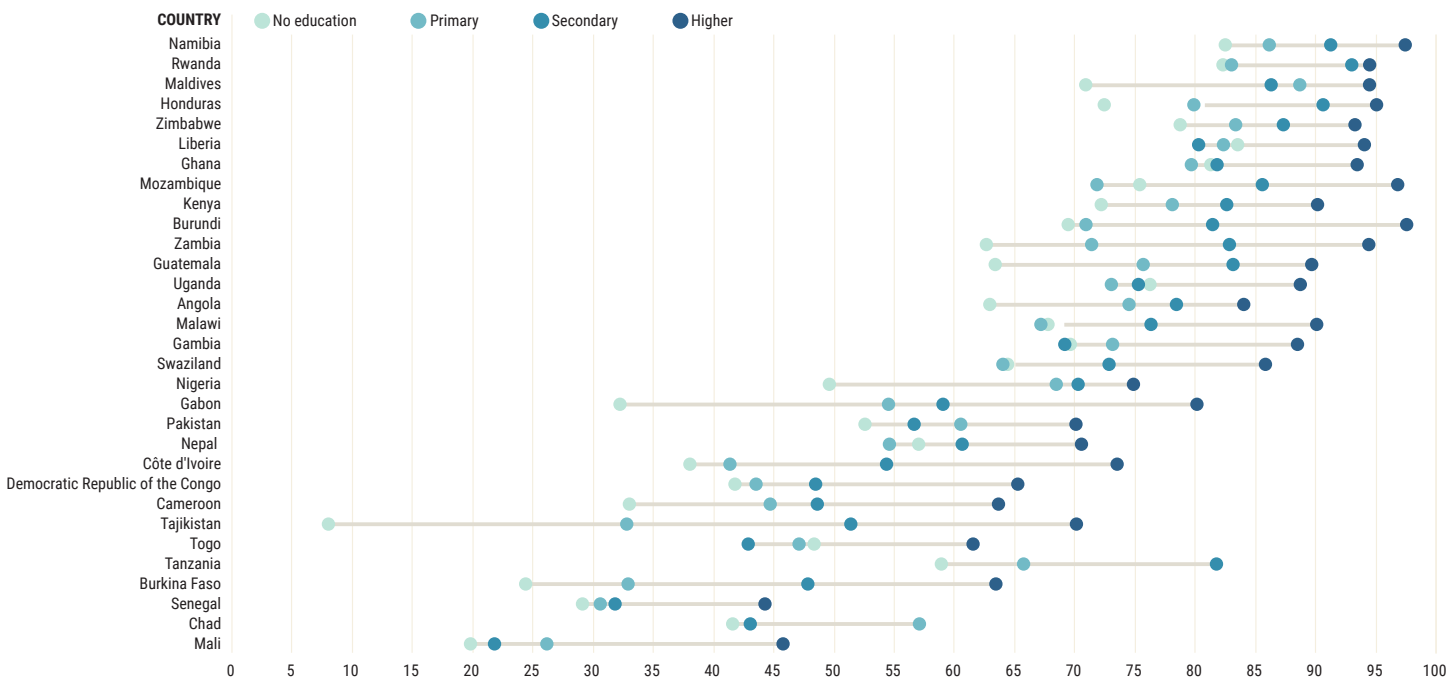
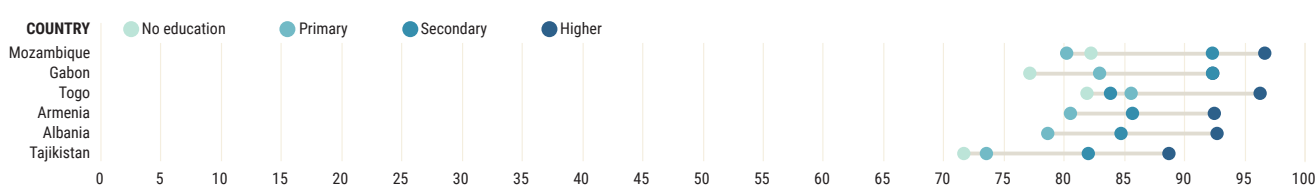


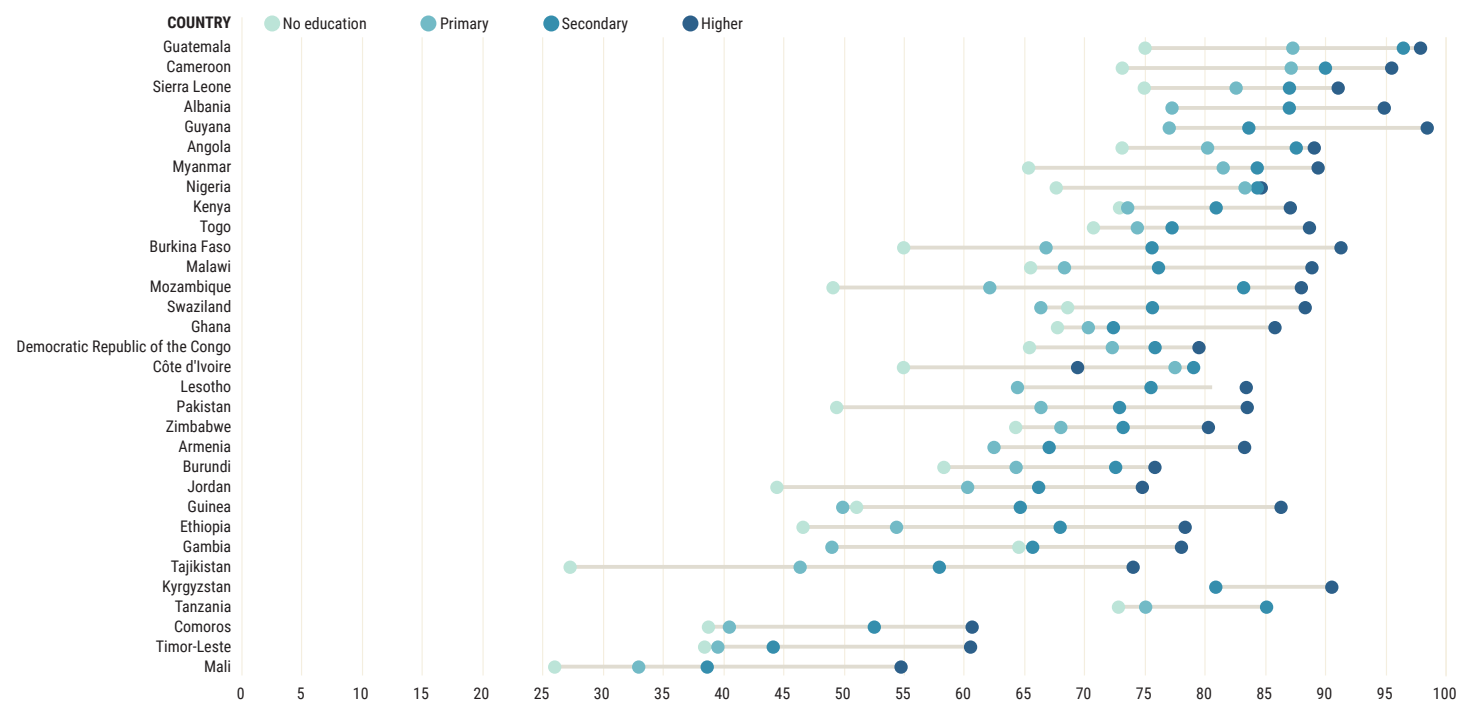
Figure 4.b Decision-making on contraception use, by women’s level of education, select countries, per cent



To achieve the Goal by 2030, unnecessary legal, medical, clinical and regulatory barriers to the utilization of sexual and reproductive health services must be removed.

FIGURE 4 - HIGHEST LEVEL OF EDUCATION (continued)

Figure 4.c Say no to sex, by women's level of education, select countries, per cent



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.



FIGURE 5 – HOUSEHOLD WEALTH

Figure 5.a Decision-making on women's own health care, by household wealth, select countries, per cent

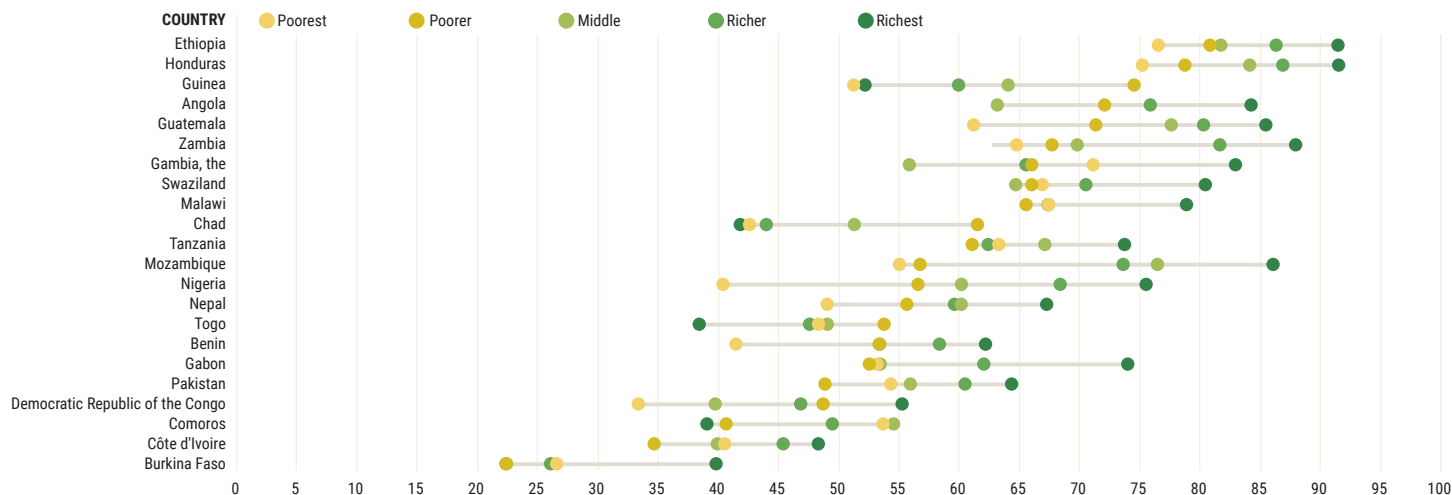


Figure 5.b Decision-making on contraception use, by household wealth, select countries, per cent

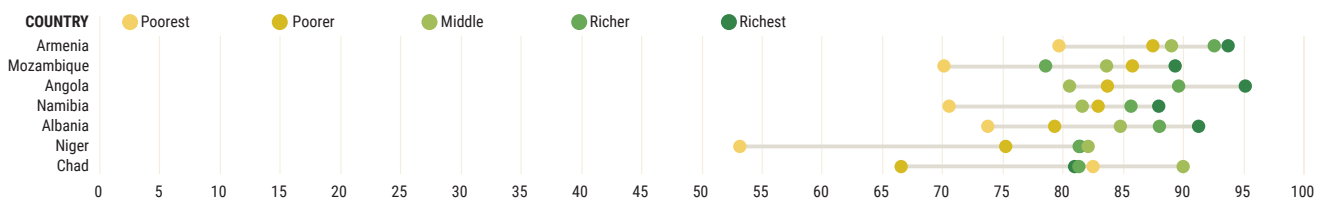
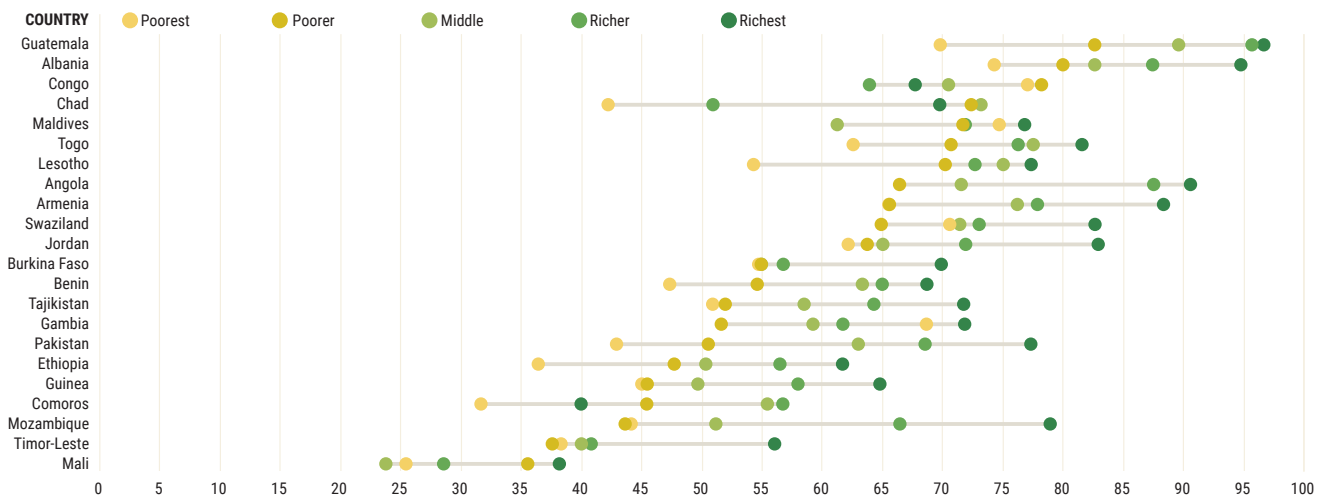


Figure 5.c Say no to sex, by household wealth, select countries, per cent



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

FIGURE 6 - PLACE OF RESIDENCE

Indicator 6.a Decision-making on women's own health care, by place of residence, select countries, per cent

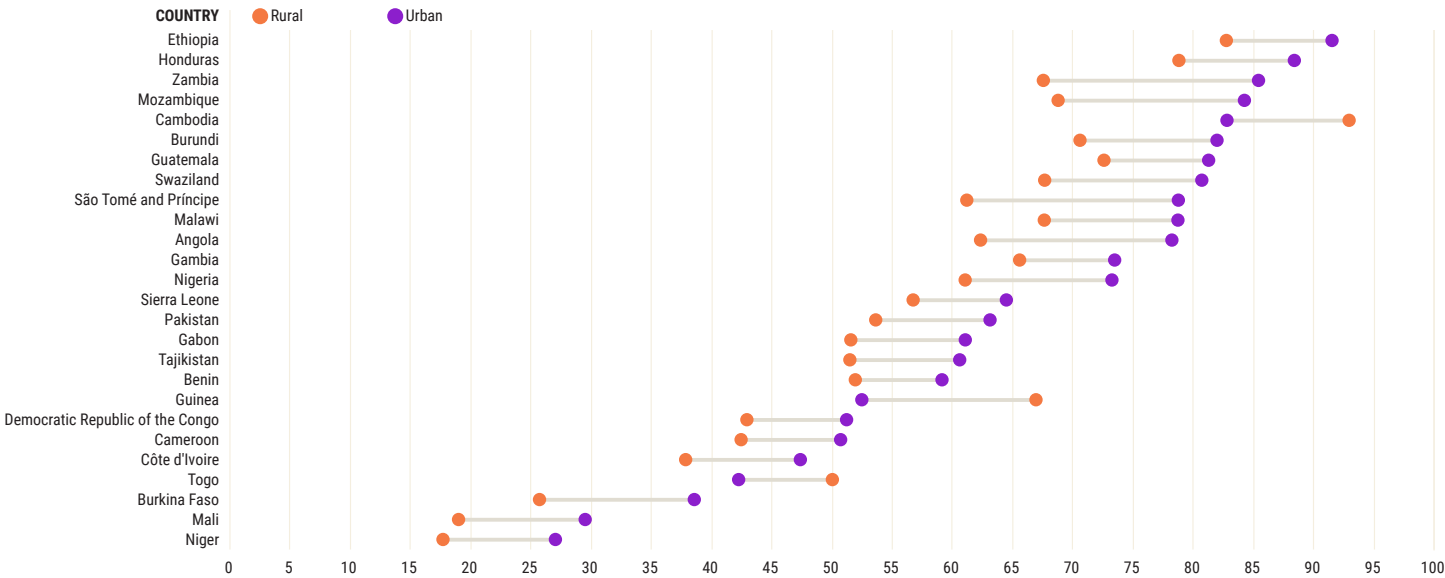


Figure 6.b Decision-making on contraception use, by place of residence, select countries, per cent

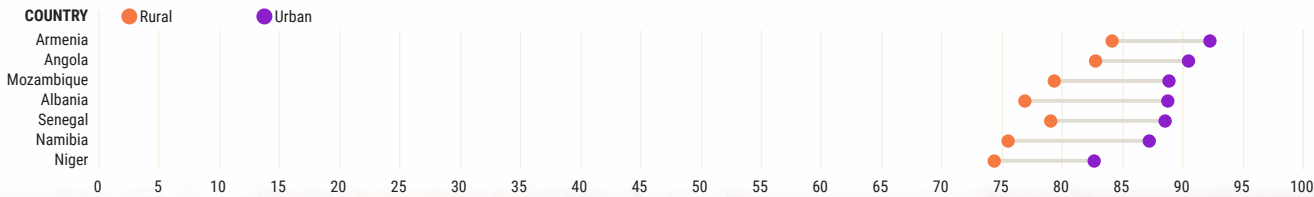
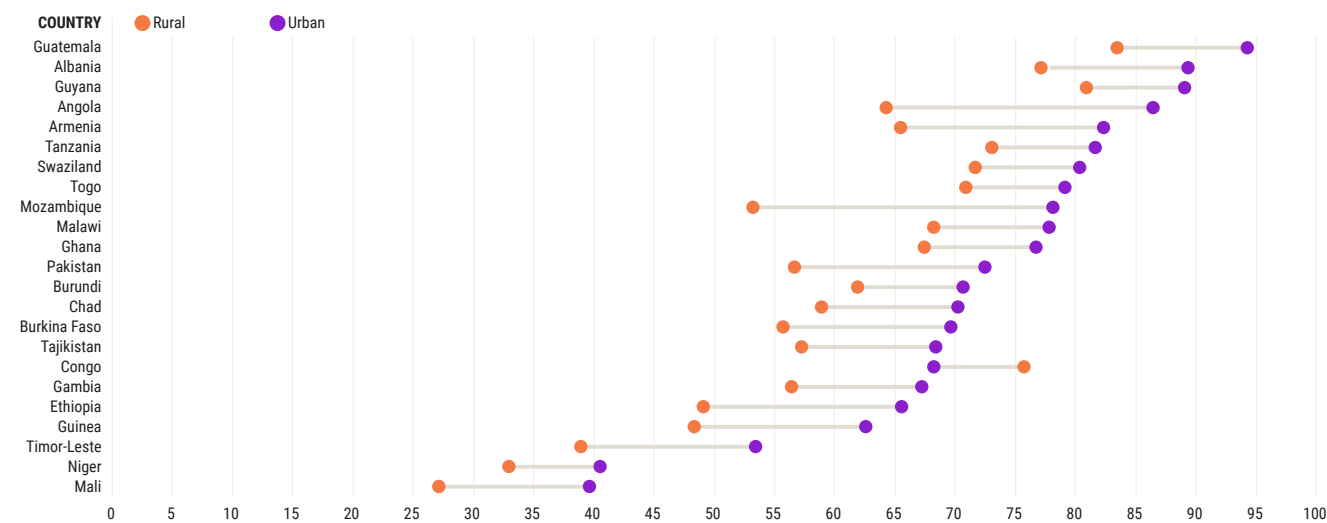


Figure 6.c Say no to sex, by place of residence, select countries, per cent



Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

Quantifying who is left behind

The majority of the following factors are significantly associated with a woman making her own decision on sexual relations, use of contraception and her own health care: age, age at first marriage, education level, wealth, exposure to media, place of residence and region of the world. Increasing levels of education has the greatest effect on women's decision-making on sexual and reproductive health and reproductive rights. Receiving at least some primary education provides a boost to women's autonomy; women who have some primary education are 38 per cent more likely (95%CI[1.33-1.44]) to meet the Indicator 5.6.1 criteria than those who do not receive any education.

In general, as women increase in age, they are more likely to make their own decisions. The greatest gains are seen as women move

through their 20s up to 34 years of age. After 35 years of age, women still are much more likely than those between 15-19 years old to achieve autonomy, but it appears that the effect levels off.

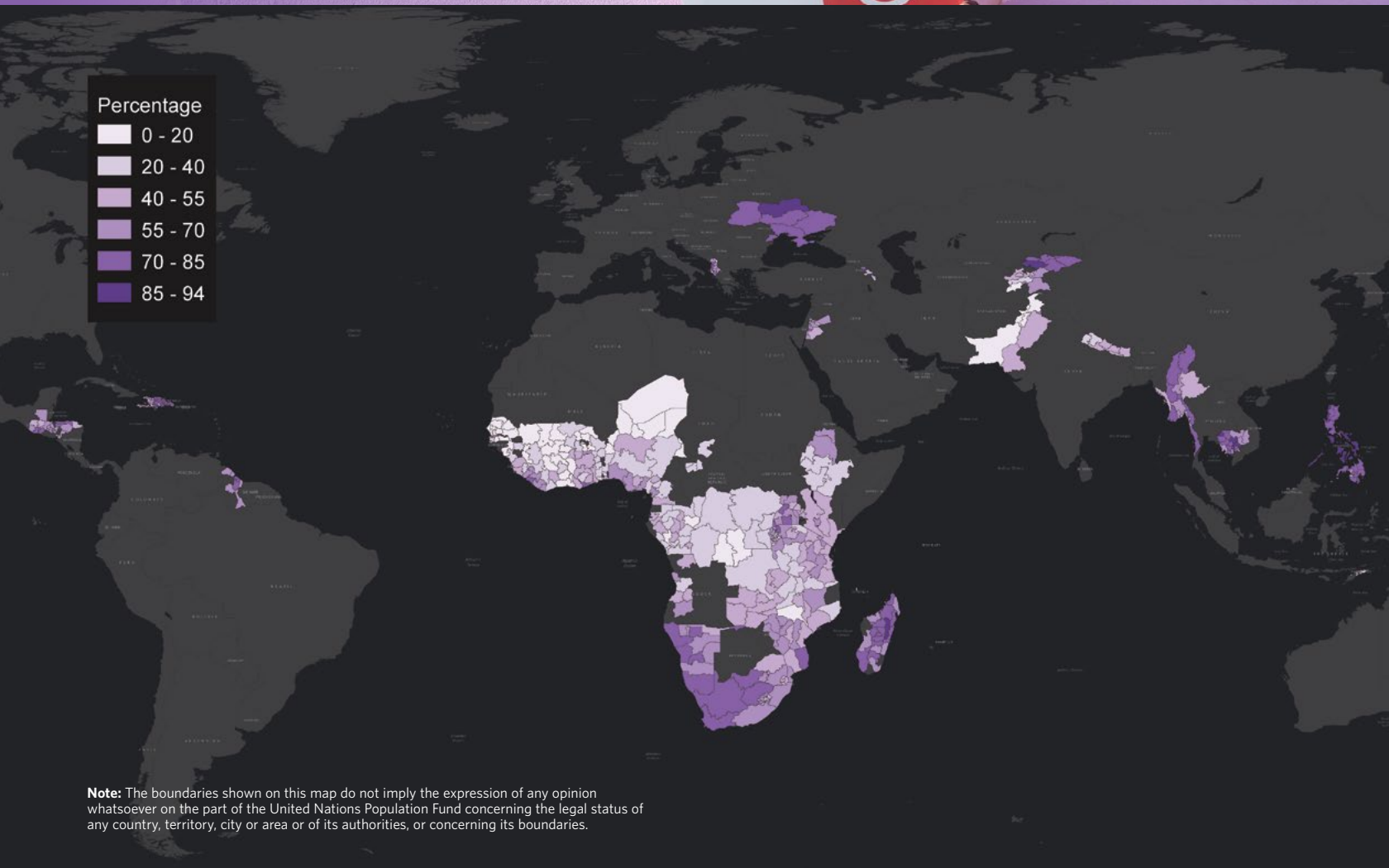
Higher levels of wealth⁴ had an effect on women's autonomy, although not as large as education. In fact, there was no significant difference between the poorest and next poorer wealth quintiles. Having first married at age 18 or older had a slight but significant effect, compared with those who were married before 18 (OR:1.06;95%CI[1.05-1.10]) as did having some weekly media exposure to newspaper, television or radio (OR:1.12; 95%CI[1.09-1.16]). However, living in a rural or urban setting did not seem to have an effect on women's decision-making regarding their sexual and reproductive health and rights.

FIGURE 7 – SUB-NATIONAL LEVEL

Figure 7.a Women's decision-making on sexual and reproductive health and rights (SDG 5.6.1), at the sub-national level, per cent



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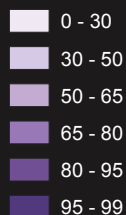
Note: The boundaries shown on this map do not imply the expression of any opinion whatsoever on the part of the United Nations Population Fund concerning the legal status of any country, territory, city or area or of its authorities, or concerning its boundaries.

FIGURE 7 - SUB-NATIONAL LEVEL (continued)

Figure 7.b

Decision-making on women's own health care; decision making on use of contraceptive; decision making on sexual relations, at the sub-national level, per cent

Percentage



Note: The boundaries shown on this map do not imply the expression of any opinion whatsoever on the part of the United Nations Population Fund concerning the legal status of any country, territory, city or area or of its authorities, or concerning its boundaries.

Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

Decision-making on women's own health care

Decision-making on use of contraceptive

Decision-making on sexual relations

What are the links with Indicator 5.6.1 and other development outcomes?

Meeting the Indicator 5.6.1 criteria is associated with better reproductive health knowledge and outcomes, as women who met this indicator are more likely to be able to identify how to prevent HIV, have the number of prenatal visits recommended by the World Health Organization, and have their most recent delivery with a skilled birth attendant (figure 8). There also appears to be significant associations between meeting Indicator 5.6.1 and gender-equal outcomes. Women who meet the three criteria are more likely to own their home and land (alone or jointly with their partner), be currently working and have health insurance coverage. They are also significantly less likely to have ever experienced intimate partner violence.

The high level of women who are **NOT** able to make their own decisions on their sexual and reproductive health and rights highlights the urgent need for policies and programmes to focus not only on the provision of services but to address women’s autonomy. Doing so will not only impact sexual and reproductive health outcomes, but contribute to achieving the broader 2030 Agenda and the Sustainable Development Goals.



Table 1. Proportion of women with desired reproductive health outcomes, by SDG 5.6.1 Status

HEALTH OUTCOME	Number of cases	Meets SDG561	Does not meet SDG561
Proportion of women who identify condom use AND having a single sexual partner to prevent HIV infection*	126,056	78.8%	70.3%
Comprehensive HIV Knowledge*	118,801	38.6%	32.7%
Proportion of women with at least 4 prenatal visits with last pregnancy*	83,398	71.7%	61.1%
Proportion of women with at least 8 prenatal visits with last pregnancy*	83,398	23.7%	12.7%
Proportion of women whose most recent baby weighed at least 2500g at birth*	67,078	92.2%	90.8%
Proportion of women with skilled birth attendance at last delivery*	66,231	78.8%	70.1%
Proportion of women with skilled birth attendance at any delivery*	66,234	80.3%	72.7%

* Pearson’s chi-squared test, p<0.001

ANNEX 1

Proportion of women aged 15-49 years who make their own decisions regarding sexual and reproductive health and rights (including deciding on their own health care, deciding on the use of contraception; and can say no to sex); by country, most recent data 2007-2018.

COUNTRY	Survey Year	Reference Year	Decision making on women's own health care	Decision making on use of contraceptive	Say no to sex	Women's decision making on sexual and reproductive health and rights (SDG 5.6.1)
Albania	2017-2018	2018	93.3	83.8	84.2	68.6
Angola	2015-2016	2016	77.3	90.1	85.3	62.1
Armenia	2015-2016	2016	96.6	88.8	75.0	66.0
Benin	2017-2018	2018	55.4	89.5	61.6	35.7
Burkina Faso	2010	2010	31.5	91.0	62.1	20.3
Burundi	2016-2017	2017	72.0	93.6	63.1	43.9
Cambodia	2014	2014	91.3	88.9	92.9	75.6
Cameroon	2011	2011	47.8	88.7	88.6	38.1
Chad	2015	2015	47.2	80.7	63.3	27.1
Comoros	2012	2012	47.0	71.3	47.4	20.8
Congo	2012	2012	40.6	87.3	70.8	26.8
Côte d'Ivoire	2012	2012	42.9	81.6	67.3	25.2
Democratic Republic of the Congo	2014	2014	47.0	84.7	73.8	30.7
Dominican Republic	2007	2007	88.2	92.3	93.3	77.0
Ecuador	2018	2018	99.5	92.0	94.6	86.7
Eswatini	2007	2007	71.7	89.3	74.4	48.9
Ethiopia	2016	2016	84.8	94.4	53.0	45.2
Gabon	2012	2012	60.2	90.2	85.6	48.0
Gambia	2013	2013	71.3	84.2	64.3	40.5
Ghana	2014	2014	82.1	89.9	72.0	52.0
Guatemala	2015	2015	76.7	91.3	88.6	64.8
Guinea	2018	2018	60.5	85.1	54.8	28.9
Guyana	2009	2009	91.8	90.3	82.8	71.3
Haiti	2016-2017	2017	78.1	93.0	80.3	59.4
Honduras	2012	2012	83.7	88.0	94.2	70.3
Jordan	2017-2018	2018	93.8	93.0	68.7	60.7
Kenya	2014	2014	80.5	89.4	77.2	56.0
Kyrgyzstan	2012	2012	93.7	94.6	85.4	76.6
Lesotho	2014	2014	90.5	93.0	71.4	60.9
Liberia	2013	2013	82.6	89.2	91.6	67.2
Madagascar	2009	2009	90.2	92.6	87.9	73.6
Malawi	2015-2016	2016	69.6	92.5	70.0	46.7
Maldives	2016-2017	2017	88.1	92.8	71.4	57.9
Mali	2018	2018	22.0	76.7	30.8	7.7
Mongolia	2018	2018	85.0	83.9	80.3	63.2
Mozambique	2011	2011	77.3	84.7	67.0	49.1
Myanmar	2016	2016	84.9	97.9	81.4	67.5
Namibia	2013	2013	90.6	83.1	93.5	71.2
Nepal	2016	2016	59.1	85.2	91.4	47.7

COUNTRY	Survey Year	Reference Year	Decision making on women's own health care	Decision making on use of contraceptive	Say no to sex	Women's decision making on sexual and reproductive health and rights (SDG 5.6.1)
Niger	2012	2012	20.6	77.0	35.3	7.3
Nigeria	2018	2018	68.2	89.6	70.0	46.3
Pakistan	2017-2018	2018	58.0	94.1	64.0	40.3
Panama	2014	2014	94.1	88.8	94.8	79.1
Philippines	2017	2017	96.6	93.8	87.8	80.6
Rwanda	2015	2015	84.2	97.9	83.4	69.5
São Tomé and Príncipe	2008	2008	69.4	78.4	79.3	46.2
Senegal	Continuous 2017	2017	30.7	84.6	19.2	6.9
Sierra Leone	2013	2013	60.1	82.2	79.0	40.2
South Africa	2016	2016	94.8	88.6	74.6	64.9
Tajikistan	2017	2017	53.9	82.9	60.3	32.5
Timor-Leste	2016	2016	94.1	94.1	43.5	39.6
Togo	2014	2014	46.7	84.3	74.5	29.6
Uganda	2016	2016	75.4	92.6	86.9	62.3
Ukraine	2007	2007	97.5	94.9	86.3	81.0
United Republic of Tanzania	2010	2010	66.4	88.6	75.9	46.8
Zambia	2014	2014	75.8	83.2	71.0	46.6
Zimbabwe	2015	2015	86.6	93.2	72.2	59.9

	Reference Year	Decision making on women's own health care	Decision making on use of contraceptive	Say no to sex	Women's decision making on sexual and reproductive health and rights (SDG 5.6.1)
GLOBAL AND REGIONAL					
World (57)	2020	75.2	91.1	75.1	55.0
Northern America and Europe (2)	2020	97.4	94.4	86.2	80.5
Europe (2)	2020	97.4	94.4	86.2	80.5
Latin America and the Caribbean (7)	2020	87.2	91.2	91.4	74.1
Central Asia and Southern Asia (5)	2020	59.1	91.9	70.1	42.6
Central Asia (2)	2020	72.3	88.3	71.9	52.9
Southern Asia (3)	2020	58.3	92.2	70.0	42.0
Eastern Asia and South-eastern Asia (5)	2020	92.3	94.3	86.2	75.8
Eastern Asia (1)	2020	85.0	83.9	80.3	63.2
South-eastern Asia (4)	2020	92.5	94.5	86.4	76.0
Western Asia and Northern Africa (2)	2020	94.5	91.9	70.3	62.1
Western Asia (2)	2020	94.5	91.9	70.3	62.1
Sub-Saharan Africa (36)	2020	71.3	89.6	70.2	47.7
Landlocked developing countries (LLDCs) (18)	2020	71.7	90.5	68.7	47.4
Least Developed Countries (LDCs) (30)	2020	71.1	90.3	72.4	49.6
Small Island Developing States (SIDS) (7)	2020	84.0	92.1	86.1	68.3

Note: The number of countries with comparable survey data included in the regional aggregations is presented in parentheses.

Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys conducted in the 2007-2018 period.

ANNEX 2

Changes in proportion of women aged 15-49 years who make their own decisions regarding sexual and reproductive health and rights (including deciding on their own health care, deciding on the use of contraception; and can say no to sex); by country.

	Survey Year	Reference Year	Decision making on women's own health care	Decision making on use of contraceptive	Say no to sex	Women's decision making on sexual and reproductive health and rights (SDG 5.6.1)
Albania	2017-2018	2018	93.3	83.8	84.2	68.6
Albania	2009	2009	86.6	87.7	74.5	61.5
Armenia	2015-2016	2016	96.6	88.8	75.0	66.0
Armenia	2010	2010	95.1	82.8	80.7	64.3
Benin	2017-2018	2018	55.4	89.5	61.6	35.7
Benin	2012	2012	66.9	80.6	63.5	38.2
Benin	2006	2006	55.3	86.0	80.6	41.1
Burundi	2016-2017	2017	72.0	93.6	63.1	43.9
Burundi	2010	2010	80.3	92.7	64.4	49.0
Cambodia	2014	2014	91.3	88.9	92.9	75.6
Cambodia	2010	2010	90.6	88.8	91.6	74.6
Democratic Republic of the Congo	2014	2014	47.0	84.7	73.8	30.7
Democratic Republic of the Congo	2007	2007	44.4	84.9	51.1	19.3
Ethiopia	2016	2016	84.8	94.4	53.0	45.2
Ethiopia	2011	2011	82.5	96.4	63.0	53.4
Ghana	2014	2014	82.1	89.9	72.0	52.0
Ghana	2008	2008	69.9	91.2	85.3	54.1
Guinea	2018	2018	60.5	85.1	54.8	28.9
Guinea	2012	2012	45.9	91.7	50.3	22.7
Haiti	2016-2017	2017	78.1	93.0	80.3	59.4
Haiti	2012	2012	70.7	91.4	85.4	56.3
Haiti	2006	2006	64.2	95.2	87.3	53.6
Jordan	2017-2018	2018	93.8	93.0	68.7	60.7
Jordan	2012	2012	90.0	95.3	84.2	72.6
Lesotho	2014	2014	90.5	93.0	71.4	60.9
Lesotho	2009	2009	86.6	88.9	68.0	53.8
Malawi	2015-2016	2016	69.6	92.5	70.0	46.7
Malawi	2010	2010	59.4	89.4	75.8	42.2
Mali	2018	2018	22.0	76.7	30.8	7.7
Mali	2013	2013	18.0	81.0	28.5	6.5
Mali	2006	2006	22.3	81.9	41.7	9.6
Namibia	2013	2013	90.6	83.1	93.5	71.2
Namibia	2007	2007	87.8	79.0	92.0	67.1
Nepal	2016	2016	59.1	85.2	91.4	47.7
Nepal	2011	2011	69.8	87.4	94.3	59.5

	Survey Year	Reference Year	Decision making on women's own health care	Decision making on use of contraceptive	Say no to sex	Women's decision making on sexual and reproductive health and rights (SDG 5.6.1)
Niger	2012	2012	20.6	77.0	35.3	7.3
Niger	2006	2006	29.7	75.1	31.4	9.3
Nigeria	2018	2018	68.2	89.6	70.0	46.3
Nigeria	2013	2013	69.0	84.6	82.8	50.8
Nigeria	2008	2008	66.9	81.6	78.8	47.1
Rwanda	2015	2015	84.2	97.9	83.4	69.5
Rwanda	2010	2010	74.5	96.5	80.9	60.1
Senegal	Continuous 2017	2017	30.7	84.6	19.2	6.9
Senegal	Continuous 2016	2016	18.6	88.9	19.3	4.9
Senegal	Continuous 2015	2015	24.0	87.5	24.3	7.1
Senegal	2011	2011	37.2	83.2	35.5	13.2
Tajikistan	2017	2017	53.9	82.9	60.3	32.5
Tajikistan	2012	2012	60.2	86.2	70.4	40.9
Uganda	2016	2016	75.4	92.6	86.9	62.3
Uganda	2011	2011	61.7	89.4	88.6	49.0
Uganda	2006	2006	62.8	90.0	82.3	48.0
Zambia	2014	2014	75.8	83.2	71.0	46.6
Zambia	2007	2007	66.5	79.8	71.9	39.5
Zimbabwe	2015	2015	86.6	93.2	72.2	59.9
Zimbabwe	2011	2011	84.5	88.5	75.8	58.8
Zimbabwe	2006	2006	83.5	91.5	68.1	52.5

Source: United Nations Population Fund, global databases, 2020. Based on the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys.

Endnotes

- 1 Reported as: Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education).
- 2 SDG geographic regions, based on the geographic regions defined under the Standard Country or Area Codes for Statistical Use (known as M49) of the United Nations Statistics Division.
- 3 Select countries with larger variations in each type of decisions are presented in the figures.
- 4 The wealth quintiles refer to the household wealth quintile the woman is in within her particular country, not the wealth quintiles of the entire sample.

UNFPA is the United Nations sexual and reproductive health agency. Our mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.



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