GUTTMACHER INSTITUTE

Sexual and Reproductive Health and Rights Indicators for the SDGs

Recommendations for inclusion in the Sustainable Development Goals and the post-2015 development process

HEALTH EDUCATION GENDER EQUALITY

The Sustainable Development Goals (SDGs) will help lay the foundation for health and development over the next 15 years. The goals come with targets and indicators for measuring global progress on that topic area. This set of recommended indicators focuses on the incorporation of sexual and reproductive health and rights (SRHR) into the SDGs. While SRHR is critical to many of the SDGs, these recommended indicators correspond specifically to three: health (Goal 3), education (Goal 4) and gender equality (Goal 5). Use at the global level of measureable indicators that are applicable to all countries, such as the ones laid out in this document, will help establish international benchmarks over the coming 15-year period for improving access to critical services and information and promoting individual autonomy related to sexual and reproductive health.

Due to realistic constraints on money, time and capability, very few indicators per SDG target will likely be used at the global level, but governments may adopt more comprehensive lists of indicators for national use. The compilation of indicators in this document can be used by countries to monitor progress toward advancing SRHR and the broader goals that attainment of SRHR underlies. Moreover, these recommendations can guide country-level conversations on data gaps and measurement system needs related to SRHR.

These proposed indicators constitute only a part of a larger SRHR agenda that builds on the framework set out in the International Conference on Population and Development (ICPD) Programme of Action.[1] Yet they address key areas of SRHR that can be implemented immediately using data where available, while proposing directions for future research toward measuring progress in other SRHR priority areas.

Development of the Indicators

The Guttmacher Institute began work on this list of high-priority SRHR SDG indicators in late 2014.[2] This process involved review, research and analysis, carried out by Guttmacher staff in collaboration and consultation with a range of technical and policy experts, including representatives from international and regional NGOs, the U.S. government and UN agencies. The recommendations presented below take into account advocates' picks for the highest priority SRHR topic areas and the imperative from the UN to limit the number of SDG indicators; they also take into account whether reliable, nationally representative data are available from a significant proportion of countries, are comparable across countries and can be tracked over time.

The recommended indicators in this document cover nine topic areas: contraception, sexual and reproductive health service availability, knowledge about SRHR, adolescent fertility, quality of care (including respect for rights), prevention of STIs, abortion, comprehensive sexuality education and gender equality in SRHR. They apply to three specific SDG targets (see sidebar).

Aspirational Indicators

The proposed indicators, to the extent possible, are grounded in existing data collection systems, but truly comprehensive global monitoring will require that some countries expand their statistical systems and NGOs expand their monitoring. Some indicators will require investment in entirely new data collection efforts; other indicators need further work to develop common definitions and data collection methodologies but remain on this list given the critical nature of the topic. These more "aspirational" indicators are identified as such on this list, and information is provided about the work needed to develop them.

Disaggregated Data

The ability to break down data by subpopulations is crucial to identifying inequities in access to and use of essential services and interventions. Disaggregation of data related to the indicators can help in assessing the scope and impact of health services and policies experienced by different segments of the population. It can also help show where targeted improvements can and should be made to ensure universal access, improve public health and fulfill human rights. Therefore, wherever possible, it is strongly recommended that data be collected in a way that they can be disaggregated by age, sex, urban or rural residence, marital status and wealth. Many other categories, such as disability, education, sexual orientation and gender identity, should also be assessed for inclusion as measurement systems improve and grow in sophistication. The disaggregation of data will be critical to ensuring that appropriate laws, policies and programs exist or are created to respond to, support and promote health and human rights.

HEALTH
TARGET 3.7

By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

EDUCATION
TARGET 4.7

By 2030, ensure that all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

GENDER EQUALITY
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 ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.

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Recommended Sexual and Reproductive Health and Rights Indicators for Post-2015 Sustainable Development Goals

	Measurement	
HEALTH GOAL Target 3.7	Available	Aspirational
Contraception		
• Proportion of family planning demand met with modern contraception	✔	
SRH Service Availability		
• Proportion of health facilities that provide essential SRH services*	✔	
• Proportion of health facilities that provide postpartum, postabortion and/or HIV services that also provide clients who use those services with contraceptive information and care		✔
Knowledge About SRHR		
• Proportion of young men and women aged 15–24 with basic knowledge about SRHR	✔	
Adolescent Fertility		
• Adolescent birthrate (among women aged 10–14, 15–17 and 18–19)†	✔	
• Proportion of births to women younger than 20 that were unplanned	✔	
Quality of Care, Including Respect for Rights		
• Proportion of women using contraceptives who were informed about possible side effects of their method and how to deal with them, who were informed about other family planning methods and who participated in the decision to use contraceptives	✔	
• Proportion of family planning service sites with at least five modern methods available†	✔	
• Whether universal access to contraceptive and other SRH information and services is included in national policy	✔	
• An indicator reflective of respectful care and human rights in provision of SRH information and services		✔
Prevention of Sexually Transmitted Infections		
• Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15	✔	
• Country includes HPV vaccination in its vaccination program	✔	
Abortion		
• Proportion of health facilities that provide care for complications related to unsafe abortion or, where it is not against the law, that provide safe abortion		✔
• Grounds under which induced abortion is legal	✔	
• Number of unsafe abortions per 1,000 women aged 15–44 (or 15–49)		✔
EDUCATION GOAL Target 4.7		
Comprehensive Sexuality Education		
• Proportion of schools that serve students in the age range of 12–17 years in which comprehensive sexuality education is available		✔
GENDER EQUALITY GOAL Target 5.6		
Gender Equality in SRHR		
• Respect for women's sexual autonomy within marriage	✔	
• Whether universal access to contraceptive and SRH information and services is included in national policy	✔	

*Currently available only in a small number of countries with special surveys. †Available for very few countries for those aged 10–14.

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TARGET 3.7

HEALTH

Contraception

INDICATORS

- **Proportion of family planning demand met with modern contraception**

• Rationale and rights

Contraceptive services are essential for individuals and couples who wish to plan and space their pregnancies. Yet at least 225 million women in the developing world have an unmet need for modern contraception.*[3] The indicator measuring the proportion of family planning demand met with modern methods affirms the right of individuals and couples to time, space and plan pregnancies. This indicator addresses the health and human rights standards and principles of availability, accessibility and nondiscrimination.[4-6]

Demand for family planning met with modern contraception is defined as the proportion of married or in-union women aged 15–49 who use modern methods, divided by the total demand for family planning, i.e., all those at risk of unintended pregnancy. Total demand for family planning is calculated by adding the number of women who report using a modern contraceptive method to the number of women who have an unmet need for family planning. In other words, it comprises all women who are sexually active and fecund and who want to delay pregnancy by at least two years or do not want to have any more children.

It is important to recognize that women who do not want to become pregnant may not be using contraceptives for a variety of reasons, including concerns about side effects, opposition from their partner or other family members, the perception that they are not at risk of pregnancy, and lack of knowledge about or access to contraceptive services. To address women's concerns, improvements are needed in the quality and accessibility of family planning services and the range of methods available. More work is also needed to develop and field measures that take into account men's childbearing intentions and demand for family planning, both in their own right and as women's partners.

• Data source/modes of measurement

Data for calculating this indicator are available from national surveys, such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). Estimates can be disaggregated by socioeconomic factors that are collected in those surveys.

• Strengths and weaknesses

Data on demand for family planning and use of modern contraception are readily available for many countries around the world and can be disaggregated to examine equity and socioeconomic characteristics. However, some data sources for this indicator only capture women who are married or in union, omitting single women who want to delay or limit childbearing. Expansion to include all women of reproductive age and extension of surveys to more countries will allow greater coverage of countries and comparability across countries and over time.

*Modern contraceptive methods include hormonal implants, IUDs, female and male sterilization, hormonal pills, injectables, male and female condoms and other supply methods, and modern methods of periodic abstinence.

TARGET 3.7

HEALTH

Sexual and Reproductive Health Service Availability

INDICATORS

- **Proportion of health facilities that provide essential SRH services**
- **Proportion of health facilities that provide postpartum, postabortion and/or HIV services that also provide clients who use those services with contraceptive information and care (aspirational)**

• Rationale and rights

The ICPD Programme of Action defines the sexual and reproductive health services that should be universally accessible to women and adolescents through the primary health care system: family planning; maternity care; prevention and treatment of infertility; abortion-related care; and prevention, detection and treatment of STIs.[1] Ensuring universal access to quality services, free of discrimination, coercion or violence, has been a core aim of the SRHR community since 1994, and is seen as an essential aspect of reproductive rights. Integration of sexual and reproductive health services, especially the integration of contraceptive services with HIV testing, treatment and care and with antenatal and postpartum care, has also emerged as a global priority within SRHR because such integration may help increase access for populations who may otherwise lack regular access to sexual and reproductive health care, including adolescents, people living with HIV and people with disabilities.[4] Integration of services may also facilitate more comprehensive, effective and convenient care for women who may need multiple types of services at once, for instance, contraception and STI care, or delivery care and HIV treatment.

Perspectives on what SRHR services are defined as essential, the level of the health system at which each service should be provided and the extent to which they should be provided in an integrated fashion vary depending on the capacity and structure of national health systems. The service components recommended for this indicator include:

- Access to at least five modern methods of contraception
- HIV prevention, testing and referral for treatment
- Maternity care, including antenatal care, skilled attendance at birth, and emergency obstetric and newborn care
- Prenatal syphilis screening and/or referral
- Care for complications related to unsafe abortion or, where it is not against the law, provision of safe abortion

Indicators reflecting key elements of quality of care related to sexual and reproductive health services are presented in a following section. Integration of contraceptive information and services with other sexual and reproductive health services, such as postpartum, postabortion and HIV care, addresses the importance of continuity of care across women's reproductive life stages.

• Data source/modes of measurement

Data to measure provision and integration of basic health services come from facility-based assessments, such as the DHS Service Provision Assessments and the World Health Organization (WHO) Service Availability and Readiness Assessment, or from health systems data. Most of the relevant questions are already included in these surveys, but some additions will be needed to cover all the specific services in this indicator. Questions to assess integration of contraceptive care with postpartum, postabortion and HIV services have been developed and used by Performance Monitoring and Accountability 2020 and could be adopted into other facility surveys.

• Strengths and weaknesses

The health services covered by these indicators are limited, reflecting the data that are available and the data collection methods currently in use. At the country level—and perhaps eventually at the global level—the package of services could be expanded (for instance, to include provision of youth-friendly services, prevention and management of infertility or treatment for cancers of the reproductive system), as long as a basic set of services is defined across all countries for comparability. Facility-level data for each country can be disaggregated by geographic area, level of the health system and type of provider (government, private or non-governmental). While this disaggregation does not directly measure access and use by people of different characteristics (since data refer to health facilities rather than clients), differences in service availability by facility characteristics provide some insight into accessibility across client subgroups.

TARGET 3.7

HEALTH

Knowledge About Sexual and Reproductive Health and Rights

INDICATORS

- **Proportion of young men and women aged 15–24 with basic knowledge about SRHR**

• Rationale and rights

Access to high-quality, evidence-based, comprehensive sexuality information is vital for young people. Evidence suggests that SRHR knowledge, such as that provided by comprehensive sexuality education, can help young people make healthy, informed choices when it comes to their reproductive lives. Adolescents may learn about SRHR through many informal channels, including media, family and friends, as well as at school. The extent to which comprehensive sexuality education is provided through the school system, and the quality of that education, are challenging to measure (though an indicator focused specifically on comprehensive sexuality education is recommended for Target 4.7 under the education goal). The proposed health indicator is intended to capture young people's SRHR knowledge more broadly.

To meet the indicator's criteria for having "basic knowledge about sexual and reproductive health and rights," a respondent would need to demonstrate the following three components, taken from the DHS:

- Awareness of at least three modern contraceptive methods
- Knowledge of the following ways of reducing the chances of sexual transmission of HIV:
  - Having just one uninfected sex partner who has no other sex partners
  - Using a condom every time one has sex
- Belief that a husband is *not* justified in hitting or beating his wife if she refuses to have sex with him

This indicator reflects the rights of adolescents to have access to high-quality, accurate information that can assist them with informed decision-making.

• Data source/modes of measurement

This indicator is calculated with data available from the DHS and other surveys. Since the data are suvey-based, disaggregation by age and other characteristics is feasible.

• Strengths and weaknesses

This indicator directly measures individual-level knowledge about sexual and reproductive health, as well as attitudes about sex, gender roles and autonomy. These measurements are not restricted to individuals in school and therefore may capture the most vulnerable adolescents. However, some countries do not survey men, and a small number of countries may not ask some of the component questions. Such surveys need to be expanded to fully cover this indicator's components. This indicator should be calculated and monitored separately for females and males.

TARGET 3.7

HEALTH

Adolescent Fertility

INDICATORS

- **Adolescent birthrate (among women aged 10–14, 15–17 and 18–19)**
- **Proportion of births to women younger than 20 that were unplanned**

• Rationale and rights

Early childbearing can have a negative impact on young people's ability to complete their education, gain job skills and employment, and foster health and well-being for themselves and their future families.[3] It can also both reflect and cause social and economic disadvantages, perpetuating cycles of poverty. In many countries, adolescents lack access to sexual and reproductive health services and may face age-based discrimination and social isolation, especially if they are unmarried while pregnant or parenting.[7] Adolescents who are sexually active and want to delay childbearing have some of the highest levels of unmet need for contraception.[3] Monitoring fertility trends and planning status of pregnancies across adolescent age-groups is crucial to assessing whether services are addressing the specific sexual and reproductive health service needs of adolescents.

While the right to health care—including sexual and reproductive health services—is not universally acknowledged for adolescents, the 1994 ICPD Programme of Action affirmed that young people have the right to the highest standards of sexual and reproductive health, accessible and confidential care, and accurate information.[8]

The recommended indicators acknowledge that adolescent childbearing sometimes occurs among very young (10–14) and young (15–17) adolescents; at these ages, childbearing carries elevated health risks, including for maternal and newborn mortality and morbidity.[9] Tracking fertility among younger adolescents can help document the scope of early childbearing and can potentially highlight the impact of harmful practices such as child marriage. Births to older adolescents aged 18–19 more often, though not always, are planned and occur within union. The indicator on the proportion of adolescent births that are unplanned identifies the extent to which adolescent mothers want to delay or space their births, another sign of how well their reproductive goals and health needs are being met.

• Data source/modes of measurement

Data for constructing adolescent fertility rates are available from country vital statistics, compilations such as UN Population Division surveillance and national surveys such as DHS and MICS. Data on planning status of recent births are collected by DHS and MICS and can be disaggregated.

• Strengths and weaknesses

Disaggregation is limited in many vital statistics systems, and therefore in the UN Population Division surveillance, because few characteristics of women giving birth are collected across all countries. Data collection may need to be expanded to capture more sociodemographic information on women giving birth. The UN Population Division birth data do not include births to women younger than 15 and should be expanded. Vital statistics systems are weak in many countries, and while they are being improved, survey-based indicators are often needed to provide disaggregation by multiple characteristics. In most countries, there are few births among young adolescents aged 10–14, making disaggregation infeasible and hindering accurate identification of differences in rates across countries and over time. Planning status of births is based on women's own reports and this retrospective information is likely to underestimate unplanned fertility. These survey-based data can be disaggregated by subgroup, including age, so long as sample sizes are adequate.

TARGET 3.7

HEALTH

Quality of Care, Including Respect For Rights

INDICATORS

- **Proportion of women using contraceptives who were informed about possible side effects of their method and how to deal with them, who were informed about other family planning methods and who participated in the decision to use contraceptives**
- **Proportion of family planning service sites with at least five modern methods available**
- **Whether universal access to contraceptive and other SRH information and services is included in national policy**
- **An indicator reflective of respectful care and human rights in provision of SRH information and services (aspirational)**

• Rationale and rights

Even where available, SRH services may not always be of high quality. High-quality services should provide access to full information, enable clients to make informed choices, and treat clients with dignity and respect. The recommended indicators aim to capture important aspects of the concepts of quality of care and respect for rights as they relate to SRH, including access and coverage, choice of and information about contraceptive methods, availability of supplies, and political commitment to providing rights-based and respectful SRH information and services. Adopted together or separately, these indicators provide information on whether family planning and other sexual and reproductive health services meet the standards of care that people deserve.

• Data source/modes of measurement

Data for the first indicator are available from DHS for women aged 15–49 and may be disaggregated by women's age and other characteristics. Following DHS methodology, the indicator is calculated for current users of female sterilization or the IUD, injectable, implant or pill who began their current period of method use in the past five years. Receipt of information is measured as of when they started their most recent period of use, and women's participation in contraceptive decision-making is established by survey responses indicating having made the decision to use a method mostly by themselves or jointly with their husband or partner.

Data on the second indicator are currently gathered through the DHS Service Provision Assessment and the WHO Service Availability and Readiness Assessment, the PMA 2020 survey, gathering information from facilities on what, if any, contraceptive methods are offered and whether commodities are currently available.

The indicator on national policy may use or adapt information from the WHO Policy Indicator Survey on adolescent health, the DELIVER Project Contraceptive Security Indicators, the ICPD Beyond 2014 Global Survey and other NGO sources. Relevant policies include access to contraceptive services and sexual health information without limitations related to age or authorization from or notification of a spouse, parent or guardian.

• Strengths and weaknesses

The first indicator addresses two key aspects of rights: being informed and having choices. However, receiving information about a variety of methods does not equate to having access to those methods. DHS data on who made the decision to use contraception (and therefore application of this indicator) is limited to women who are married or in union. This question should be asked of all contraceptive users, including unmarried women. Questions on whether or not a user has been informed about side effects, how to deal with side effects, other family planning methods and contraceptive decision-making need to be included in national surveys to fully cover this indicator's components. Since the existing data are survey-based, disaggregation by women's characteristics is feasible.

The second indicator does not capture data on potential barriers to access beyond WHO's guidance for medical eligibility for method use. Disaggregation by client characteristics would likely require country-level perspectives and would not be suitable for global comparisons across countries. However, it may be useful within countries, especially where accessibility of health facilities varies (for example, with regard to client costs).

Laws and policies mandating universal access to information and services related to contraception and other aspects of sexual and reproductive health can be important tools for ensuring care is accessible to all. Specific topics and data sources need to be identified, and research into the effects of laws and policies on service provision is also needed because official guidelines may not translate effectively into practice and may otherwise differ from what is happening on the ground. Further work is needed to define indicators of respectful care, to identify measurement tools and methodology, and to ensure comparability of indicators across countries.

TARGET 3.7

HEALTH

Prevention of Sexually Transmitted Infections

INDICATORS

- **Proportion of females who have received the recommended number of doses of human papillomavirus (HPV) vaccine prior to age 15**
- **Country includes HPV vaccination in its vaccination program**

• Rationale and rights

According to WHO, eight infections account for the majority of the total burden of disease attributable to STIs.[10] These include four curable, bacterial STIs (chlamydia, gonorrhea, syphilis and trichomoniasis) and four incurable, viral STIs (HIV, herpes simplex virus type 2, hepatitis B and HPV). Nationally representative information on the incidence and prevalence of STIs other than HIV is extremely limited in most countries because of a lack of routine and full surveillance. Proposing a robust STI indicator on a non-HIV STI is therefore difficult. However, data are available which allow the global public health community to track rollout of vaccines which can prevent HPV.

HPV can cause cervical cancer, which is the second most common cancer among women living in less developed regions.[11] Indicators on HPV vaccination address this major public health burden, while incorporating a focus on youth (WHO recommends initiation of HPV vaccination at age 9–13, prior to becoming sexually active[12]) and a focus on the importance of access to preventive services.

Adolescents have the right to health information and services that will protect their sexual and reproductive health. Preventive health measures, like the HPV vaccine, should be provided without discrimination.

• Data source/modes of measurement

Data for both of these indicators are collected through the yearly WHO-UNICEF Joint Reporting Form, which is completed by ministries of health in all UN member states. Vaccine doses vary depending on country guidelines. WHO currently recommends two vaccine doses, while some countries recommend three.[12]

• Strengths and weaknesses

These indicators would measure progress in rolling out HPV vaccination globally. The indicators indirectly offer insight into progress on STIs, prevention among youth, vaccinations, reinforcing adolescent health and access to services, and the integration of sexual and reproductive health services into other health areas. A country may have a policy to integrate HPV into its vaccination program without that necessarily translating into actual practice at the facility or client level. The indicator on proportions of females covered can shed light on implementation, as well as provide a public health measure of vaccination coverage. Because HPV vaccination programs are still nascent in many countries and because this topic was only recently introduced into WHO-UNICEF vaccination monitoring, the extent and quality of reporting across countries has yet to be determined.

TARGET 3.7

HEALTH

Abortion

INDICATORS

- **Proportion of health facilities that provide care for complications related to unsafe abortion or, where it is not against the law, that provide safe abortion (aspirational)**
- **Grounds under which induced abortion is legal**
- **Number of unsafe abortions per 1,000 women aged 15–44 (or 15–49) (aspirational)**

• Rationale and rights

Induced abortion is a key sexual and reproductive health service. Every year more than 80 million women have unintended pregnancies and about 40 million of these women chose to have abortions.[14] Half of this group (20 million women) have an abortion that is unsafe—that is, performed by people lacking the necessary skills or in an environment that does not meet minimum medical standards, or both.[15] Availability of safe abortion services and postabortion care is vital in addressing the health needs of women around the world, and it is called for in many global and regional UN documents, including the ICPD,[1] ICDP+5,[16] ICPD Beyond 2014 Global Report,[17] Beijing Platform for Action,[18] Beijing +5,[19] the Maputo Protocol,[20] the Convention on the Rights of the Child[21] and the Committee on the Elimination of Discrimination Against Women.[22] Despite this, data on the provision and incidence of abortion and postabortion care are unavailable for many countries, especially those where abortion is most likely to occur in unsafe conditions.

• Data source/modes of measurement

Data on the rate of unsafe abortions and the proportion of health facilities providing care for complications of unsafe abortion are limited to special studies in select countries and regional modeling estimates. Countries where abortion is legally permissible may have information on abortion provision from administrative records. Data on the grounds under which abortion is legal is compiled by the UN Population Division and by NGOs covering national laws and policies.[23]

• Strengths and weaknesses

Collection of comprehensive data on both safe and unsafe abortion is important to understanding the full scope of sexual and reproductive health issues across the globe. Because of political sensitivities and restrictions on the availability of services in many countries, collection of accurate information on this commonly performed procedure is challenging but will be important in assessing the impact of laws and policies related to SRHR.

Questions about provision of abortion and postabortion care services need to be included in facility-level surveys, and such surveys need to be conducted in more countries. Careful assessment of reporting quality will be needed, especially in countries where abortion is highly stigmatized. The definitions of safe and unsafe abortion are currently being assessed for revision by WHO. Data on levels of unsafe abortion are generally available only from special studies. Major investments in the collection of these data at the country level will be necessary for this indicator to be technically adequate. A common definition of categories for the grounds under which induced abortion is legal needs to be identified to ensure comparability of the law and policy indicator across countries.

TARGET 4.7

EDUCATION

Comprehensive Sexuality Education

INDICATORS

- **Proportion of schools that serve students in the age range of 12–17 in which comprehensive sexuality education is available (aspirational)**

• Rationale and rights

Sexually active young people face many challenges, including a high risk of unintended pregnancy, HIV and other STIs.[3,7] Comprehensive sexuality education can educate young people on gender, SRHR, HIV, violence prevention, interpersonal relationships, empowerment, sexual orientation and identity diversity, and help them make informed decisions on healthy, responsible behaviors and mutually protective relationships. Having access to accurate, evidence-based, age-appropriate information and education on such topics is a right all young people should be able to enjoy.

Some reviews suggest that comprehensive sexuality education can be effective at improving sexual health knowledge and reducing self-reported risky sexual behaviors, although evidence for its impact on measurable outcomes (such as unintended pregnancy or STIs) is less robust and harder to measure.[24] However, mounting evidence suggests that comprehensive sexuality education programs using an "empowerment approach" can have a beneficial impact on reducing undesirable sexual health outcomes.

This indicator on comprehensive sexuality education coverage would apply only to in-school youth; an indicator on SRHR knowledge has also been proposed to complement this indicator and to measure SRHR knowledge among all young people, including out-of-school youth. Together, these indicators will provide a picture of SRHR information levels across all adolescents. There is no standard definition of comprehensive sexuality education, and programs' content, delivery mechanisms, and frequency and duration of instruction are typically left to the discretion of individual communities and schools. Yet despite the lack of global agreement on a definition, it is important that comprehensive sexuality education be embraced and supported at both global and national levels.

• Data source/modes of measurement

This indicator is aspirational, and relevant data sources are extremely limited. Although direct measurement of comprehensive sexuality education is very difficult, school-based surveys and the UNESCO Sexuality Education Review and Assessment Tool can provide some data, specifically on HIV prevention and sexuality education at primary and secondary schools.

• Strengths and weaknesses

This indicator would measure the implementation of comprehensive sexuality education in a comparable way across all countries. Because comprehensive sexuality education is not globally defined and interpretation of the term remains varied, the proposed indicator will be difficult to measure. If it is created as a composite, it may be difficult to ensure that all components of "comprehensive" are adhered to.

TARGET 5.6

GENDER EQUALITY

Gender Equality in SRHR

INDICATORS

- **Respect for women's sexual autonomy within marriage**
- **Whether universal access to contraceptive and SRH information and services is included in national policy**

• Rationale and rights

Lack of gender equality affects almost every facet of life for women and girls around the world and leads to the denial of their full participation in society, including making health decisions, gaining access to education and job markets, and managing finances. The gender indicators proposed here continue the work of the 1994 ICPD, recognizing gender equality and SRHR as key factors in development and the promotion of positive health outcomes for women and girls. Because SRHR is intrinsically linked to gender, it is important that SRHR indicators are included in discussions around gender and that gender is considered a part of health agendas.

The first of the proposed indicators measures the percentage of women and of men who agree to both of the following statements from the DHS:

- A wife is justified in refusing to have sex with her husband when she knows he has sex with other women
- A wife is justified in asking to use a condom during sex if she knows her husband has a disease that she can get during sexual intercourse

This indicator measures the societal attitudes of men and women and their beliefs about women's autonomy in marriage. The other recommended indicator measures national policies supporting access to sexual and reproductive health information and services, which reflects the rights of accessibility and informed decision-making.

• Data source/modes of measurement

Data for the indicator on respect for women's sexual autonomy are available from the DHS and currently measured for women aged 15–49 and for men aged 15–59. The questions used in this indicator would need to be included in other national surveys to cover a larger number of countries. For the policy indicator, some data may be collected or could be adapted from official records, the WHO Policy Indicator Survey on adolescent health and the USAID DELIVER Project Contraceptive Security Indicators.

• Strengths and weaknesses

The indicator on women's sexual autonomy gauges social attitudes among both men and women about women's autonomy in marriage. Data on such attitudes may help in understanding behaviors and in assessing the scope of future support for policy and legal changes advancing women's rights. Because these questions are collected through population-based surveys, they can be disaggregated for many population subgroups.

The indicator on national policy examines legal and regulatory frameworks that guarantee the right to access information, education and services that are confidential and free from discrimination and abuse. It will be necessary to construct an indicator that covers these concepts in a comparable way across countries. The existence of a policy does not necessarily reflect women's status and autonomy and may mask limitations in access to services and information, especially for traditionally underserved populations such as single women, adolescents and individuals living with HIV.

Other indicators on women's autonomy and decision-making in relation to sexual and reproductive health have been proposed by UNFPA and UN Women and are listed below; they differ in that they focus on behavior, rather than attitudes, but they are broadly consistent in aim with the recommended indicators above.

- Percentage of women aged 15–49 who make their own sexual and reproductive decisions (aspirational)
- Proportion of countries with laws and regulations that guarantee all women and adolescents access to sexual and reproductive health services, information and education

The first proposed UNFPA/UN Women indicator would use DHS data on women's reported ability to say no to sexual intercourse with their husband or partner and on whether women were main or joint participants in decisions about the use of contraception. A third component of this measure, whether a woman can make a decision about sexual and reproductive health care for herself, awaits the development and evaluation of a new question that can be included in DHS, MICS and other national surveys.

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