Health

Women’s decision-making on andequalaccess to sexual and reproductive health [UNFPA]

Key points

- Based on data from 57 countries, around only 50% of women make their own decisions on health care and contraceptive use and can say no to sexual intercourse.
- There are large disparities among regions, from less than 40% of women making their own decisions in Middle Africa and Western Africa, to nearly 80% in some countries in Europe, South-Eastern Asia and Latin America and the Caribbean.
- Older women, more educated women, women living in urban areas and women from wealthier households are more likely to make their own decisions. Higher levels of education, in particular, have the greatest effect on women's ability to make their own decisions on sexual and reproductive health and reproductive rights.
- Most women (91%) seem to have autonomy over the decision to use contraception, but only 75% of women can decide on their own health care or say no to sex.
- While there are many countries with enabling laws on sexual and reproductive health and reproductive rights, there are also many legal barriers that prevent women and adolescents from having equal access to these services and information. Such barriers are most prevalent in the case of legal access to abortion.
- On average, countries have 73% of the laws and regulations needed to guarantee full and equal access to sexual and reproductive health and reproductive rights.
- The findings are particularly encouraging when it comes to HIV: on average, countries have enacted 87% of enabling laws and regulations for HIV counselling and test services; 91% for HIV treatment and care services; and 96% for HIV confidentiality.
- The lowest level of achievement is in the provision by countries of sexuality education curricula: on average, countries have 57% of enabling laws, regulations or national policies needed to make sexuality education a mandatory component of the national school curriculum.

Background

Women's ability to make decisions on their reproductive health, contraceptive use and sexual relations is pivotal to gender equality and universal access to sexual and reproductive health and reproductive rights. While a wide range of contraceptives must be made available and staff trained to provide sexuality education, all 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.

Current situation

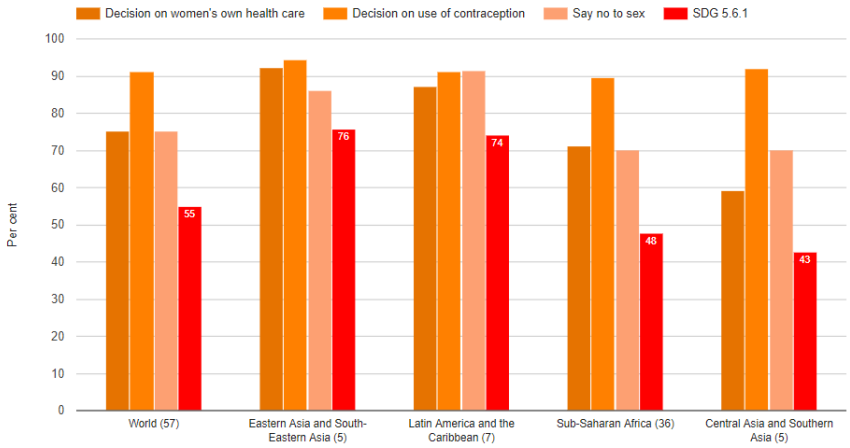
Only around 50% women can make their own decisions on health care and contraceptive use and can say no to sexual intercourse

Based on data from 57 countries, only 55% of married or in-union women aged 15—49 make their own decisions

regarding sexual and reproductive health and rights (see figure I). Data reveal large disparities among regions, from less than 40% of women in Middle Africa and Western Africa to nearly 80% in some countries in Europe, South-Eastern Asia and Latin America and the Caribbean. Analysis of the three sub-indicators shows that while 91% of women would seem to have autonomy in deciding to use contraception, only three in four women (75%) can decide on their own health care or say no to sex. Overall, gaps still exist in women's autonomy, even where high levels of individual decision-making are observed in some areas.

Levels of women's autonomy in decision-making regarding their sexual and reproductive health care also vary greatly across countries and regions. Among 57 countries with data, women in Ecuador have the highest level of autonomy, at 87%, followed by the Philippines and Ukraine, where 81% of married or in-union women have the power to take their own decisions on sexual and reproductive health care. In Mali, Niger and Senegal, countries with the lowest levels, less than 10% of married or in-union women can make their own decisions on sexual and reproductive health care.

Figure I: Proportion of women aged 15-49 who can make their own decisions regarding sexual and reproductive health and reproductive rights: 2007-2018 (latest available)



Source: United Nations Population Fund (UNFPA), global databases, 2020 (https://www.unfpa.org/data)
Note: The number of countries with comparable survey data included in the regional aggregations is presented in parentheses. Based on the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys conducted in the 2007-2018 period. Decisions regarding sexual and reproductive health and reproductive rights include: deciding on their own health care, deciding on the use of contraception, and can say no to sex.

Education has the greatest effect on women's decision-making on sexual and reproductive health and reproductive rights

Overall, older women, more educated women, women living in urban areas and women living in wealthier households are more likely to make their own decisions over their sexual and reproductive health and reproductive rights.

Age at first marriage, education level, wealth, exposure to the media, place of residence and region of the world all play a role in a woman's ability to make her own decisions on sexual relations, the use of contraception and health care. Above all other factors, 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% more likely to meet SDG indicator 5.6.1

criteria than those who receive no education at all.

In general, as women get older, they are more empowered to make their own decisions. The greatest gains are seen among women aged 20—34; after age 35, while women still are much more likely than those aged 15—19 to achieve autonomy, the effect appears to level off.

Higher levels of wealth has an effect on women's autonomy, although not to the same extent as education, while between the two poorest wealth quintiles there was no significant difference in the level of women's autonomy. First marriage at age 18 or older had a slight but significant effect on women's autonomy, compared with women who were married before age 18: women who married after age 18 were 6% more likely to make their own decisions. In addition, weekly media exposure to newspapers, television or radio had a positive effect on women's empowerment: women with media exposure were 12% more likely to make their own decisions.

Country in focus: Uganda

In Uganda there has been consistent progress in women's decision-making ability in all three aspects of SDG indicator 5.6.1

In Uganda, during the period 2006—2016, women's autonomy in decision-making on sexual relations increased by 4.6 percentage points; on contraceptive use by 2.6 percentage points; and on reproductive health care by 12.6 percentage points. This trend was supported by better education and income levels, as well as by interventions such as the abolishment of user fees and the introduction of vouchers or conditional cash transfers. The activities of SASA!,[1] a prevention programme on HIV infection and violence against women, led to lower social acceptance of intimate partner violence and violence against women and greater acceptance of women's right to refuse sex. Couples have improved their communication and levels of joint decision-making. SASA! engages health workers and trains community activists who work door-to-door to raise awareness levels through discussions, training, public events, films and performances by soap opera groups.

National laws and regulations on sexual and reproductive health and reproductive rights

Legal barriers still prevent access of women and adolescents to reproductive health-care services and information

Among 75 countries with data, on average, 73% of the laws and regulations needed to guarantee full and equal access to sexual and reproductive health and reproductive rights are in place (see figure II). With this access guaranteed in laws and regulations in many countries, the future focus must be on ensuring that policies, budgets and actions that can translate the laws into practice.

In national actions on HIV, in particular, on average, countries have enacted 87% of enabling laws and regulations for HIV counselling and test services; 91% for HIV treatment and care services; and 96% of laws needed for ensuring HIV confidentiality. In addition, countries have 79% of relevant enabling laws and regulations that stipulate full, free and informed consent of individuals before they receive contraceptive services, including sterilization (see figure II). This data indicate that there is a broadly supportive framework protecting women from coerced or forced practices.

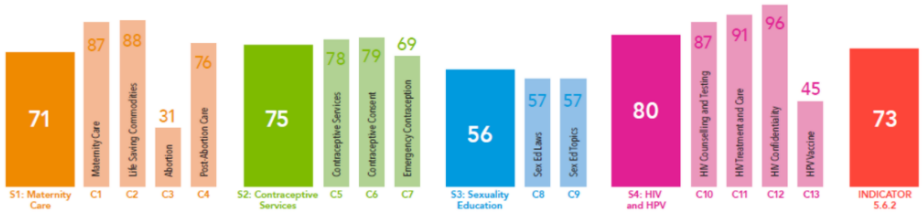
In terms of laws and regulations on sexuality education, on average, countries have only 57% of the enabling

laws, regulations or national policies needed to make a sexuality education a mandatory component of the national school curriculum (see figure II). In countries with those laws and regulations in place, 75% of such frameworks include all key concepts recommended by international norms and standards for sexuality education. In 90%, all but two concepts, relationships, and sexuality and sexual behaviour, are included.

In many countries, there are legal barriers to full and equal access to sexual and reproductive health and reproductive rights, the most prevalent in blocking legal access to abortion. Although abortion is legal on some or all grounds in 93% of reporting countries, in 28% of those countries a husband's consent is required in order for married women to access abortion services. Moreover, women may be criminally charged for having an illegal abortion in more than 50% of the 107 reporting countries.

Although there are laws and regulations guaranteeing access to maternity care in almost all countries with data (95%), 9% of those countries have restrictions based on marital status and 10% have restrictions based on age. Access to contraceptive services is also restricted in some countries. In 21% of countries, third party authorization (consent by parent, spouse, judge or medical committee) is required to access contraceptive services. Moreover, 20% of countries have multiple legal systems, for example at the state level, some of which can contradict some or all of the national laws and regulations on sexual and reproductive health and reproductive rights in the country.

Figure II: Percentage of laws and regulations guaranteeing full and equal access to women and men aged 15 and older to sexual and reproductive health care, information and education that have been enacted by countries: 2019



Source: United Nations Population Fund (UNFPA), global databases, 2020 (https://www.unfpa.org/data)
Note: Based on official responses to the United Nations Twelfth Inquiry among Governments on Population and Development. Data for SDG 5.6.2 are based on 75 countries with complete data. Data for the sections are as follows: 79 countries for section 1, Maternity Care, 104 countries for section 2, Contraceptive Services, 98 countries for section 3, Sexuality Education, and 101 countries for section 4, HIV and human papillomavirus infection (HPV).

About the data

Definitions

- **Proportion of women aged 15—49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (Sustainable Development Goal (SDG) 5, indicator 5.6.1)**: Proportion of women aged 15—49 (married or in a union) who make their own decisions on: (a) health care; (b) use of contraception; and (c) saying no to sexual intercourse with their husband or partner if they do not want. Only women providing a "yes" answer to all three components are considered to be women who make their own decisions regarding sexual and reproductive health.[2]

- **Extent to which countries have laws and regulations that guarantee full and equal access to women and men aged 15 and older to sexual and reproductive health care, information and education (SDG Goal 5, indicator 5.6.2)**: The indicator is a percentage (%), on a scale of 0 to 100 (extent of national laws and regulations to guarantee full and equal access), of a country's status and progress in instituting national laws and regulations guaranteeing women such rights and levels of access. Indicator 5.6.2 measures only the existence of laws and regulations, it does not measure their implementation. Indicator 5.6.2 seeks to provide the first comprehensive global assessment of legal and regulatory frameworks on access to sexual and reproductive health and reproductive rights.
The indicator measures the legal and regulatory environment across four broad sections of sexual and reproductive health and reproductive rights: (a) maternity care; (b) contraception and family planning; (c) comprehensive sexuality education and information; and (d) sexual health and well-being. These four sections are broken down into 13 components. The total indicator score is the arithmetic mean of 13 component scores and the four section scores are the arithmetic mean of constituent component scores.[3]

Coverage and Availability

- **For women making their own decisions**: Married or in union women aged 15—49. As of early 2020, a total of 57 countries, the majority in sub-Saharan Africa, had at least one survey with data on all three questions necessary for calculating SDG indicator 5.6.1. Efforts to increase data coverage are under way. Current data on the indicator are derived from Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys conducted during the period 2007—2018.

- **For laws on equal access**: Data are reported by national Governments, including national statistics authorities and line ministries. In 2019, data from 107 countries, covering 75% of the world's population, were collected through the United Nations Twelfth Inquiry among

Governments on Population and Development.[4] Of those 107 countries, 75 reported complete data, which allowed for the calculation of SDG indicator 5.6.2. For the 32 countries that reported partial data, data for components and sections have been calculated where possible.

Footnotes

1. SASA! is a non-governmental organization working on the prevention of violence against women and children.

2. More information on the methodology can be found at the United Nations Population Fund (UNFPA) site on concepts and definitions used in determining the indicator and UNFPA, Ensure universal access to sexual and reproductive health and reproductive rights, measuring SDG target 5.6, February 2020.

3. More information on the methodology can be found at the United Nations Population Fund (UNFPA) site on concepts and definitions used in determining the indicator and UNFPA, Ensure universal access to sexual and reproductive health and reproductive rights, measuring SDG target 5.6, February 2020.

4. United Nations Twelfth Inquiry among Governments on Population and Development, Module II, Fertility, Family Planning and Reproductive Health .