AN ADVOCATE'S GUIDE:

Integrating Human Rights in Universal Access to Contraception

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asian-pacific resource & research centre for women

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About this Guide

This guide, as the name suggests, is meant for use by advocates for sexual and reproductive health and rights (SRHR) at the country level. The guide uses the recommendations made to national governments in the publication "Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations" published by the World Health Organization in 2014, with the aim of ensuring that "the different human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services".

The guide takes into account recommendations made by the WHO Guidance document, elaborates on what the recommendations actually mean, and provides a checklist with series of questions that probe into the extent of which a government has implemented or complied with a specific (set of) WHO recommendation (s). There are 17 such checklists, which together constitute a 'tool box' for assessing whether human rights are ensured in the provision of contraceptive information and services. The guide also provides an illustrative list of indicators for tracking adherence to human rights norms by contraceptive programmes.

The guide can be used by SRHR advocates, this includes women's organisations, civil society organisations working on women, young people's health and SRHR. The tool can also be used by health professionals within the health systems at the national level, as a resource and assessment tool for provision of rights based contraceptive information and services.

This advocate's guide is meant as a generic tool. It will have to be adapted to different national and even sub-national settings, depending on its history of population control and the ethos of adherence to human rights, health system characteristics and resource levels. We hope this guide will enable SRHR advocates to use these WHO recommendations as a basis for holding governments accountable to respecting and upholding human rights in policies and strategies related to contraceptive information and services, and in the actual organisation and delivery of contraceptive services to users.

Preface

In recent years, governments, donors, UN agencies and NGOs have paid close attention to the issue of providing access to contraception as a key development strategy. Access to contraception is an essential reproductive right: enabling individuals and couples to make and follow-through on decisions around the number, timing and limiting of pregnancies. Data testifies to the fact that women and men who are unable to access contraception, in any country, come mostly from the poorer wealth quintiles, lower education quintiles, live in rural or hard-to-reach areas. The gap in accessing contraception between the rich and the poor, the better and the lesser educated, the urban and the rural and hard-to-reach, speaks of a social inequality in being able to realise this fundamental right. Women being able to plan, space and limit their families is key in reducing poverty and ensuring gender equality.

However, while being able to access contraception is a fundamental right in itself, there have been examples in the past which show that other aspects of rights have been trampled in providing contraception. These have been especially true when states have employed coercive strategies in population reduction plans. If we truly want the contraception and family-planning agenda to be sustainable and be part and parcel of everyday conversations and decisions of individuals and families we need to respect all the other different facets of reproductive rights that exist. These include, but are not limited to, the right to information and counselling, the right to choice of method and a variety of methods to choose from, the right to access all other reproductive health services (because ill-health drives families further into poverty), the right to safe sex, the right to termination of pregnancy when contraception fails. These rights should be realised by even the most marginalised people: the poor, the less educated, those living in rural and hard-to-reach areas, the young and those most often over-looked such as sex workers and transgender people.

This guide serves to help civil society advocates understand and help governments uphold the highest standards possible when implementing this critical development strategy. The tools in the guide can also be used by health professionals within the health systems at the national level, as a resource and assessment tool for provision of rights based contraceptive information and services.

ARROW and our partners are working to ensure that universal access to SRHR remains high on the development agenda in the Asia-Pacific region and the Global South and that national and international policy- and decision makers are improving SRHR policies and investments to benefit the under-served and most marginalized groups, especially women and girls. As the SRHR agenda has prominence within Agenda 2030 we feel it is critical that provision of SRH and contraception services are available, accessible, acceptable and of the highest quality. Human rights standards help ensure this.

ARROW recognises the contributions of TK Sundari Ravindran who has been working in close collaboration with ARROW to develop this guide. Her dedication to mentoring and guiding ARROW staff and partners in understanding human rights standards has enriched our ability to hold service providers to accountable to higher standards.

It is our greatest hope that this contribution helps build a strong movement of governments, donors, civil society, service providers and UN agencies who are committed to ensuring and fulfilling rights in providing universal access to contraception.

Sivananthi Thanenthiran
Executive Director

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This publication, An Advocates guide: Integrating Human Rights in Universal Access to contraception, was developed by TK Sundari Ravindran. It is based on the WHO Guidance and Recommendations "Ensuring human rights in the provision of contraceptive information and services". Sundari has been working with ARROW for a long time in fine-tuning our understanding of translating human rights standards at ground level.

We also acknowledge the contributions of ARROW staff: Sivananthi Thanenthiran and Nadia Rajaram who coordinated, gave feedback and finalised the publication; and to Sai Jyothirmai Racherla and Dhivya Kanagasingham for coordinating the final draft and printing the publication. The design and the layout of this book is the work of TM Ali Basir.

CHAPTER 1

TOUCHING BASE ON CONCEPTS

Introduction

Voluntary choice in marriage and family formation; determination of the number, timing and spacing of one's children; and access to the information and means needed to exercise voluntary choice are not only goals to aspire for. These "reproductive rights" are core to the protection of human rights, self-determination and equality embodied in the Universal Declaration of Human Rights.

In 1994, the International Conference on Population and Development (ICPD) in Cairo rejected demographically driven population policies and upheld respect for reproductive rights. Through the ICPD Programme of Action, 179 countries who signed on to it acknowledged that reproductive rights are human rights recognised by international and national laws. In the subsequent decades, many UN institutions and mechanisms including the Human Rights Council and Human Rights Treaty Monitoring Bodies have contributed to the recognition of sexual and reproductive health and rights as an integral part of the entitlements guaranteed to all persons by human rights.

And yet, during this second decade of the 21st century, an estimated 222 million women globally, constituting 26% of women who wish to avoid a pregnancy, are not using a modern method of contraception. This group of women with an 'unmet need' for contraceptive services account for 79% of all unintended pregnancies.[1] Given the legal restrictions on abortion services in many countries of the world, they are forced to continue with an unwanted pregnancy or resort to illegal and often unsafe abortions putting their health and lives at jeopardy.

The London Summit on Contraceptive organised in 2012 by the Bill and Melinda Gates Foundation and the UK government brought together private foundations, governments, international NGOs to reaffirm their commitment to achieving a significant reduction in the numbers and proportions of women with an unmet need for contraceptive. Countries pledged US$ 4.6 billion over the next eight years towards realising this goal.

Even while SRHR advocates and activists have reason to laud the increased investment in contraceptive services, they also have reason to be watchful about the ways in

which this will impact realities on the ground. Memories of coercive population control policies and their traumatic consequences are as yet fresh in the minds of SRHR advocates and the people in many countries of the Global South.

Who is this Guide for and what it contains

This Advocate's Guide, as the name suggests, is meant for use by advocates for sexual and reproductive health and rights at the country level. The Guide uses the recommendations made to national governments by a "Guidance document" published by the World Health Organization in 2014, with the aim of ensuring that "the different human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services"[2]. The aim of the Guide is to enable advocates to use these WHO recommendations as a basis for holding governments accountable to respecting and upholding human rights in policies and strategies related to contraceptive information and services, and in the actual organisation and delivery of services to users.

This introductory chapter will present concepts and definitions related to rights-based contraceptive information and services. Chapter two is the core chapter in which each section starts with a recommendation made by the WHO Guidance Document (verbatim) and an elaboration of what it means, and is followed by a checklist. Each checklist refers to and follows a given set of WHO recommendations. Each checklist consists of a series of questions which probe into the extent to which a government has implemented or complied with a specific (set of) WHO recommendation(s).

There are 17 such checklists in Chapter 2, which together constitute a 'tool box' for assessing whether human rights are ensured in the provision of contraceptive information and services. More details on how the checklists may be used are given in the introduction to Chapter 2.

It is important to note that some of WHO's recommendations may be contrary to the law of the land in some countries. For example, same-sex sexual orientation is criminalized in some countries, and it may not be legal to provide contraceptives services to adolescents below 18 years of age. In such instances, advocacy may first be directed at changing laws and policies, drawing attention to the fact that WHO's recommendations are grounded in international human rights law, and the country may have ratified Human Rights Conventions and Treaties that support these recommendations.

Chapter 3 contains an illustrative list of indicators for tracking adherence to human rights norms by contraceptive programmes, and this short list of indicators may be used for a rapid assessment.

This advocate's guide is meant as a generic tool. It will have to be adapted to different national and even sub-national settings, depending on its history of population control and the ethos of adherence to human rights, health system characteristics and resource levels.

Key Concepts

This section presents concepts and definitions related to contraceptive services and human rights that are used throughout this guide.

Comprehensive contraceptive information and services

Throughout this document 'contraceptive services' has been used rather than the term 'family planning' services, although latter term has been in use for many decades, and may be better understood in many country contexts. This is because the term 'family planning' is inherently biased in that it suggests that the services are only for those within the context of a family. The indirect implication is that unmarried adolescents and young people, sex-workers and others who have a need to prevent pregnancy but may not be part of a "family" are not legitimate clients of the programme.

In using the term 'contraceptive services' this guide explicitly considers sexually active adolescents and young people, women and men of all ages and diverse sexualities as legitimate contraceptive users and clients of contraceptive information and service programmes.

'Comprehensive' contraceptive information and services refers to the provision of information and services for all methods of contraception without imposing programme-based or provider-based restrictions of specific contraceptive methods.

Human Rights-Based Approach

A human-rights-based approach has two major features.

One, it takes a position that ensuring access to education and health care and other basic needs and amenities for all its citizens are not acts contingent on the good will of governments, but obligations that they are required to fulfil as a result of their ratification of international and/or regional human rights treaties.[3]

And two, a rights-based approach integrates international, regional and national human rights standards, principles

and processes into plans, policies and programmes. The human-rights-based approach considers all persons as **rights-holders,** while the government and its agents are **duty-bearers** with specific obligations to fulfil. This will mean for example, that providing contraceptive services is an obligation of the state, not an act of charity and not left to the discretion of governments to provide or not (Box 1). High levels of unmet need for contraceptive services or poor quality of care are not inevitable but the consequence of deliberate decisions and policies, and governments are obliged to explain why they did not increase progressively their investments in contraceptive and allied health services.[4]

BOX 1. GOVERNMENTS' HUMAN RIGHTS OBLIGATIONS AS DUTY BEARER

Governments have three levels of obligation: to respect, protect and fulfil every right.

Respecting rights means that the state cannot violate rights or interfere in the enjoyment of rights. For example, the state cannot have laws or procedures that discriminate against the access to sexual and reproductive health services for single women.

Protecting rights means that the state has to prevent violations of rights by non-state actors, and offer redress if a violation does occur. For example the state would be responsible for make it illegal for a private health facility to automatically deny health care to a person on the basis of a health condition. Likewise, it would be the responsibility of the state to ensure that women are not subjected to violence within their homes or in their workplace.

Fulfilling rights means that the state has to take all appropriate action (e.g. legislative and administrative measures, budgetary and judicial measures) to create conditions that enable people to enjoy rights. For example, even a low-income state is expected to show an increase every year in the resources it mobilizes to meet the public health needs of its entire population.

Source: Adapted from WHO-EURO. Checklist for assessing the gender responsiveness of sexual and reproductive health policies.Pilot document for adaptation to national contexts. Copenhagen, World Health Organization Regional Office for Europe, 2010.Page.[5]

Within the context of contraceptive policies and programmes, human-rights-based approach may be understood as including the following key human rights principles and standards:

- Non-discrimination in the provision of contraceptive information and services
- Availability of contraceptive information and services
- Accessibility of contraceptive information and services
- Acceptability of contraceptive information and services
- Quality
- Informed decision-making
- Privacy and confidentiality
- Participation, and
- Accountability

A contraceptive programme adopting human rights-based approach would not be a vertical, stand-alone programme but integrated within a comprehensive sexual and reproductive health programme

These principles and standards are further elaborated below.

Non-discrimination in the provision of contraceptive information and services

Contraceptive services information and services must be accessible and provided without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status. The design of programmes should take account of the fact that vulnerable groups may face special barriers.

Availability of contraceptive information and services

Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals); goods (e.g. contraceptives, other drugs, equipment); basic amenities such as potable drinking water and sanitation; information and services on sexual and reproductive health including contraception; must be available in sufficient quantity within the state, and distributed equitably across geographical areas and communities.

Accessibility of contraceptive information and services

All health care must be accessible to all without discrimination. No one shall be denied preventive, promotive or curative health care including contraceptive services and allied sexual and reproductive health services that s/he needs. Accessibility has three overlapping dimensions: Physical accessibility; economic accessibility or affordability; and access to information[6].

Acceptability of contraceptive information and services

Health care institutions and providers must be respectful of medical ethics. They should respect the dignity of all clients, provide culturally appropriate care, be responsive to needs based on gender, age, culture (including religion, belief, values, norms and language), and physical abilities.[9]

BOX 2. THREE OVERLAPPING DIMENSIONS OF ACCESSIBILITY

Physical accessibility: Sexual and reproductive health facilities, goods and services must be within safe physical reach during all seasons of the year for all sections of the population, especially marginalized groups. Accessibility also implies that underlying determinants of health, such as safe water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.[7]

Economic accessibility (affordability): Sexual and reproductive health facilities, goods and services must be affordable for all, and no one should have to forgo or postpone seeking appropriate and timely health care because s/he cannot afford to pay for it at the time of need. Publicly financed sexual and reproductive health services, free at the point of service delivery, would remove financial barriers to access.

Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas concerning sexual and reproductive health issues, and about the entire range of contraceptive methods, both modern and traditional. Information should be made available to all through appropriate communication channels and methods to meet the needs of different language-speaking groups; persons with limited literacy skills; those with disabilities and so on [4]. The content of information provided should uphold rights and be sensitive to differences in needs by gender, age, ethnicity and other axes of vulnerability.

Source: UNFPA and Harvard School of Public Health. A Human Rights-Based Approach to Programming.Practical implementation manual and training materials.New York, United Nations Population Fund, 2010.[8]

Quality

All health care, including contraceptive information and services must be medically appropriate and guided by technical quality standards and control mechanisms. More importantly they should be characterized by positive attitudes on the part of providers, informed decision-making on the part of the client and provided in a timely and safe manner, and to the client's satisfaction.[10]

Informed decision-making

Informed decision-making is already a component of services that are acceptable and respect medical ethics. It is also a characteristic of good quality of care. However, this element is considered separately because client autonomy and informed decision-making are key characteristics of a rights-respecting contraceptive programme. Free, full and informed decision-making is an expression of autonomy, upheld by medical ethics and international human rights law.[11]

Privacy and confidentiality

Respect for client's privacy, confidentiality and dignity is a fundamental tenet of medical ethics. Upholding the client's privacy and maintaining confidentiality is important in all areas of health care. It is especially critical when providing contraceptive information and services, failing which several negative consequences can arise. For example, the service loses the client's trust and the client may not return for a service or follow up.

Participation

Individuals and communities must be able to play an active, free and meaningful part in the design and implementation of contraceptive services policies and programmes. Policies and programmes are therefore required to create structures and mechanisms that will allow and enable such participation by all stake-holders, especially traditionally excluded and marginalised groups.

Accountability

Governments and public agencies must be held accountable and answerable for their acts or omissions in relation to their duties related to protecting the right to health care, including right to contraceptive information and services, through enforceable standards, regulations, and independent compliance-monitoring bodies.[12] Governments are also accountable for regulating the

actions of private entities such as private health care providers, insurance companies and pharmaceuticals so that their actions do not violate citizens' right to health.

Why a human rights-based approach to contraceptive information and services?

What is the "value-added" of adopting a human-rights-based approach in the context of contraceptive services?

- A human-rights-based approach provides an overall framework and a set of universal values – for example equality, non-discrimination, participation and accountability - on which to base contraceptive services.
- The principle of equality enshrined in a human-rights-based approach calls for a focus on the most vulnerable and marginalized sections of society, and makes it obligatory to ensure reaching the 'difficult-to reach' sections of the population.
- Attention to gender equality follows from the principle of non-discrimination that a human-rights-based approach stands for.
- The principle of participation requires that people participate meaningfully in decisions about contraceptive policies and programmes.
- The accountability principle guarantees the availability to client/ users of programme of redress mechanisms for grievances and rights violations.[13]

The cost of not adopting a human-rights-based approach in the provision of contraceptive information and services could be high. For example, it may result in lack of attention to less powerful or poorly resourced groups – low-income groups, young people, single women, persons with different sexualities. This would influence the programme's ability to reduce unmet need. Worse still, the consequences for the under-served group could be unwanted pregnancies ending in poor pregnancy outcomes or unsafe abortions.

When human rights are not the guiding principle for programme planning, programmes may focus exclusively on achieving fertility reduction, contributing inadvertently to inadequate importance to quality of care in service delivery settings. The consequence may be avoidable reproductive morbidity including the threat of HIV infection and a poor image and low acceptability for contraceptive services. Providers who are not aware of the need for maintaining client confidentiality may inadvertently disclose to the husband contraceptive use by his wife. In the case of women experiencing gender-based violence this could seriously threaten their safety and security.

For these and many other such reasons, ensuring human rights in the provision of contraceptive information and services is not only an added value to an efficient programme, but a moral imperative.

CHAPTER 2

HUMAN-RIGHTS-BASED PROVISION OF CONTRACEPTIVE INFORMATION AND SERVICES: GUIDELINES FOR MONITORING WHO RECOMMENDATIONS

WHO's recommendations for human-rights standards are organised into nine sections , each section pertaining to one of the nine human rights principles and standards defined in Chapter 1 (non-discrimination; availability; accessibility; acceptability; quality; informed decision-making; privacy and confidentiality; participation; and accountability).[14] This chapter is therefore organised into the same nine sections.

Each section is further divided into sub-sections pertaining to recommendations from the WHO Guidance document. Following each (set of) WHO recommendation(s) presented, the definition of important terms used in the recommendation and the rationale for the recommendation are presented. Where necessary, the operational implications of the recommendation are described. Following each recommendation or a set of recommendations is a box with a checklist of questions, which probe into the extent to which a government has implemented or complied with the WHO recommendation(s) in question. Not all checklists and questions may be relevant to every setting, and these will have to be suitably adapted. Some of the questions in the checklist are about policies and programme guidelines, and to find answers to these, a review of the latest policy or programme documents would be necessary. Policy documents include not only formally published policies of the government, but regulations and official orders of the government or administrative structure at different levels, and of published and unpublished studies and reports which comment on the content of these policies and programmes.

Other questions are about what the situation is 'in practice'. To answer these, one may draw on published statistical data where relevant, or examine small-scale studies on the situation, or even undertake a limited data-collection exercise in one's own setting. It may be feasible to undertake a "fact-finding" exercise of the situation by visiting a cross-section of facilities or by speaking to key informants and community members and users of services. The collection of answers to questions in the checklist will yield a human rights 'report-card' for a given setting at a given time point. Not all recommendations and checklists have to be used at the same time. One may decide to focus on a particular set of rights principles at a given time

and carry out a situation analysis on that. For example, an organisation may decide to carry out a situational analysis on whether or not the right of users for informed decision-making in matters related to contraception is being upheld.

At the end of a situation analysis, rights violations and failure to uphold rights within a given setting are likely to come to light. For example, in the situation analysis on informed decision-making, it may emerge that users are given information only on a limited range of contraceptives (or even just one); or that they receive almost no information on side-effects of contraceptives; or that the information given is not in a format that is easily understood by a large proportion of users. It will then be up to the advocates to decide which of the issues would be an immediate priority for advocacy and action.

Periodic reviews will indicate whether or not there is 'progressive realization' of a rights-based approach. These results may then be used to hold governments accountable. The use of WHO recommendations as basis for the checklist gives us as SRHR advocates greater leverage to demand that governments adhere to these recommendations from a multilateral technical entity.

Non-discrimination

WHO Recommendation 1.1.

Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice).[15]

Forced or coerced sterilizations and IUD insertions have been reported from many parts of the world. 'Forced' refers to sterilization or IUD insertion without a person's knowledge, while 'coerced' includes situations when misinformation or intimidation is used to make a person accept a method of contraception, or when other benefits/services are made conditional on the 'acceptance' of contraception.[16] For example, studies from India have reported that medical termination of pregnancy in government health facilities is often conditional on acceptance of sterilization or IUD.[17]

In Uzbekistan, a 2010 report stated that some women were required to produce sterilization certificates in order to obtain employment[18]. Women from low-income groups and marginalized communities such as the Roma, women with disabilities and women living with HIV are reported to be particularly vulnerable to the risk of coercive or forced sterilization.[19] Coercion by health care workers to undergo sterilization has been documented in Chile, Dominican Republic, Mexico, Namibia and South Africa, and anecdotal evidence indicates that the practice may be common across the globe.[20]

Incentives and disincentives are a more indirect means of taking away choice from the hands of the client. Many countries have had a history of building in incentives and disincentives to ensure "acceptance" of contraception. This may take the form of cash or other benefits to clients for adopting a contraceptive method[21], or denying them a benefit if they chose not to accept any method. There are also rewards offered to health-care providers for achieving specific contraceptive "targets" or penalties imposed for non-achievement of specific targets. Not only are these clearly violations of clients' right to choose.

In practice, the system of incentives and disincentives has been seen to deteriorate into coercive or unethical practices on the part of health care providers; clients have accepted contraception not because they did not want to have a child just yet or wanted to stop childbearing, but because they were in financial distress.[22]

CHECKLIST 1

Examine the contraceptive programme guidelines, government orders and other official documents related to the programme.
Also draw on observations from the field.

1.1 Do any programme Guidelines and/or G.Os/ government documents state upfront that no person shall be forced against his/her will to accept any method of contraception that s/he does not wish to?
1.2 Is there a practice of offering any incentives (money or gifts) to the client for adoption of contraception in general or a specific method of contraception at any time or under any circumstances (e.g. those with three children in order to prevent higher order births)?
1.3 Is there a practice of offering any rewards to service providers/their institutions for achieving a specified "target" in terms of numbers/proportions of contraceptive users?
1.4 In practice, do service providers/health facilities experience any disincentives or penalties for not achieving a specified number or proportion of "acceptors" of contraception?
1.5 In practice, is any service (e.g. medical termination of pregnancy) or benefit (subsidised food, employment, maternity benefits) made conditional on acceptance of/ being a user of contraception?
1.6 Does the contraceptive programme have mechanisms in place (spot-checks, feed-back mechanisms) to ensure protection from forced or coerced contraceptive for persons from marginalized groups (e.g. low-income, minority communities, PLHIV)?

WHO Recommendation 1.2

Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalized populations in their access to these services.

In many countries, contraceptive information and service programmes have focused exclusively on women for a number of ideological reasons. Unfortunately, this has had the effect of burdening women with the entire responsibility for contraception, while at the same time restricting access to services even for those men who want to use contraception. Less than 9% of all users of contraceptive methods in developing countries are men. Use of vasectomy among men ranged from close to 0% in Africa to 2.2% and 2.3% in Asia and Latin America respectively (2013) while condom use ranged from 2% in Africa to 7.4% in Asia and 10.1% in Latin America.[23] A rights-based approach to contraception should invest in correcting this anomaly by making contraceptive information and services widely available to men and boys through service delivery mechanisms that take on board their specific needs and preferences.

For contraceptive information and services to be 'inclusive' and provided to all segments of the population, the very terminology of 'family-planning' may need to be dropped, so that those who require contraceptive services outside the context of 'family' – e.g. single persons, adolescents and young people, sex workers - do not feel intimidated and excluded. Combining contraceptive services with maternal health care – the classic MCH/FP programming model – is another example of discriminatory programming that sends signals to the community that single women, 'non-mothers' – women who have not yet begun childbearing or women who do not intend having children, as well as men –are not considered as potential clients.

An inclusive contraceptive information and services programme will not be a vertical stand-alone programme but an integral component of a comprehensive Sexual and Reproductive Health (SRH) Programme (See Box 2 for the components of a comprehensive SRH programme) that takes into account the diverse needs of specific population sub-groups.

Unmet need for contraception is much higher among adolescents (15-19 years) than among women age 20-49 years in Asia, Africa and in Latin America.[25] Lack of sexuality education, legal barriers to access and lack of affordability are all factors that contribute to the high levels of unmet need for contraception among adolescents and young people. However, even in the absence of legal and policy barriers, social attitudes related to adolescents' and young people's sexuality may deter health workers from providing services. Evidence shows that adolescents and young people often face discrimination in contraceptive service provision. According to studies in Kenya, Zambia, Lao PDR and China, health providers often believed that distributing contraceptives to adolescents and young people will encourage promiscuity.[26]

Fear of being scolded and humiliated by the provider is an often reported reason for not use of SRH services by adolescents in many developing countries. Young women are more affected by providers' gender double-standards regarding appropriate sexual behaviour.[27, 28, 29] Young or nulliparous women may be denied contraception because of provider-beliefs that contraceptive is not for women without any children. [30, 31]

Sufficient evidence and know-how exists on how to set up youth-friendly sexual and reproductive health services. Because young people are not a homogenous group, contraceptive information and services for them would have to be available in multiple sites to cater to their

BOX 2. COMPONENTS OF A COMPREHENSIVE PACKAGE OF SRH SERVICES

A comprehensive package of SRH services includes:
- Contraceptive (FP)/birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Safe abortion services and provision of post-abortion care
- Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) including HIV/AIDS
- Early diagnosis and treatment for breast cancer and reproductive tract cancers in women and men
- Promotion, education and support for exclusive breastfeeding
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting (FGC)
- Adolescent sexual and reproductive health services
- Prevention and management of gender-based violence (GBV)

Source:Adapted from Reerink IH and Campbell BB. Improving reproductive health care within the context of district health services: A Hands-on Manual for Planners and Managers. New York, UNFPA, 2004.[24]

varying needs. For example school-based services will not cater to out-of-school youth, whose numbers may be significant in some settings. Studies show that whatever the location, young people wanted assurance of privacy and confidentiality, affordable or free services, and youth-friendly staff.[32, 33, 34, 35]

Discrimination by race, ethnicity and socio-economic status in the delivery of contraceptive services are prevalent in many settings[36, 37, 38, 39] and usually takes the form of being pressured to limit family size and to use contraception, "for their own good". Request for contraceptive services by women with disabilities are often met with shock and surprise and subject to interrogation by health care providers who tended to assume that persons with disabilities are asexual.[40, 41]

People living with HIV are often told by health providers that they should refrain from sex and childbearing, and may fear seeking contraceptive services. The risk of being coerced into sterilization would also be a barrier to accessing contraceptive services for PLHIV. [42]

Availability

WHO Recommendation 2.1

Recommend integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to ensure availability.[43]

This recommendation by WHO focuses on reproductive commodity security at the programme level. This would mean for example, that the full range of contraceptive commodities and supplies including emergency contraception, and the equipment necessary to provide these should be included in the National Essential Medicines List. The concept of a single first line or second line treatment, adopted for curative care, does not apply in the case of contraceptive services, where the range of contraceptives made available could make the difference between use and non-use of contraception. Also, because contraceptives are for prevention, they may be considered as not contributing to saving lives in the same way as other essential drugs for curative care. Contraceptives may be the first to be cut out of a National Essential Medicines list in case of a financial crunch. Advocacy may also be needed for adequate public funding for procuring contraceptive and reproductive commodities.[44]

When contraceptive supplies are stocked-out, or equipment and supplies necessary to provide a specific method are unavailable at the service delivery point, this represents a major opportunity lost to serve clients – predominantly women – who may have reached the services after negotiating many hurdles. They may never be able to return, and unintended pregnancy may be the consequence. Increasing product-availability at the service delivery point calls for good supply-chain management of all contraceptive commodities, supplies and equipment at all levels.

CHECKLIST 2

2.1 Is the contraceptive information and services programme labelled as a "family planning" programme?
2.2 Is the programme a part of the maternal and child health programme?
2.3 Are gender-equality and women's empowerment explicit objectives of the programme?
2.4 Do programme objectives explicitly mention attention to the contraceptive needs of men?
2.5 If yes, have men-specific services been planned, whose location and timing, physical infrastructure human resources been planned taking into account the special needs of men?
2.6 Are there any legal and/or policy restrictions to the provision of contraceptive information and services based on marital status? Based on age (below 18 years)?
2.7 Do programme objectives explicitly mention attention to the needs of adolescents and young people?
2.8 If yes, in practice, do young people and adolescents get contraceptive information and services? Are these available to different groups of young people and adolescents? (e.g. in-school and out-of-school? Girls and boys? Married and single?
2.9 Do programme objectives include attention to marginalized groups such as people living in remote geographic areas; members of marginalized community groups; single women; disabled persons; sex workers; PLHIV; people of diverse sexual orientations and gender identities?
2.10 Have the location and timing of services, the physical infrastructure and the human resources been planned taking into account the special needs of disadvantaged groups such as people living in remote geographic areas; members of marginalized community groups; single women; disabled persons; sex workers; PLHIV; people of diverse sexual orientations and gender identities?
2.11 Are data available on who the excluded and marginalized groups are; their sexual and reproductive health needs; and barriers encountered by them in accessing contraceptive information and services? How large or small are the gaps in information? Which groups have been left out?
2.12 Have resources been invested in data collection and research to obtain such data (as specified in 2.11?)

The recommendation also talks about an effective contraceptive supply chain. The aim of an effective contraceptive supply chain would be to get the "right quantities of the right contraceptives to the right places at the right time in the right condition at the right cost".[45] Procurement of contraceptives must be based not only on estimates developed by tracking past use.

A needs assessment should be undertaken among under-served groups or hitherto un-served groups in the community so that supplies are adequate to cater to all those who need them. Such estimates must be periodically reassessed to account for changes in patterns of demand. They should also account for all methods including emergency contraceptive pills and condoms and for all distribution points e.g. facility level, community level and self-dispensing points like for condoms.

Another aspect of an effective supply chain is planning for storage of contraceptive devices. Such storage areas should be clean, well ventilated, dry, well lit, out of direct sunlight and pest free. A system of First - in First - out (FIFO) should be put in place and expired stock should be regularly removed. Quality of contraceptive devices should be routinely checked and staff must be trained to check for quality and warning signs that a device is of poor quality or damaged. Planning for quality control and storage of contraceptive commodities, supplies and equipment is an essential component of good supply-chain-management.[46]

Accessibility

WHO Recommendation 3.1

Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition.

Sexuality education is defined as "an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality Education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality'.[48]

The term 'comprehensive' in relation to sexuality education indicates that this approach will encompass the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. For example,

CHECKLIST 3

3.1 Does the National Essential Drugs list include the full range of contraceptives including emergency contraceptive pills?
3.2 In practice, is the full range of contraceptives available to clients visiting service-delivery points?
3.3 Have there been instances of stock-out of any contraceptive supplies ((w.r.t. a fixed reference period and in a specific reference location)?
3.4 Have there been instances of women reporting discontinuation of contraception because of non-availability of supplies?

OTHER DIMENSIONS OF AVAILABILITY

3.5 Has the public spending on health increased progressively over the past decade?
3.6 Are there enough service delivery (including community-outreach) points in the government sector to ensure population coverage? (Minimum threshold specified by WHO: 2 service delivery points per 10,000 population).
Are they distributed rationally across rural/urban locations and sub-regions?
3.7 Are human resources adequate to ensure population coverage? (Minimum threshold specified by WHO: 23 physicians, nurses and midwives per 10,000 population). Are they distributed rationally across rural/urban locations and sub-regions?
3.8 Does every primary health facility have adequate space and facilities to cater to its clients?
3.9 Does every primary health centre have a health service provider trained to provide information and services for a wide range of contraceptives?
3.10 How often is staff absent in contraceptive service delivery points (including community-out reach points)?
3.11 Is there a point-person or an office to which clients may report about staff absenteeism in contraceptive service-delivery points?
3.12 Are there policy guidelines regulating conscientious objection by service providers to not provide contraceptive and abortion services? Do they affirm reproductive rights?[47]

** In a recent case before the European Court of Human Rights relating to conscientious objection to provide abortion services, the Court decreed that providers may not "give priority to their personal beliefs over their professional obligations"*

Source: O'Rourke A, De Crespigny L and Pyman A. Abortion and conscientious objection: the new battleground. Monash Law Review 2012; 38(3): 87-119.

they will not be narrowly focused on abstinence-only or on HIV/AIDS prevention.

According to the International Planned Parenthood Federation (IPPF), comprehensive sexuality education should be rights-based and gender-sensitive. It should also be citizenship-oriented, fostering responsible behaviour and action skills that promote enabling social conditions for sexual and reproductive health and well-being. Most importantly, comprehensive sexuality education should be sex-positive. This means that the curriculum should demonstrate a positive attitude towards sexuality and sexual pleasure as important for personal well-being and happiness.[49]

In terms of major themes to be covered by the curriculum, UNESCO guidelines on comprehensive sexuality education emphasize educating children and young people on six key concepts:

- relationships;
- values, attitudes and skills;
- culture, society and law;
- human development;
- sexual behaviour; and
- sexual and reproductive health.[50]

The right of adolescents and young people to have access to comprehensive sexuality education is upheld by a number of international conventions and documents. For example, the UN Convention on the Rights of the Child (1989) states that children and young people have the right to have access to information which will allow them to make decisions about their health (Article 17) including contraceptive (Article 24). The United Nations Committee on the Rights of the Child (2003) has required State Parties to provide adolescents with access to accurate sexual and reproductive health information, "including on contraceptive and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)", regardless of marital status and parental consent.[51]

There is also considerable research evidence, which shows that well-planned and executed sexuality education programmes for adolescents and young people, implemented in schools and communities have resulted in increased knowledge of human sexuality. Many of the interventions have helped to delay the onset of sexual activity among adolescents and young people, reduce the frequency of unprotected sex and the number of sexual partners and increase condom use and contraceptive use.[52, 53, 54, 55, 56]

And yet, comprehensive sexuality education may not receive explicit policy or legal support in many countries.

CHECKLIST 4

4.1 Is comprehensive sexuality education a component of one or more national policies?
4.2 Is there a policy or government order to implement comprehensive sexuality education a) in schools b) for out-of-school youth?
4.3 What proportion of schools has any sexuality education as part of its curriculum?
4.4 What proportion of out-of-school young people is covered by any sexuality education Programme?
4.5 Examine the curricula of any sexuality-education programme implemented by government. How 'comprehensive' are they, based on UNESCO's guidelines on six essential components?
4.6 Does the sexuality education curriculum a) promote gender-equal values and norms? b) address rights, stigma and/or discrimination? c) Is it sex-positive? d) Does it include diverse sexual and gender identities?

For example, a UNESCO review of comprehensive sexuality education in 28 countries of the Asia-Pacific region reported that in only about half the countries was comprehensive sexuality education mentioned in the national HIV, reproductive health, population or youth policies. The review also found that coverage of schools and out-of-school youth through comprehensive sexuality education was limited, and the content of the education was often narrowly focused on safe sex and prevention of HIV.[57] Even where governments have been committed to implementing Comprehensive Sexuality Education, there may be resistance from religious leaders and from a section of the parents[58] or from within the education sector itself.[59] Advocacy to change community attitudes to Comprehensive Sexuality Education is a challenge that SRHR advocates will have to take on.

WHO Recommendation 3.2

Recommend eliminating financial barriers to contraceptive use by marginalized populations including adolescents and the poor, and make contraceptives affordable to all.

It is now well established that charging user fees for services or requiring the client to purchase medicines and supplies – leading to out-of-pocket expenditure for the client - reduces access especially for preventive and promotive services. Studies have also shown that households are unwilling to spend money for contraceptive services.[60]

Thus, in order to ensure maximum access especially for low-income women and young people without a source of

CHECKLIST 5

5.1 Are contraceptive services available free at the point of delivery in public sector facilities to all sexually active individuals from low-income groups and not only to married persons of reproductive age?

5.2 Are there mechanisms such as government sponsored insurance schemes in place to ensure that the non-poor who cannot pay for contraceptive services are not denied access?

5.3 Are contraceptive services a part of the Benefits Package of all insurance schemes: community-based health insurance and other prepayment schemes, other compulsory or voluntary insurance schemes (e.g. government-sponsored, employer-sponsored or paid for by individual insurers)? Do they cover the entire range of contraceptive options?

5.4 Are there measures to check and contain the practice of informal payments such as under-the counter payment for services, drugs and supplies that are meant to be available free of cost?

income, contraceptive services have to be made free at the point of delivery at the least, for such population sub-groups.

Contraceptive services are often not covered by many insurance schemes. Since almost all women need contraceptive services, they are non-random and/or high probability events, and therefore considered "uninsurable" as stand-alone benefits. As a result, contraceptive services may be unaffordable not only for the poor but also for from non-poor groups without a regular income or access to cash. It is important to ensure that contraceptive services are a part of the Benefits packages of insurance schemes.

Even where affordability has been addressed at the Programme level through suitable measures, there may be financial barriers to overcome at the service-delivery level. One example is the demand by various levels of personnel and health providers, for payments for services or supplies that are supposed to be free. 'Informal payments' are fairly widespread in many developing and transition countries and constitute a significant proportion of out-of-pocket expenses incurred.[61, 62]

Informal payments may be hiked up in the case of particularly vulnerable individuals such as undocumented individuals and single women who may fear being stigmatised for seeking contraceptive services.

BOX 3
ADDRESSING GENDER-BASED BARRIERS TO CONTRACEPTIVE ACCESS

- Many gender-based barriers to contraceptive access, may be addressed by suitable changes in service delivery. The following are some examples:
- Plan clinic timings to suit the convenience of the majority of women
- Ensure availability of women health providers
- Take steps to minimize waiting time
- Have clear signs in the clinic on days and times in which contraceptive services are available
- Ensure that rooms have sign-boards so that clients can easily identify where to go
- Have a help-desk at the reception with a facilitator who helps clients in negotiating the systems and procedures within facilities; the facilitator should be able to communicate with marginalized and minority communities
- Provide home-based contraceptive information and services through women community-health workers who would accompany the women for referral services such as long-acting or permanent methods of contraception

WHO Recommendation 3.3

Recommend interventions to improve access to comprehensive contraceptive information and services, for users and potential users with difficulties in accessing services (e.g. rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines (Safe abortion: technical and policy guidance for health systems, 2 edition)

WHO Recommendation 3.8

Recommend that mobile outreach services be used to improve access to contraceptive services for populations who face geographical barriers to access

In 2011, 215 million women in low and middle income countries were estimated to have an unmet need for modern contraception: of these, 140 million were not using any method of contraceptive while 75 million were using less effective, traditional methods.[63] While the recommendation focuses on especially marginalised and disadvantaged groups, it may be important to acknowledge that being a woman in a patriarchal society in and of itself imposes many barriers to women's access to contraceptive information and services (See Box 3). Unmet need for contraception is on average 2-4 times higher among low-income women than women from higher

income groups. Women living in rural areas and with lower levels of education are similarly disadvantaged.[64] A recent analysis of Demographic and Health Surveys spanning 20 years from over 100 countries found that although average levels of contraceptive use had risen in all countries, the gap between the poorest and the average had also steadily risen, and was wider in richer countries.[65] The low coverage of rural and less developed areas including urban slums by contraceptive services, and the cost of services are major factors contributing to this disparity.

As noted earlier, contraceptive services provided free-of-cost or at subsidised cost to the client would help removing financial barriers. Community-based distribution of contraceptives is another strategy to increase access to contraceptive services, and addresses both cultural/gender-based barriers and time/cost related barriers to reaching functional contraceptive services. Several studies from Africa and Asia have shown that trained community-based providers are able to provide information as well as services effectively to those located in rural, remote and difficult to reach areas. Community-based services are also cost-effective.[66, 67, 68] However, they do not provide access to long-acting contraceptive methods including intra-uterine contraceptive devices and surgical sterilization.

Mobile outreach services have been identified as a strategy to fill this gap. Mobile outreach service delivery is defined as "FP services provided by a mobile team of trained providers, from a higher-level health facility to a lower-level facility, in an area with limited or no FP or health services.[69] In some cases, services are actually provided in the mobile unit, while in other instances, services are provided in a fixed location within communities.

Access to safe abortion information and services

With increasing access to contraceptive information and services during the past decades, the rates of induced abortion have tended to decline. For example, globally the rates of induced abortion declined from 35 per 1000 women age 15-44 years in 1995, to 29 in 2003.[70] However, women will always need access to safe abortion services even if they were contraceptive users. According to the WHO, in 2008 globally 33 million women were estimated to become accidentally pregnant while using a method of contraception.[71]

Restricting the availability of safe abortion services pushes women to seek unsafe abortion at considerable cost to their health. Nearly 47,000 women were estimated to have died from complications of unsafe abortion in 2008, while million women suffered disability from the same cause.[72]

CHECKLIST 6

6.1 Have the location and timing of services, the physical infrastructure and human resources been planned taking into account the special needs of disadvantaged groups (e.g. those with low literacy; those with physical disabilities; linguistic and ethnic minorities)?

6.2 Are there mobile contraceptive outreach services to reach out to underserved populations with the full range of contraceptive services? What proportion of low-income and hard-to-reach population are covered by mobile out-reach services? Do they routinely provide the full range of contraceptive services including long-acting reversible methods?

6.3 Do the country's laws/regulations related to safe abortion services adhere to international Human Rights Law? Which of the protected human rights are violated by the law?

6.4 Are safe abortion services (that are within the ambit of the country's law) available to all sections of women at affordable costs? Are some groups routinely excluded?

6.5 Are there policy, programmatic and budgetary provisions for making safe abortion services (that are within the ambit of the country's law) available at the primary health care level?

Support for women's right to accessing safe abortion services may be found in a number of international human rights treaties. Drawing on these, the 2012 WHO Technical and Policy Guidance Document on Safe Abortion calls on governments to remove regulatory, policy and programme barriers to safe abortion services, and to abide by the principle that the laws of the land should protect women's health and human rights. The Guidance Document recommends that safe abortion services be made available starting from primary health care level, with referrals to higher level facilities as appropriate; and that services be affordable to all sections of women including young women and adolescents.[73]

WHO Recommendation 3.4:

Special efforts should be made to provide contraceptive information and services to displaced populations and those in crisis settings, and to survivors of sexual violence who particularly need access to emergency contraception.

In 2012, two-thirds of the world population or 4.4 billion people were living in a country affected by a major disaster or conflict. Of these, 144 million were directly affected by disaster or displaced by conflict.[74] A significant proportion of those displaced is sexually active persons who are likely to be in need of sexual and reproductive health services including contraceptive services. Many

would desire to prevent a pregnancy and childbirth during a time of displacement and emergency, and especially to prevent exposing a newborn to the risks posed by such a situation. Many of them may have been unable to bring with them the contraceptive method they used or run out of supplies. And yet, contraceptive services are not often prioritised in the Minimum Initial Services package (MISP) provided in humanitarian settings.

The Inter-Agency Working Group on Reproductive Health in Crisis has, in a 2010 statement, recommended that contraceptives should be available to meet demand from the onset of an emergency; and that comprehensive contraceptive services should be available as soon as the situation stabilizes.[75] Implementation of contraceptive services in humanitarian settings involves staff training, community education, logistics and supply chain management and developing a system of client follow-up. The Inter-Agency field manual on reproductive health in humanitarian settings (2010) provides detailed guidelines on implementing contraceptive services in humanitarian settings.[76]

A number of recent studies have reported that women and girls in humanitarian situations are also at a higher risk of experiencing sexual violence because of the use of rape as a weapon of war, or exposed to coercive sex.[77] Emergency Contraception is therefore a critical need for women and girls displaced by disasters and conflict.[78]

Sexual violence is not unique to humanitarian situations but prevalent also in everyday life across diverse cultures and social and economic settings. An estimated 7.2% of adult women experience sexual violence from a non-partner at some time in their lives, and 30% experience physical and/or sexual violence from an intimate partner.[79] WHO recommends the inclusion of emergency contraception as a part of the protocol for medico-legal services for survivors of sexual violence to prevent unwanted pregnancy resulting from the sexual violence.[80]

CHECKLIST 7

7.1 Do government agencies engaged in emergency (disaster) management have a policy related to reproductive health needs assessment in emergency situations, including assessing the demand for contraceptives?

7.2 If there is a positive policy in place, to what extent was its provisions implemented in practice during the most recent emergency? i.e. were reproductive health services, including contraceptive services, made available to all women and men as part of the Minimum Initial Services Package?

7.3 Are there legal or policy provisions preventing the availability of emergency contraception to the general population (e.g. requirement for a judge's decision or police report confirming sexual assault)? If yes, can an exception be made to those in humanitarian settings to include emergency contraception as a part of Minimum Initial Services Package?

7.4 Are providers in the humanitarian setting trained to provide services for survivors of gender-based violence and especially sexual violence? Are they trained to provide contraceptive services, including emergency contraception?

7.5. Does the protocol for medico-legal services to survivors of sexual violence include the provision of emergency contraception to prevent unwanted pregnancy resulting from the sexual violence? If yes, is emergency contraception made available to survivors of sexual violence as a part of medico-legal services?

WHO Recommendation 3.5:

Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health care setting.

About 80% of all women and men living with HIV are in their reproductive years. As ART becomes more widely available with a concomitant increase in life expectancy among Persons Living with HIV (PLHIV), many of them will want to have the option of choosing whether and when to have children. They may wish to avoid pregnancy for a number of reasons, including fear that the child will be infected with HIV, or because they want to preserve their resources on maintaining their own health and the health of their families.

Unfortunately, contraceptive information and services are often inaccessible or unavailable to persons living with HIV. One of the reasons is the providers do not often have the knowledge and skills to counsel persons living with HIV on their contraceptive options. For example, a study from Ghana among health care providers found that many of the providers violated client's rights to contraceptive counselling. Providers also expressed their inability to provide qualified guidance on reproductive options to HIV positive women because of lack of training and the absence of clear guidelines.[81] Also, provider bias and stigma results in many of them pressuring women to undergo sterilization, rather than present them with all reproductive options.[82]

Universal access to contraceptive services implies planning to address the specific needs of PLHIV in the planning and implementation of services. Most contraceptive methods are safe and effective for persons living with HIV. However, a number of factors will have to be considered

BOX 4

Factors affecting contraceptive choice for HIV positive persons

Country of residence	Access to health care services, methods available and cost
Gender-related factors	Women's status in society, decision-making power, experience of/fear of gender -based violence
HIV status of person	CD 4 count, viral load, physical well-being
HIV serostus of partner	Concordant, discordant, not known
Menstrual, sexual and reproductive history	Menorrhagia, dysmentthea, past pelvic infection, past ectopic pregnancy
Medical history	Abnormal liver function, past history of venous thromboembolic disease, hypertension, hyperlipidoemia, current drug abuse
Medications	Enzyme inducers, antibiotics, tuberculosis drugs, teratogenic agents

Source: Adapted from Mitchell HS, Stephen E. Contraceptive choice for HIV positive women. Sexually transmitted Infections 2004; 80: 167-173, Table 2. [83]

when offering them contraceptive advice (See Box 4). For example the choices will be different for persons whose partners are uninfected as compared to those whose partners are infected. Dual protection from infections as well as pregnancy should be an important part of contraceptive options offered to HIV positive persons. Integrating contraceptive services with VCT, treatment and care services makes it possible to reach not only persons living with HIV but also sections of the population who are unlikely clients of contraceptive services. For example, whether HIV positive or not, contraceptive information and services may be offered to groups often underserved by contraceptive programmes, such as adolescents and young people, men who have sex with men (but also have female partners), transgender persons and sex workers. Programmes to prevent parent-to-child transmission of HIV should logically include contraception as a key element.[84]

CHECKLIST 8

8.1 Does the National HIV Policy prioritise the integration of contraceptive services within HIV testing, treatment and care services? Is there a strategy in place on integration of contraceptive services within HIV testing, treatment and care services?

8.2 Are there mechanisms for coordination between the departments/authorities responsible for HIV/AIDS and those responsible for sexual and reproductive health including contraceptive services in matters related to service integration? Are such mechanisms present at the sub-national and local levels of health administration?

8.3 Have clinical protocols and standards for HIV testing, treatment and care been reviewed and revised to integrate contraceptive information, counselling and services?

8.4 Have HIV service providers been trained in providing contraceptive information and services to women and men? Have they been trained in addressing stigma and discrimination?

8.5 In practice, are contraceptive services routinely offered to users of HIV services? Are information and communication resources available that provide information on contraceptive options for PLHIV?

8.6 In practice, are contraceptive and other sexual and reproductive health services offered to users of HIV services without any element of coercion? Is the environment of service provision free from stigma and discrimination?

WHO Recommendation 3.6:

Recommend that comprehensive contraceptive information, counselling and services be provided during antenatal and postpartum care

WHO Recommendation 3.7:

Recommend that comprehensive contraceptive information, counselling and services be routinely integrated with abortion and post-abortion care

Integration of contraceptive information and services with prenatal and postpartum care

According to WHO, after a live birth the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce risk of adverse maternal, perinatal and infant outcomes.[85] It is also known that a large proportion of women throughout the world (92-97%) do not want another child within two years of the previous delivery. But globally, 65% of women in the first year postpartum do not use a method of contraception although they express an intention to use contraceptive.[86]

CHECKLIST 9

9.1. Do national guidelines on pregnancy, delivery and postpartum care; and on abortion and post-abortion care include the integration of comprehensive contraceptive services?

9.2 If contraceptive services are integrated with postpartum and abortion/post-abortion services de jure, are there indications of any elements of coercion? For example, are women coaxed into accepting postpartum contraception during labour or in the immediate post partum period? Are there anecdotal reports of post partum or post abortion contraceptive methods being given without women's consent?

9.3 If contraceptive services are integrated with postpartum and abortion/post-abortion services de jure, are there indications of restricting voluntary choice of contraception per se or of specific methods of contraception? Some examples of restricting choice may be post-partum sterilization programmes or post-partum IUCD programmes in instances where they offer only a single method; or requiring women seeking abortion services to accept a method of contraception.

9.4 Have clinical protocols and standards for maternal health-care and abortion/post-abortion care been reviewed and revised to integrate the provision of comprehensive contraceptive information, counselling and services?

9.5 Have service providers been trained in providing comprehensive contraceptive information and services to women and men? i.e, do they know about the full range of methods, and have the knowledge and skills to counsel and provide services?

9.5 In practice, are comprehensive contraceptive information routinely offered to users of antenatal services? Are comprehensive contraceptive information and services routinely offered as part of postpartum services? To users of abortion and post abortion services? Are information and communication resources available that provide information on contraceptive options to women and men postpartum and post-abortion?

Interventions integrating contraceptive and prenatal and postpartum services have been implemented in many low and middle income countries,[87] and robust evaluations exist of the effectiveness of these in increasing contraceptive use among postpartum women and in achieving healthy birth spacing as recommended by WHO.[88, 89, 90] The unmet need for contraception among women in the first year postpartum indicates the need for integrating contraceptive services with prenatal and postpartum care as an essential component of a human rights-based and gender-responsive contraceptive programme.

A word of caution is in order here. Integration of contraceptive counselling and services with postpartum care should not be misinterpreted to justify actions such as compelling women to accept a method of contraception when they are feeling vulnerable, during labour and immediately after childbirth. Nor does it mean providing without the woman's knowledge and clearly expressed consent a method such as an IUCD immediately after placental delivery or sterilisation alongside a c-section.

Integration implies providing women with comprehensive counselling regarding sexual and reproductive health issues of concern, including contraception, at various points of contact with the health services during pregnancy, childbirth and the immediate postpartum period, allowing the woman and her spouse ample time to consider the matter and make an informed choice. They may then avail of the services in the postpartum period before sexual activity is resumed, at a time that is most convenient to her/him.[91]

Integration of contraceptive services with post-abortion care

The WHO guidelines of birth spacing specify that after an abortion or miscarriage there should be at least a six month interval before attempting the next pregnancy in order to avoid adverse maternal, perinatal and infant incomes.[92] Women who have had an abortion are at high risk of pregnancy soon after the abortion (could be as soon as one week after), and are in need of contraceptive information, counselling and services almost immediately. Studies of women receiving post-abortion care indicate that they have a high unmet need for contraception. A review of 10 studies of women receiving post-abortion care reported that more than half of all women expressed an interest in using contraception after post-abortion care. A subset of 6 studies which had relevant data showed that only about a quarter (27%) of the women left the facility with a method.[93] As in the case of integrating contraceptive services with prenatal and postpartum services, there exist a number of effective models of integrating contraceptive services with abortion and post-abortion services. Essential points to bear in mind include providing contraceptive services at the same time and location where women receive abortion or post abortion services; and offering a wide range of contraceptive methods including condoms, spermicides, oral contraceptives, emergency contraceptive pills, injectables, implants, IUDs and sterilization.[94]

Here again, it needs to be clarified that integration of contraceptive information and services with post abortion care is meant for the convenience of the woman seeking safe abortion services. Making abortion services conditional on acceptance of contraception – a practice

CHECKLIST 10

10.1 Is there a law; or are there Ministry of Health/Family Planning guidelines that require husband's/male partner's authorization for a woman to obtain any contraceptive services?.
10.2 In practice, do contraceptive service providers insist on husband's/male partner's authorization for a woman to obtain any contraceptive services?
10.3 Is there a law or regulation, which requires parental authorization for any adolescent? For adolescents below 18 or 16 years? For those who are not married?
10.4 Is there a policy or strategy document on SRH services for adolescents and young people, which specifies that services will be available irrespective of marital status and does not mandate guardian or parental consent for accessing services for adolescents?
10.5 Are there clear guidelines from the Ministry of Health on how health care providers are to assess the competence of an adolescent to take independent decisions on SRH?
10.6 Do any training programmes for service providers address how third party authorization requirements for sexual and reproductive health services can be gender-discriminatory and in contradiction with fulfilment of sexual and reproductive rights of adolescents?
10.7 In practice, do service providers insi st on parental/ guardian's authorization for an adolescent to obtain any SRH services including contraceptive services?

CHECKLIST 11

11.1 Do the contraceptive/SRH programme guidelines uphold the need for gender-sensitive service delivery? If yes, do they set out norms for the same?
11.2 Do the contraceptive/SRH programme guidelines highlight the specific needs of clients experiencing intimate partner violence? If yes, do they set out norms for the counselling and service delivery for such clients?
11.3 Are providers trained for gender-sensitive service provision? Does this include training for gender-sensitive counselling for contraception?
Does gender-training for RH service providers include training to address the specific needs of women experiencing reproductive coercion or other forms of intimate partner violence?
Are contraceptive services made available as part of services for gender-based violence (where such a service exists)?
11.4 Are health facilities equipped with the personnel, physical space for counselling and educational materials appropriate for different levels of literacy and cultural diversity?
11.5 Do health facilities provide an enabling environment for disclosure and discussion by clients experiencing intimate partner violence and/or reproductive coercion? For example,posters in public spaces such as waiting rooms, examination rooms, hallways)
Referrals to domestic violence services
Screening for reproductive coercion or intimate partner violence is standard procedure prior to discussion of reproductive intentions and contraceptive options.

reported from some countries - constitutes a violation of women's reproductive rights.

WHO Recommendation 3.9:

Recommend elimination of third-party authorization requirements, including spousal authorization for individuals/women accessing contraceptive and related information and services

WHO Recommendation 3.10:

Recommend provision of sexual and reproductive health services, including contraceptive services, for adolescents without mandatory parental and guardian authorization/ notification, in order to meet the educational and service needs of adolescents

In many countries, service providers ask for authorization from the spouse, usually the husband, for providing family planning services. This requirement may be found in the laws, or regulations of Ministries of Health/Family Planning or in the health facility guidelines.[95] At times, even after the laws and regulations have changed, health providers may continue the practice because of their own beliefs that a woman's reproductive choices have to be approved by her husband.

The practice of requiring women to obtain their husbands' authorisation in order to obtain contraceptive methods would be especially damaging to women experiencing forms of intimate partner violence that include "birth control sabotage" and/or "pregnancy coercion" which include not allowing a woman to use contraception or actively sabotaging her use of contraception.[96]

Spousal authorisation requirements are usually applied exclusively to women and as such, represent a violation of women's right to equality and non-discrimination. International Human Rights Treaty Bodies such as the CEDAW (Convention on the Elimination of All forms of Discrimination Against Women) have expressed concern over laws that mandate authorisation by the husband for the wife to obtain contraceptive methods such as sterilization, and recommended the removal of such restrictions.[97]

Third-party authorization is often mandatory for adolescents below 18 years who seek contraceptive services. Research studies show that making parental consent mandatory for providing contraceptive services to adolescents discourages contraceptive use, without necessarily altering adolescents' sexual behaviour. The consequence is an increase in the number of unwanted pregnancies.[98]

Contraceptive services, while encouraging adolescents to inform their parents, should not make parental involvement a precondition. For example in the UK, any 'competent' young person can consent to medical treatment. Young people over 16 years of age are presumed to be competent to give consent to medical treatment unless otherwise demonstrated. For young people under the age of 16 years, however, competence to consent is assessed. In addition, for contraceptive advice and provision, health providers are advised to use checklists such as Fraser Guidelines (Box 5).[99, 100]

The Convention on the Rights of the Child (CRC) explicitly recommends that states parties make available and accessible appropriate SRH services keeping in mind adolescents' best interests and taking into account the 'evolving capacities'[102] of adolescents to exercise autonomy and participate in decisions.[103, 104, 105, 106]

BOX 5

Assessing Competence
- Competence is demonstrated if the young person is able to:
- Understand the treatment, its purpose and nature, and why it is being proposed.
- Understand its benefits, risks and alternatives.
- Understand in broader terms what the consequences of the treatment will be.
- Retain the information long enough to use it and weigh it up in order to arrive at a decision.

Fraser Guidelines/criteria
- The young person understands the professional's advice.
- The young person cannot be persuaded to inform their parents.
- The young person is likely to begin, to continue having, sexual intercourse with or without contraceptive treatment.
- Unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer.
- The young person's best interest requires them receive contraceptive advice or treatment with or without parental consent.

Source: RCOG. Contraceptive choice for young people.London, Clincial Effectiveness Unit, Faculty of sexual and reproductive healthcare clinical guidance, Royal College of Obstetricians and Gynaecologists, 2010.[101]

Acceptability

WHO Recommendation 4.1:

Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that includes skill building (i.e. communications and negotiations) and that are tailored to meet communities' and individuals' specific needs.

There are two dimensions of acceptability at the service delivery level: medical and socio/cultural. Services should respect medical ethics; and they should be organized and delivered in a gender-sensitive manner and be tailored to the specific needs of the communities being served. The recommendations on informed decision-making and privacy and confidentiality address aspects of medical ethics and the focus here is on gender-sensitivity and meeting community-specific needs.

Acceptability implies that all sexual and reproductive health facilities, goods and services should be respectful of the needs of different population subgroups. Some examples include: having a staff member who is from the same language-speaking or ethnic group as minority or immigrant communities; using suitable media for disseminating information to a low-literacy population; providing sexual and reproductive health services to indigenous populations where and how they would feel comfortable; tailoring services to meet the specific needs of men.

The recommendation talks of "gender-sensitive" counselling, educational interventions and 'skill-building' for communication and negotiation. Gender-sensitivity implies acknowledging differences in needs between women and men because of biology as well as socially constructed gender-norms; and being aware of the ways in which gender-based inequalities between women and men constrain women's autonomy and choices.

In particular, gender-based norms about appropriate sexual and reproductive behaviour restrict women's knowledge about their bodies and their sense of entitlement to make reproductive decisions. Patriarchal society restricts women's sexuality and controls their reproduction, making reproductive autonomy beyond the reach of a majority of the world's women.

Women facing intimate partner violence may have several concerns that affect contraceptive use. Partner support for certain methods like condoms or vaginal diaphragm may not be available. They may not have adequate financial resources to pay for a particular service. Women may fear further violence for using or talking about contraception. Or intimate partner violence may cause disruptions in every-day life, which make it difficult to use methods such as oral contraceptive pills.

Gender-sensitive counseling will try to understand the underlying, often gendered, reasons why women are hesitant to make contraceptive decisions and encourage them to express their constraints and fears.[107] During counselling sessions, the specific needs of clients experiencing intimate partner violence, e.g. visibility of the method used, side effects or need for partner support - must be considered and providers must be able to offer contraceptive choices accordingly.[108]

Beyond gender-sensitive counselling, specific gender-responsive interventions may be needed such as workshops to help women develop skills for negotiating contraceptive use with their husbands, or interventions with men to encourage them to be better informed and to take responsibility for contraception.[109]

WHO Recommendation 4.2:

Recommend that follow-up services for management of contraceptive side-effects be prioritised as an essential component of all contraceptive service delivery.

CHECKLIST 12

12.1 Are there protocols for different levels of facilities and providers for follow-up visits, management of side-effects, switching of methods on request by the user, and referrals for contraceptive services?
12.2 Are clients provided with comprehensive information on potential side-effects of various contraceptives and what to do when side-effects are experienced?
12.3 Are providers trained in follow-up and referral procedures related to contraceptive services?
12.4 In practice, are clients given full information about when to come for a follow-up visit, the purpose of the visit and the procedures that will be carried out?
12.5 In practice, to service providers comply with clients' requests for removal of a method or for switching of methods?
12.6 In practice, do service providers facilitate access to contraceptive methods of the client's choice but not available at a give site? Do clients receive appropriate follow-up care for contraceptive side-effects at the same facility, or elsewhere without incurring additional expenditure?

Recommend that appropriate referrals for methods not available on site be offered and available.

Concern about side-effects is an important reason why women do not use a contraceptive method despite intending to postpone or stop childbearing. According to an analysis of Demographic and Health Survey data of all surveys carried out during 2000-2008 in South Asia and Sub-Saharan Africa, health concerns and fear of side effects was responsible for unmet need for contraception among 37% and 39% of women in South Asia and sub-Saharan Africa respectively.[110]

This shows the critical importance of follow-up services in contraceptive service delivery, for reviewing the client's health, for counseling to address any concerns, for managing any side effects and for removal of the method and switching to an appropriate alternative contraceptive method when the user so desires.

At the Programmatic level, a full range of appropriate methods for a particular facility is decided based on the level of facility, the skills of providers and legal requirements. The Programme has to plan for providing clients with easy access to methods that cannot be made available at lower levels of care. However, a rights- based contraceptive service should be able to provide a range of contraceptive methods that meet the varying needs of different clients, and this may be done through a number of ways. For example, specialist providers may be brought in on specific fixed days. Organizing mobile services to provide long-acting reversible methods on site is another option and has been discussed in an earlier section. If these are not feasible, the facility should make provisions for referral, and also transportation to reach the referral facility at no extra cost to the client and with minimum delay.[111]

Quality

WHO Recommendation 5.1:

Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes

WHO Recommendation 5.2:

Recommend that provision of long-acting reversible contraception (LARC) methods should include insertion and removal services, counselling on side-effects, in the same locality

WHO Recommendation 5.3:

Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.

Quality of care is a major determinant of contraceptive use in many developing country settings.[112] Within the context of contraceptive services, six elements of quality of care put forth by Judith Bruce (1990), has been in use for many decades: choice of methods; information given to clients; technical competence of providers; interpersonal relations; follow-up and continuity mechanisms; and appropriate constellation of services.[113] More recently, Germain (2013) outlined the following six action elements that are necessary to ensure that quality standards meet human rights norms, some of which are addressed by the WHO recommendations related to quality:

- "Widest possible range of choices among contraceptive methods
- Decent facilities equipment and commodities
- Training and supervision of service providers
- Essential package of integrated SRH services as agreed originally in the ICPD POA paragraph 7.6
- Outreach and communications
- Quality assurance mechanisms, monitoring, redress for individuals and mechanisms to remedy policy failures as well as to prevent and correct discrimination in access and other abuses".[114]

Quality assurance is "an organisation's guarantee that the product or service it offers meets the accepted quality standards. It is achieved by identifying what "quality" means in context; specifying methods by which its presence can be ensured; and specifying ways in which it can be measured to ensure conformance".[115] Quality assurance is a component of quality management, which involves putting in places processes and mechanisms that guarantee that products and services meet the defined quality standard.

A rights-based approach to quality of contraceptive services has at least two major components: one, the assurance of quality of medical standards of care, and two, responsiveness to client's expectations from contraceptive services. Assurance of the quality of medical care is usually done through supervision, clinical reviews and audits and through accreditation by quality assurance bodies such as the ISO. Some ways in which client feedback may be sought are suggestion boxes, formal review committees in which clients participate, and periodic client-exit interviews and studies on client perspectives. Box 6 provides clients' expectations from contraceptive services ascertained through a study.

BOX 6

- Women users' perceptions on what constituted good quality family planning services
- Clinic timings suitable to women's work schedule
- Short waiting times
- Feeling respected by providers
- Feeling that providers felt empathy for them
- Attentive listening by providers
- Attention to client comfort by providers
- Privacy during counselling, physical examination and procedures
- Assurance that providers will keep their personal information confidential
- Client's health need met/ health problem resolved

Source:Creel LC, Sass JV, Yinger NV. Client-centred quality: clients' perspectives and barriers to receiving care. New Perspectives on QOC. No. 2. New York, Population Council and Population Reference Bureau, 2002. At: <http://www.prb.org/pdf/NewPerspQoC-Clients.pdf>. Accessed on 19 November 2013.[117]

A key component of good quality contraceptive services, especially in the case of long-acting reversible methods, is the assurance to clients that should they decide on discontinuation of the method because of side-effects or for any other reason, the decision will be respected; and that removal services will be provided, if not in the same facility, then, within a reasonable distance at affordable costs without undue delay. For example, if clients want to discontinue using a medication or contraceptive method, staff would be required to discuss with them their reasons for wanting to discontinue; offer appropriate alternatives or provide support and information if they wish to become pregnant.

Technical competence of the provider is an important aspect of quality of care. Development and use of standard protocols for provision of contraceptive services constitutes an important component of high technical quality. Towards this, investment must be made to train providers of contraceptive services on the latest clinical guidelines which the World Health Organization publishes at regular intervals.[118]

Informed decision-making

WHO Recommendation 6.1:

Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.

CHECKLIST 13

13.1 Is a comprehensive strategy for Quality Assurance, including for contraceptive information and services, a component of the sexual and reproductive programme guidelines?
13.2 Have standards of quality care been elaborated for the provision of contraceptive services at different levels of care?
13.3 Is the budgetary allocation sufficient to assure adherence to the quality standards?
13.4 Are there processes in place for regular audits and monitoring of quality of contraceptive services?
13.5 Are there processes and mechanisms in place at the district level and at facility levels to obtain client feedback on the quality of contraceptive services? Are there examples of incorporating results of the feedback for modifying/improving service provision?
13.6 Do protocols for service provision explicitly mention client's right to request removal of long acting contraceptives such as the IUCD and implants?
13.7 Is there a system of regularly updating providers' knowledge and clinical skills about contraceptive methods?
13.8 In practice, does the quality of contraceptive care in health facilities satisfy human rights norms as specified by Germain (2013). Do they satisfy the quality criteria from women users' perspectives as mentioned in Box 7.

WHO Recommendation 6.2:

Recommend every individual is ensured an opportunity to make an informed choice for their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination

Client autonomy and informed decision-making are key characteristics components of a rights respecting contraceptive service. 'Informed decision-making' in contraception means that the client makes a decision considering all the circumstances of his/her life, after hearing all the information related to a wide range of contraceptive options. It also means that if the client receives all relevant information and decides not to use any contraceptive method, this is still a successful outcome.[119, 120]

For "informed" decision-making, clients should receive at least the following information on each available method of contraception:

- Benefits and risks, including protection offered for prevention of STIs/HIV/AIDS taking into account the specific circumstances of the individual
- Conditions that would make the contraceptive inadvisable to use
- Common side effects.[121]

Some ways in which informed decision-making may be facilitated within contraceptive information and services are mentioned in Box 7 below:

Privacy and confidentiality

WHO recommendation 7.1:

Recommend that privacy of individuals is respected

BOX 7. FACILITATING INFORMED DECISION-MAKING AMONG USERS OF CONTRACEPTIVE SERVICes

- Contraceptive information services are not a one-off activity. One example of an empowering information strategy is the 'Smart Patient' initiative in Indonesia, which provided contraceptive information to women and men in community-based outreach programmes so that they could think through the pros and cons of different methods, discuss it with others and make an informed choice[122].
- Multiple modes and sites of information delivery are important to ensure coverage of diverse audience. One size does not fit all.
- Because they have not been traditionally encouraged to take decisions, women may often request the health provider to take a decision on their behalf. Rather than try to 'fix' the problem for them, providers would be helping the woman most when they help her assess her choices and make an informed decision.
- In settings where couples are jointly counselled for family planning, providers need to be conscious of the unequal power relations between the man and the woman, and ensure that men do not control the decision-making process. The following scenarios are some examples of men's control of decision-making in a joint-counselling session: the husband responds for many questions asked of the woman; frequently interrupts her or contradicts her when she is speaking; or the woman remains silent and lets her husband do all the talking on her behalf. If this happens, then joint counselling may not be a good approach.
- Providers should not allow their own assumptions, beliefs and moral values come in the way of giving information to all clients on all methods of contraception. For example, providers may refuse to provide emergency contraceptives because of the belief that it causes abortion. Patriarchal values related to appropriate sexual behaviour may prompt providers to deny information on contraception to adolescents and young people and all single persons. Clients may not be given information on non-reversible methods of contraception such as surgical sterilization because the provider thinks that s/he has not yet completed family size.

CHECKLIST 14

14.1 Do any programme Guidelines and/or G.Os/ government documents specify that informed consent be obtained from any client receiving contraceptive services?
14.2 Do guidelines and protocols for counselling and service provision elaborate on elements of and processes for informed decision-making on contraception?
14.3 Are providers aware of and trained to facilitate informed decision-making, especially among the less empowered and marginalised groups? Do they know that adolescents may be assessed for their competence for informed decision-making and informed consent? Are they aware of criteria for assessing such competence?
14.4 Do providers have the resources necessary to ensure informed contraceptive decision-making by clients?
14.5 In practice, do all clients receive essential information on all contraceptive methods available (in that country/ region)? (i.e.Benefits and risks including protection offered for prevention of STIs/HIV/AIDS; conditions that would make the contraceptive inadvisable to use; common side effects[123])
14.6 In practice, do providers facilitate informed decision-making by clients, especially those from marginalised groups and adolescents? (See Box 8. For various forms of facilitation. Is one or more of these done by the service provider?)

throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information

Privacy is "the right and power to control the information (about oneself) that others possess".[124] Privacy also commonly refers to respecting the rights of individuals not to be physically exposed against their will. Confidentiality is "the duty of those who receive private information not to disclose it without the patient's consent".[125]

Confidentiality is the mechanism through which the provider protects the client's right to privacy.[126]

Upholding the client's privacy and maintaining confidentiality is important in all areas of health care. It is especially critical when providing sexual and reproductive health services. Failure to do so may result in loss of client trust on the services. While in many settings extended families and spouses may be considered to have the 'right' to know about a client's contraceptive decisions, providers must always make efforts to uphold an individual client's privacy unless the client specifically indicates a desire to include others in the decision making (in which case it must be respected and provided for). Likewise, irrespective of the cultural context, young people have a right to privacy and confidentiality when seeking sexual and reproductive health services. Box 8 below summarises some ways in which client privacy and confidentiality may be upheld in a health facility:[127]

BOX 8. SOME WAYS OF ENSURING PRIVACY AND CONFIDENTIALITY IN A HEALTH CARE SETTING

Visual Privacy
- partitioning space with curtains or blinds;
- closing doors and drawing curtains when the provider is interacting with a client or when the client is dressing or undressing;
- ensuring that examination couches face away from windows and doors;
- putting up signs on doors of counselling and examination areas on not to disturb when a patient is in;
- ensuring that colleagues do not walk in and out of counselling and examination areas.

Auditory Privacy
- speaking softly;
- keeping doors closed;
- not speaking to a client in a public area where one can be overheard;
- ensuring that colleagues do not walk in and out of counselling and examination areas, and that
- other clients are not seated where they can hear the interaction[128]
- Confidentiality
- Some ways in which confidentiality may be ensured are:
- Making medical records anonymous; and keeping them in a secure place, preferably locked up;
- staff providing SRH services should not discuss the details of the health problem in a public space even with the concerned client;
- staff providing SRH services should not share client information with persons from the community, for example, for reasons such as follow-up of a defaulting client.
- No member of the service delivery team, including support staff may be allowed to be present during client provider interactions or discussions between providers about a client.
- Information regarding the client should not be discussed / shared with his/her partner or a family member without his/her express consent.
- Partner or family members should be invited to participate in the counselling / examination sessions only with the client's permission.[129]

Participation

WHO recommendation 8.1:

Recommend that communities, particularly people directly affected, have an opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring

Participation by different stakeholders, especially those who are less powerful and have scarce resources, is an important tenet of a human rights-based programme. One of the most common mechanisms for community or users' participation in health programmes is committees: health centre or clinic committees, facility health committees; village health committees.

A systematic review of studies evaluating the role of such committees reports some measure of success in enhancing service accountability. Key factors that influenced the success of health committees were: how committee and group members were selected and their motivation for involvement; whether they received adequate support in terms of financial and technical resources for effective participation; and the extent to which they received co-operation from health workers and health managers.[130]

The extent to which community-participation mechanisms address contraception-related concerns and give voice to gender-specific needs and needs of marginalized groups is not clear from the literature. Because of power hierarchies and social stratification within communities, community-based structures may exclude women and those from less powerful groups, and as representatives of patriarchal values, oppose contraception and SRH services.[131] Another challenge would be that duty-bearers such as policy makers, health managers and health care providers may not always see the need for or value of consulting with users of services.

Measures such as fixing specific quotas for the inclusion of women and those from marginalized groups and building their skills for meaningful participation through capacity-building initiatives; as well as enhancing duty-bearers' knowledge and skills to encourage and engage with community-participation mechanisms may be useful in ensuring that participation actually happens in practice.[132]

Stronger Voices for Reproductive Health' is a Project in Geita District of Tanzania that aimed to build capacity of women to be informed and empowered users of sexual and reproductive health services. The project implemented a series of seven capacity-building workshops for women on sexual and reproductive health and rights. The Project worked not only with women rights-holders, but also with duty-bearers, consisting of local government representatives and health care providers. This was considered to be important for ensuring an informed response to the rights claimants by duty-bearers. During the project period of about five years, the proportion of service providers who were aware of clients' rights to privacy increased from 22% to 80%. Proportion of women engaging in discussions with health care providers to improve quality of care increased from 3% to 20% during the project period.[133]

Accountability

WHO Recommendation 9.1:

Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.

WHO Recommendation 9.2:

Recommend that evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur.

Recommend that, in settings where performance-based financing (PBF occurs), a system of checks and balances should be in place, including assurance of non-coercion and protection of human rights. If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability.

Accountability may be defined as the "obligation of power-holders to take responsibility for their actions... towards citizens who have the right to demand".[134]The concept of accountability combines three elements: keeping track of what is happening where and to whom, and what is not happening; reviewing progress against objectives, targets and bench-marks, noting differentials in progress across population groups and reflecting on barriers and facilitators for progress; and action to improve performance and provide redress to those who have been ill-served by a programme. Accountability mechanisms exist at various levels, from the international to local.

At the international level, Governments that have ratified various treaties[135] supporting reproductive rights including the right to information and services related to contraception are obligated to submit regular, periodic reports to the committee which monitors compliance of states with the treaty's obligations. This is an

accountability mechanism at the international level. The committees use these reports to engage in a constructive dialogue with representatives of the State party and then issue concluding observations, which commend the positive aspects but also raise concerns and make recommendations for further action. NGOs may hold their governments accountable by preparing and submitting a "shadow report" to the same treaty monitoring body which addresses omissions, deficiencies, or inaccuracies in the official government reports.

Accountability mechanisms at the national and sub-national levels may include Human Rights Commissions, professional disciplinary proceedings, Annual Health or Health-Condition Specific Reviews produced by the government, and so on. In China, for example, provincial governors regularly report progress on maternal mortality; and funding is dependent on progress.[136]

Civil society actors have participated in holding governments accountable through 'social accountability' mechanisms. Budget tracking is one such activity. The amount that a government allocated in its budget for a particular programme may be seen as an indicator of its real priorities, no matter what its policy documents proclaim. Another example is the publication of 'Report Cards' of government performance. For example in Bogotá, Colombia, the annual Report Card entitled "How are we doing in Health?' measures yearly changes in coverage, quality and public perceptions of health services. Two types of data are collected. The first is statistical data on health systems coverage and health status indicators such as maternal mortality ratio. The second is a survey among citizens which measures citizens' satisfaction with the quality of health services on a scale of 1 (worst) to 5 (best). The survey has been implemented since 1998[137].It would be important to produce such Report Cards on sexual and reproductive health and rights, including contraceptive information and services.
No matter what the manner of tracking progress is, one important consideration is that the indicators used are "human-rights-based". This would mean, for example, that we track not only end-results such as contraceptive prevalence rates, but also processes that ascertain that human rights were upheld or at the least, not violated, in the course of achieving these results.[138]

In a human rights framework, accountability combines elements of responsiveness, answerability and redress. Formal redress procedures in the health sector are intended to rectify something that has gone wrong, and consist of "official venues in which individuals can present their understanding of their entitlements, receive an attentive hearing, and be given an explanation or compensation."[139] National Human Rights Commissions and Offices of Ombudsmen are some examples of remedial and redress mechanisms at the country level. Where "Right to Health' as elaborated in international human rights treaties has been incorporated into domestic laws, courts of law within a country would be an effective mechanism of remedy and redress. At the international level, the CEDAW Committee oversees complaints procedures including for the violation of reproductive rights of a woman. Any woman who is not satisfied with redress provided within her own country may approach the CEDAW Committee with her complaint. The CEDAW Committee has a good track record of redress for the violation of reproductive rights.[140]

The emergence of Performance-Based-Financing (PBF) raises some concern from a human rights perspective. PBF is a national tool for improving utilization and provision of health care services "based on financial or in-kind rewards made to providers, payers or consumers after measurable actions have been taken".[141] Examples include Conditional-Cash Transfers (CCTs) to clients; and incentives paid to providers for meeting targets. Evidence on the effects of PBF suggests that there are many down-sides to the approach, including a focus on quantity rather than quality of services; and increase in inequity by rewarding users, providers and facilities that are better able to meet conditionality or targets set by the programme.[142] Both these are in conflict with a human-rights-based approach.

CHECKLIST 15

15.1 Do guidelines and protocols for contraceptive information and services elaborate on how to ensure privacy and confidentiality of the client seeking contraceptive services, including for young people?
15.2 Are norms related to space requirements of health facilities developed keeping in mind the need for visual and auditory privacy?
15.3 Are adequate infrastructural facilities available in health facilities to ensure privacy and confidentiality of all clients?
15.4 Are separate waiting, counselling and examination spaces available for men? For adolescents and young people?
15.5 Are providers aware of the importance of ensuring privacy and confidentiality?
15.6 In practice, are norms related to privacy and confidentiality adhered to by health care providers? (See Box 9 for basic indicators of privacy and confidentiality)
15.7 Are clients comfortable with the privacy and confidentiality aspects of contraceptive information and service provision? Are assessments of client comfort with privacy and confidentiality carried out at regular intervals?

CHECKLIST 16

16.1 Does the SRH policy/programme guidelines specify the creation of mechanisms for regular participation and consultation of community members and service-users?
16.2 If mechanisms for participation exist, what proportion of the members of these groups are women? Members of marginalized groups? Are there specific sub-groups that are systematically absent from the membership of such mechanisms?
16.3 In practice, what proportion of participatory mechanisms are functional (i.e. conduct regular meetings? Maintain meeting records? Have records of action taken on the decisions made at a previous meeting?
16.4 In practice, what proportion of women members and members of marginalized groups actually attend meetings of the participatory mechanisms? Which population sub-groups are absent?
16.5 In practice, what proportion of women members and members of marginalized groups speak up in meetings (as evidenced in meeting minutes) of the participatory mechanisms? Which population sub-groups remain silent?

CHECKLIST 17

17.1 Does the government submit regular reports to Human Rights Treaty Bodies on how it has acted to fulfil reproductive rights supported by the treaties that it has ratified? What proportion of the drafting committee consists of civil society actors? SRH advocates?
17.2 Are sexual and reproductive rights supported by international human rights treaties incorporated into domestic laws? Identify examples of domestic laws that may violate SRR supported by treaties that the government has ratified.
17.3 What are the various grievance redress mechanisms available to users of SRH services at the a) National and provincial/state levels? b) At the district level? c) At the facility level? Which of these mechanisms (if any) have legal backing?
17.4 In the past year, have the local grievance redress mechanisms received any complaints related to the provision of contraceptive information and services? What proportion of these complaints has been addressed? What proportion has been resolved?
17.5 What proportion of complaints received/addressed/resolved by grievance redress mechanisms are from members of marginalized groups?
17.6 In practice, at the facility/district levels, are there special officers/ volunteers who help clients with grievances to approach the appropriate grievance redress mechanisms?
17.7 Are any of the indicators used by the government for tracking progress in sexual and reproductive health, including in contraception, 'rights-based'?
17.8 Has Performance-Based-Financing been adopted in sexual and reproductive health services? Are there studies on the equity impact of these? Is any marginalized group disadvantaged as a result of the PBF?

Beyond WHO recommendations: Protecting and upholding the rights of service providers

Rights-based contraceptive information and services depend on the extent to which providers and the service delivery team as a whole are equipped and supported by the health system to do so. We therefore outline some essential dimensions of upholding the rights of contraceptive service providers, although recommendations contained in the WHO Guidance document do not address this issue explicitly.

Non-discrimination and affirmative action

If health care providers are to imbibe rights-based and gender-sensitive responsive values, then these same values must be reflected in various domains of health providers' work-environment including in recruitment, working conditions, work-place safety and security. For example, recruitment of health providers must be such that the work force represents the diversity of the community it serves in terms of gender, race, religion, caste etc. This may require specific affirmative action policies and long term investment in education and training of persons from marginalized groups.

Health workers must be protected from discrimination based on caste, race, religion, gender or sexual orientation. There should be a clear policy on zero-tolerance for discriminatory behaviour, and redress mechanisms for violation of such a policy. The management should signal its commitment to equality and non-discrimination in word as well as in deed.

Workplace safety and security

Health care workers are exposed to a number of health and safety hazards in their workplace on an everyday basis. A worker health and safety policy is essential for the health sector, which addresses hazards faced by all levels of health workers, especially those working in outreach and community services.

Violence in the workplace is an important concern. It is estimated that about 25% of all work place violence takes place in the health sector. Since a large majority of the health work force consists of women, a large number of

victims of violence are women.[143] Studies show that this violence may be gender based too.[144] Hate crimes based on homophobia, racism and other prejudices also pose risks.

Capacity-building for human-rights based and gender-responsive approaches to service delivery

Pre-service training of health professionals does not equip health care providers adequately in human rights, culturally sensitive or gender responsive approaches. A survey in Nicaragua and El Salvador among 183 medical and nursing students found that only 37% felt confidence in their ability to identify human rights violations in the delivery of health care services; 40% said they would be able to take action if rights violations occurred and 33% reported that they would be able to advocate for their rights as health care providers to supervisors.[145]

Early innovations offer some potential models for in-service training of reproductive health care/family planning service providers on human rights. For example, experiences from pilot interventions in Nicaragua and El Salvador to build capacity of doctors and nurses on human rights issues in sexual and reproductive health care suggest that human rights training should focus on developing problem-solving skills which build provider-capacity to identify and act on human rights and ethical dilemmas in real-world settings, e.g. through services audit or critiquing video-taped service delivery scenarios.[146]

Enabling Community Health Workers (CHW)

In many developing countries, a large cadre of women community workers are recruited to provide community-based SRH services, especially contraceptive information and distribution. Enabling them to adopt a human-rights-based approach poses some specific challenges.

There are no standard guidelines for how CHWs may be identified and recruited. Experience from several countries across the world has demonstrated that in order to be effective, CHWs must be recruited from the communities that they will be serving.[147] In hierarchical societies, 'community-selection' may not be a good option and caste/ethnic/race based biases in the community may play out in CHW selection, and a member of a dominant social group may be recruited.

Once CHWs are recruited, their training is an essential element and has to be more than cursory. In addition to knowledge inputs, training should include a focus on human rights and the value of social justice and gender equity.[148, 149] This is because many of them would have internalised the dominant cultural values and norms in the community that are not supportive of equity (e.g. caste or ethnicity based discrimination, elitism) and will need to unlearn these.

CHWs encounter high safety and security risks. When they take-up human rights issues, CHWs face backlash both from vested interests and from within the community[150, 151] Often, cultural norms work at cross purposes with values of human rights and equity. Community Health Workers who belong to the local community face the additional burden of maintaining their place within the community when they go against culture and traditions to uphold human rights values.

Community based health workers, like any other staff of the health system, need support in the form of supportive personnel policies, training, supportive supervision, and access to supplies and equipment. But they do not always receive these because there is no clarity on whether she is a representative of the community or is a worker of the health system. The lack of clarity on the CHW's role also results in poor and unfair compensation of the CHW's time and efforts. She is often recruited as a 'volunteer' and if paid at all, only given ad hoc payments for specific tasks done. This situation needs to be reviewed and reconsidered as a matter of workers' rights.

CHAPTER 3
AN ILLUSTRATIVE LIST OF INDICATORS

The previous sections gave detailed checklists to review compliance with or implementation of WHO's recommendations for ensuring human rights in the provision of contraceptive information and services. In this section we have short-listed a sample of indicators evolved from the checklist that may be used for monitoring or tracking a government's performance in this regard. This is merely an illustrative list. The development of an agreed set of indicators for monitoring is a consensus-building process involving all stakeholders, and has to be undertaken in different settings taking into account the specificities of the setting.

Sample list of indicators evolved from WHO recommendations for monitoring respect for human rights in contraceptive information and services

Non-discrimination

1. Gender equality and women's empowerment are explicit objectives of the SRH programme. Yes/No
2. Proportion of users who report using a contraceptive method of their choice
3. Number of reports in the media in the past year of any coercion in the provision of contraceptive services, and numbers of persons affected (if available)
4. Data on contraceptive prevalence rates are available, disaggregated
   a) By sex Yes/No
   b) By age, including adolescence Yes/No
   c) By rural-urban location Yes/No
   d) By income/wealth Yes/No
   e) By any other axes of vulnerability (specify) Yes/No

Availability

5. National Essential Drugs List includes the full range of contraceptive methods including emergency contraception. Yes/No
6. Proportion of ever-users (women age 15-44 years) reporting discontinuation of contraception because of disruption in supply
7. Proportion of never-users (women age 15-44 years) reporting non-use because of non-availability of contraceptives

Accessibility

8. A comprehensive sexuality-education programme is in place. Yes/No
   If yes,
   a) Does it address rights, stigma and/or discrimination? Yes/No
   b) Is it sex-positive? Yes/No
   c) Does it talk about diverse sexual and gender identities? Yes/No
9. Proportion of young people (10-24 years) covered by a comprehensive sexuality education programme.
10. Contraceptive services are available free at the point of delivery to all sexually active individuals including adolescents and young people, irrespective of marital status. Yes/No
11. Proportion of women age 15-44 years covered by contraceptive information and services within their communities.
12. The country (or province/state)'s laws/regulations related to safe abortion services adhere to international Human Rights Law. Yes/No
13. Unsafe abortion ratio[152]
14. The protocol for medico-legal services to survivors of sexual violence includes the provision of emergency contraception. Yes/No
15. Proportion of medico-legal cases of sexual violence in women which were administered emergency contraception.
16. Guidelines for HIV services include the provision of contraceptive services as part of the counselling and service delivery protocol. Yes/No
17. Proportion of women living with HIV of reproductive age who are users of contraception.
18. Proportion of women living with HIV reporting an unwanted pregnancy (or seeking termination of pregnancy).
19. Women are required to obtain their husbands' authorisation for use of one or more methods of contraception. Yes/No
20. Adolescents require parental or guardian's authorisation for accessing any SRH service, including contraceptive information and/or services. Yes/No

Acceptability

21. Protocols for service provision explicitly require providers to
    a) Give complete information of a comprehensive range of contraceptive methods including on benefits and risks including protection offered for STIs/HIV; contra-indications and common (affecting 10% or more of users) side effects. Yes/No
    b) Refer clients for obtaining contraceptive methods not available in a given facility. Yes/No
    c) Manage side-effects of contraception at no additional costs to the client. Yes/No
    d) Act on clients' demand for removal of a long-acting reversible method of contraception such as the IUCD or the implant. Yes/No
22. Proportion of clients satisfied with the privacy and confidentiality offered in contraceptive information and service delivery settings.

Informed decision-making

23. Contraceptive programme guidelines specifically highlight that clients have the final say in whether, when and which method of contraception to use. Yes/No
24. Proportion of current users of contraceptive users reporting that they were
    a) informed about
    b) the side effects of the method used
    c) what to do if side effects were experienced
    d) other methods that could be used for contraception
25. Proportion of women currently sterilised who were informed that they would not be able to have any more children

Participation

26. SRH policy or programme guidelines outline the creation of mechanisms for users' participation in contraceptive programmes. Yes/No. If yes,

    Mention is made of specific quotas for the membership of women and for other marginalised groups in the mechanisms of participation. Yes/No

Accountability

27. Sexual and reproductive rights supported by international human rights treaties are incorporated into domestic laws. Yes/No(If yes, specify which treaties and which laws)
28. There are domestic laws and/or regulations that violate sexual and reproductive rights supported by treaties that the government has ratified. Yes/No(If yes, specify which treaties and which laws)
29. There is a national or sub-national Accountability Mechanism with legal backing for protection of sexual and reproductive rights (e.g. Human Rights Commission, Ombudsman's Office etc). Yes/No
    a) If yes, proportion of complaints related to the provision of contraceptive information and services received.
    b) Proportion of these complaints that have been resolved.

ANNEX-1 GATHERING INFORMATION TO ANSWER QUESTIONS IN THE CHECKLIST: AN ILLUSTRATIVE EXAMPLE.

Answering the questions included in the checklists, in order to assess whether or not a WHO recommendation has been implemented may require gathering information from multiple and diverse sources. This would include looking at policy documents and data sources, talking to key informants or even gathering primary data on a limited scale. The following table containing illustrates potential ways in which questions in Checklist 2 may be answered.

Question	**Data sources**
2.1. Is the contraceptive information and services programme labelled as a "family planning" or a "family welfare" programme?	The name of the programme should give the answer. To call it family planning or family welfare would indicate exclusion, for example, of young unmarried people, others who are currently single, sex workers and so on.
2.2. Is the programme a part of the maternal and child health programme?	This is also usually indicated in the name (MCH/FP). If not, document describing the maternal and child health programme will be able to give the details. The main concern is that MCH programmes do not generally include services for men and hence a combined MCH/FP programme would tend to exclude men.
2.3. Are gender-equality and women's empowerment explicit objectives of the programme?	Information would be available from the official document about the programme, usually found on the website of the Ministry of Health. If the objectives do not mention these, it may be useful to check whether the targets or goals include gender equality or women's empowerment.
2.4. Do programme objectives explicitly mention attention to the needs of adolescents and young people? To men?	Information would be available from the official document about the programme, usually found on the website of the Ministry of Health. If the objectives do not mention these, it may be useful to check whether the targets or goals include adolescents, young people or men.

2.6. Are data available on who the excluded and marginalised groups are; their sexual and reproductive health needs; and barriers encountered by them in accessing contraceptive information and services? How large or small are the gaps in information? Which groups have been left out?	Obtaining information on this will be a complex task requiring a review of available information on contraceptive use, from official sources such as annual reports of government; from large scale surveys such as national, provincial and district health surveys and the Demographic and Health Survey data for national and provincial levels; and smaller studies. What we want to know is whether data are available by ethnicity/ race/caste; other minority groups and vulnerable groups such as migrants, people with disabilities, sex workers, PLHIV and so on, both on coverage by services and barriers to access.
2.7. Have resources been invested in data collection and research to obtain such data (as specified in 2.6?)	This again, will require looking for information on whether there are any specific projects that address data gaps in sexual and reproductive health including contraception about the situation of vulnerable groups; if yes, which groups are being addressed by the project and so on. For example, has there been an attempt to include persons with disabilities as a category for disaggregation of data on contraceptive prevalence? Or has there a special survey on the reproductive health needs - including contraception – of sex workers or persons living with HIV?
2.8. In practice, are contraceptive information and services available to all sexually active persons irrespective of age, marital status or sexual orientation (e.g. single women; all men; adolescents and young people; sex workers, PLHIV)?	There are two ways in which one may be able to gather information on this. One is to review all data and research which address one or more parts of this question. The second is to engage in a primary data collection process in one's own district or sub-district. Data may be gathered through qualitative interviews with health service providers working at different levels about who their clientele for contraception is, specifically probing for whether they have ever provided services to single women; PLHIV etc. and specifically probing as to what they think should be the policy towards providing services to all groups; and why.

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