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# Women's Ability to Decide about Sexual Relations, Contraceptive Use and Reproductive Health Care in India (SDG Indicator 5.6.1)

A woman's ability to make decisions about her own reproductive health, contraceptive use and sexual relations is pivotal to gender equality, and universal access to sexual and reproductive health and rights. However, too often women are not able to exercise their autonomy on these issues due to harmful and discriminatory social norms and practices compounded by their lack of agency and financial resources. Gender norms represent a significant deterrent for women's independent or joint decision-making. Women are expected to be submissive and passive in sexual roles and relations, to fulfil reproductive obligations in wedlock and to obey their husbands' decisions regarding their own reproductive health.[1].

Achieving gender equality and empowerment of all women and girls is a critical and crosscutting Sustainable Development Goal (SDG Goal-5). Within SDG-5 for the very first time, an international development framework includes targets that address the barriers and human rights-based dimensions. SDG target 5.6 states 'Ensuring universal access to sexual and reproductive health and reproductive rights has been agreed in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents of their review conferences'. Two indicators under SDG 5.6 measure this target - 5.6.1 and 5.6.2, which are designed to complement each other. Those women who take their own decision in three key areas (illustrated in diagram below), are considered to have autonomy in reproductive health decision-making and empowered to exercise their reproductive rights. In a ground-breaking exercise, this analytical series provides information about SDG indicator 5.6.1 and unpacks its differentials by population groups and geographies in India. Three questions are included in the latest round of the National Family Health Survey (NFHS-5, 2019-21) in India. The unit level data allows estimating the composite indicator to assess women's autonomy in accordance to the methodology described in SDG indicator meta-data:

5.6.1: Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

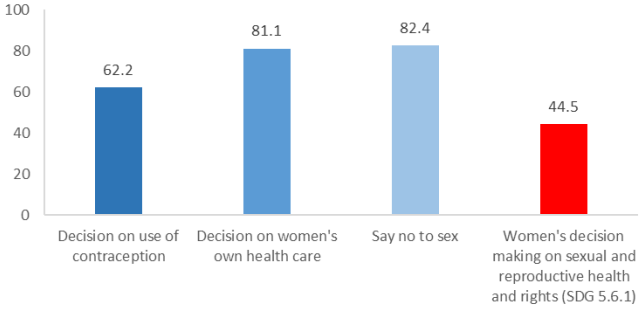
| Reproductive Health care | Contraception use | Sexual relation |
|---|---|---|
| Who usually makes decisions about health care for yourself? | Who usually makes the decision on whether or not you should use contraception? | Can you say no to your husband/partner if you do not want to have sexual intercourse? |
| ▪ **You**<br>▪ Your Husband<br>▪ **You and Your husband/partner jointly**<br>▪ Someone else | ▪ **Mainly respondent**<br>▪ Mainly husband<br>▪ **Joint decision**<br>▪ Other, Specify | ▪ **Yes**<br>▪ No<br>▪ Depends/not sure |

The indicator does provide new insights to inform interventions for accelerating progress towards all Sustainable Development Goals. Though it has some limitations that unmarried women and girls are not included and that women may "choose" to comply with sexual conditions imposed by husbands, as a way to negotiate autonomy in other aspects of their lives, and this may influence survey question response[2].

## Findings

- Analysis of the three sub-indicators highlights: While women seem to have the most autonomy in deciding on their own healthcare, with 81% empowered and 82% being able to say no to sex, only around three in five women can decide about the use of a method of contraception (Figure-1).
- Only 45% of married women aged 15 to 49 make their own decisions regarding sexual and reproductive health and rights, based on the composite indicator (SDG 5.6.1).

Fig 1: Women's ability to make decisions about reproductive health, contraceptive use and sexual relations , India, 2019-21



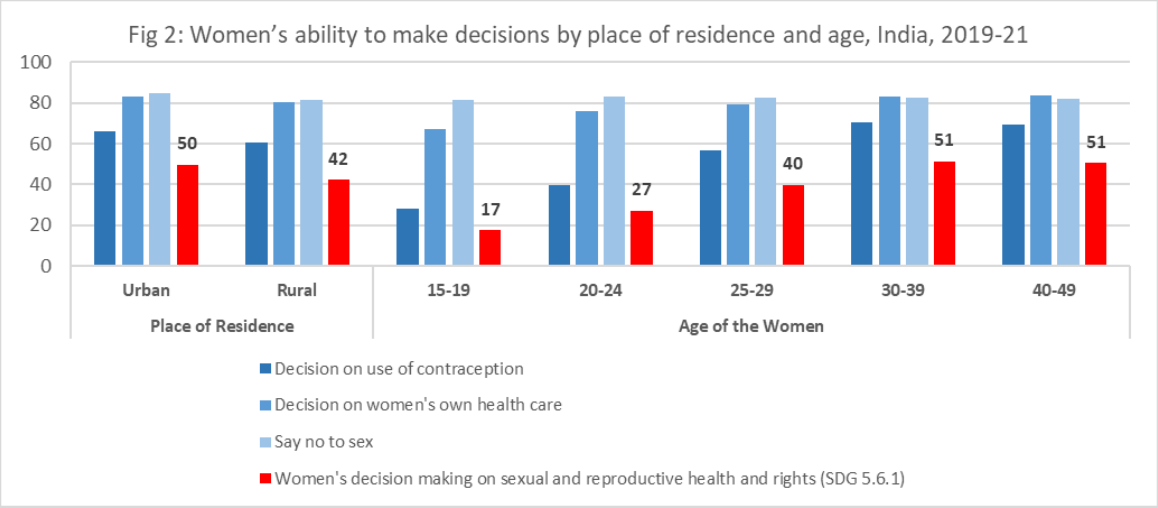

[1] *Women's Ability to Decide, Issue Brief on Indicator 5.6.1, UNFPA, 2020 (https://www.unfpa.org/sites/default/files/resource-pdf/20-033_SDG561-IssueBrief-v4.1.pdf)*

[2] *Ensure universal access to sexual and reproductive health and reproductive rights, Measuring SDG Target 5.6, UNFPA, February 2020 (https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-SDG561562Combined-v4.15.pdf)*

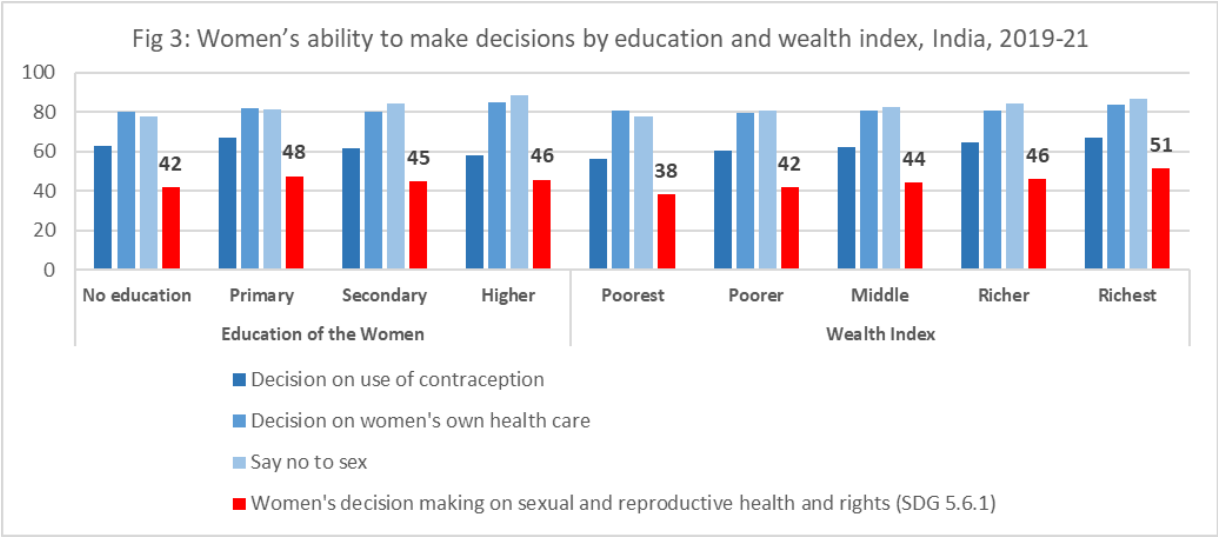
## Differentials

Leaving no one behind will require the use of disaggregated data for an in-depth look at levels across different population groups. The data allows examining differentials regarding a woman's ability to decide about her sexual and reproductive health by socio-economic and other background characteristics. The indicators on women's autonomy were estimated separately for the age category of the women; educational level, place of residence, caste and by the household wealth index, which is a proxy indicator of the economic status.

- Dynamics in sexual and reproductive health decision-making vary substantially across the age category of women and the place where they reside, either in urban or rural areas. For example, older women and those living in urban areas are more likely to make their own decisions (Figure-2).
- Even in urban areas, only one in two women is able to decide about her own sexual and reproductive health, while the other half are not able to.
- Married adolescent girls have a very low level of autonomy as only 17% of them could take decisions on their own or jointly with their partner about sexual and reproductive health for themselves as compared to around half of the women belonging to the older age group.



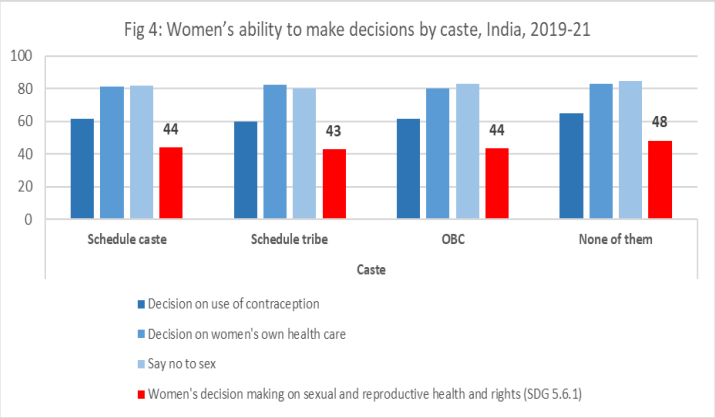

- The levels in women's decision-making regarding reproductive healthcare seems unvarying by their level of education. Women with no education are not much lower (42%), who participate in decision making on their healthcare than the average. Among various levels of education of women, the percentage of those who can decide, varies in a range of 42% to 48%. This clearly indicates that even women's higher education does not translate into her negotiation power to take decisions on her sexual and reproductive healthcare, and strong patriarchal systems and negative social norms exacerbate this (Figure-3).

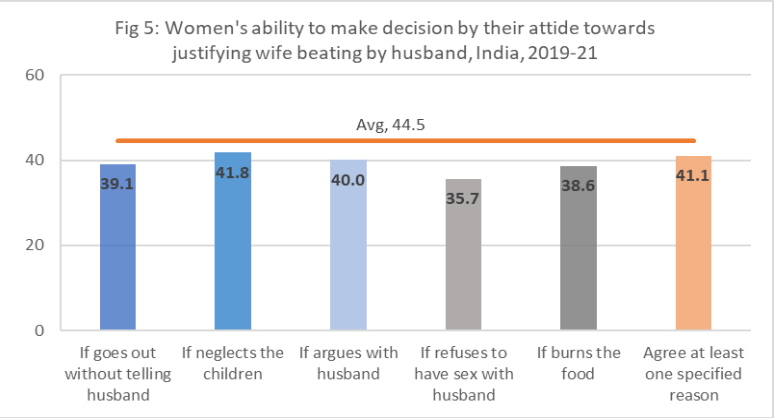



- Only around one-third of women from the lowest wealth quintile (38%) seem to have the ability to take decisions. The ability to decide about their sexual and reproductive health increases from the lower to higher wealth quintile. However, a striking fact

remains that only half of the women belonging to the highest quintile are able to participate in the decision-making. This again clearly reflects the role of a male dominated society and regressive social norms (Figure-3).

- The levels in women's decision-making regarding care generally do not vary much by ethnicity (Figure-4). Around 44% of women from the Scheduled Castes and Tribes communities are able to participate in the decision-making about their sexual health, which is marginally higher among those other than these castes (48%). The finding further enforces that overarching negative social norms prevails over the background characteristics of women.



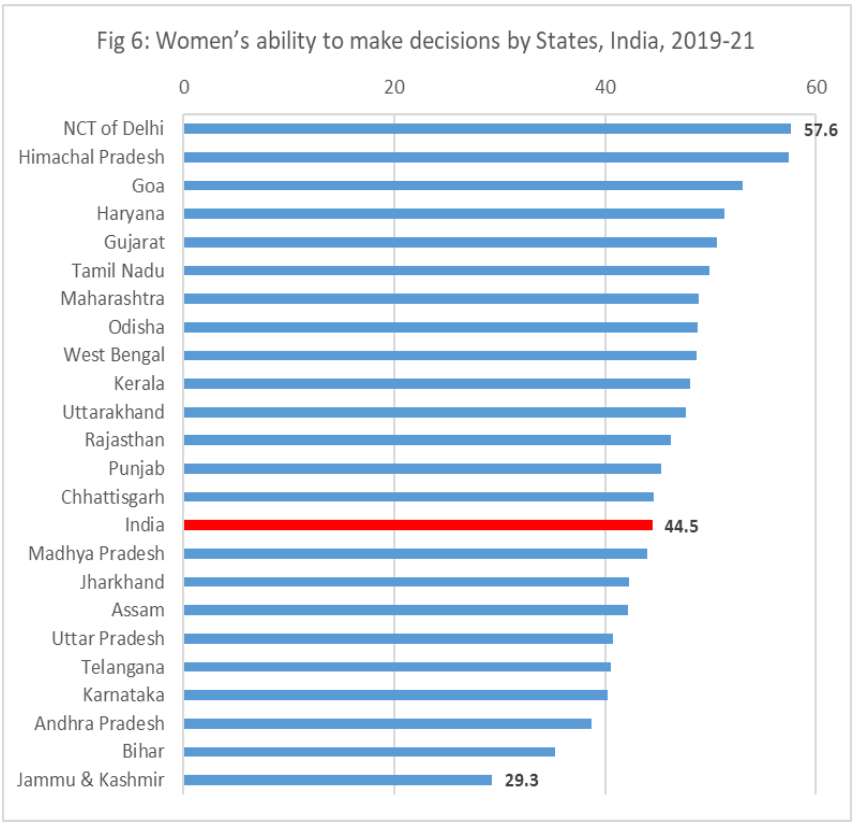




- An important indicator of women's empowerment is the rejection of norms that underlie and reinforce gender inequality. The survey posed questions about women's agency and their attitudes, if they agree that a husband is justified in hitting or beating his wife under certain circumstances. A deeper look into data for those women justifying wife beating suggest that the decision-making power for their sexual and reproductive health is limited. For example, women justifying wife beating for refusing to have sex with their husbands, exhibited lower decision-making autonomy at 35.7% than the average (Figure-5). Similarly, the ability on decision making for reproductive health care was lower than the average among those justifying other conditions such as -- if she goes out without telling the husband, neglects children, argues with him or doesn't cook food properly, where the husband is thus justified to beat his wife.
- The level of decision-making ability on reproductive health is also lower (41.5%) among those women who agree to at least one of the five specified reasons for justifying wife beating (Figure-5).

## Differentials by State

- Around 58% of the women from Delhi and Himachal Pradesh has the ability on engaging in sexual relations and deciding about reproductive healthcare for themselves (Figure-6).
- In eight states (Goa, Haryana, Gujarat, Tamil Nadu, Maharashtra, Odisha, West Bengal and Kerala), more than 48% of the women are able to exercise their rights.
- On the other hand, less than 40% of women are able to decide about reproductive healthcare in Andhra Pradesh, Bihar and Jammu & Kashmir.

To achieve the SDG Goal by 2030, various types of barriers faced by women towards the utilization of sexual and reproductive health services need to be removed, including a strong push towards changes in social norms. Government policies that allow women and girls to exercise fully their reproductive rights must be prioritized.




**Methodology:** Numerator is the number of married women aged 15-49 years old, who satisfy all three empowerment criteria. A woman is considered to have autonomy in reproductive health decision making and to be empowered to exercise their reproductive rights if she 1) decides on health care for themselves, either alone or jointly with their husbands or partners, 2) decides on use or non-use of contraception, either alone or jointly with their husbands or partners; and 3) can say no to sex with their husband /partner if she does not want to. Denominator is the total number of married women aged 15-49 years old. Proportion = (Numerator/Denominator) * 100