



GLOBAL GOALS INDICATOR 5.6.1

**Research on factors that
determine women's ability to
make decisions about sexual and
reproductive health and rights**

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This report presents research on the factors that determine women’s ability to make decisions about their sexual and reproductive health. The research was commissioned by the Technical Division of UNFPA, the United Nations Population Fund, under the coordination of Emilie Filmer-Wilson, the technical guidance of Maria Teresa Bejarano and Mengia Liang and support from Leyla Sharafi. It was carried out by **hera** (Right to Health and Development) through the research team of Alice Behrendt, Marieke Devillé, Michèle Dramaix and Dia Timmermans.

Selected key informants from four countries (Ghana, Rwanda, Senegal and Uganda) and global institutions were interviewed as part of this research. Special thanks is owed to Benoit Kalasa, Director of the Technical Division, UNFPA, for his strategic leadership and support with this research.

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The present publication is Volume I of the research reporting and includes the key findings and analysis. Volume II expands on the four country examples and provides details on data and methodology. Volume II is available on request from the UNFPA Human Rights Adviser.

Background

Women's ability to make choices about their sexual and reproductive health and rights (SRHR) is a key factor affecting their sexual and reproductive health outcomes. Women are often unable to access sexual and reproductive health services due to harmful and discriminatory social norms and practices, lack of agency and limited financial resources. In the past, monitoring has focused on access to services, thereby neglecting dimensions related to women's ability to make choices about their sexual and reproductive health. In the context of the Sustainable Development Goals (SDGs), UNFPA has taken up a role as custodian of Indicator 5.6.1, which focuses on women's ability to make autonomous choices. This composite indicator provides data on whether a woman can refuse sexual intercourse to her husband or partner; whether using or not using contraception is primarily the woman's decision or a joint decision with her husband or partner; and whether a woman can make her own decisions about reproductive health care. It includes three components, or data points, that yield one result.

Purpose of the research

The research was commissioned by the UNFPA to bring attention to new information and data on the factors that determine women's ability to decide make decisions about their SRHR, to explore and identify interventions that correlate with the changes in Indicator 5.6.1 and to propose areas in which further research is needed.

Methodology

A consultant team conducted the research, which included a systematic review of the factors associated with women's SRHR decision-making; a quantitative trend analysis covering 22 countries to identify those where significant change has been observed and to understand what factors contributed to these changes; a qualitative study involving four case studies; and key informant interviews to further explore which factors affected the Indicator 5.6.1 outcomes in those countries and which programme approaches and strategies have been shown to influence those outcomes.

Trend analysis

The quantitative data analysis showed that the trends are heterogenous across regions and the indicator's components. The most positive changes were observed in Eastern Africa and Southern Africa, where eight of 10 countries showed positive trends. The most negative trends were observed in the West and Central Africa region, where data from five countries indicate negative changes.

The composite nature of the indicator makes it difficult to interpret the results, however, because its components often evolve in different directions and the composite result hides both significant progress and downward trends on individual components. The health care decision-making component has the largest positive trend, with 16 of 22 countries seeing an increase in the proportion of women making decisions about their health care use. Most of the negative trends are observed in the area of sexual relations, where more than half of the countries registered a decrease in women's ability to make the decision to say yes or no to sexual relations, especially across West and Central Africa. Improvements in this component are most visible across Eastern Africa and Southern Africa, as well as Cambodia and Albania. Women's decision-making on contraceptives has remained quite stable, with slight variations, an unsurprising finding, since this indicator focuses exclusively on women who are married or in union and are currently using modern family planning methods.

Factors influencing women's decision-making

The analysis of determinants affecting women's SRHR decision-making enabled the research team to identify a set of determinants that had been consistently documented in both qualitative and quantitative studies. These factors are highly interdependent and act at different levels. The most important determinants are the education level of both the women and their partners, household wealth status, area of residency (i.e. sociodemographic factors), women's agency and knowledge levels on SRHR (individual level), a woman's partner's position on sexual and reproductive health matters, the level of a couple's communication on SRHR (interpersonal level), sociocultural and gender norms (community level) as well as affordable, accessible and acceptable quality reproductive health care services (institutional level). These determinants are highly relevant to the design and implementation of successful SRHR programmes. The analysis also identified a range of different context-specific determinants that highlight the importance of formative research and of gender analysis during the design and implementation phase.

A wide range of interventions have been rolled out to improve women's decision-making, as seen in the literature review of good practices. All good programme models affect both supply and demand dimensions and seek to effect change by tackling barriers at several levels (individual, interpersonal, institutional, etc.). The use of community outreach strategies, encouragement of male engagement and information technologies for development (IT4D) and formative research have shown promising results, although their effectiveness at both the outcome and sustainability levels merit further investigation. An increasing number of studies demonstrate how results at the outcome level can be improved by targeting men through community mobilization activities and informal education. Because of the authority that men hold in the decision-making process, this is not a surprising finding. In addition, evidence of interventions focusing on improving dialogue between couples on SRHR matters is promising; data show that these interventions lead to lower levels of sexual violence. However, the number of interventions aiming to enhance the quality of couples' communication is still quite low. Several interventions have been tested and were replicated, but sufficient evidence was not found about good practices that have been brought to scale.

The research provided limited information on the impact of policies, laws and state investments on women's SRHR decision-making. Although key informants reported a positive impact of changes in policies and laws, evidence from the literature is insufficient to support these claims. The impact of specific policy initiatives and the legal environment on behavioural changes is neither well documented nor monitored.

Conclusion

The quantitative results and trends on Indicator 5.6.1 only capture the results of married girls and women aged 15–49. The contraceptive use component includes only married girls and women who are currently using contraception. The findings from the qualitative research confirm that the profile of the women captured in Demographic and Health Surveys are not representative of all girls and women. As well, the data do not capture whether women make *informed* decisions and whether *joint* decision-making is sufficiently representative of women's decision-making power. Particularly in rural settings, women with low levels of education are more likely to be overruled by men. Unmarried girls and women are in a disadvantaged position compared with married women and therefore have additional barriers to realizing their SRHR. This situation also applies to context-specific marginalized groups such as women with disabilities, women from indigenous groups or those affected by crisis. A strategy needs to be developed to systematically capture information about trends among vulnerable and discriminated groups.

Recommendations

The analysis of the research recommends a closing of the research gap by further analysing data trends in countries with weak performance against the indicator. Analysis should also consider the impact and causal

relations of policy changes and the quality of reported joint decision-making. Suggestions are also made to improve SDG monitoring by ensuring that the indicator is monitored in a disaggregated way, as well as complemented by data on unmarried women and girls and marginalized groups. To reduce inequities, the analysis proposes providing technical and financial support to the “weak performers” and lobbying for increased governmental and donor investments on SRHR and gender equality. Finally, in relation to SRHR interventions, the analysis recommends integrating formative research during the programme design and evaluation, including an in-depth gender analysis, to support the documentation, publication and dissemination of holistic gender-transformative programming approaches and to harness further investments in IT4D and other innovative approaches that have proven to be effective.

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ABBREVIATIONS

BCC	behaviour change communication
CCU	covert contraceptive use
CSE	comprehensive sexuality education
DHS	Demographic and Health Survey
HIV	human immunodeficiency virus
IAEG–SDGs	Inter-agency and Expert Group on SDG Indicators
ICPD	International Conference on Population and Development
IPV	intimate partner violence
IT4D	information technology for development
KII	key informant interview
MDG	Millennium Development Goal
PMNCH	Partnership for Maternal, Neonatal and Child Health
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCT	randomized controlled trial
SDG	Sustainable Development Goal
SGBV	sexual and gender-based violence
SRHR	sexual and reproductive health and rights
UNFPA	United Nations Population Fund
VAWG	violence against women and girls
YFHS	youth-friendly health services

1 BACKGROUND

It is widely acknowledged that women’s sexual and reproductive health outcomes are not solely dependent on their access to quality health services.¹ Another key influencing factor is women’s ability to make choices about matters related to their sexual and reproductive health and rights (SRHR). Women in general—but particularly those from marginalized and at-risk groups such as adolescent girls, first-time young mothers or women with disabilities—are often denied access to sexual and reproductive health services because of harmful and discriminatory social norms and practices and the women’s lack of agency and financial resources. Historically, however, monitoring data have mostly focused on access to services and have largely neglected dimensions related to women’s ability to make autonomous choices about their sexual and reproductive health.

In this report we define “women” as all girls and women of reproductive age (15-49 years old), whether married, unmarried or in union.

In the context of the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals, the data gap is being addressed through the introduction of Indicator 5.6.1, which focuses on women’s ability to make autonomous choices about sexual relations, contraceptive use and reproductive health care. It goes beyond measuring health system performance and puts women’s individual decision-making capacity at the centre. By opting for a focus at the individual level, specifically at a woman’s ability to make her own choices, meeting the targets for this indicator requires tackling complex barriers and enablers related to rights-based dimensions of SRHR and gender equality more broadly. Progress on this indicator is not possible without changing discriminative gender norms and attitudes. In the context of persisting gender inequalities, the critical importance of this indicator cannot be underestimated.

1.1 INDICATOR 5.6.1 OF THE SUSTAINABLE DEVELOPMENT GOALS

Indicator 5.6.1 is one of two indicators measuring progress against Target 5.6: to “ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action.” Indicator 5.6.1 measures the “proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care”; whereas Indicator 5.6.2 measures the existence of laws related to access to SRHR.

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 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 education.

¹ The WHO definition of quality of care is “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred.” See www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/

Indicator 5.6.1 is a tiers-based II indicator² that has an agreed-on operational concept and internationally agreed-on methodology and standards, although data are not regularly collected by countries. This reflects the updated tier classification as of 13 February 2019 for the indicators, as developed by the Inter-agency and Expert Group on SDG Indicators (IAEG–SDGs). The indicator is derived from the following three questions:

- Whether a woman can say no to her husband/partner if she does not want to have sexual intercourse;
- Whether using or not using contraception is mainly the woman’s decision or a joint decision with her husband/partner; and
- Whether a woman can make her own decision about reproductive health care.

Box 1: Questions and responses on DHS questionnaires		
1. Can you say no to your husband/partner if you do not want to have sexual intercourse?	2. Who usually makes the decision on whether or not you should use contraception?	3. Who usually makes decisions about health care for yourself?
<ul style="list-style-type: none"> — Yes — No — Depends/not sure 	<ul style="list-style-type: none"> — Mainly respondent — Mainly husband/partner — Joint decision — Other, specify 	<ul style="list-style-type: none"> — You — Your husband/partner — You and your husband/partner jointly — Someone else

The UNFPA is the custodian of Indicator 5.6.1 and has worked in partnership with the IAEG–SDGs to clarify the conceptual framework and for developing metadata accessible to all. At present, data are available for 51 countries from at least one survey; the majority of these countries (35) are located in sub-Saharan Africa. For 22 countries, at least two components are available.

1.2 THE RESEARCH

In 2018, UNFPA commissioned quantitative research to analyse which factors determine the results of Indicator 5.6.1 and how it relates to reproductive health and gender equality outcomes using logistic regression analysis models. The research analysed a sample of 130,007 married women from 47 countries who use modern contraceptives. Of this sample, more than half of the women (55.8 per cent) met all three criteria under the indicator, and almost 90 per cent (89.3 per cent) met two criteria.

The analysis found that educated women living in urban areas are more likely to meet the three indicator criteria compared with younger, less-educated women. 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. As well, getting married after the age of 18 years and being exposed to media at least once a week had a small but significant effect on meeting the indicator criteria. Strong performance is also correlated with better sexual and reproductive health and gender equality outcomes. Women who meet the three indicator criteria are more likely to identify a human immunodeficiency virus (HIV) prevention method (34 per cent), have a minimum of four antenatal visits (27 per cent) and have their latest child delivered by a skilled birth attendant (16 per cent). They were also more likely to own their own home (23 per cent) and land (19 per cent), either alone or together with a partner,

² Tier Classification for Global SDG Indicators, 13 February 2019. Available at: https://unstats.un.org/sdgs/files/Tier%20Classification%20of%20SDG%20Indicators_13%20February%202019_web.pdf

to be working (30 per cent) and have health insurance coverage (35 per cent); they were also less likely to have suffered from intimate partner violence (IPV) (14 per cent).

The analysis is not without limitations. The findings are drawn from a specific group of women who are married and currently using contraception, who represent only 20 per cent of the original sample of women aged 15–49, and over half of whom are from a higher socioeconomic strata. Some regions were underrepresented due to lack of data, and qualitative data were not explored. The current research aims to close this gap by investigating how the indicator behaves and evolves over time and by exploring to what extent qualitative research corroborates the findings from the quantitative analyses.

The three main objectives of the research were to:

- Bring attention to new information and data that exist about women’s empowerment and what the determining factors are for women’s ability to decide on their SRHR;
- Explore and identify interventions that correlate with the changes in Indicator 5.6.1 and, if possible, to identify a causal relationship; and
- Propose areas in which further research is needed to address the findings from this analysis, while using this evidence to inform UNFPA programming interventions.

2 METHODOLOGY

2.1 GENERAL APPROACH

The research team conducted a systematic review on factors associated with women's decision-making on SRHR. This review included peer-reviewed literature covering low- and middle-income countries published between 2005 and March 2019; a quantitative trend analysis covering 22 countries with data available for at least two of the three data points for the indicator, to identify those where significant change has been observed and to deepen understanding on the contributing factors to these changes; and a qualitative study comprising four case studies and eight key informant interviews, to further explore which factors affected the 5.6.1 outcomes in those countries and what programme approaches and strategies have shown to be good practices. The research was implemented by a team of four independent consultants contracted through **hera** (Right to Health and Development) and was conducted from May to October 2019.

2.2 RESEARCH QUESTIONS

The research used a mixed-methods approach to answer five main research questions:

- How does indicator 5.6.1 change over time, and what the trends are evident, both of the three components and overall?
- What factors influence women's informed decision-making about sexual relations, contraceptive use and reproductive health care use?
- What kinds of interventions have a positive and sustainable impact on women's informed decision-making on sexual relations, contraceptive use and reproductive health care?
- To what extent can the findings from the quantitative data analysis be corroborated by qualitative analysis?
- Who is being left behind? Are the poorest and most marginalized being prioritized?

Each main question comprises a set of sub-questions. A full research matrix outlining the sub-questions, type of data, data sources and data collection methods is available in Volume II.

2.3 DATA COLLECTION AND TOOLS

The research has triangulated data from different sources, including 98 quantitative data sets from the Demographic and Health Surveys (DHS) of 22 countries, 345 peer-reviewed articles selected from more than 13,000 initially identified records, grey literature, and eight national and global key informants with relevant SRHR background. To explore these data sources, the research team used four research methods:

- Statistical analyses of DHS survey data from 22 countries with at least two components;
- Systematic review of over 13,000 peer-reviewed articles published between 2005 and March 2019 in relation to the research questions and in alignment with the steps and guidelines of PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses;
- Key informant interviews (KIIs) with five national and three global key informants to gather their expert opinions on the research questions;
- Descriptive case studies to investigate positive trends, identify good practices and inform learning and further research gaps drawing on negative trends or lack of progress.

Four countries were selected for case studies: Uganda and Rwanda, because they have demonstrated consistent progress across all components; Senegal, because it shows an overall negative trend; and Ghana, because it shows a slight overall decrease, with strongly diverging trends on the three components.

2.4 LIMITATIONS

Quantitative data analysis of the DHS data was limited by the following constraints:

- The last (valid) DHS publication was published more than five years ago for several countries (e.g. Niger and Rwanda) and even more than 10 years ago (Ethiopia). The trend analysis therefore only captures trends to a certain point in time; it does not reflect changes achieved since the last data collection.
- Caution is warranted when interpreting the consolidated data from the three components. The indicator creates an overall value by using data from the three different components, which do not necessarily evolve in the same direction. The average fails to unveil significant changes and variance across the three components (as it is the case for instance for Benin and Ghana) and trends cannot be understood without analysing the changes on each; and
- The DHS data themselves are subject to certain limitations. The three components only collect data on women married or in union (15–49 years) who are currently using contraception. They do not assess whether women make “informed” decisions, i.e. the extent to which they have access to quality information. The access to reproductive health care component assesses general “health care” and not “reproductive health care” specifically. These limitations are mitigated through the triangulation of quantitative data with qualitative data analysed as part of the systematic review and the case studies.

For the systematic review, two limitations were identified:

- The search strategies did not include search terms related to SRHR policy and legislations, which may have led to an omission of articles; and
- Due to the high number of articles identified, the research team was not able to conduct an independent screening of all records. This was mitigated by frequent exchanges between the team, during which questions and grey areas of inclusion criteria were discussed and agreed upon.

For the KIs and case studies, the main constraints were lack of time and lack of availability of eight key informants. The number of KIs at the country level was too low to reach saturation. This constraint was mitigated, however, by triangulating the data with peer-reviewed articles and grey literature, as well as with the quantitative analyses.

2.5 REPORTING STRUCTURE

The research report is divided into two volumes. Volume I contains a synthesis of the research findings and the conclusions and recommendations of all methods and data sources. Volume II contains a detailed description of the methodology, the quantitative data analysis, the systematic review and the case studies. It also includes annexes with all additional tables and figures.

3 FINDINGS

The findings outlined in this section are a compilation of data from both quantitative and qualitative data sources and cover a wide range of country contexts from low- and middle-income countries across the world. However, the trend analysis (see section 3.1) only presents data from 22 countries, as these were the only countries for which more than one component was available.

3.1 HOW DOES INDICATOR 5.6.1 CHANGE OVER TIME, AND WHAT ARE THE TRENDS?

Based on the 22 countries studied, the percentage of women who meet the criteria of Indicator 5.6.1 varies greatly across countries and regions, with the weakest result noted in Mali, where 6.5 per cent of women meet all three components, and the strongest result noted in Cambodia, with 75.6 per cent of women considered “empowered” in these areas of decision-making.

Three countries where less than 10 per cent of women meet the indicator criteria are found in West and Central Africa (Mali, Niger and Senegal). This result clearly indicates the need to strengthen support to these countries and to investigate trends in other countries located in the region that were not included in this analysis due to the lack of data, specifically Burkina Faso, Chad, Mauritania and Sudan.

In the other regions—Arab States, Asia and Latin America and the Caribbean—at least 30 per cent of women satisfy the indicator by making their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

3.1.1 WHAT ARE THE OVERALL TRENDS AT THE COUNTRY AND REGIONAL LEVELS?

The trend analysis showed an overall positive development in 13 countries, while nine countries displayed downward trends. The range of positive trends varies from +1.8 per cent in Armenia to +14.3 per cent in Uganda. Negative trends range from –11.8 per cent in Nepal to –2 per cent in Niger. The most positive changes were observed in Eastern Africa and Southern Africa, where eight out of 10 countries showed positive trends and six countries increased the percentage of women meeting the indicator criteria by at least 7 per cent: Uganda (+14.3 per cent), Democratic Republic of the Congo (DRC; +11.4 per cent), Rwanda (+9.4 per cent), Zimbabwe (+7.5 per cent), Lesotho (+7.1 per cent) and Zambia (+7.1 per cent).

The most negative trends can be observed in West and Central Africa, where data for five countries indicate negative changes: Senegal (–6.3 per cent), Benin (–5.4 per cent), Mali (–3.0 per cent), Ghana (–2.1 per cent) and Niger (–2.0 per cent). Only one country, Nigeria, showed a slight upward trend at +3.7 per cent. Only three countries were included in the analysis for Eastern Europe, and two were included for the Central Asian Region and the Asia and Pacific region, which did not allow for conclusive trend observations to be drawn at the regional level.

3.1.2 WHAT ARE THE TRENDS IN RELATION TO EACH COMPONENT?

The analysis of trends at the level of the three components revealed interesting results. First, in most of the countries, there are strong variances (20 to 50 per cent) between the percentages displayed in each of the three components. In Mali, for example, 81 per cent of women independently or jointly, with their partner, decide on contraceptive use, but only 18 per cent are able to do the same for their health care needs. In Ethiopia, only 53 per cent of women reported being able to refuse sexual relations, whereas 93 per cent reported that they independently or jointly make decisions about contraceptive use.

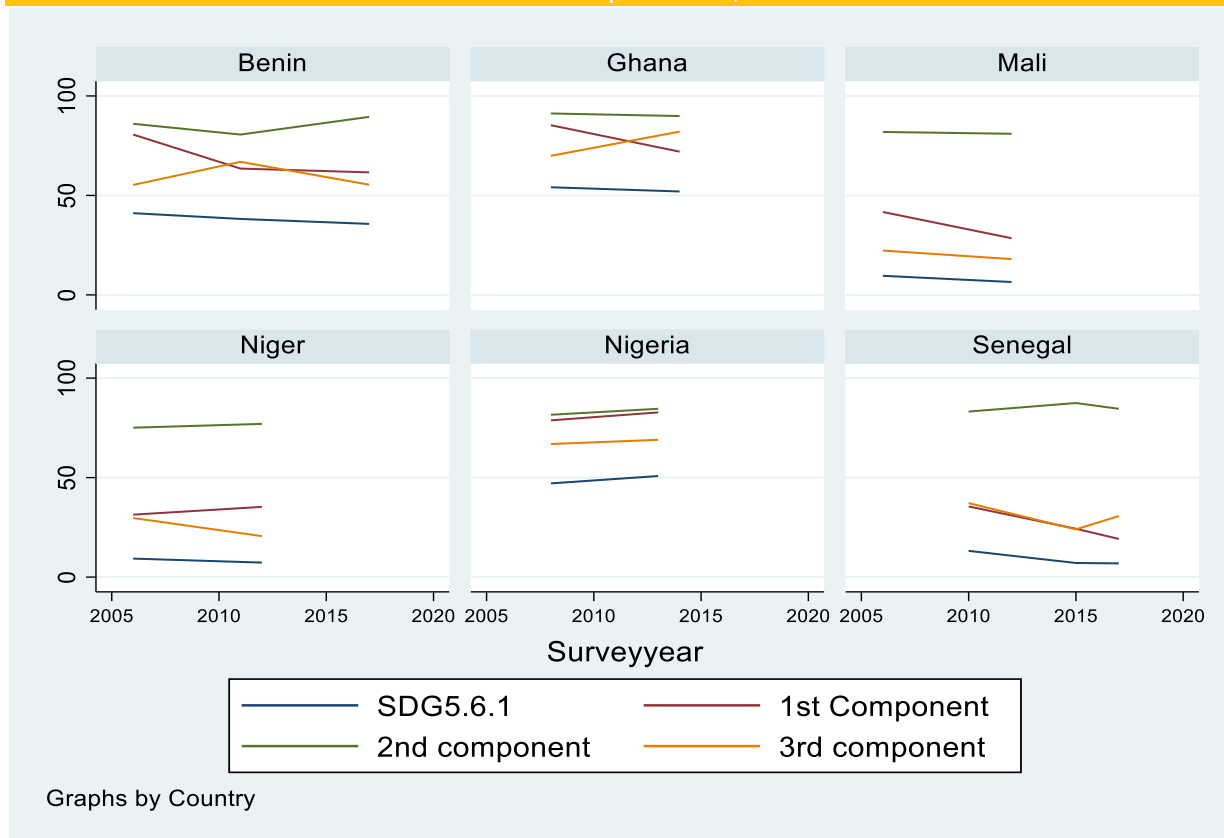
Second, the components often evolve in different directions. Over the past 10 years in Benin, for example, women's ability to refuse sex decreased by 20 per cent while at the same time the percentage of women who meet the criteria of component two on contraception and three on health care showed little change. This type of diverging trend can be observed to different degrees in most of the countries (see figure 1). Only Uganda and Rwanda show consistent positive trends, and Nepal is the only country that displays a downward trend across all components. These diverging trends merit close attention in the monitoring of Indicator 5.6.1 because they imply that the one overall result can hide both positive and negative disparities at the level of the three individual components. The trends also indicate that policy and legal changes as well as SRHR interventions can have either a positive or negative impact on girls' and women's agency in one SRHR outcomes, but not necessarily on other outcomes.

The number of countries with **positive** trends is generally highest in the component on health care decision-making. Most countries report progress on this component, except for six countries, some of which have been affected by conflict (e.g. Burundi, Mali and Niger).

Most **negative** trends, on the other hand, can be observed on decision-making about sexual relations, where more than half of the countries registered a decrease. This trend applies particularly to West and Central Africa, where most countries reported large decreases on women's decision-making regarding sexual relations. Overall, there are large variations between countries, ranging from -19 per cent in Benin to +22.7 per cent in the Democratic Republic of the Congo. Improvements on this component are most visible across Eastern Africa and Southern Africa, but also in Cambodia (+5.8 per cent) and Albania (+9.7 per cent).

Women's decision-making on contraceptive use has remained quite stable, displaying mostly small variations. This may be partly due to how this component is measured, since it focuses exclusively on women who are married or in union and are currently using modern family planning methods. Findings from the case studies and the systematic review indicate that the trends for this component might look different if a more representative sample of women was considered.

Figure 1. Evolution of the percentage of women who met the criteria for Indicator 5.6.1 and its components, West and Central Africa



3.2 WHAT FACTORS INFLUENCE WOMEN’S INFORMED DECISION-MAKING ON SEXUAL RELATIONS, CONTRACEPTIVE USE AND REPRODUCTIVE HEALTH CARE?

The triangulation of data with qualitative data sources reveals a complex picture of the determinants for decision-making on sexual relations, contraceptive use and reproductive health care seeking.³ Generally, more similarities were noted across components two on contraceptive use and three on reproductive health care seeking, since they share similar barriers and enablers at the health system level, something that is less relevant to the sexual relations component. The systematic review revealed highly specific and context-dependent factors for each of the three components.

The most critical demographic and socioeconomic determinants across all components are the **woman’s education level** [1]–[5], [6], [7], [8], [9], [10], [11], [12], [13], [14], [15], [16], [17], [18], [19], [20]–[24]; the **education level of her partner or spouse** [21], [22], [25], [26], [9], [27], [28], [11], [29], [30], [5]; **household wealth status** [31], [32],[33], [34], [35], [21], [22], [36]–[38], [24], [39]–[44]; **urban residency** [40], [45]–[47], [24], [48], [49], [30], [50], [17], [18], [2], [5]; and **access to media** (radio, television, etc.) [51], [52], [53], [54], [55], [56], [57], [18], [19], [26], [58]–[61]. In urban areas, women (and men as well) are increasingly concerned about how to afford the cost of raising and fulfilling responsibilities towards their existing

³ While the quantitative data focus on health care seeking overall, in the systematic review, the researchers focused on reproductive health care seeking; thus, the determinants in this report focus on reproductive health care.

children. This perception is a strong enabler for women's contraceptive uptake and for increased compliance with postnatal check-ups [49], [30], [50], [17], [18].

At the individual level, three determinants are particularly influential: **adequate knowledge of SRHR** [62], [63], [32], [34], [64], [65], [66], [67], [68], [88], [29], [69], [34], [70], [16], [50], [71], [16], [72]–[75], [76]–[81]; **previous health experiences** [82], [67], [83], [84], [85], [86], [87], [88], [89], [60], [73], [90]–[92] or **a woman's health status** [93], [4], [93]–[95], [188], [252], [262], [78], [96], [26], [39], [91]; and **a woman's autonomy and agency** in relation to household decisions, mobility and finances [97], [98], [23], [40], [99]–[101], [26], [101]–[103], [81], [103]–[109], [110], [52], [17], [111], [112], [113], [114], [115].

The depth of knowledge is important for two reasons. First, access to trustworthy and quality information enables women to discount misinformation and myths that they hear about contraception from their peers. Second, it empowers women to respond to questions from their partners or spouses and to negotiate family planning decisions in favour of their needs. Previous experience with health care providers also plays a significant role in women's decision-making process on family planning, contraceptive use and reproductive health-seeking behaviour. Negative pregnancy experiences that have occurred as a result of complications or side effects can lead to an increased desire to use contraception [116] as well as influence the decision to seek reproductive health care services [60], [73], [90]–[92].

Previous experience with contraceptive use can also have a strong influence on women's future contraceptive decision-making. Negative experiences can act as a strong deterrent, even if women have unmet contraceptive needs, whereas positive experiences and benefits are associated with user satisfaction and meeting the need for contraception [82], [67], [83], [84], [85], [86], [87], [88], [89]. There is consistent evidence that the experience of side effects from contraceptive use is common and that the lack of support for mitigating these effects results in decision-making outcomes against contraceptive use despite unmet family planning needs. The most commonly cited medical/physical side effects were weight gain, nausea, depression, anxiety, hypertension, physical weakness, hormonal or menstrual irregularities, backaches and headaches, and lack of effectiveness [85], [117], [118], [119], [120], [51], [121], [122], [66], [49], [123], [124], [125], [83], [86], [126], [127], [128], [129], [29], [116]. Women's agency—measured mostly through concepts of autonomous decision-making on their movements and in terms of household purchases—has also been shown to influence women's autonomous decision-making on contraceptive use and reproductive health care services such as abortion or attending antenatal and postnatal care services. In terms of decision-making on sexual relations, women's agency was not always a significant factor; instead some studies pointed to the fact that women may “choose” to comply with the sexual demands imposed on them by their husbands as a way to negotiate autonomy in other aspects of their lives [130], [4], [131].

The interpersonal level plays a critical role in all three components: the decision-making dynamic is at least influenced if not fully determined by the **partner's or spouse's position on the subject**. Men, who generally act as head of their households, hold full decision-making power, including power over SRHR issues, that are socioculturally perceived as “women's matters” [21], [41], [92], [102], [132], [133], [134], [60], [100], [135], [136], [40], [137]. Men report that they feel entitled to dominate women, a clear expression of unequal power relations, ensuring that women are unable to control the timing of sex [1], [4], [93]–[95], [138]–[142]. In rural areas, women rarely make a decision to use contraception without consulting their husbands first. If their partner decides against family planning, women sometimes resort to covert contraceptive use (CCU) [143], [86], [144], [49], [123], [71], [84], [116], [145], [118], [119], [66], [27], [146], [128], [52], [69], [147] [148], [149], [150], [124], [151], [152], [153]. Women who receive support from their partner for family planning or reproductive health care, on the other hand, are more likely to have access to and use these services [148], [149], [150], [124], [151], [152], [153], [60], [100], [135], [154], [76].

Communication between partners or spouses on SRHR is a positive predictor for joint or women's independent decision-making [32], [95], [140]. Although couples' communication on SRHR matters is generally low [32], [95], [140], [155], [88], [156], [120], [41], and often not initiated by women out of fear of their partner or spouse's reaction [105], [157], [158], [159], [160], [144], [116], [155], [161], [162], [163], [164], there is consistent evidence that couples who communicate on SRHR matters on a regular basis are more likely to make joint decisions. This applies in particular to contraceptive use [165], [166], [9], [10], [167], [168], [169], [170], [171], [172], [88], [173], [13], [15] and reproductive health care [22], [26], [100], [154], [174], [25]. Fear of a violent reaction from a woman's partner is often also cited a reason to not refuse sex [31], [34], [93], [94], [142], [175] or not insist on the use of a condom [155], [161], [162], [163], [164], [176], [127]. 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 for contraceptive use [177], [178], [179], [49], [88], [180], [181], [182], [183], [144] and reproductive health care seeking [102], [21], [17], [24], [28], [38], [39], [47], [66], [74], [191], [278].

The interpersonal level is subject to the strong influence of sociocultural perceptions and norms, which exist at the community level. **Gender norms** related to reproductive health are a significant deterrent for women's independent or joint decision-making on sexual and reproductive health: women are expected to be submissive and passive in sexual relations [3], [31], [32], [94], [95], [138], [140]–[142], [185] and they need to fulfil their reproductive obligations in wedlock and to obey their husbands' decisions regarding their own reproductive health [119], [120], [85], [186], [160], [88], [155], [116], [187], [21], [41], [90], [132], [134], [136], [158], [159], [174], [188]–[190], [191]. At the same time, sociocultural norms define sexual and reproductive health as a women's issue that is not to be discussed with men [25], [26], [37], [188], [192]–[195]. These gender norms make it particularly challenging for girls and women to negotiate sexual relations, contraceptive use and reproductive health care needs. Adolescents face additional barriers due to sociocultural norms that classify sexual activity out of wedlock as deviant behaviour [32], [33], [196], [66], [51], [34], [197]–[199]. These beliefs are also rooted in taboos that prevent parents and caretakers from discussing sexual and reproductive health issues with their children [51], [200], [34], [201], [57], [147]. As a result, sexually active unmarried adolescent girls are shamed socially by other community members and discriminated against by health care providers.

Religion, no matter the type, also plays a significant role in women's decision-making process related to contraceptive use and reproductive health care seeking. Either women themselves perceive that their religion is against contraception and choose not to use it, or their husbands will not authorize the use of family planning methods due to their religious values [67], [51], [176], [27], [127], [146], [202], [128], [203], [170], [88], [129], [155], [29], [116], [34], [70], [180], [89], [54], [204], [163], [205], [181], [206], [207], [15], [208], [16], [18]. In terms of reproductive health care seeking, religion mostly plays an influence on decisions related to abortion or pregnancy among unmarried women [47], [97], [158], [209], [197].

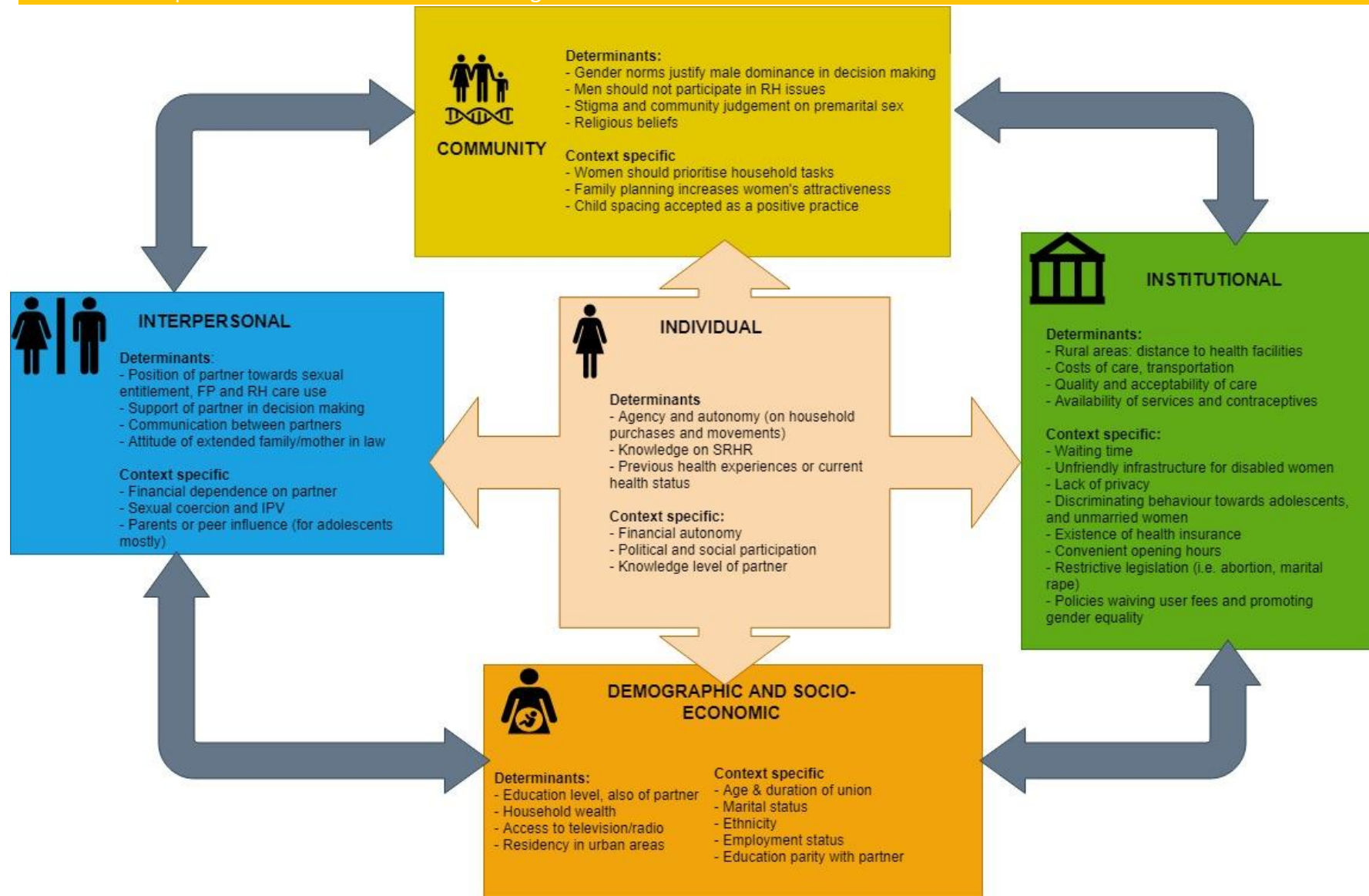
Girls and women also face significant barriers at the health system level. These barriers centre mostly on **access**, particularly in terms of the distance women must travel to health facilities in rural areas [44], [46], [133], [159], [210], [51], [85], [122], [66], [9], [211], [203], [129], [206], [114], [35], [212], [207], but also in terms of the **availability** of (youth-friendly) services and a sufficient supply of different types of contraceptives [194], [197], [213], [148], [200], [129], [206], [212], [50], [207], [214], [211], [124], [215], [175], [212], [207], [18], [206]. The **affordability** of services and the cost of transportation are other major barriers to accessing reproductive health services, but also to purchasing contraceptives or pursuing additional consultations and medications when side effects occur [92], [137], [154], [210], [21], [38], [41], [90], [92], [96], [97], [135], [154], [209], [210], [216]–[219], [44], [92], [189], [90], [132], [163], [197], [51], [211], [212], [203], [201], [175], [180], [207], [85], [49]. The **quality and acceptability** of services are other major deterrents; these include unfriendly, disrespectful and harsh treatment by health care providers, long

waiting times, lack of privacy and, in some cases, gender preferences for health workers [61], [92], [133], [137], [154], [90], [92], [96], [98], [197], [217], [220], [221], [148], [197]–[199], [222], [148], [122], [223], [206], [201], [200], [121], [128], [222], [224], [124].

Mainly anecdotal evidence is available on the influence of policies and laws on SRHR outcomes in relation to the indicator's three components. Key informants emphasized the importance of a conducive legal and policy environment such as, for example, the provision of free maternal health care (Uganda) or sufficient health insurance coverage (Ghana and Rwanda), as well as political efforts and commitments to improve gender equality (Rwanda, Senegal and Uganda). Because financial cost was often considered a barrier to a household's decision-making on whether to use reproductive health services, the improved affordability of services could, in fact, explain the significant improvements in terms of health care decision-making in countries such as Ghana, Uganda and Rwanda. However, Senegal has made significant progress towards increasing the affordability of family planning services without experiencing a comparable positive trend in reproductive health decision-making. As well, there is a lack of studies that can corroborate these assumptions or associate these policies directly with improved decision-making by women. In terms of gender equality, it is interesting to observe that countries which have made important strides in terms of adopting gender-transformative policies and laws, such as Rwanda and Senegal, show opposite trends in the percentage of women who meet the criteria. In the absence of quantitative research, it is therefore difficult to draw a connection between policy and legal changes that enhance gender equality in political spheres and women's decision-making ability on sexual and reproductive health outcomes. This research gap merits future attention.

The determinants described above, as well as context-specific factors, are outlined in figure 1. Context-specific factors are factors for which there was either inconsistent evidence (e.g. some studies found significant correlations while others did not) or the factor was only replicated in fewer than five studies. Determinants, on the other hand, are factors that were consistently reported in at least five studies across different contexts.

Figure 2. Common determinants of women's informed decision-making on sexual relations, contraceptive use and reproductive health care seeking



3.2.1 HOW DO HUMANITARIAN CRISES INFLUENCE WOMEN'S INFORMED DECISION-MAKING ON SRHR?

There is limited evidence as to what extent and how women's decision-making on SRHR outcomes changes during periods of crisis. Qualitative and quantitative data sources confirm an increase in sexual and gender-based violence (SGBV) in conflict and displacement settings, which implies that a corresponding decrease in women's decision-making capacity in sexual relations occurs [44], [91]. The researchers did not find information on this component in other types of disasters.

Although crises often lead to a deterioration of public services, there is also evidence to suggest that women's decision-making agency in family planning matters and reproductive health care use can be enhanced during these times. One reason for this is the dismantling of social fabrics and community norms in crisis-affected settings, which lead to a shift in focus on safety and survival priorities and thus redefine decision-making parameters. In countries with long histories of civil war, such as Eritrea and Liberia, the progressive dissolution of community norms enables women to acquire increased autonomy, freedom of speech and decision-making authority at the household level. This was illustrated by studies in conflict settings, but also in areas affected by natural disasters such as droughts, where an increased uptake of contraception, for example, was documented. Another reason for this is the availability and ease of access to quality information and services in refugee camps, which remove barriers related to health systems [61], [119], [225].

3.3 WHAT TYPE OF SRHR INTERVENTIONS HAVE A POSITIVE AND SUSTAINABLE IMPACT ON WOMEN'S INFORMED DECISION-MAKING ON SEXUAL RELATIONS, CONTRACEPTIVE USE AND REPRODUCTIVE HEALTH CARE?

3.3.1 WHAT TYPES OF INTERVENTIONS AND PROGRAMMES HAVE A POSITIVE EFFECT ON USE OF CONTRACEPTIVES AND REPRODUCTIVE HEALTH SERVICES?

A wide range of project activities have been rolled out to help improve outcomes on women's decision-making on the contraceptive and reproductive health care use. All good programme models for enhancing this decision-making aim to have an impact on both supply and demand dimensions and to achieve change by tackling barriers at several levels (individual, interpersonal, institutional, etc.). Typical components of interventions considered to be good practices include health system strengthening interventions (e.g. training/coaching for health care providers on quality and competency gaps, supervision of health facilities in partnership with local government health officials and the provision of contraceptives and medical devices to improve supply components) as well as community mobilization and clinical outreach strategies (to improve the demand component). Programmes that combine context-specific supply and demand building blocks have shown to be effective in both stable and crisis-affected settings [226], [227], [228], [229], [230], [231], [232], [233], [234], [235], [236], [237], [238]. The research team also found consistent evidence that the effectiveness of programmes can be further catalysed by integrating formative research at the design,

Formative research

Formative research uses qualitative and quantitative methods to collect information before planning an intervention. It helps researchers identify and understand the characteristics (interests, behaviours and needs) of the target population and how their decisions and actions are influenced. It is used to ensure that interventions are both culturally and geographically appropriate. Formative research is conducted before an intervention is designed and implemented, but also during implementation to help refine and improve the activities. Formative research is conducted through a literature review; primary data collection to address gaps in knowledge; and quantitative research [329].

baseline or mid-term review stages of programmes (see sidebar, “Formative research”). Formative research is critical to developing context-specific strategies to barriers and enablers, in particular those related to sociocultural norms, attitudes and perceptions [229], [230], [227], [239], [240], thereby helping researchers design more holistic programme approaches. Vertical projects or programmes that tackle only one specific barrier, on the other hand, have shown to be less effective [241], [242], [243].

The integration of community outreach strategies and continuum of care components are of critical importance in rural areas to build knowledge and achieve sustainable behaviour changes. An effective continuum of care⁴ connects essential maternal, newborn and child health packages throughout the lifecycle—adolescence, pregnancy, childbirth, postnatal and newborn periods and into childhood—building on their natural interactions. It also strengthens the links between the home, first-level facility and hospital, thus helping to assure that appropriate care is available in each place [244]. The training, equipment and supervision of community health workers has shown to be effective in rural areas in different countries [230], [240], [245], [246], [247], [248]. This approach, however, has often shown gaps in terms of sustainability, especially if community health workers are not an integrated part of the national health system.

The use of information technology for development (IT4D) strategies to promote SRHR information has increased rapidly in the past decade and has shown promising results in different settings, reaching migrant women, pregnant and post-partum women, women interested in knowing their fertility status and adolescents [249], [250], [251], [252], [253], [254]. These applications have demonstrably increased access to important SRHR information, although results at the outcome and sustainability levels remain to be further investigated [255], [256], [257], [258], [259].

⁴ “The continuum of care for maternal, neonatal, and child health requires access to care provided by families and communities, by outpatient and outreach services, and by clinical services throughout the lifecycle, including adolescence, pregnancy, childbirth, the postnatal period, and childhood. Saving lives depends on high coverage and quality of integrated service-delivery packages throughout the continuum, with functional linkages between levels of care in the health system and between service-delivery packages, so that the care provided at each time and place contributes to the effectiveness of all the linked packages.” See www.who.int/pmnch/topics/20071003lancet.pdf

There is also an increasing number of studies that demonstrate how results at the outcome level can be improved by targeting men in community mobilization activities [260], [261], [262], [263], [264], [265], [266], [267], [268], [269], [270], [271] as well as through specific interventions that promote male engagement on sexual and reproductive health issues (see sidebar, “Male engagement”) [272], or through “husband schools” in Niger [273]. Due to the decision-making authority of men in women’s SRHR outcomes, this is not a surprising finding. Despite the importance of dialogue between couples on SRHR matters and male involvement, the number of evaluated and documented interventions with the objective of enhancing the quality and frequency of couples’ communication is still small.

To reach vulnerable population groups such as poor women and adolescent girls, or to catalyse access to services in conflict setting, the introduction of vouchers or conditional cash transfers has shown to be an effective strategy for increasing access to SRHR services in different settings and regions [274], [247], [275]. Conditional cash transfers were also found to be successful in increasing the use of so-called long-acting reversible contraceptive methods [276].

Male engagement

The Bandebereho intervention, which was implemented by the Rwanda Men’s Resource Center, aimed to transform norms around masculinity by demonstrating positive models of fatherhood. Men were invited to participate in 15 sessions (of which eight were completed together with their partners) on sessions such as gender and power, fatherhood, couple communication and decision-making, IPV, caregiving, child development and male engagement in reproductive and maternal health. A randomized controlled trial (RCT) found that women reported less physical and sexual violence, higher rates of men’s participation in antenatal care visits, greater use of modern contraception and significantly lower decision-making by men in relation to income and expenses compared with the control group [272].

3.3.2 WHAT TYPES OF SRHR INTERVENTIONS AND PROGRAMMES HAVE A POSITIVE, SUSTAINABLE IMPACT ON WOMEN’S ABILITY TO REFUSE SEX?

There is considerably less evidence on good practices that aim to have an impact on women’s decision-making ability with regards to sexual relations. The researchers identified a few examples of good practices in this area, mostly programmes that are participatory, gender-transformative and context-specific, and that address prevention of sexual and gender-based violence. Key findings from these programmes include the following:

- A mixed-sex approach that engages both partners was effective in facilitating positive change in relationships and reducing IPV. It helped couples explore the benefits of mutually supportive gender roles, improve communication, increase levels of joint decision-making and introduce non-violent ways to deal with anger or disagreement [277], [278], [272].

- The combination of introducing concepts during informal activities (such as community conversations and meetings, public events, film shows and drama), coupled with the engagement of community members as change agents, was effective because the informal activities allowed participants to identify themselves with the issues and improved their understanding of the causes and effects of IPV, while the concurrent influence from interpersonal communication with change agents and different social network members facilitated changes in behaviour [279], [278].
- By promoting relationship values and nurturing positive relationship dynamics, more balanced power can be achieved in relationships without necessarily addressing gender roles specifically. This might be a gentler and more effective way to achieve shifts in these areas without requiring individuals to openly reject existing norms, and may help to address these issues in contexts in which there is a backlash against addressing gender inequality or SRHR [279].
- Formative research during the intervention design phase is an important way to (1) examine who advises on and influences relationships in a given context (e.g. peers, elders, religious leaders, local leaders, schools), to ensure that the intervention also engages them; and (2) understand how communication between partners about their relationship can be effectively promoted [280], [281], [279], [278].
- Interventions that were implemented over a longer period (between 1 and 4 years) seemed to be more successful than shorter interventions [282], [281], [280], [277], [279], [283].
- Interventions that combine the provision of hard vocational skills with soft life skills focused on sexual and reproductive health for girls and young women (14–20 years of age) were found to improve economic empowerment and control over their body for young women and girls, with fewer reporting having had sex unwillingly. However, these interventions did not address gender roles and norms in the wider community, and the results in terms of changed aspirations related to marriage and childbearing were less prominent [284], [285].

Critical analysis and discussion of power and power inequalities

SASA! (which mean “now” in Kiswahili) is a combination HIV and violence against women prevention programme designed by Raising Voices and implemented in Kampala, Uganda, by the Centre for Domestic Violence Prevention. The intervention promotes critical analysis and discussion of power and power inequalities to catalyse community-led change in the norms and behaviours that perpetuate gender inequality and violence. It does this through engaging health workers and local authorities and training community activists, who introduce concepts during informal activities in their communities. A cluster randomised controlled trial found that the intervention led to lower social acceptance of IPV and greater acceptance of the fact that a woman can refuse sex. Qualitative research also found that couples improved their communication and levels of joint decision-making and that there was a reduced acceptability of violence against women at the community level [280], [281].

More programmes were not documented for the following reasons:

- Interventions in this area need to tackle the complex and broader environment of gender inequality where sustainable outcomes at scale can only be achieved through long-term investments.

- Many more interventions are tackling reproductive health rights than sexual rights.⁵
- Changes are more complex to measure and require an in-depth understanding of gender norms and sociocultural norms and perceptions.

3.3.3 TO WHAT EXTENT HAVE GOOD PRACTICES BEEN REPLICATED AT SCALE?

Several programmes designed to influence changes in decision-making on sexual relations, contraceptive use and reproductive health care use have been tested and replicated. The SASA! programme (see sidebar, “Critical analysis and discussion of power and power inequalities”), which addresses gender and power inequities, has been documented and widely translated and is currently used in 20 different countries and in diverse contexts (humanitarian, rural and urban). The research found evidence of other evaluated programmes that explicitly noted using the SASA! approach. The Indashyikirwa programme in Rwanda, for example, promoted a 5-month curriculum among heterosexual couples aged 18–49 to support them to identify the causes and overlapping consequences of economic, emotional, physical and sexual IPV. An RCT is still being conducted on this programme, but a qualitative study found that both partners reported significant changes in their sexual relationship, including reduced experiences of coerced sex, greater communication about sex and increased acceptability of women initiating sex [278]. SASA! has also been adapted to a rural context in Tanzania, and this process was well documented [286]. The case study documented the various challenges encountered, such as resistance from men and community leaders, and how these were overcome in the adaptation process. Overall, the case study reaffirmed that community-wide mobilization and engagement in a rural context is a viable strategy for the reduction of physical and/or sexual IPV against women, increased knowledge and reduced acceptance of violence against women and girls (VAWG) and increased capacity to respond to VAWG [286].

Couples counselling is another approach used in different contexts. It has been shown to have positive results on couple’s communication around contraceptive use and male participation on reproductive health. Key informants from Rwanda reported that couples counselling is a strategy actively being promoted by the government for both HIV and family planning use at the community level, and has delivered positive results. A recent literature review assessed 41 interventions from high-, middle- and low-income countries, including different reproductive health topics (23 focused on HIV, 14 on FP, two on maternal and child health, and two on abortion and post-abortion care). Most interventions were conducted in health facilities; others involved community outreach activities, home-based counselling or workplace engagement. The study found that couples counselling led to improved contraceptive use; improved couple communication and partner support for family planning; improved knowledge about fertility and family planning; and increased male outreach and participation in post-partum and general health clinic visits. However, the interventions use a variety of different approaches and the effectiveness varies greatly in the extent to which they address

⁵ “The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include: the rights to equality and non-discrimination; the right to be free from torture or to cruel, inhumane or degrading treatment or punishment; the right to privacy; the rights to the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one's children; the rights to information, as well as education; the rights to freedom of opinion and expression, and the right to an effective remedy for violations of fundamental rights.” See www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

gender and power dynamics, couple communication and intimacy [287]. The research did not find enough evidence of interventions that have been implemented at scale.

3.4 TO WHAT EXTENT CAN THE FINDINGS FROM THE QUANTITATIVE DATA ANALYSIS BE CORROBORATED BY QUALITATIVE DATA ANALYSIS?

Indicator 5.6.1 measures women’s ability to make informed decisions about their sexual and reproductive health; however, the quantitative data analysis does not measure whether women make **informed** decisions—that is, decisions that are based on sufficient knowledge. Although the indicator assesses whether women can make decisions on their contraceptive use and health care by **themselves or jointly**, it does not assess whether women alone have decision-making power over these two matters. In this section, we triangulate data from quantitative and qualitative sources to assess whether the quantitative data can be corroborated by qualitative findings.

3.4.1 TO WHAT EXTENT DO GIRLS AND WOMEN HAVE ACCESS TO QUALITY INFORMATION DURING THEIR DECISION-MAKING PROCESS?

For all components, SRHR-related knowledge is a key predictor for women’s decision-making ability. The findings of this research showcase the importance of distinguishing awareness and knowledge on SRHR matters. The incidence of awareness on sexual relations, contraceptive use and reproductive health care is high in most settings, whereas knowledge is strikingly low, particularly in rural settings [72]–[75], [76]–[81], [64], [65], [66], [67], [68], [88], [29], [69], [34], [70], [16], [50], [71], [16]. Awareness is an insufficient foundation for informed decision-making because it is rarely fact-based but rather is rife with misconceptions, rumours and myths, all of which have been shown to be catalysts for negative SRHR outcomes [177], [68], [85], [214], [51], [122], [176], [288], [66], [49], [211], [146], [128], [203], [289], [88], [29], [65], [89], [147], [163], [183], [35], [206], [16]. This applies in particular to contraceptive use, where misinformation and the exaggeration of side effects often dissuade contraceptive uptake despite an unmet need for family planning need [50], [290], [291], [206], [292], [54], [170], [289], [88], [129], [29], [89], [180]. Because knowledge levels continue to be insufficient in most reviewed studies, it can be concluded that access to quality information is either absent or communicated in inadequate ways, making it difficult to know whether women actually make informed decisions about their sexual and reproductive health.

3.4.2 TO WHAT EXTENT IS JOINT DECISION-MAKING ON CONTRACEPTIVE USE AND ACCESS TO HEALTH SERVICES REPRESENTATIVE OF WOMEN'S INDIVIDUAL DECISION-MAKING ON SRHR?

The results from the systematic review indicate that the nature of joint decision-making depends on the determinants for contraceptive use and access to sexual and reproductive health services. Women in rural areas who have low levels of education and agency are much more likely to be subjected to unequal power relations and to have little or no communication with their partner or spouse on sexual and reproductive health-related matters. Decisions that are reported as being taking “jointly” are often likely to include a substantial percentage of decisions in which women are overruled by men [116], [18], [110], [54], [207], [88], [15]. The considerable incidence of covert contraceptive use in rural areas (between 20 and 30 per cent, according to available studies) is another indication of how women cope with the results of “joint” decision-making. The results for Indicator 5.6.1 therefore need to be interpreted carefully, and further research is needed to explore the nature of joint decisions among couples in rural areas and to understand to what extent reported joint decision-making can be associated with covert contraceptive use.

The literature on individual versus joint decision-making and their respective impact on the use of contraception or health services is also inconclusive. Some authors suggest that joint decision-making reflects gender equality within couples, whereas decisions made only by women denote wives’ autonomy,

with little or no support from their husbands. These authors conclude that joint decision-making is therefore better for women's well-being [293], [76]. However, one study found that when autonomy is defined as women having the final say on a decision, a significant and positive association is seen with women's use of health care services compared with when autonomy is defined as women having the final say or jointly making a decision [23]. Disaggregating joint and individual decision-making in the indicator components as a way to monitor the trends of both variables should therefore be considered. In urban areas where both partners are educated, study findings indicate that joint decisions are mostly representative of women's sexual and reproductive health needs if the women have agency as well as a degree of financial independence [7], [186], [294], [54], [15], [110], [52], [17], [111], [112]. The findings of this study therefore lead to the hypothesis that the number of determinants met (see figure 2) is positively correlated with joint decision-making, if these are aligned with women's needs. If few determinants are met, it is likely that joint decision-making is less representative of women's wishes.

3.4.3 TO WHAT EXTENT CAN CHANGES IN VARIABLES FROM INDICATOR 5.6.1 BE CORROBORATED WITH OTHER DATA FROM THE SELECTED COUNTRIES?

The in-depth case studies on Ghana, Senegal, Uganda and Rwanda showed that changes on Indicator 5.6.1 can, in some cases, be explained by other qualitative and quantitative data sources. The significant improvements in women's decision-making on their (reproductive) health care use is often linked to (1) the removal of financial barriers due to improved health insurance coverage (Ghana, Rwanda); (2) the abolition of user fees (Uganda); or (3) the use of vouchers and/or conditional cash transfers (Uganda); coupled with improved levels of education, wealth, fewer people living in the household and higher levels of media exposure. Those aged 20–29 years had the largest increase in decision-making on health care use, which could be linked to changes in access to primary education (Uganda, Rwanda).

In terms of decision-making on contraceptive use, the quantitative data did not show much variation across the four country studies, and very few variables showed a significant association with the changes observed. In general, a large proportion of women (+80 per cent) met the criteria of this component; however, it is important to bear in mind that the component only examines a very restricted sample: women who are married or in union and currently using contraception, a group that has already made a positive decision around contraceptive use. Qualitative data, on the other hand, show that many determinants at the individual, interpersonal, community and institutional levels influence women's decision-making ability on contraceptive use. Barriers are particularly significant for non-users with unmet needs, unmarried women and girls who are not represented in the analysed samples. Other quantitative indicators, such as the one on contraceptive uptake, show significant changes in the four countries showcasing a significant increase of new family planning users, which would not be possible without a significant increase in women making joint or individual decisions on family planning use. Based on the findings of this study, the assumption is that the low variation in the second component is a reflection of its limited sensitivity for change, rather than a lack of change in women's ability to make family planning decisions. This is a major limitation to Indicator 5.6.1 and the researcher's assumption should therefore be further explored in future research.

Data on sexual relations show a more diverse trend in the four country case studies. Although both Senegal and Ghana registered a decrease (–16.3 per cent in Senegal and –13.3 per cent in Ghana), both Rwanda and Uganda experienced an increase in women being able to refuse sex (+2.5 per cent in Rwanda and +4.6 per cent in Uganda). The proportion of women being able to refuse sex was four times higher in Uganda and Rwanda compared with Senegal (see Table 1). The trends were similar for women using or not using contraception, with those using contraception slightly more likely (except in Ghana) to reporting being able to refuse sex. Other data sources from the case study countries demonstrate that changes in the first component are much more difficult to achieve because they require changes in social and gender norms.

However, data also suggest that sex is a domain in which women can exert power, which they can also use to negotiate autonomy in other areas. Sexuality can therefore also become a resource or a trade-off that women make in order to practise safer sex or access decision-making power and material resources [130]. In Senegal, key informants confirmed that women’s sexual rights had not been addressed by programmes and that women cannot refuse sex to their spouse without expecting severe sanctions (IPV, withholding of financial support, divorce, etc.). Sociocultural norms and the teachings of Islam as understood in Senegal dictate that sexual intercourse is part of the marital duties owed to husbands by wives. One key informant noted that women might give biased responses to this question during the DHS as a way show the interviewers that they are compliant with their husband’s demands and prevailing sociocultural norms. While this explains the low performance in Senegal on the first component, no information could explain the important negative trend in the country.

In Uganda, several interventions have focused on power relations and power inequality among couples, thereby influencing the dynamics of relationships and broader community norms, which may be one of the catalysts for this positive trend.

Table 1. Comparison of evolution of the first component for Senegal, Ghana, Rwanda and Uganda

Country (data latest survey)	Ever-married women		Women in union using contraception	
	% at latest survey	% change	% at latest survey	% change
Senegal (2017)	17.8	–11.2	19.2	–16.3
Ghana (2014)	73.9	–5.6	72	–13.3
Rwanda (2014)	82.4	3.7	83.4	2.5
Uganda (2016)	85.6	8.6	86.9	4.6

3.4.4 WHAT ARE THE MOST SIGNIFICANT DETERMINING FACTORS IDENTIFIED BY QUALITATIVE SOURCES FOR INFLUENCING WOMEN’S INFORMED DECISION-MAKING ON SRHR?

Generally, qualitative data provide in-depth information on causal relationships that is not captured by quantitative data. Qualitative research explores sociocultural gender norms and perceptions, provides evidence on the needs of specific groups and reveals the underlying causes of marginalization and discrimination. In the context of this research, qualitative studies also explained why certain factors are powerful determinants for sexual and reproductive health decision-making, and demonstrated the complexity of interpersonal and community dynamics. The following findings are particularly relevant⁶:

- The position of the spouse or partner in the decision-making process is a key factor affecting women’s decision-making. If the partner strongly believes that he is entitled to dominate women, a woman will be less likely to be able to refuse sexual intercourse. If he decides against family planning or the use of health care services, it becomes more difficult for the woman to challenge his decision. However, women who receive support from their partner to access family planning or reproductive health care services are more likely to seek these services. Communication between partners or spouses on SRHR is a positive predictor for joint or women’s independent

⁶ Refer also to section 3.2, where these findings are discussed in more detail.

decision-making. Consistent evidence indicates that couples who communicate about SRHR matters on a regular basis are more likely to make joint decisions.

- The weight and complexity of sociocultural and religious norms, gender perceptions and unequal power relationships are root causes for lack of progress on Indicator 5.6.1. Gender norms are a significant deterrent to women’s independent or joint sexual and reproductive health decision-making: women are expected to be submissive and passive in sexual relations, to fulfil the reproductive obligations in their marriage and to obey their husbands’ decisions regarding their own reproductive health. These norms make it particularly challenging for girls and women, especially those who are unmarried, to negotiate sexual relations and reproductive health care with their spouse or partner.
- It is important to distinguish between sexual and reproductive health awareness and sexual and reproductive health knowledge. Awareness is an insufficient foundation for informed decision-making because it is rarely fact-based; instead, it is informed by misconceptions, rumours and myths, all of which have shown to be catalyst for negative SRHR outcomes. Knowledge about SRHR, on the other hand, is a key predictor for women’s decision-making ability; however, knowledge levels are often strikingly low, in particular in rural settings.
- The impact of contraceptive side effects on women’s life—not only physically and psychologically but also on other areas, such as household-rearing, intimate relationships, religious practice and social life—has been shown to influence their decision-making on whether to continue using contraceptives. As well, when women lack access to family planning services, the experience of side effects may often result in a decision to discontinue the use of contraceptives.
- The research shed light on barriers—especially disrespectful, unfriendly and discriminatory treatment by health workers, inconvenient opening hours of facilities, informal costs, stock-outs and the lack of diversity of available family planning methods—to the access, affordability and acceptability of health services on joint or women’s individual decision-making to use contraception or access reproductive health services. In certain contexts, the lack of health workers of the same sex has also been reported as a substantial barrier for women. All of these factors play a role in a household’s decision-making process.

3.5 WHO IS BEING LEFT BEHIND?

3.5.1 WHICH GROUPS OF GIRLS AND WOMEN ARE THE MOST DISADVANTAGED IN TERMS OF NEGOTIATING SEXUAL RELATIONS, CONTRACEPTIVE USE AND REPRODUCTIVE HEALTH CARE?

Although the quantitative data analysis only looks at women who are married or in union and highlights that married, educated and wealthier women in urban areas are relatively well positioned in terms of their SRHR decision-making, it also sheds light on other groups of women who are more disadvantaged and vulnerable and who have not been sufficiently reached through sexual and reproductive health programmes. There a number of disadvantage and vulnerable groups:

- Unmarried girls and women with low educational status in rural areas who want to access family planning and maternal health care are often subjected to community sanctions and discriminatory behaviour. Health care providers and pharmacists may refuse or provide only limited services to this group because of sociocultural norms that perceive sexual activity and pregnancy out of wedlock as deviant, “bad” behaviour. These norms are particularly harmful for the sexual and reproductive health outcomes of adolescent girls [51], [66], [51], [200], [34], [201], [57], [147],

[66], [51], [34], [197], [295], [296], [200], [297], [206], [298], [199] [194], [161], [198], [288], [47], [97], [158], [209] [197], [161], [199], [291].

- Young adolescent girls (10–14 years) are mostly excluded from programmes and services even though they are very vulnerable and have little agency in sexual relationships. Due to lack of access to information and support, they are exposed to sexual and gender-based violence, unwanted and high-risk pregnancies and sexually transmitted infections [198], [199], [299], [57], [175], [1], [31], [33], [35], [175], [19], [175], [197], [201], [197]–[199].
- Girls and women belonging to marginalized groups are excluded or discriminated against because of language, communication and cultural barriers. Marginalized groups vary from one context to the other, but often include women with disabilities, women from indigenous groups, refugees and internally displaced populations, women who are illiterate and woman who are members of nomadic groups. These girls and women face particular challenges in accessing quality services because health care providers either lack knowledge and tools on how to respond to their needs or because they discriminate against them [300], [301]–[309].
- Girls and women in areas with very low levels of decision-making ability may require focused support. In terms of geographic disparities, it is important to highlight and deepen our understanding of the low percentage of women (less than 10 per cent) who meet the indicator criteria in Mali, Niger and Senegal, for example. They score over 20 points lower than other “weak performers” such as Benin, the Democratic Republic of Congo and Tajikistan, where between 31 and 36 per cent of women meet the criteria. In Senegal, this number was only 7 per cent in 2017. All three countries show a negative trend, with Senegal decreasing by 6.3 per cent, Mali by 3 per cent and Niger by 2 per cent. Further investigation into the causes of this trend is warranted.

Men have received insufficient attention in SRHR strategies and interventions. As a result, studies confirm that men are less knowledgeable about SRHR matters and more prone to adhere to misconceptions and false information compared with women of the same age [120], [310], [203], [311], [176], [312], [25]. Due to men’s important role in the decision-making process, however, this is an important gap that needs to be closed. Evidence from interventions that involve men (e.g. through couples counselling/training or regular visits from a trained community volunteers) or that focus primarily on men show positive results and changes in relation to sexual violence reduction, an increase in women’s decision-making on sexual relations, and improved communication and participation from husbands in seeking reproductive health care and family planning use [278], [282], [281], [280], [277], [279], [283].

3.5.2 TO WHAT EXTENT ARE MARGINALIZED GROUPS TARGETED IN SRHR INTERVENTIONS?

A number of interventions target marginalized and particularly disadvantaged groups. Significant efforts are being made by global development actors, governments and civil society organizations to improve the sexual and reproductive health of adolescents and young people. Many of these programmes focus on improving access for young people to SRHR information and youth-friendly services, whereas other programmes focus more specifically on norms at the community level that affect child marriage and female genital mutilation [313], [255], [259], [274], [314]–[321].

SRHR in crisis-affected settings has received increased attention over the past five years. The members of the Inter-agency Working Group on Reproductive Health in Crisis have demonstrated a commitment to scaling up programmes and conducting research on adolescents’ SRHR and their access to services, the implementation of safe abortion care in humanitarian settings and increasing access to contraception for

crisis-affected populations. Given the extent of conflict and natural disasters, however, the unmet for family planning remains significant [322], [301], [323]–[327], [248].

Special programmes have been designed to meet the needs of specific marginalized groups such as indigenous women, women with disabilities and women who are members of nomadic communities, although at a smaller scale. Voucher programmes have shown to work well for increasing access to reproductive health services for marginalized groups. However, there is little evidence regarding their effectiveness for increasing marginalized women’s informed decision-making [274], [247], [276], [275], [328]. The researchers identified one programme in the Philippines in which women with disabilities were empowered to demand and claim their access to sexual and reproductive health services, but there was no evidence of how disability could be mainstreamed in ongoing national sexual and reproductive health programmes to ensure that women with disabilities are not excluded [305].

In interviews, key informants pointed out that marginalized groups are often not reached for a number of reasons:

- Donors (and governments) give preference to reaching a high number of beneficiaries and prioritize population reach over the inclusion of marginalized groups. Despite the existence of certain funds that are earmarked for vulnerable and marginalized population groups, many programmes are still designed to reach large numbers of beneficiaries, to the detriment of vulnerable and marginalized groups with special needs.
- Marginalized groups are often more difficult to reach and require specific knowledge and competencies that are not locally available, or because implementers ignore their availability.
- Limited data are available on vulnerable and marginalized groups and their needs. Consequently, governments, donors and implementing agencies do not often understand the number of girls and women in need, what their needs are and the extent to which they are excluded from existing services.

The lack of programme approaches to advancing decision-making on sexual relations compared with the investments made on improving decision-making on contraceptive and health care use is also worth noting. Increasing demand for and access to quality services has been the main focus of interventions, whereas gender inequalities in decision-making at the household level—for sexual rights in particular—has received much less attention.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

The quantitative data analysis of 22 countries for which data on at least two components were available showed that the trends are heterogeneous across regions and components. The composite nature of the indicator makes it difficult to interpret its results, especially during trend analysis. The components often evolve in different directions and the composite result can show significant progress or a downward trend on one of the components. To undertake effective monitoring and translate it into recommendations for governments, results and trends need to be analysed in a disaggregated manner. Low performance in countries such as Mali, Niger and Senegal demonstrates significant geographic disparities among low-income countries, a finding that merits further attention and analysis. Negative trends in certain countries are also of concern and need to be carefully investigated and monitored by governments, as in Benin, Burundi, Ethiopia and Senegal. The positive results of certain countries such as Rwanda and Uganda, on the other hand, can serve as encouraging examples for other countries.

This research has shown that, in some instances, other data sources such as research on gender and social norms can generate assumptions that are used to explain the data trends.

In the first component (sexual relations), wide variations are observed. This finding highlights the complexity of this component and indicates that women's decision-making on sexual relations is highly dependent on the broader sociocultural environment, which circumscribes sexual norms for women.

In the second component (contraceptive use), minimal changes are observed. The high proportion of women who are able to make decisions on the use of contraception indicates that this component is not sensitive to changes. This may be due in part to the restricted sample on which it draws (i.e. women who are married or in union and who are using contraception). The issue here is about the limitations of this sample group. This will need to be explored through further research because it would strongly affect the validity of this component and the indicator as a whole.

In the third component (health care use), positive changes are likely related to countrywide policy changes for reducing financial barriers, whereas negative trends may be explained by the existence of conflict or other contextual factors.

The quantitative results and trends exclusively capture the results of married girls and women aged 15–49. The contraceptive use component is even less representative because it includes only married girls and women currently using contraception. The findings of this research confirmed that the profile of the women included in the DHS survey is not representative of all girls and women. Unmarried girls and women are in a disadvantaged position compared with married women on all three components and are confronted with additional barriers in realizing their SRHR. This also applies to context-specific marginalized groups such as women with disabilities, women from indigenous groups or those affected by crisis.

Further, there is a clear need to develop strategies to systematically capture information about trends among vulnerable and discriminated groups.

The issue of making decisions that are “informed” is another cause for concern. The quantitative data do not provide details on whether women and girls can make informed decisions on their SRHR. The research has highlighted the importance of distinguishing between awareness and knowledge on SRHR matters. The incidence of awareness about sexual relations, contraceptives and reproductive health care is high in most settings, whereas knowledge is strikingly low, particularly in rural settings. Decisions are therefore rarely

fact-based, but rather informed by misconceptions, rumours and myths, all of which have shown to be catalysts for negative SRHR outcomes.

Distinguishing between individual decision-making versus joint decision-making is important, but not satisfied by the quantitative data. This is a significant issue, particularly for women in rural settings and those with low levels of education, as they are more likely to be subject to unequal power relations and have little or rare communication with their partner or spouse on sexual and reproductive health matters. Decisions that were reported as being taking “jointly” are likely to include a substantial percentage of decisions in which women were overruled by men. To further collect details, it may be worth disaggregating the questions asked.

The UNFPA-supported research on Indicator 5.6.1 provided an opportunity for a systematic review of determinants for sexual relations, contraceptive use and reproductive health care seeking. This systematic review enabled the researchers to identify a set of generic determinants that have been consistently documented in qualitative and quantitative studies conducted in a wide range of low- and middle-income countries. These factors are highly interdependent and can be visualized across different dimensions:

- Socio-demographically, the most important determinants are the education level of women and their partners, household wealth status and area of residency;
- At the individual level, women’s agency and SRHR knowledge levels are important predictors;
- At the interpersonal level, the partner’s position on SRHR matters as well as a couple’s communication on SRHR were found to be predominant factors in women’s decision-making. The partner’s position on SRHR is often influenced by sociocultural and gender norms as well as by the position of the extended family; and
- At the institutional level, the availability of affordable, accessible and acceptable quality reproductive health care services was an enabling factor in women’s decision-making processes.

These determinants are very relevant to the design and implementation of successful SRHR programmes. The researchers also identified a range of different context-specific determinants that highlight the importance of formative research and of a gender analysis during the design and implementation of sexual and reproductive health programmes.

The research provided limited information on the impact of policies, laws and state investments on women’s decision-making in relation to sexual relations, contraceptive use and the utilization of reproductive health care services. Key informants reported the positive impact of changes in policies and laws, and these were further explored in the case studies. However, evidence from the literature is still insufficient to support these claims. The impact of the specific policy and legal environment on behavioural changes is neither well-documented nor well monitored.

The analysis of good programmes and practices showed a growing awareness that vertical interventions—each aimed at addressing a specific health care issue or disease in a siloed manner—fail to consider sociocultural norms and power inequities as well as their implications on the broader health system. Consequently, these programmes and practices are neither effective at the outcome level nor sustainable. To address persistent gender inequalities and to achieve lasting and significant change, the required actions include holistic gender-transformative approaches that focus on individual, interpersonal, community and institutional factors, including context-sensitive demand and supply components. Because interventions often invest disproportionately in the supply side, it is important to highlight the need for more investment in activities that focus on the demand side. A number of examples were identified:

- Some evidence showcases the potential of IT4D in SRHR interventions, specifically with adolescents, but also with other vulnerable populations. IT4D components have shown to be cost-efficient and

effective for increasing access to quality information, but also for making services available in remote areas, for empowering women to hold health care providers to account and for reducing inequities. However, there are inconsistent results in terms of expected behaviour change and sustainability.

- There is useful evidence to indicate that the involvement of men through couples counselling, training sessions or wider community-based interventions has been successful in improving relationships, reducing physical and sexual violence, improving contraceptive use and addressing norms at the community level.
- The use of trained community volunteers with more informal awareness-raising was found to be particularly effective.

Promising interventions all used formative research to carefully plan and design the intervention and were often found to be more successful when implemented over a longer period.

4.2 RECOMMENDATIONS

Research gaps: The findings of this research showed gaps in the following areas. Further research will help to:

- Understand the weak results and negative trends and assess the situation and trends that may exist regarding geographic disparity. It may also be important to examine subnational data for countries with weak results in order to analyse whether these trends are specific to regions or are countrywide trends. At this time, such results are notably in the Sahel countries.
- Investigate the impact and causal relations of policy and legal changes in SRHR and gender equality on Indicator 5.6.1.
- Explore the quality of reported joint decision-making in the DHS survey through qualitative research, and to analyse potential interlinkages with covert contraceptive use.
- Analyse the sensitivity of the data used to calculate the results for the second component, in order to assess whether the component reflects women's ability to make decisions on contraceptive use.

SDG indicator monitoring: To enable effective monitoring and tailored support to governments, the researchers propose to:

- Monitor Indicator 5.6.1 in a disaggregated manner and act on diverging trends at the component level.
- Consider disaggregating the data for the three components in order to gain more insights on women's ability to make those decisions either by themselves or jointly with their partners.
- Complement the SDG tracking of Indicator 5.6.1 with additional research to regularly analyse the situation of unmarried women and girls as well as marginalized and vulnerable groups.

Leaving no one behind: To reduce inequities, the researchers propose to:

- Provide technical and financial support to weak performers to understand and tackle the root causes of failing to meet the indicator criteria.
- Lobby for increased government and donor investments on SRHR and gender equality in these countries, to ensure that the most vulnerable groups are also targeted.

SRHR programme interventions: To support the scaling up and improving of quality SRHR interventions, the researchers recommend the following:

- Provide support to donors and implementing agencies for integrating formative research, with the objective of analysing SRHR decision-making determinants and context-specific factors during programme design and evaluation. Conducting an in-depth gender analysis is also critical during the early stages of programme design.
- Support the evaluation, documentation, publication and dissemination of holistic gender-transformative programming approaches, especially in relation to decision-making on sexual relations.
- Harness further investments in IT4D and other innovative approaches that have proven to be effective, in order to reduce inequities in accessing quality sexual and reproductive health services.

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