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| INDICATOR\_NUM | METADATA\_CATEGORY | METADATA\_CATEGORY\_DESC | METADATA\_DESCRIPTION |
| IV.6 | 1 | Contact point in international agency | Emilie Filmer-Wilson  Human Rights Adviser  UNFPA  [filmer-wilson@unfpa.org](mailto:filmer-wilson@unfpa.org)  [www.unfpa.org](www.unfpa.org)  Mengjia Lianga  Technical Specialist  UNFPA  [liang@unfpa.org](mailto:liang@unfpa.org)  [www.unfpa.org](www.unfpa.org) |
| IV.6 | 2 | International agreed definition | Proportion of women aged 15-49 years \(married or in union\) who make their own decision on all three selected areas, i.e. decide on their own health care; decide on use of contraception; and can say no to sexual intercourse with their husband or partner if they do not want. Only women who provide a “yes” answer to all three components are considered as women who make their own decisions regarding sexual and reproductive health. A union involves a man and a woman regularly cohabiting in a marriage-like relationship.  Women’s autonomy in decision-making and exercise of their reproductive rights is assessed from responses to the following three questions:   1. Who usually makes decisions about health care for yourself?  * RESPONDENT * HUSBAND/PARTNER * RESPONDENT AND HUSBAND/PARTNER JOINTLY * SOMEONE ELSE * OTHER SPECIFY  1. Who usually makes the decision on whether or not you should use contraception?  * RESPONDENT * HUSBAND/PARTNER * RESPONDENT AND HUSBAND/PARTNER JOINTLY * SOMEONE ELSE * OTHER SPECIFY  1. Can you say no to your husband/partner if you do not want to have sexual intercourse?  * YES * NO * DEPENDS/NOT SURE   A woman is considered to have autonomy in reproductive health decision making and to be empowered to exercise their reproductive rights if they \(1\) decide on health care for themselves, either alone or jointly with their husbands or partners, \(2\) decide on use or non-use of contraception, either alone or jointly with their husbands or partners; and \(3\) can say no to sex with their husband/partner if they do not want to. |
| IV.6 | 3 | Method of computation | Numerator: Number of married or in union women and girls aged 15-49 years old:   * for whom decision on health care for themselves is not usually made by the husband/partner or someone else; and * for whom the decision on contraception is not mainly made by the husband/partner; and * who can say no to sex.   Only women who satisfy all three empowerment criteria are included in the numerator.  Denominator: Total number women and girls aged 15-49 years old, who are married or in union.  Proportion = \(Numerator/Denominator\) \* 100  Global and regional aggregates are computed as weighted averages of country level data. The weighting is based on the estimated population of married women aged 15-49, who are using any type of contraception in the reporting year. The estimates of number of women married/ in union and contraceptive prevalence rate are obtained from UN Population Division. |
| IV.6 | 4 | Importance of the indicator in addressing gender issues and its limitation | \*\*Rationale\*\*  Women’s and girls’ autonomy in decision making about sexual and reproductive health services, contraceptive use and consensual sexual relations is key to their empowerment and the full exercise of their reproductive rights.  Women who make their own decision regarding seeking healthcare for themselves are considered empowered to exercise their reproductive rights.  Regarding decision-making on use of contraception, a clearer understanding of women empowerment is obtained by looking at the indicator from the perspective of decisions being made “mainly by the partner”, as opposed to decision being made “by the woman alone” or “by the woman jointly with the partner”. Depending in the type of contraceptive method being used, a decision by the woman “alone” or “jointly with the partner” does not always entail that the woman is empowered or has bargaining skills. Conversely, it is safe to assume that a woman that does not participate, at all, in making contraceptive choices is disempowered as far as sexual and reproductive decisions are concerned.  A woman’s ability to say no to her husband/partner if she does not want to have sexual intercourse is well aligned with the concept of sexual autonomy and women’s empowerment.  \*\*Comment and limitations\*\*  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 phase of the national Demographic and Health Survey \(DHS–7\) and later rounds, as well as in other data collection instruments including the MICS and GGS, the questionnaire are extended to respondents whether they are using contraception or not. The measure does not cover women and girls that are not married or in union, as they do not usually make “joint decisions” on their own health care with their partners.  As of early 2021, a total of 64 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.  In many national contexts, household surveys, which are the main data source for this indicator, exclude the homeless and are likely to under-enumerate linguistic or religious minority groups. |
| IV.6 | 5 | Sources of discrepancies between global and national figures |  |
| IV.6 | 6 | Process of obtaining data | Data are mainly derived from nationally representative Demographic and Health Surveys \(DHS\). Data sources increasingly include Multiple Indicator Cluster Surveys \(MICS\) and Generations and Gender Surveys \(GGS\), and other country-specific household surveys.  Data is collected in line with the methodology used for the relevant national survey and may be collected through existing county-specific surveys.  For existing national household surveys, it must be ascertained that the sampling design does not systematically exclude subgroups of the population that are important, specifically, women of reproductive age \(15-49\) that are currently married or in union. Surveys that cover only certain population subgroups, such as women who speak the dominant language or women from the main ethnic group, may exclude the experiences of a large number of women. Data on the ethnicity and religion of the survey participants should be collected whenever available. The survey should have a large sample size \(usually between 5,000 and 30,000 households\), be nationally representative, and representative, at least, at one administrative level below the national level.  Surveys on unrelated topics may not be good candidates for the incorporation of the questions. The sensitivity of the topics addressed in health surveys, in particular those examining women’s health, making them a feasible instrument for incorporating questions on women’s experience of decision making in sex relations, use of contraceptive, and health care for themselves.  In order to generate data, all three questions must be included in the survey. The three questions in the Definition section provides generic questions that can be used in country-specific surveys. For the first and the second questions, these should include distinct categories for women making decisions herself, and women making decisions jointly with her husband/partner. |
| IV.6 | 7 | Treatment of missing values |  |
| IV.6 | 8 | Data availability and assessment of countries’ capacity |  |
| IV.6 | 9 | Expected time of release | Annual, as per DHS, MICS, GGS and country-specific survey cycles |
| IV.6 | 10 | Data source | Data and metadata were extracted from Global SDG Indicators Database on 30 July 2021.  For more information, please go to the following:   * [https://unstats.un.org/sdgs/indicators/database/](https://unstats.un.org/sdgs/indicators/database/) * [https://unstats.un.org/sdgs/metadata/files/Metadata-05-06-01.pdf](https://unstats.un.org/sdgs/metadata/files/Metadata-05-06-01.pdf) |