

# Ensuring human rights within contraceptive service delivery: implementation guide



World Health  
Organization



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# Acronyms

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AAAQ	available, accessible, acceptable and of good quality
ANM	auxiliary nurse midwives
CBD	community-based distributors
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHW	community health workers
CSE	comprehensive sexuality education
CSO	civil society organization
EC	emergency contraception
FP	family planning
HFAC-SL	Health For All Coalition Sierra Leone
ICPD	International Conference on Population and Development
IPV	intimate partner violence
IUD	intrauterine device
LAPM	long-acting and permanent methods
LARC	long-acting reversible contraception
LMIS	logistics management information system
LPR	law, policy, protocol and guideline review
M&E	monitoring and evaluation/accountability
MOHSW	Ministry of Health and Social Welfare
MP	meaningful participation
NA	needs assessment
NGO	non-governmental organization
PBF	performance-based financing
RH	reproductive health
RHCLMIS	reproductive health commodities logistics management information system
SRH	sexual and reproductive health
STI	sexually transmitted infection
SV	sexual violence
TMC	Teenage Mothers Clubs
TR	training and supervision of health workers and others involved in the provision of contraceptive information and services
UNFPA	United Nations Population Fund
VAW	violence against women
VPE	volunteer peer educators
WHO	World Health Organization
YFRC	youth-friendly resource centres

# Foreword

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We are pleased to share with you this joint WHO and UNFPA publication on *Ensuring Human Rights within Contraceptive Service Delivery: Implementation Guide*.

This guide brings together the framework and recommendations from WHO's guidelines *Ensuring Human Rights in the Provision of Contraceptive Information and Services*, and of *Choices not Chance: UNFPA's Family Planning Strategy 2012–2020*. Additionally the guide has benefited from broad review, and input from a variety of experts.

Access to contraceptive services and information is a human right, central to gender equality and women's empowerment, and is a key factor in reduction of poverty and enhancement of development. The lives and well-being of millions of women and adolescent girls depend on whether they have what they need to exercise choice about when to have children, how many to have, and at what intervals. Access to the appropriate information and services, including to contraceptive choices, is also one of the most powerful ways to enable girls to remain in education, and thus achieve their fullest potential. In other words, sexual and reproductive health and well-being is a cornerstone of sustainable human development.

Unprecedented momentum has been galvanized globally to make contraceptives available to all, including to about 225 million women who want to avoid a pregnancy but are not using an effective

contraceptive method. However, improving health outcomes requires more than the provision of contraceptive services alone. Health and human rights considerations require governments to ensure human rights in the context of service provision — including the human rights of all who seek and/or use contraceptive information and services. Yet, many women and girls still are not able to access and or freely use quality contraceptives. Governments have binding obligations to make contraceptive information and services available to all. This is particularly important with regards to adolescent girls and such efforts should be set within the context of a broader effort to end gender discrimination and promote gender equality.

Unwavering commitment to health and human rights principles can be effectively operationalized by providing appropriate operational tools and 'how-to' guidance to explain how best to put human rights principles and standards into practice. This guide is designed to do just that. It outlines for health programme planners, managers and providers the key considerations and practical action steps for planning and programming of rights-based contraceptive services.

We trust this guide will prove to be a real asset to all who are working to ensure contraceptive information and services are rights-based and uphold the dignity of all who access them.

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# Introduction

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It is now well recognized that expanding access to contraceptive services and improving health outcomes require services to be delivered in ways that respect, protect and fulfil the human rights of everyone who seeks, or uses contraceptive information and services.

WHO is committed to the mainstreaming of gender, equity and human rights, and also works to develop evidence-based norms, standards and tools for scaling up equitable access to quality care services within a rights- and gender-based framework. In 2014, to help guide its Member States, WHO published guidelines on *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. Developed according to WHO standards for guideline development, these guidelines provide 24 recommendations, grouped under nine headings that reflect human rights principles and standards, and their health and human rights rationales, based on available evidence. The guidelines do not provide details about implementation of the recommendations.

This implementation guide for ensuring human rights within contraceptive service delivery is a companion document to the WHO guidelines. This implementation guide sets out core minimum actions that can be taken at different levels of the health system, and provides examples of implementation of the recommendations in the WHO guidelines. This implementation guide was developed using a rigorous methodology which included: identification of key considerations and action points for each of the WHO guidelines based on assessment and synthesis of evidence. An expert working group from UNFPA and WHO was identified, including country-level programming experts, to review and give inputs related to key considerations and key actions. Human rights and gender equality principles were systematically incorporated in the development of this guide.

UNFPA supports the integration and achievement of human rights standards in all aspects of its

programming work, and has produced a number of publications to help explain its approach. A guide and training package on human rights-based approach to programming entitled *A Human Rights-based Approach to Programming: Practical Implementation Manual and Training Materials* developed in 2010 provides UNFPA country offices and implementing partners with step-by-step guidance on how to apply a culturally sensitive, gender-responsive, human rights-based approach to programming in each of UNFPA's three core areas of work: sexual and reproductive health, gender, and population and development. The 2012 State of the World Population report, for example, lays out the UNFPA Family Planning Strategy 2012–2020, which states, "All policies, services, information and communications must meet human rights standards for voluntary use of contraception and quality of care in service delivery." At the same time, UNFPA's Strategy on Adolescents and Youth: Towards Realizing the Full Potential of Adolescents and Youth, represents the organization's strong and unequivocal commitment to the human rights of young people. Furthermore, UNFPA's commitment to gender equality, central to its Strategic Plan 2014–2017, places the promotion of women's rights at the heart of UNFPA's policies and programmes and as such requires integration of gender and human rights across all of the Fund's activities.

Under force of its Strategic Plan and consistent with its policy framework, UNFPA has elaborated the concrete actions it takes — in partnership with others — to assist countries achieve human rights-based and gender-responsive family planning services. Key actions are set out in this implementation guide.

## Who this document is for

This document is addressed to midlevel policymakers and programme managers/implementers involved with family planning service provision in all settings.

# Human rights standards for contraceptive information and service delivery

The interlinked human rights standards and principles set out in the WHO guidelines *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations* form a unified whole as follows:

## 1. Non-discrimination

The human rights principle of non-discrimination obliges States to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation [1]. This obligation in connection with the right to health means countries are to ensure the availability, accessibility, acceptability and quality of services **without discrimination**.

## 2. Availability of contraceptive information and services

Functioning health and health-care facilities, goods and services, as well as programmes, have to be **available** in sufficient quantity within the State [2]. The characteristics of the facilities, goods and services will vary depending on numerous factors, including the State's developmental level. Countries must, however, address the underlying determinants of health, such as provision of safe and potable drinking water, adequate sanitation facilities, health-related education, hospitals, clinics and other health-related buildings, and ensure that trained medical and professional personnel are receiving domestically competitive salaries. As part of this core obligation, countries should ensure that the commodities listed in national formularies are based on the *WHO Model List of Essential Medicines*, which guides the procurement and supply of medicines in the public sector [2]. A wide range of contraceptive methods, including emergency contraception, is included in the WHO core list of essential medicines [3].

## 3. Accessibility of contraceptive information and services

Under international human rights law, countries are also required to ensure that health-care facilities, commodities and services are **accessible** to everyone. This includes physical and economic accessibility, as well as access to information [2]. Human rights bodies have called on countries to eliminate the barriers people face in accessing health services, such as high fees for services, the requirement for authorization by spouse, parent/guardian or hospital authorities, distance from health-care facilities, and the absence of convenient and affordable public transport [4].

## 4. Acceptability of contraceptive information and services

All provision of health-care facilities, commodities and services must be acceptable to those who are their intended beneficiaries. They must be provided in a manner respectful of medical ethics and of the culture of individuals, minorities, peoples and communities; sensitive to gender and to life cycle requirements; must be designed to respect confidentiality, and improve the health status of those concerned [ 2]. Countries should place a gender perspective at the centre of all policies, programmes and services affecting women's health, and should involve women in the planning, implementation and monitoring of such policies, programmes and services.

## 5. Quality of contraceptive information and services

Fulfilment of human rights requires that health-care facilities, commodities and services be of good **quality**, including scientifically and medically appropriate. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation [2].

## 6. Informed decision-making

Respect for individual dignity and for the physical and mental integrity of each and every person using a health facility means also providing each person the opportunity to make reproductive choices autonomously [4,5]. The principle of autonomy, expressed through **free, prior, full and informed decision-making**, is a central theme in medical ethics, and is embodied in human rights law [6]. People should be able to exercise their contraception choice from across a range of options but also be free to refuse any and all options. In order to make an informed decision about their preference in respect to safe and reliable contraceptive measures, comprehensive information, counselling and support should be made accessible for all people without discrimination, including young people, persons living with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people [7].

## 7. Privacy and confidentiality

The right to privacy means that as and when an individual accessing health information and services, they should not be subject to interference with their privacy, and they should enjoy legal protection in this respect [8]. Sexual and reproductive health involves many sensitive issues that are not widely discussed within families or communities, and health workers are often entrusted with very personal information by their patients. Confidentiality, which implies the duty of providers to not disclose or to keep private the medical information they receive from patients and to protect an individual's privacy, has an important role to play in sexual and reproductive health.

## 8. Participation

Under international human rights law, countries have an obligation to ensure active, informed **participation** of individuals in decision-making that affects them, including on matters related to their health [2]. The ICPD Programme of Action reaffirms this core principle in relation to SRH, stating that “the full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community”[9]. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically requires countries to ensure that women have the right to participate fully and be represented in the formulation of public policy in all sectors and at all levels [10].

## 9. Accountability

Countries are accountable for bringing their legal, policy and programmatic frameworks and practices in line with international human rights standards [11]. Further, effective accountability mechanisms are key to ensuring that the agency and choices of individuals are respected, protected and fulfilled, including when seeking and receiving health care. Effective accountability requires individuals, families and groups, including women from marginalized populations, are made aware of their rights, including with regard to sexual and reproductive health, and are empowered to claim their rights [12].

## Translating human rights standards into concrete actions

Human rights terminology may be unfamiliar or perhaps not fully understood by health-care providers and health programme managers. Therefore, in this

implementation guide, the human rights principles and standards outlined in the box above have been “translated” into the concrete categories often used in the provision of primary health care and contraceptive information and services. The table below indicates how this is done.

Human rights standard as set out in WHO Guidelines	Rights-related outcomes (examples)	Measures	Category for programme implementation	Recommendation from WHO guidelines
1. <i>Non-discrimination</i>	Equal access to contraceptive services and information	Contraceptive cost; contraceptive uptake by new users adolescent contraceptive use	<b>1. Ensuring access for all</b>	1.1; 1.2; 3.2; 3.9; 3.10
2. <i>Availability of contraceptive information and services</i>	Method mix; modern contraceptive prevalence; facilities available; commodity stock outs; provider capacity; funds budgeted to family planning	Method mix; modern contraceptive prevalence; facilities available; commodity stock outs; provider capacity; funds budgeted to family planning	<b>2. Commodities, logistics and procurement</b>	2.1
3. <i>Accessibility of contraceptive information and services</i>	Contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use	Contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use	<b>3. Organization of health facilities: outreach; integration</b>	3.3; 3.8 3.5; 3.6; 3.8
4. <i>Acceptability of contraceptive information and services</i>	Client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in programme; demand for services	Client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in programme; demand for services	<b>4. Quality of care</b>	4.1; 4.2
5. <i>Quality in contraceptive information and services</i>		Meeting the established standard of care; method mix; range of services available; client satisfaction; provider satisfaction; access to follow-up		5.1; 5.2; 5.3
6. <i>Informed decision-making</i>				6.1; 6.2; 1.1
7. <i>Privacy and confidentiality</i>				7.1
Comprehensive sexuality education (under "Accessibility")	Good-quality evidence-based comprehensive information on sexuality and sexual and reproductive health		<b>5. Comprehensive sexuality education</b>	3.1
Crisis settings (under "Accessibility")	Contraceptive methods, including emergency contraception, and abortion		<b>6. Humanitarian context</b>	3.4
8. <i>Participation</i>	Mechanisms for women's participation		<b>7. Participation by potential and actual users of services</b>	8.1
9. <i>Accountability</i>	Redress and remedies		<b>8. Accountability to those using services</b>	9.1; 9.2; 9.2bis

As is the case for human rights standards, many action categories will only be effective if other actions are also taken. For example, accountability (category 9) also requires investment in participation (category 7), as well as strong management information systems (categories 3 and 4), among others. Further, several, or all, human rights standards may apply to a particular action or category of action. For example, provision of services that are available, accessible, acceptable and of good quality (commonly referred to as AAAQ) is core to the realization of people's right to the highest attainable standard of health as enshrined in the International Covenant on Economic, Social and Cultural Rights. Thus, achieving quality contraceptive services requires attention not only to the human rights standards presented under "Quality" in the WHO guidelines (Recommendations 5.1, 5.2 and 5.3), but also to those outlines under "Availability" (WHO guidelines, Recommendation 2.1), and "Acceptability" (WHO guidelines, Recommendation 4.1), among others.

It is essential to recognize that the standards, along with the categories, are an integrated whole and must all be addressed together or incrementally, depending on local circumstances.

## How to use this guide

The sections in this guide are numbered according to the fourth column of the table above. In this guide, each category for programme implementation contains:

- An introductory text recalling the public health and human rights imperatives of the topic.
- The relevant recommendations from the WHO guidelines.
- Key considerations — points which should be borne in mind as the reader thinks about what needs to be considered and addressed.
- Action points — presented as an example of actions to be undertaken, but exactly which ones are actually undertaken will depend on the specific

context. Each situation is likely to require additional actions for full implementation of the WHO recommendations. These actions include:

- **Meaningful participation**  recognizing and nurturing the strengths, interests, and abilities of stakeholders through the provision of real opportunities for them to become involved in decisions that affect them at individual and systemic levels.
- **Conducting a review** (assessment) of the current situation; this may be a law, policy, protocol and guideline review , or a needs assessment .
- **Training and supervision** of health workers and others involved in the provision of contraceptive information and services .
- **Development or modification of policies, protocols and guidelines**, with clear indicators and monitoring and evaluation mechanisms (monitoring and evaluation/accountability) .

Note that the icons are intended to help those who decide to take on board all the actions in a comprehensive approach. In this way, if training is to be undertaken, for example, users of this implementation guide can easily identify where "training" is an action point and, ideally, ensure that all training and actions related to it, such as curriculum development, are consistent in content and implemented in appropriate stages. Similarly, if a legal, policy and protocol review is to be undertaken, it would be most productive to combine those actions where law policy and guideline review  is indicated.

- **Examples** — provided to illustrate concrete actions along the lines of one or more of the suggested actions that have been taken in different situations.
- **Resources** — further reading, often practical guides or training manuals that readers can refer to and use as they implement certain actions.

## Using human rights in the process of implementation

Implementing human rights standards, as laid out in this implementation guide, requires a process that is itself grounded in human rights: the process must be **participatory**, and whoever undertakes the actions involved must also be **accountable**, as is set out in the WHO guidelines.

### Meaningful participation

Both human rights principles and public health evidence affirm that participation of stakeholders and affected communities is essential for success in health outcomes and their longer-term sustainability.

Participation requires that countries create an enabling environment for citizen engagement and develop capacity **to ensure that duty-bearers (e.g. contraceptive services and information providers) can fulfil their obligations and that rights-holders (contraceptive users) have the knowledge that allows them to claim their rights**. Participation should be viewed as fostering critical awareness, and decision-making as the basis for active citizenship. In the case of young children, such capacity-building may be targeted towards their caregivers. Besides the fact that stakeholder engagement is essential to ensuring accountability, evidence shows that laws, policies and programmes better reflect and respond to the needs and perspectives of affected populations when members of those populations take an active part in their development [13,14].

Public health managers and decision makers at all levels, when planning, monitoring and/or evaluating service provision, should bring together the various stakeholders to participate in assessment, decision-making, implementation and evaluation. Involving a variety of stakeholders builds legitimacy for sexual and reproductive health and rights, including contraceptive provision. A wide range of stakeholders can potentially be engaged, including:

- Representatives of the federal, provincial/state and local governments, particularly from ministries of health or health departments, but also from other

departments such as education, planning, finance and justice.

- Other key policymakers: parliamentarians, advisers and others with particular influence in the field of sexual and reproductive health.
- Managers of health programmes at both public and private facilities, whether specialized in family planning information and services, or providing a broad range of health services at different levels from primary health care to tertiary care.
- Health workers, particularly those who are involved in providing contraceptive information and services. These are likely to include, depending on the context, nurses and midwives, family health workers, village workers, etc.
- Organizations of health professionals, particularly obstetricians and gynaecologists, nurses and midwives, and paramedics.
- Community based organizations and civil society actors, especially individuals and organizations working to promote women's rights and of (or working with) those who are more susceptible to exclusion or marginalization, such as adolescents and young people, indigenous peoples, those living in hard-to-reach areas, persons with disabilities, people living with HIV, sex workers, minority communities, and low-income groups.

A process of ensuring human rights in contraceptive information and services should generally start with a consultation process involving representatives from some or all of the groups listed above. This can be done in a variety of ways, details of which are laid out in other WHO and UNFPA documents, listed at the end of this implementation guide [15-17].

### Accountability and transparency

Accountability is a key principle of human rights. It requires compliance by countries with their obligations to bring their laws, policies and practices — including in relation to sexual and reproductive

health — in line with international, regional and national human rights standards. The establishment of precise global standards, accessible and well-funded monitoring mechanisms, redress and reparations for harm, and long-term follow-up, are the main elements of accountability [18,19]. This will be achieved through a variety of processes and institutions at all administrative levels. Monitoring requires strong capacity and a well-designed and functioning health management information system, civil registration system and availability of data disaggregated by sex, age, urban/rural residence, ethnicity, level of education, wealth quintile and geographic region, as well as the use of a range of qualitative indicators [20–22]. To be consistent with human rights, all the suggested actions in this document should be done in tandem with such monitoring mechanisms.

Establishing effective accountability mechanisms is intrinsic to ensuring that the agency and choices of individuals are respected, protected and fulfilled. Effective accountability requires individuals, families and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to sexual and reproductive health, and empowers them to claim these entitlements [23]. Such accountability mechanisms should be independent and include representatives from CSOs including groups working on sexual and reproductive health and rights, women's organizations and other stakeholder groups.

The ICPD Beyond 2014 International Conference on Human Rights recognized that gaps remain in

countries' fulfilment of rights in respect of sexual and reproductive health, specifically with regards to: upholding equality and ending discrimination in all its forms; quality in provision of sexual and reproductive health services, information and education; and, in accountability of key actors and in enforcement of rights. Furthermore, the ICPD Beyond 2014 review highlighted that growing inequalities threaten to undo significant gains in health and longevity made over the past 20 years: "To sustain these gains, governments must pass and enforce laws to protect the poorest and most marginalized, including adolescent girls and women affected by violence as well as rural populations."

To support countries with monitoring of human rights in contraceptive services, WHO has also issued a report that provides a methodology for identifying quantitative indicators that can be used in a rights analysis of contraceptive programmes, and a set of prioritized quantitative indicators. The report also identifies the remaining gaps, highlighting rights-related outcomes that we are currently not able to adequately monitor in the context of contraceptive programmes. A comprehensive approach to monitoring rights will require identifying and developing qualitative and policy indicators, as well as new quantitative indicators [24].

WHO and UNFPA would be pleased to receive feedback and comments regarding the experience of those using this implementation guide so that future versions are improved.

# Implementation: actions for fulfilling human rights standards

## 1. Ensuring access for all (Non-discrimination)

The human rights principle of *non-discrimination* obliges countries to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation [1]. As part of their human rights commitments, countries must strive to eliminate all forms of discrimination and to promote equality by ensuring that vulnerable groups have access to information and services [4].

**Laws and policies must 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. (Recommendation 1.2)**

**Eliminate financial barriers to contraceptive use, especially by marginalized or disadvantaged populations such as adolescents and the poor, and make contraceptives affordable to all. (Recommendation 3.2)**

**Eliminate third-party authorization requirements, including spousal authorization for individuals/women accessing contraceptive and related information and services. (Recommendation 3.9)**

**Sexual and reproductive health services, including contraceptive information and services, should be provided for adolescents without mandatory**

**parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents. (Recommendation 3.10)**

**Key considerations for policymakers and programme managers**

- Laws, health sector regulations and/or policies can be barriers to people accessing contraceptive information and services. For example, laws and/or policies may specify that such services cannot be provided to individuals under a certain age (adolescents), or individuals of any age who are not married. Laws and policies, however, should actively support universal access to services, and specifically for these and other disadvantaged or marginalized populations, and steps should be taken to combat possible negative attitudes of providers in this regard.
- People with limited resources may not be able to afford access to even life-saving commodities such as contraceptives. Having to pay for services and methods places these out of reach of many people: If the bulk of a person's or family's income is spent on food and lodging, spending money on contraception is out of the question. Policies thus should enable provision of free or subsidized access to contraceptives particularly for those with limited resources.
- Requirements for third-party authorization prior to receipt of contraceptive information and services are a significant barrier. In many countries, especially where women are expected to have as many children as possible, women may be left in a position where they cannot make an autonomous

decision regarding contraception without their husband's authorization. Adolescents may be required (by law or by clinic practice) to obtain authorizations from their parents or guardians in order to access contraceptive information and services. Requirements that prevent those capable of exercising free, prior and informed consent from due exercise of choice should be removed.

## Action points

1. Initiate opportunities for meaningful participation of stakeholders  to carry out the following assessments:

1.1. Assess whether national laws and policies, including criminal and administrative laws and those related to education and to the provision of public information, and service policies and protocols (where relevant) :

- (a) state clearly that all persons have a right to contraceptive information and services;
- (b) attend sufficiently and effectively to the specific needs of disadvantaged and marginalized groups;
- (c) include contraceptive information and services as part of a comprehensive sexual and reproductive health programme which serves all sexually active persons irrespective of age, marital status or sexual orientation (including single women, all men, adolescents and young people, sex workers, people living with HIV, persons living with disabilities);
- (d) prohibit any attempt to provide a method of contraception without the individual's informed consent. (See also Section 4, Quality of care.)
- (e) impede access to services of any sections of the population such as those listed in (c) above;
- (f) require a husband's or male partner's or other third-party authorization for a woman to obtain any contraceptive services;
- (g) require parental authorization for an adolescent woman to obtain contraceptive information and services;

- (h) contain guidelines on how health-care providers are to assess the competence of an adolescent to take independent decisions on SRH, including contraception.

The assessment should include a process whereby shortfalls in laws, policies and protocols — i.e. an answer “no” to points (a)–(d), or “yes” to points (e)–(g) — can be rectified, including a process to formalize the legal and policy review with relevant government officials and others, with a view to eliminating the restrictions.

If the answer is “yes” to point (f), examine whether the country's constitution upholds equality of sexes; if it does, then the regulation is in violation of the law of the land, and could form the basis for advocacy for its withdrawal. If the regulations are silent on this issue, advocate for the inclusion of explicit guidelines not requiring spousal authorization or consent.

If the answer is “yes” regarding requirement for parental authorization (point (g)), initiate a process of meaningful participation whereby the human rights standards (see box in Introduction) can be clearly laid out to policymakers, underlining the importance of having services available and provided to sexually active young people irrespective of their marital status.

1.2. Assess whether programmes and protocols are based on a situational analysis that includes an analysis of data and information on which groups are excluded or marginalized; their sexual and reproductive health needs; and barriers encountered by them in accessing contraceptive information and services.

1.3. Based on the results of this assessment, initiate a process to review/develop/adapt contraceptive programmes and clinic protocols to ensure that attention is paid to those from disadvantaged and marginalized groups, and particularly adolescents and young people whether or not they are married, migrants, people living with HIV, persons living with disabilities, and sex workers. 

2. Support evidence-based advocacy and information, education and communication interventions targeting key stakeholders and policymakers to ensure their support of provision of comprehensive contraceptive information and services to disadvantaged or marginalized populations including adolescents and young people.
3. Provide pre-service and in-service training in these protocols to all relevant service providers. 
4. Ensure that funding and financing for contraceptive provision includes as many of the following as are appropriate to the country's situation: 
  - (a) contraceptive services are available free at the point of delivery to all sexually active individuals from low-income groups including migrants as well as adolescents and young people regardless of marital status;
  - (b) mechanisms exist in public health facilities to ensure that the non-poor who cannot pay for contraceptive services are not denied access.
  - (c) contraceptive services, including the full range of contraceptive options, are 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).

- (d) measures exist to check and contain the practice of informal payments.

If contraceptives are not free to the groups mentioned above, and if other mechanisms are not in place, initiate a process with appropriate actors to help put in place such mechanisms. 

### Gender-responsive programmes

Adopting a human rights-based approach already includes attention to gender equality in family planning policies and programmes based on the principle of non-discrimination. Gender-responsive programming tells us how to do this.

A policy or programme may fall anywhere along a continuum of gender responsiveness. For practical purposes, five levels of gender responsiveness have been identified. The first two levels — 'gender-unequal' and 'gender-blind' — hinder the achievement of gender equality and health equity (see box below). The third level, gender sensitivity, is the turning point — when policies or programmes recognize the important health effects of gender norms, roles and relations. Only when a policy or programme is gender sensitive can it be gender responsive [7].

# The gender-responsiveness continuum

A gender-responsive programme fulfils two criteria:

- It takes steps to identify the socially constructed differences and inequalities between women and men, and boys and girls in roles and responsibilities, norms related to appropriate behaviour, opportunities and resources, and power and decision-making.
- It also takes measures to address actively the harmful effects to health and well-being of these differences and inequalities [7].

A gender-responsive approach in the context of family planning will be informed by an understanding that in some societies it is not considered appropriate for women and girls to have information about their bodies and about contraception; and that decisions about whether, when and how many children to have are taken by the husband or male partner or, at times, by members of the extended family. At the least, a gender-responsive approach will refrain from 'victim-blaming' — for example, blaming the women themselves (e.g. ignorance, wrong beliefs) for non-use of contraception.

## Sources:

- (1) WHO. 2010. *Gender Mainstreaming for Health Managers: a Practical Approach*. Geneva: World Health Organization. Available from: [http://whqlibdoc.who.int/publications/2011/9789241501071\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501071_eng.pdf). Accessed 27 November, 2014.
- (2) UNFPA. 2013. *Engaging Men and Boys: a Brief Summary of UNFPA Experience and Lessons Learned*. New York, UNFPA. Available at <http://www.unfpa.org/resources/engaging-men-and-boys-brief-summary-unfpa-experience-and-lessons-learned>. Accessed 3 December 2014.

## Examples

### WHO Toolbox for examining laws, regulations and policies on reproductive, maternal, newborn and child health and human rights: experience in Indonesia

The WHO Human Rights Toolbox involves compiling data relating to laws, regulations and policies on the one hand and health systems and health outcomes on the other, from readily available and reliable sources. Carried out by national researchers appointed by the ministry of health with support from international agencies such as WHO, the process also engages a wide range of relevant stakeholders including various government sectors such as education, finance, justice, planning, religion, transport and women's affairs as well as representatives from non-governmental organizations, human rights and academic institutions, bilateral and multilateral partners, health workers and civil society.

Used in Indonesia in the early 2000s to examine the legal context of sexual and reproductive health, the Toolbox revealed that the Population Law restricted family planning services to married couples only, and therefore unmarried women, particularly young women, did not have access to family planning services, thus exposing them to the risk of unwanted pregnancy and its attendant ill-health problems. The adolescent reproductive health programme for unmarried young people aged 10–24 years focused only on moral issues and abstinence.

In the analysis of the compiled data, stakeholders noted that, among the many international human rights treaties the State has ratified, the Convention on the Rights of the Child guarantees non-discrimination for minors, including the that no child should be deprived of his or her right of access to health care services. In addition, the Convention on the Elimination of All Forms of Discrimination against Women, adopted *in toto* as the "Law on CEDAW", stipulates that the State shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care

services, including those related to family planning. Stakeholders concluded that laws and clinical policies and practices that set chronological age limits for types of care, and deny to adolescents the sexual and reproductive health information and services that they are able and competent to request according to their evolving capacities, are contradictory to international human rights treaties ratified by the State and national laws that protect the right to health without discrimination.

This was just one aspect of many issues revealed by the law and policy review, and analysed by the stakeholders. To address the specific problem of the dissonance between the Population Law and the human rights standards the State has acceded to, stakeholders recommended that:

- both the Population Law and the Health Law should be amended and revised to make comprehensive reproductive health services including contraceptive services available, accessible and affordable for unmarried women and men, including adolescents;
- the accessibility and affordability of contraceptive services for unmarried people has to be assured as an integral part of the amendment of the Health Law;
- access to family planning services for the unmarried should be ensured and be integrated into the amendment process of the Population Law;
- local schools should be forbidden by law to expel pregnant girls and young women from school;
- regulations to ensure budget allocation for the education of girls and young women should be issued.

Sources: Cottingham J, Kismodi E, Martin Hilber A, Lincetto O, Stahlhofer M, Gruskin S. 2010. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bulletin of the World Health Organization*, 88:55-555. Available from: <http://www.who.int/bulletin/>

volumes/88/7/09-063412/en/. Accessed 18 November 2014.

Using human rights for maternal and neonatal health: a tool for strengthening laws, policies and standards of care. A report of the Indonesia field test analysis. Jakarta: World Health Organization and Ministry of Health of the Republic of Indonesia. 2006. Available from [http://www.ino.searo.who.int/LinkFiles/Reproductive\\_health\\_Using\\_Human\\_Rights\\_for\\_Maternal.pdf](http://www.ino.searo.who.int/LinkFiles/Reproductive_health_Using_Human_Rights_for_Maternal.pdf). Accessed 27 November, 2014.

### **Ecole des Maris, Niger, UNFPA**

The UNFPA initiative Ecole des Maris (EdM), or Husbands' School, in Niger engages men at the community level in the promotion of reproductive health including maternal health and family planning. The aim is not only to discuss and debate issues related to sexual and reproductive health, but also to make husbands aware of their own responsibility in being supportive partners. EdM, which was launched after a study that demonstrated that men were posing significant barriers to women's access to sexual and reproductive health (SRH) services, started in the Zinder Region in 2008 in areas with low reproductive health indicators, and has now been scaled up throughout the country.

The EdMs are based on voluntary membership and the prospective 'husbands' must meet the programme's nine point criteria. The schools have no leader, and they operate in a nonhierarchical format, with each member assuming his share of responsibilities on a rotational basis. Husbands meet periodically with a trained facilitator from a local NGO — these forums become a space for discussion, decision-making and action. The initiative's success has relied on community mobilization and is rooted in a multi-stakeholder partnership between UNFPA, CSOs, the Government including the Ministry of Health, local health facilities, and community members including husbands, wives, and religious leaders. A formal evaluation has been completed and observations point to improved reproductive health indicators with particular rises in deliveries assisted by skilled personnel, prenatal and postnatal consultations and family planning.

In addition, the EdMs have led to positive spin-off effects and community actions for the village such as hygiene initiatives, latrines, midwives' residences, an observation room for women in labour, and a prenatal consultation room. EdM is being scaled up in Niger and replicated in a number of countries in West Africa. Integration of more topics related to women and girls' rights, such as girls' education, ending gender-based violence and harmful practices into the discussions, are now being integrated into the sessions.

## Resources

For a formal process to review national laws and policies, see:

Cottingham J, Kismodi E, Hilber AM, Lincetto O, Stahlhofer M, Gruskin S. 2010. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bulletin of the World Health Organization*, Jul;88(7):551-5.

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For country examples of measures taken for financing, see: Lewis M. 2007. Informal payments and the financing of health care in developing and transition countries. *Health Affairs (Millwood)*. Jul-Aug; 26(4):984-97.

For further information on international human rights treaties that oblige the State to reform laws that restrict adolescents' access to contraceptive information and services, see:

Centre for Reproductive Rights. 2006. Adolescents' reproductive rights. In: *Gaining Ground: a Tool for Advancing Reproductive Rights Law Reform*. New York: Centre for Reproductive Rights. Available from: [http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub\\_bo\\_GG\\_TOC\\_Foreward.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_bo_GG_TOC_Foreward.pdf). Accessed 25 November, 2014.

Advance Family Planning Advocacy Portfolio, Johns Hopkins School for Public Health for AFP. Available from: <http://advancefamilyplanning.org/portfolio>. Accessed 25 November 2014.

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Guttmacher Institute and IPPF. 2013. *Demystifying Data: a Guide to Using Evidence to Improve Young People's Sexual and Reproductive Rights*. New York, Guttmacher Institute. Available from: <http://www.guttmacher.org/pubs/demystifying-data.pdf>. Accessed 25 November 2014.

Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. Report of the Office of the United Nations High Commissioner for Human Rights. 2012. Available from: [http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22\\_en.pdf](http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf). Accessed 25 November 2014.

Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age. Report of the Office of the United Nations High Commissioner for Human Rights. 2014. Available from: <http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf#sthash.oYu1bgAy.dpuf>. Accessed 25 November 2014.

UNFPA. 2012 *Choices not Chance: UNFPA Family Planning Strategy 2012-2020*. New York: United Nations Population Fund. Available from: [at: http://www.unfpa.org/publications/choices-not-chance](http://www.unfpa.org/publications/choices-not-chance). Accessed 3 December, 2014.

UNFPA and Center for Reproductive Rights. 2011. *The Rights to Contraceptive Information and Services for Women and Adolescents: Briefing Paper*. New York: Center for Reproductive Rights. Available from:

<http://web3-da.dmz.unfpa.io:6081/sites/default/files/resource-pdf/Contraception.pdf>. Accessed 3 December 2014.

UNFPA and Guttmacher Institute. 2012. *Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2012*. New York: United Nations Population Fund. Available from: <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>. Accessed 3 December 2014.

UNFPA and Guttmacher Institute. 2014. *Adding It Up: Costs and Benefits of Contraceptive Services: Estimates for 2014*. New York: United Nations Population Fund <http://www.guttmacher.org/pubs/AddingItUp2014.pdf>. Accessed 4 December 2014.

UNFPA and Harvard School of Public Health. 2010. *A Human Rights-based Approach to Programming Practical Information and Training Materials*. New York: United Nations Population Fund. Available from: <http://www.unfpa.org/resources/human-rights-based-approach-programming-0>. Accessed 28 November 2014.

UNFPA. ICPD Beyond 2014, International Conference on Human Rights, Noordwijk, Netherlands, 7-10 July 2013. Available from: [http://icpdbeyond2014.org/](http://icpdbeyond2014.org/uploads/browser/files/human_rights_english_web.pdf)

[uploads/browser/files/human\\_rights\\_english\\_web.pdf](http://icpdbeyond2014.org/uploads/browser/files/human_rights_english_web.pdf). Accessed 3 December 2014.

UNFPA. 2014. *Lessons from the First Cycle of the Universal Periodic Review: from Commitment to Action on Sexual and Reproductive Health and Rights*. New York: United Nations Population Fund. Available from: [http://www.unfpa.org/sites/default/files/pub-pdf/Final\\_UNFPA-UPR-ASSESSMENT\\_270814..pdf](http://www.unfpa.org/sites/default/files/pub-pdf/Final_UNFPA-UPR-ASSESSMENT_270814..pdf). Accessed 3 December 2014.

*UNFPA Strategy on Adolescents and Youth: Towards Realizing the Full Potential of Adolescents and Youth*. 2013. New York: United Nations Population Fund. Available from: <http://countryoffice.unfpa.org/india/drive/UNFPA+Adolescents+and+Youth+Strategy+20121120.pdf>. Accessed 3 December 2014.

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## 2. Commodities, logistics and procurement (Availability of contraceptive information and services)

Access to a secure, reliable and steady supply of a broad range of modern contraceptive commodities is an essential part of health care to a broad range of people: couples wishing to space the birth of their children; women who would die giving birth but whose lives could be saved if unintended pregnancy is prevented; adolescents too young to be parents; people in need of protection from HIV and sexually transmitted diseases. Any service delivery point, including community-based ones, that provides contraceptive services should have available sufficient quantity of a broad mix of contraceptive methods so that no individual or couple goes away empty handed.

As part of this core obligation, countries should ensure that the commodities listed in national formularies are based on the *WHO Model List of Essential Medicines*, which guides the procurement and supply of medicines in the public sector [2]. A wide range of contraceptive methods, including emergency contraception, is included in the core list of essential medicines [3].

Note: this section deals specifically with commodities and logistics. Other aspects of availability of contraceptive information and services, such as extending coverage to places and populations that might not otherwise be reached, are covered both under the section “Ensuring access for all (Non-discrimination)”, and the section “Organization of health facilities (Accessibility)”.

**Contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, should be integrated within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability. (Recommendation 2.1)**

### Key considerations for policymakers and programme managers:

- In many low- and middle-income countries a full range of contraceptives is still not available. This may be due to inadequate laws and policies; inefficient systems of supply or logistics management; low or absent funding.
- Lack of or restrictions in availability may also result from ideology-based rather than evidence-based policies affecting the range of medicines or services. For example, in some countries emergency contraception is not made available on the false grounds that it causes abortion.
- Countries' estimates of need for contraceptive commodities may not have taken into account the fact that women rely on different methods at different points in their reproductive lives, and may want and need to switch from one method to another for health, personal preference and other reasons. As patterns of choice and preference become clear and as a country's total clientele for contraceptive information and services change in age, marital status, rates of STIs and HIV, countries need to consider not only the number of methods provided but also how methods work, and ensure their policies, supply chains and service protocols take into account that women must be able to and will want to choose to switch methods.
- Public sector procurement and supply may be hampered by various factors including: restrictive national legislation; special agreements with pharmaceutical companies; lack of national capacity in management information systems and supply chain management; poor infrastructure (e.g. transportation and warehouses). More often, a functioning supply chain and adequate provision of commodities must be coordinated with a

variety of partners and requires a robust logistics management information system (LMIS).

### Action points:

1. Initiate meaningful participation  processes to undertake the following:

1.1. Examine what is known about unmet need for contraception, focusing on practical barriers to access; the reasons for discontinuation of methods, and the potential demand for different methods, depending on the age and risk-factors of the population. 

1.2. Advocate for political and financial commitment to contraceptive provision by the government in the national budget, for sufficient transparency in budgets, and for the tracking of the flow of resources, in relation to contraceptives.

1.3. Review the national essential drugs list and assess whether it includes the full range of contraceptives. These include methods that act in different ways: male and female condoms, emergency contraception, short-acting hormonal methods (the pill, injectables, the vaginal ring), long-acting reversible methods (implants and IUDs), and permanent methods (male and female sterilization).

1.4. Advocate for the inclusion of the full range of contraceptives onto the national essential medicines list, as per the *WHO Model List of Essential Medicines* [3]. Ensure that emergency contraceptive commodities are included.

1.5. Conduct regular monitoring of contraceptives distribution and stocks with attention to stock outs and method mix at all levels of service delivery points. Work towards putting in place a robust supply chain management system to ensure that at least five types of methods are available everywhere, taking into account provider capacity and facility quality.

1.6. Review whether information, forecasting, procurement and supply chain for contraceptives

have been created or updated to ensure a steady supply of methods, in both the private as well as the public sector. If not, initiate a process whereby this can be undertaken, including the establishment of a LMIS (see Gribble and Clifton, 2010 (Resources)).

1.7. Advocate for and support the establishment of coordination mechanisms with partners.

1.8. Advocate for and support capacity-building of logisticians, supply chain managers and specialists in forecasting and procurement. 

1.9. Engage civil society and the private sector in contraceptive supply, distribution and monitoring to strengthen the national supply chain management.

### Examples

#### Partnership with civil society in strengthening monitoring of reproductive health commodities in Sierra Leone

Prior to 2010, over 50 per cent of drugs and medical supplies intended for public health facilities in Sierra Leone, were unaccounted for. The country's drugs supply chain management system was characterized largely by weak accounting and transparency. In light of the aforementioned irregularities in the health system, UNFPA's country office in Sierra Leone decided to support a network of local civil society organizations represented by the Health For All Coalition Sierra Leone (HFAC-SL). They were asked to undertake the monitoring of health commodities and supplies and to advocate for a sustainable drugs supply management system that includes budgeting for RH commodities in the national health budget. The partnership between UNFPA and HFAC-SL is yielding demonstrable results. The interventions have increased accountability and transparency, and have reduced leakages of drugs. This is evidenced by an increase in the percentage of drugs that were accounted for from the central medical stores to district medical stores, this rose from 50 per cent in 2010 to 94.3 per cent in 2011. In 2012, the figure was at an all-time high of 99.7 per cent.

Until 2012, HFAC-SL monitors used a manual paper-based system to report stock outs and theft of drugs to development partners including UNFPA on a quarterly basis. However at the beginning of 2013, together with the UNFPA country office, HFAC-SL reviewed and altered their monitoring and evaluation system to report stock outs on a weekly basis. Under the new system, the community monitors use mobile phones (through text/SMS messages) to report on theft and stock out of essential free health care drugs. Using phones to collect data not only saves on resources and reduces risks associated with loss of paper forms in transit, but it also minimizes errors during data entry and analysis. In addition, it also serves as a unique tool that helps HFAC-SL national and regional offices to keep in touch with volunteers in the field and significantly improves their ability to respond to issues in real time without unnecessary delay.

*More details available from UNFPA.*

### **Strengthening logistics and supply chain management in the public health system for reproductive health commodities, Odisha, India**

Contraceptives in India are provided by the central Government to the states for distribution through the public health system. However, there are several challenges in ensuring uninterrupted supply at various levels. Prior to 2011, there was no efficient tool to track contraceptive supplies and the software in use could track supplies only up to the district level. It was difficult to obtain information on stocks and supplies on a real-time basis at sub-district levels (community health centres, primary health centres and sub-centres) where health records are maintained manually. The forecasting and ordering for stocks did not follow a scientific process and supply was not needs-based. It was difficult for the programme managers to have real-time data on contraceptive availability and utilization at various health facilities and the contraceptive supply chain was barely monitored. A “push system” existed whereby the supplies received from the central Government were distributed to health facilities without assessing the actual need. This often resulted in shortage of supplies at many health facilities and over stocks at others.

### **Key challenges:**

- Introducing technological innovation through a large public health system having functionaries with varied capacities and interests. The available computer software could connect health facilities and warehouses and access information only up to the state and district levels. The challenge was to establish a system that could connect the auxiliary nurse midwives (ANMs) at all 6688 sub-centres in the State and have access to real-time information on stocks and supplies at the cutting edge of service delivery.
- Shifting emphasis towards birth spacing methods of family planning and, moreover, introducing an information and communications technology-enabled system to track contraceptive supplies in a State that had focused mainly on sterilization for more than half a century.
- Attitude and motivation levels of health functionaries considerably influence use of new technology. Key functionaries, the pharmacists and ANMs at health sub-centres were not well versed with mobile technology, particularly in the use of text messages.
- UNFPA is partnering with the Government of Odisha to improve the family planning programme of the State. One of the main focus areas of support includes strengthening and streamlining the supply management system for contraceptives.

The Reproductive Health Commodities Logistic Management Information System (RHCLMIS), an online and text message based system was introduced with technical and financial support from UNFPA in 2011. The RHCLMIS handles the following commodities: condoms, oral contraceptive pills, emergency contraceptive pills, intrauterine contraceptive devices, pregnancy test kits and tubal rings (used in laproscopic sterilization) that are received from the national government for distribution through the public health system.

### **Key features of RHCLMIS include:**

- Real-time tracking of stocks of reproductive health commodities: one can have instant access to information on contraceptive stocks at all 7000 public health facilities either through the website ([www.rhclmisodisha.com](http://www.rhclmisodisha.com)) or by a text message sent by mobile phone using a specified code.
- Data transfer through SMS: information related to contraceptive indents, issue, receipt, including short supply can be transferred through text messages at various levels particularly at sub-district levels where computer/Internet facilities are unavailable. The transactions made over mobile phones by the peripheral health functionaries are automatically updated in the software, and for every transaction an acknowledgement message is received on the mobile phone.
- Auto alerts: health functionaries responsible for managing family planning stocks receive alert messages on their registered mobile phones on reaching minimum/maximum stock levels including the quantity to be ordered. A copy of the text message is also sent to their respective supervisors. Auto alerts are also received regarding stocks that have a short expiry.
- Programme management: using RHCLMIS, programme managers are able to estimate and forecast the requirements for contraceptives at state and sub-district levels based on population. The system allows orders based on annual requirements forecasted and helps in reallocation and re-distribution of supplies thereby avoiding stock outs. Relevant reports on the supply chain can be generated from the software and used to review programme performance linking demand, supply and distribution.

### **Progress and results**

The entire contraceptive supply chain management under the Government's family planning programme in the state is now being managed and tracked through the RHCLMIS. The Department of Health and Family Welfare has been able to streamline its supply

management system avoiding stock outs over the past two years (2012–2013).

Across 7000 health facilities in Odisha, the ANMs and health workers are using the new technology. The system has helped nearly 150,000 women users of contraceptives in the past year alone, and the incidence of stock outs has reduced significantly.

### **Lessons learned**

- Advocacy at various levels is essential for introduction, replication and institutionalization of any innovation. Technology should be user-friendly for its acceptance by health-care functionaries.
- Intensive capacity-building of key functionaries is critical for the success of any innovation. Over the past 2 years, about 8000 health functionaries at state, district and sub-district levels including logistics managers, district and block data managers, pharmacists, store managers and ANMs have been trained.
- For successful integration and sustainability of any innovation the involvement of key stakeholders from the stage of inception to implementation is vital.

### **Scalable and sustainable**

- The RHCLMIS was introduced in the State in four districts on a pilot basis connecting 1524 health facilities. Considering its use and user-friendliness the system was scaled up to cover 7000 health facilities across 30 districts of the State. There are now plans to adopt the RHCLMIS in two other states of India.

*More details available from UNFPA.*

## Task-shifting and task-sharing

There are multiple barriers to accessible, equitable and high-quality family planning care in developing countries; however, a critical barrier is a shortage of trained providers. Task-shifting, or task-sharing, has been proposed as a strategy to optimize the available workforce to deliver essential health services to those in need. Task-shifting is defined as the delegation of specific tasks to less specialized health workers. Task-sharing refers to a partnership in which different levels of providers do similar work, rather than having less-credentialed providers take over provision completely.

Task-sharing is a key strategy for reducing unmet need for contraception. While a wide range of modern, effective methods of contraception exist, there are inadequate numbers of providers to supply them, particularly in rural areas. The most effective forms of contraception, the long-acting and permanent methods (intrauterine devices, implants, female and male sterilization) are particularly inaccessible due to the health worker shortage. Multiple studies have examined the effectiveness and safety of task-shifting delivery of injectable progestin or contraceptive pills, and provision of IUDs by a range of midlevel providers. The World Health Organization recognizes task-shifting as a key strategy to optimize reproductive health, and has issued recommendations on which family planning services can be safely provided by different cadres of workers.

### Reference:

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### Resources

For guidance and experience on selecting and introducing new methods to a national programme, see:

Centers for Disease Control and Prevention. 2000. *Pocket Guide to Managing Contraceptive Supplies*.

Available from: <http://www.who.int/rhem/supplychain/pockguidmanacont/en/>. Accessed 8 May 2014.

Gribble J and Clifton D. 2010. *Contraceptive Security: a Toolkit for Policy Audiences*. Washington, D.C: Population Reference Bureau. Available from: <https://www.k4health.org/toolkits/fp-logistics/contraceptive-security-toolkit-policy-audiences>. Accessed 9 July 2014.

Institute for Reproductive Health, Georgetown University (IRH/GU), John Snow Inc. (JSI), and Population Services International (PSI) for the Reproductive Health Supplies Coalition (RHSC). 2012. *A Forecasting Guide for New and Underused Methods of Family Planning: What to Do When There is No Trend Data?* Washington, DC: IRH/GU, JSI and PSI for the RHSC. Available from: [https://www.k4health.org/sites/default/files/A%20Forecasting%20Guide%20for%20New%20and%20Underused%20Methods%201st%20Edition%202012\\_0.pdf](https://www.k4health.org/sites/default/files/A%20Forecasting%20Guide%20for%20New%20and%20Underused%20Methods%201st%20Edition%202012_0.pdf). Accessed 25 November 2014

UNFPA. 2012. *Global Programme to Enhance Reproductive Health Commodity Security: Ten Good Practices in Essential Supplies for Family Planning and Maternal Health*. New York: UN Population Fund. Available from: <http://www.unfpa.org/publications/ten-good-practices-essential-supplies-family-planning-and-maternal-health>. Accessed 3 December 2014.

UNFPA. 2012. *Increasing Contraceptive Security in Eastern Europe and Central Asia*. Istanbul: UN Population Fund. Available from: <http://eeca.unfpa.org/publications/increasing-contraceptive-security-eastern-europe-and-central-asia>. Accessed 25 November 2014.

UNFPA. 2012. *Contraceptives and Condoms for Family Planning and STI/HIV Prevention*. New York: UN Population Fund. Available from: <http://www.unfpa.org/publications/contraceptives-and-condoms-family-planning-and-stihiv-prevention>. Accessed 3 December 2014.

UNFPA and PATH. 2013. *Road-Mapping a Total Market Approach for Family Planning and Reproductive Health Commodity Security*. New York: UN Population Fund. Available from: <http://eeca.unfpa.org/publications/road-mapping-total-market-approach-family-planning-and-reproductive-health-commodity>. Accessed 3 December 2014.

USAID. 2012. *High Impact Practices in Family Planning (HIP). Supply Chain Management: Investing in Contraceptive Security and Strengthening Health Systems*. Washington, D.C: United States Agency for International Development. Available from: <https://www.fphighimpactpractices.org/resources/supply-chain-management-investing-contraceptive-security-and-strengthening-health-systems>. Accessed 25 November 2014.

WHO 2007. *The WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes*. Geneva: World Health Organization. Available from: [http://www.who.int/reproductivehealth/publications/strategic\\_approach/RHR\\_07.7/en/](http://www.who.int/reproductivehealth/publications/strategic_approach/RHR_07.7/en/). Accessed 9 July 2014.

WHO, UNFPA, PATH and RHSC. *Reproductive Health Essential Medicines: Supply Chain and Logistics Management*. Available from: [http://www.who.int/rhem/supplychain/all\\_resources/en/](http://www.who.int/rhem/supplychain/all_resources/en/). Accessed 25 November 2014.

## 3. Organization of health facilities (Accessibility)

International human rights law requires that health-care facilities, commodities and services to be accessible to everyone. This includes physical and economic accessibility, as well as access to information [2]. Human rights bodies have called on countries to eliminate the barriers people face in accessing health services including, among other things, high fees for services, distance from health-care facilities and the refusal by health-care providers to provide some services to certain populations.

Note: See also Module 1: Ensuring Access for All.

### 3a. Access and outreach

**Interventions should be undertaken 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, 2nd edition). (Recommendation 3.3)**

**Mobile outreach services be used to improve access to contraceptive information and services for populations who face geographical barriers to access. (Recommendation 3.8)**

#### Key considerations for policymakers and programme managers

- Among the factors that contribute to unmet need for contraception are barriers to physical accessibility and mobility of women including geographical distance from services, poverty, lack of access to insurance or high out-of-pocket expenses especially for migrants and adolescents. Other barriers include a number of gender-based disadvantages such as husbands' disapproval of

contraception, or lack of information about how one gets pregnant. Features of facilities that may present a barrier include restricted opening times, lack of information in an appropriate language, and lack of health workers who are equipped to provide contraceptive information and services. Some of these barriers can be addressed through modifications in the way service delivery is organized. Unmarried women may also face barriers in access.

- Prevention of unintended pregnancies must always be given the highest priority by governments. This requires governments to provide women and girls with access to comprehensive sexuality education and contraceptives. However, contraceptives may fail, and women may become pregnant as result, or women may face circumstances in which contraception is not possible or may need to terminate a pregnancy for health or other reasons. Women therefore need access to safe abortion to the full extent of the law. The WHO guidelines, *Safe Abortion: Technical and Policy Guidance for Health Systems*, recommends that: laws and policies on abortion should protect women's health and their human rights; regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed; and an enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care (WHO 2012, page 9 (Resources)). Provision of contraceptive information and offers of counselling and methods is an essential part of comprehensive abortion care, as it helps women to avoid unintended pregnancies in future. Women should always be given access to care if they have undergone an unsafe abortion.

# Mobile outreach services

In developing countries, contraceptive prevalence rates are lower in rural compared with urban areas, and in less-developed compared with more developed regions. 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.” (USAID, 2010 (Resources)). Mobile outreach services have emphasis on both supply and demand for contraceptive services. There is also a wide range of community outreach programmes in rural and hard-to-reach areas using community-based distributors, community health workers (CHWs), health extension workers, etc. These health workers provide information, pills, condoms and in some cases injectables, as well as generate demand for contraceptive services in their communities and provide referrals and follow-ups.

## Action points

1. Initiate meaningful participation processes to undertake the following:

1.1. Mapping of the different models for service delivery, including health facility-based, community-based, mobile, referral, and social franchising models, including the costs of all such services.  Market segmentation analysis to examine how the market for contraceptive services is structured and to identify the extent to which different providers serve various population segments.

1.2. Depending on the findings from the mapping and market segmentation analysis, initiate a process whereby different service delivery models could be introduced in order to reach rural, urban poor and adolescents, at the same time as reducing costs to a minimum for those having financial difficulties in accessing services. The process may include: a revision of service delivery protocols and

clinical guidelines; introducing innovative financing programmes for contraceptive services as part of sexual and reproductive health services; supporting social marketing and community-based services; and mobile outreach.

1.3. A review of whether there are existing mobile contraceptive outreach services to reach out to underserved populations, and whether they provide a full range of contraceptive services including access to follow-up, management of side-effects and other kinds of ongoing care. If not, initiate a process whereby such outreach services can be established. (See also module on Humanitarian contexts, below.)

1.4. A review of whether different types of health-care providers — such as midwives, pharmacists, traditional medical practitioners, CHWs, female village workers and volunteer agents — are accredited to deliver contraceptive information and services.  If not, support the state to adopt relevant legislation and policies to enable such workers to provide contraceptive information and services and build their capacity in a broad range of contraceptive methods. 

1.5. An assessment of whether the location and timing of services, the physical infrastructure and human resources are planned taking into account: (1) gender-based barriers to access that women face; (2) the special needs of disadvantaged groups (e.g. those with low literacy; those with physical disabilities; linguistic and ethnic minorities). If not, carry out a rapid needs assessment among women and other disadvantaged groups ; identify changes needed and take steps to implement these.

1.6. Address gender-based barriers to contraceptive access:

- Plan clinic timings that are convenient for 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 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.
  - Ensure there are separate rooms for women who want privacy for consultation and counselling.
  - Provide home-based contraceptive information and services through women CHWs who would accompany the women for referral services such as long-acting or permanent methods of contraception.
  - Ensure a process by which women can give inputs in setting up the services and feedback for services received.
2. Review whether services are available for providing safe abortion to the full extent of the law to remote areas, urban poor, adolescents and other potential users who might have difficulties in accessing services.  If not, initiate a process whereby existing primary health care services start to provide safe abortion. 

## Examples

### A mobile contraceptive service delivery programme, United Republic of Tanzania

Marie Stopes International in collaboration with the Ministry of Health and Social Welfare (MOHSW) operates a mobile outreach family planning programme in the United Republic of Tanzania. There are 20 teams, and all teams provide family planning and integrated voluntary counselling and testing services for HIV.

Staff from the MOHSW health centres and dispensaries register clients seeking family planning services, and once a number have registered, the information is submitted to the district medical officer who contacts the mobile service team to fix a date and time for their visit. Clients are informed of the visit date through village leaders and clinic staff. Prior to the scheduled mobile team visit, clinic staff counsel clients on the different methods.

The mobile service team provide services in MOHSW facilities. Services are provided free of charge to clients. All contraceptive methods, including long-acting and permanent methods, are offered. Follow-up care is provided by the MOHSW facility staff.

Source: Vance G and Bratt J. Mobile outreach services for family planning in Tanzania: an overview of financial costs. *The RESPOND Project Study Series: Contributions to Global Knowledge*. Report No. 14. New York: EngenderHealth; 2013.

### Scaling up access to long-acting family planning methods in Ethiopia: Implanon

Ethiopia has made commitments to increase access to contraceptives ensuring informed choice and method mix with a focus on rural populations. The most commonly used contraceptive in Ethiopia has been injectables. Recognizing a demand to meet needs for long-acting methods especially in rural areas, the government launched an Implanon® scale-up initiative in 2009. The aim of the scale-up was twofold: to increase access to family planning information and services particularly in rural areas, and to satisfy the huge unmet need for family planning services.

UNFPA is among the key partners of the Government that provided support to this initiative. The support took the form of procurement of supplies and establishing training of health extension workers (HEWs), which was also a part of the national task-shifting programme. This support has been crucial in keeping the project on track and focused. Preliminary results show the initiative has been a success both in achieving increased access to and demand for long-acting family planning methods.

### Lessons learned

- Improving the capacity and skills of HEWs can be instrumental to improving access to family planning services at the community level.
- Providing communities with a better range of family planning options leads to an uptake in long-acting options for better child spacing.

- Working with health partners has been key in extending and scaling up the project.

## Resources

High impact practices in family planning (HIP). 2014. *Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives*. Washington, D.C.: United States Agency for International Development. Available from <https://www.fphighimpactpractices.org/resources/mobile-outreach-services>. Accessed 9 July 2014.

USAID and ICF Macro. 2010. *Expanding Contraceptive Choice to the Underserved Through Delivery of Mobile Outreach Services: a Handbook for Program Planners*. Washington, D.C: United States Agency for International Development, ICF Macro. <https://www.k4health.org/toolkits/communitybasedfp/expanding-contraceptive-choice-underserved-through-delivery-mobile>. Accessed 25 November 2014.

UNFPA and PATH. 2013. *Road-Mapping a Total Market Approach for Family Planning and Reproductive Health Commodity Security*. Istanbul: UN Population Fund. Available from: <http://eeca.unfpa.org/publications/road-mapping-total-market-approach-family-planning-and-reproductive-health-commodity#sthash.WkbssCRO.dpuf>. Accessed 25 November 2014.

WHO. 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd edition. Geneva: World Health Organization. [http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf). Accessed 25 November 2014.

## 3b. Access and integration of services

Experience in a variety of different settings has shown that integrating contraceptive information and services into other SRH services increases accessibility of such services [25,26].

### Contraceptive information and services, as a part of sexual and reproductive health services,

**should be offered within HIV testing, treatment and care provided in the health-care setting. (Recommendation 3.5)**

**Comprehensive contraceptive information and services should be provided during antenatal and post-partum care. (Recommendation 3.6)**

**Comprehensive contraceptive information and services should be routinely integrated with abortion and post-abortion care. (Recommendation 3.7)**

### Key considerations for policymakers and programme managers

- Integration of services is defined as “The management and delivery of health services so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of the health system [27].
- Contraceptive services are often not well integrated into other sexual and reproductive health services and HIV services, thus missing opportunities to reach people who need contraception. Experience in a variety of different settings has shown that integrating contraceptive information and services into other sexual and reproductive health services and HIV services has the potential for increasing accessibility of such services. For example, integrating contraceptive services into HIV services provides an opportunity to reach women living with HIV, who often have a high unmet need for contraception [28]. Integration of HIV services and maternal health services contributes to reaching improving overall family health, including the number of new HIV infections in children, is convenient for clients, and cost-effective for the health system [26].
- Globally, 65 per cent of women in the first year post-partum do not use a method of contraception although they express an intention to use contraception (K4Health Postpartum Family Planning Toolkit (Resources)) Provision

of post-partum IUDs is one effective strategy to address unmet need but should be offered as one option among others.

- 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. However, a subset of six studies with relevant data showed that only about a quarter (27 per cent) of the women left the facility with a method [28].

### Action points

1. Initiate meaningful participation processes to undertake the following: 

1.1. Review whether the national HIV Policy prioritizes the integration of contraceptive services within HIV testing, treatment and care services.



If not, advocate for such integration.

1.2. Review whether there is a strategy and guidelines for the integration of contraceptive information and services within the following:

- HIV testing, treatment and care services;
- pregnancy, delivery and post-partum care;
- abortion and post-abortion care.

If not, initiate the process of developing and implementing such strategies and guidelines, including establishing a set of criteria for evaluation. The plan for implementation should include:

- (a) Specific training of HIV service providers to deliver contraceptive information, counselling and services specifically for people (both women and men) living with HIV, with information about available contraceptive options; and the organization of health facilities providing HIV services to facilitate contraceptive provision. 
- (b) Specific training of maternal health and abortion/post-abortion care providers as

well as health workers at community level in skills for delivering contraceptive information, counselling and services, that includes developing an understanding of the gender and rights dimensions of services and change in values and attitudes that stigmatize women seeking abortion or post-abortion services. 

- (c) Specific protocols and standards for maternal health care (antenatal and post-partum) and abortion/post-abortion care that integrate contraceptive information, counselling and services.
- (d) Support integration of post-partum contraception into training curricula for health providers including midwives and CHWs, and ensure that regular training takes place.

1.3. Ensure the availability of appropriate commodities. (See also Module 2: Commodities and procurement (Availability)).

1.4. Support government and civil society organizations in development and implementation of social and behaviour change communication activities for post-partum contraception to ensure that women and couples receive full information on optimal birth spacing and contraceptive methods during pregnancy and after birth. Ensure that educational and counselling interventions related to this are available at health facilities.

1.5. Ensure integration of services to address violence against women in family planning services in line with WHO *Clinical and Policy Guidelines for Responding to Intimate Partner Violence and Sexual Violence against Women* [30].

### Examples

#### Integration of contraceptive information and services with post-partum and post-abortion care

The 'Men in Maternity' project in India aimed to provide pregnant women and their husbands with education, counselling and service provision in a clinic setting. Contraceptive use at 6–9 months post-partum was significantly higher in the intervention group

compared with the comparison groups. Among non-users, intention to use contraception was significantly higher among women in the intervention groups compared with the comparison groups [31].

In Egypt, counselling of women and their husbands was a component of an intervention to improve post-abortion care and integrate family planning services with post-abortion care in six public hospitals. Counselling of women and their husbands was done separately so that women could ask questions or express concerns freely. Husbands were recruited for counselling only after receiving consent from their wives. The content of counselling revolved around four main messages: patient's need for rest and adequate nutrition; warning signs in the post-abortion period that warranted medical attention; the possibility that fertility would return within two weeks; and the need for adopting family planning to prevent ill-timed or unwanted pregnancy [32].

Sources: Varkey LC, Mishra A, Das A et al. 2004. *Involving Men in Maternity Care in India*. Washington, D.C.: Population Council. Available from: [http://www.popcouncil.org/uploads/pdfs/frontiers/FR\\_FinalReports/India\\_MIM.pdf](http://www.popcouncil.org/uploads/pdfs/frontiers/FR_FinalReports/India_MIM.pdf). Accessed 27 November 2014.

Youssef H, Abdel-Tawab N, Bratt J, van der Velden T, Abou-Gabal M. 2007. *Linking family planning with postabortion services in Egypt: testing the feasibility, acceptability and effectiveness of two model of integration*. New York: Population Council, and Chapel Hill (North Carolina): Family Health International. Available from: [http://www.popcouncil.org/uploads/pdfs/frontiers/FR\\_FinalReports/Egypt\\_PAC.pdf](http://www.popcouncil.org/uploads/pdfs/frontiers/FR_FinalReports/Egypt_PAC.pdf). Accessed 27 November 2014.

### **Strengthening health system responses to gender-based violence in Eastern Europe and Central Asia — a resource package**

*Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia — a Resource Package* developed jointly by Women Against Violence Europe and UNFPA's Regional Office for

Eastern Europe and Central Asia is a set of tools for health-care staff, health facility management and policymakers, with a focus on the Eastern Europe and Central Asia Region. Part I provides background information and practical guidelines for strengthening policies and programmes for better health system response to gender-based violence. Part II offers a ready-made training curriculum to strengthen the knowledge and skills of health-care professionals to address gender-based violence. The tool is being used to inform capacity development of health professionals in five European countries, while serving as the foundation for workshops on strengthening the health system response to gender-based violence within the Eastern Europe and Central Asia Region. The materials are available from: <http://www.health-genderviolence.org/>

### **Resources**

Farrell BL. 2007. *Family Planning-Integrated HIV Services: a Framework for Integrating Family Planning and Antiretroviral Therapy Services*. New York: EngenderHealth/The ACQUIRE Project. Available from [http://www.engenderhealth.org/files/pubs/acquire-digital-archive/6.0\\_integrate\\_fp-lapms/6.2\\_resources/6.2.4\\_tools/fp-hiv-integration\\_framework\\_final.pdf](http://www.engenderhealth.org/files/pubs/acquire-digital-archive/6.0_integrate_fp-lapms/6.2_resources/6.2.4_tools/fp-hiv-integration_framework_final.pdf). Accessed 25 November 2014.

K4Health. Family planning and HIV service integration toolkit. Available from: <https://www.k4health.org/toolkits/fphivintegration>. Accessed 23 May 2014.

UNFPA. 2010. *Health Sector Response to Gender-based Violence: An assessment of the Asia Pacific Region*. Bangkok: UN Population Fund. Available from: <http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2010/Assessment.pdf>. Accessed 25 November 2014.

UNFPA, UNAIDS and EU. 2013. *The Swaziland Linking HIV and SRH Programme Best Practice Series*, 2014. Available from: [http://esaro.unfpa.org/webdav/site/africa/users/Lbarnes/public/FINAL%20Swaziland\\_SRH\\_BestPracticeSeriesReport\\_.pdf](http://esaro.unfpa.org/webdav/site/africa/users/Lbarnes/public/FINAL%20Swaziland_SRH_BestPracticeSeriesReport_.pdf). Accessed 25 November 2014.

UNFPA and WAVE. 2014. *Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia: a Resource Package*. Istanbul, Turkey: UN Population Fund. Available from: <http://eeca.unfpa.org/publications/strengthening-health-system-responses-gender-based-violence-eastern-europe-and-central>. Accessed 25 November 2014.

For further reference on setting up and running youth-friendly services, see for example:

IPPF. Provide: Strengthening Youth Friendly Services. Available from: [http://www.ippf.org/sites/default/files/inspire\\_provide.pdf](http://www.ippf.org/sites/default/files/inspire_provide.pdf). Accessed 23 May 2014.

For guidance for physicians, see Engenderhealth. 2002. *Youth-friendly Services: a Manual for Service Providers*. New York: Engenderhealth. Available from: <http://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf>. Accessed 23 May 2014.

For further reference on setting up family planning services for men, see:

C-CHANGE. Incorporating male gender norms into family planning and reproductive health programs. Washington, D.C., C-CHANGE (Undated). Available from: [https://www.c-changeprogram.org/sites/default/files/Gender%20Norms%20Program%20Brief%20Nov09%20FINAL\\_0.pdf](https://www.c-changeprogram.org/sites/default/files/Gender%20Norms%20Program%20Brief%20Nov09%20FINAL_0.pdf). Accessed 23 May 2014.

For further guidance on how to implement integration of family planning services with prenatal and postpartum care, refer to:

BASICS Healthy Timing and Spacing of Pregnancy Toolkit User Guide. USAID and BASICS. Post-partum Family Planning Toolkit. Available from: <https://www.k4health.org/toolkits/fp-trm/family-planning-references-and-resources>. Accessed 25 November 2014.

For further guidance on how to implement integration of family planning services with abortion or post-abortion care, refer to:

USAID 2012. *High Impact Practices in Family Planning (HIP). Post Abortion Family Planning: Strengthening the Family Planning Component of Post Abortion Care*. Washington, D.C.: United States Agency for International Development. Available from: <https://www.fphighimpactpractices.org/resources/postabortion-family-planning-strengthening-family-planning-component-postabortion-care>. Accessed 25 November 2014.

See also:

USAID High Impact Practices (HIP). 2013. *Family Planning and Immunization Integration: Reaching Post-partum Women with Family Planning Services*. Washington, D.C.: United States Agency for International Development. Available from: <https://www.fphighimpactpractices.org/resources/family-planning-and-immunization-integration-reaching-postpartum-women-family-planning>. Accessed 25 November 2014.

WHO. 2013. *Programming strategies for post-partum family planning*. Geneva: World Health Organization. Available from: [http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496_eng.pdf?ua=1). Accessed 2 December 2014.

For information in integrating contraceptive information and services into HIV EMTCT see:

Inter-agency Task Team for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children 2012. *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015*. Available from: [http://www.who.int/reproductivehealth/publications/linkages/hiv\\_pregnancies\\_2012/en/](http://www.who.int/reproductivehealth/publications/linkages/hiv_pregnancies_2012/en/). Accessed 3 December 2014.

USAID, Knowledge4Health Project. Postpartum Family Planning (PPFP) Toolkit. Available from: <https://www.k4health.org/toolkits/ppfp>. Accessed 28 November 2014.

## 4. Quality of care (Quality, Acceptability, Informed Decision-making, Privacy & Confidentiality)

In the provision of contraceptive information and services, studies show that where people feel they are receiving good-quality care, contraceptive use is higher [31-34], and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them [35,36]. Elements of quality of care include: choice among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent training health workers; provider-user relationships based on respect for informed choice, privacy and confidentiality; and the appropriate constellation of services (including follow-up) that are available in the same locality [37].

The fulfilment of human rights requires that all health-care facilities, commodities and services be respectful of medical ethics and of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, and must be designed to respect confidentiality and improve the health status of those concerned [2].

The principle of autonomy, expressed through free, prior, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law [6]. In order to make an informed decision about safe and reliable contraceptive measures, comprehensive information, counselling and support should be accessible for all people, including adolescents, persons with disabilities, indigenous peoples, ethnic minorities, migrants, people living with HIV, and transgender and intersex people [7].

Note: as quality of care covers a multitude of aspects of the provision of contraceptive information and services, to help the reader this implementation guide uses the three sub-divisions listed below. It is important to note, however, that there is much overlap

in the three sections, and that those using this guide will need to ensure they are all addressed.

### (i) Informed decision-making, counselling, and information

**Gender-sensitive counselling and educational interventions should be conducted on family planning and contraceptives that are based on accurate information, that include skills building (i.e. communications and negotiations) and that are tailored to meet communities' and individuals' specific needs. (Recommendation 4.1)**

**Offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice. (Recommendation 6.1)**

**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. (Recommendation 6.2)**

**Access to comprehensive contraceptive information and services should be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice). (Recommendation 1.1)**

### Key considerations for policymakers and programme managers

- Counselling in family planning is intended to help users make voluntary and informed decisions on whether and when to use contraception and to choose a contraceptive method that is medically appropriate and suitable to their needs. There may be gender-based barriers to contraceptive use, such as intimidation from a husband. Gender-responsive counselling takes into account the ways in which

contraceptive decision-making may be influenced by gender roles and norms about appropriate sexual and reproductive behaviour.

- The information provided to people so that they can make an informed choice about contraception must be scientifically accurate, must emphasize the advantages and disadvantages, the health benefits, risks and side-effects, should assuage fears and dispel myths or misconceptions, should be easily understandable and geared for different age groups, and should enable comparison of various contraceptive methods.
- Concerns about the side-effects of contraceptive methods — particularly hormonal methods — remain a major reason why users discontinue or switch to other, often less effective, methods [44]. Counselling about how to manage side-effects and information about options for switching to other methods is therefore crucial to helping individuals to make contraceptive choices.
- People living in particular circumstances, such as those living with disabilities or with a health condition such as HIV may be coerced into accepting certain contraceptive methods, often permanent. National laws or policies may or may not speak to these situations, but at the service level, providers may take the position that people in these circumstances should not have children, and should therefore be sterilized.
- Women subjected to intimate partner violence may fear further violence for using or talking about contraception. “Reproductive coercion” includes sabotage of contraceptive use by the intimate partner, pressure to become pregnant, and coercion to continue with or terminate a pregnancy. [39].

## Action points

### 1. Initiate meaningful participation processes to:

1.1. Assess whether policies, guidelines and protocols  related to the provision of contraceptive information and services:

- (a) state explicitly and upfront that no person shall be forced against his/her will to accept contraception, or to accept a specific method of contraception if they do not wish to;
- (b) prohibit the offering of incentives or disincentives to the client or to the provider/facility for adoption of a specific method of contraception;
- (c) protect from forced or coerced practices against persons from marginalized groups (e.g. low-income, minority communities, people living with HIV, persons with disabilities) through monitoring and client feedback mechanisms (spot-checks, evaluation boxes, mystery client, client-exit interviews);
- (d) include modalities of informed decision-making, including gender-based dimensions such as attention to whether it is the woman who is making the decision, without pressure from her husband or other parties; and facilitating informed decision-making for young people;
- (e) provide for appropriate and adequate information to users about follow-up visits, timings and procedures.

If any of these elements are missing from contraceptive policies and guidelines, initiate a process whereby they can be expressly integrated, and a process/strategy for disseminating and adoption of the new guidelines. The process may include evidence-based advocacy at policy level, technical reviews of existing national guidelines, legislation and protocols; and institutional capacity-building including in adopting/developing evidence-based guidelines and protocols.

### 1.2. Identify whether **health care workers** are **trained** in the following:

- (a) How to ensure that users, including adolescents, can make an informed choice, including choosing to accept or not to accept a contraceptive method, without imposing their own views or using coercion (i.e. provider bias).

- (b) Building perspective on power dynamics both in the families and between providers and clients as part of the training.
- (c) Ways in which gender-based inequalities may affect informed decision-making. For example, 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 (e.g. if the husband responds for many questions asked of the woman) in which case an individual counselling session would be a better option.
- (d) Safeguarding the privacy of individuals and confidentiality of their medical records, with particular attention to adolescents, whose privacy is often not safeguarded.
- (e) Follow-up procedures including management of side-effects and removal of long-acting reversible contraceptives.
- (f) Addressing the specific needs of women subjected to intimate partner violence and/or sexual violence in accordance with WHO guidelines for responding to intimate partner violence and sexual violence against women [30].

If any of these dimensions are not included in both pre-service and in-service training, initiate a process whereby all of the issues can be integrated into health-care provider training.  (See also sub-division (c) Quality assurance.)

# What do we mean by engaging men to promote gender equality?

Engaging men for gender equality focuses on three specific potential areas (men as clients, and supportive partners in egalitarian decision-making related to reproductive health, and men as agents of change in promoting gender equality) although it is not limited to these areas.

## **Men as clients**

Often, men underutilize reproductive health services or see no place for themselves within those services. Men should be encouraged to recognize that they too have sexual and reproductive health issues and needs; have the right to access sexual and reproductive health services themselves and those services should be available to them. For example, in terms of family planning, some programmes focus on encouraging men to take an active role through the use of condoms or voluntary vasectomy.

## **Men as supportive partners in egalitarian decision-making related to reproductive health**

Men may not consciously engage in decision-making about or support around reproductive health or family planning issues. They may see this as an area that is exclusively their partner's responsibility. Or they may engage in a negative way either by preventing women from practising behaviours or adopting family planning in ways that negatively affects women's sexual and reproductive health. Men can engage by exerting control over women's decision-making in both positive or negative ways. Programmes that address men as supportive partners in making egalitarian decisions need to: (a) increase awareness and understanding of men about women's sexual and reproductive health needs; and (b) promote a process of joint and egalitarian decision-making that is mutually respectful including of women's choices and decisions regardless of the outcomes. Through this approach they also need to enhance the positive influence that men can have on women's sexual and reproductive health. Such programmes recognize that men can play an important role in decision-making, planning, and resource allocation in women's health issues and seek to harness this role in a way that promotes more egalitarian decision-making — one that is supportive and respectful of women's choices. Programmes using this approach target men to involve them as supportive partners in a variety of areas, including maternal health, family planning, neonatal care, and in prevention and management of HIV/AIDS and STIs.

## **Men as agents of change in promoting gender equality**

While this guide is geared towards service delivery programmers rather than social change, writ large, this third approach focuses on challenging unequal power relations and gender norms that put women and men at risk (e.g. norms around multiple sexual partners, non-use of contraception, abuse of alcohol, violence, etc.). Programmes that fall under this category explicitly focus on identifying and addressing the key gender and social norms and unequal power roles and relationships that contribute to gender inequality and may result in adverse health outcomes. Such programmes need to work with men, women and entire communities in order to bring social change towards gender equality. An implicit assumption about these programmes is that more progressive norms around masculinity and femininity and gender equality will translate into improved reproductive health outcomes.

Constructively engaging men also does not mean just targeting men. Programming with men should always be done in consultation and ideally in conjunction with programming with women. In fact, often, the best results can be achieved with programmes that are gender synchronized, or that work “with men and women, boys and girls, in an intentional and mutually reinforcing way that challenges gender norms, catalyses the achievement of gender equality, and improves health”). Although parts of this guide focus on how men can be engaged, much of its guidance can be adapted to apply to programming that is gender synchronized (especially since gender synchronized programming implicates engaging men as well as women).

## (b) Privacy and confidentiality

**Privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information. (Recommendation 7.1)**

### Key considerations for policymakers and programme managers

- Providers must always make efforts to uphold an individual user's privacy unless the person specifically indicates a desire to include others in the decision-making. If people feel that their confidentiality and privacy are not guaranteed in the health-care environment, they may decide not to seek services, thus jeopardizing their own health and potentially that of others.
- Health-care providers have an obligation to keep medical information confidential, both written records and verbal communications. Such information may be disclosed only with the consent of the client.

### Action points

**1.** Initiate meaningful participation processes  to assess whether policies, guidelines and protocols related to the provision of contraceptive information and services:

- (a) give clear indications as to how to ensure privacy and confidentiality of the person seeking contraceptive services, including those who are unmarried, and sexually active adolescents;
- (b) have strict instructions about how to keep medical records confidential, and in what circumstances they may be revealed, with the client's consent;
- (c) ensure accountability and remedies in case of violation of policies, guidelines and protocols.

If these elements are missing from contraceptive policies, guidelines or protocols, initiate a process whereby they can be expressly integrated, and a process/strategy for disseminating and adoption of the new guidelines.

## (c) Quality assurance

**Quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes. (Recommendation 5.1)**

**Provision of long-acting reversible contraception (LARC) methods should include insertion and removal services, and counselling on side-effects, in the same locality. (Recommendation 5.2)**

**Follow-up services for management of contraceptive side-effects should be prioritized as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on-site be offered and available. (Recommendation 4.2)**

**Ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services should be undertaken. Competency-based training should be provided according to existing WHO guidelines. (Recommendation 5.3)**

### Key considerations for policymakers and programme managers

- A key component of good-quality family planning services, especially in the case of long-acting reversible methods (LARCs) such as IUDs and implants, is the assurance to clients that, should they decide on discontinuation of the method because of side-effects or for any other reason, their decision will be respected. Sites offering LARCs must have the capacity either to remove the method or refer individuals for removal services within a reasonable distance at affordable costs without undue delay.
- Standard training for providing contraceptive information and services may be one module as part of training for other aspects of reproductive health or obstetrics and gynaecology. It may not include all the aspects required by quality of care. Because the subject of contraception involves (directly or indirectly) discussion about

sexuality, it may be difficult for some health-care providers to talk about comfortably unless they have received specific training in this regard. The content of such training must, therefore, include interpersonal communication and counselling skills, and familiarity with human rights including gender inequality and violence against women.

- Supportive supervision must be provided to health-care workers, with ongoing monitoring for technical quality. Where improvements are needed, mentoring and additional on-site training is highly desirable.

## Action points

1. Initiate meaningful participation processes  to:

1.1. Assess whether contraceptive **protocols and guidelines**:

- Exist for different levels of facilities and providers for follow-up visits, management of side-effects and referrals for contraceptive services.
- Explicitly mention the user's right to request removal of long-acting contraceptives such as the IUD and implants; and protocols for referral in case removal cannot be safely carried out in the facility providing insertion services. For example, if a client wants to discontinue using a medication or contraceptive method, staff would be required to:

- treat their wishes with respect
- discuss with them their reasons for wanting to discontinue
- offer appropriate alternatives
- provide support and information if they wish to become pregnant.

- Assess whether contraceptive protocols and guidelines are in line with WHO *Clinical and Policy Guidelines for Responding to Intimate Partner Violence and Sexual Violence against Women* with respect to provision of care to survivors of intimate partner violence

and sexual violence. Align all protocols and guidelines with respect to violence against women to these WHO guidelines.

- Include specific reference to adolescents and particular considerations for providing contraceptive information and services to them.
- Explicitly provide for users' feedback.

1.2. Review whether the **training curriculum**, both pre-service and in-service, for providers of contraceptive information and services includes all the core competencies laid out in the WHO guidelines for responding to intimate partner violence and sexual violence. If not, initiate a process for ensuring that the curriculum adheres to the guidelines on contraception and competency requirements for violence against women services.



1.3. Review whether there is a system of regularly **updating providers' knowledge** and clinical skills on contraceptive methods, and their skills and knowledge on all the aspects of quality of care mentioned in this implementation guide. If not, initiate a process for putting such a system in place.

1.4. Assess the appropriateness of health care **facilities** in respect of quality:

- Are health facilities equipped with the personnel, physical space for counselling and educational materials appropriate for different levels of literacy, comprehension and cultural diversity and acceptability, including language and format that is accessible to clients?
- Do health facilities provide an enabling environment for safeguarding privacy and confidentiality, including for disclosure and discussion by clients experiencing intimate partner violence and/or sexual violence? (For example, posters in public spaces such as waiting rooms, examination rooms, hallways.)
- Do clients have access to their own medical records?
- Do the norms related to space requirements

of health facilities take account of the need for visual and auditory privacy, and for separate waiting, counselling and examination spaces for young people?

If the answer is no to any of the above, initiate a process of putting these procedures in place.

1.4 Examine whether the **budgetary allocation** (at different levels of the health system) is sufficient to assure adherence to the quality standards as elaborated above. If not, initiate a process to advocate for the allocation of adequate financial and human resources to enable adherence to quality standards.

2. After undertaking the above assessments and reviews, ensure that there is a comprehensive strategy for quality assurance, including clear indicators for the standards of quality of care, and a process of monitoring and evaluation to keep track of all the items in this section.

## Examples

### **Intercultural sexual and reproductive health among indigenous peoples in Latin America**

For many years, UNFPA has been supporting the efforts of governments and indigenous women's organizations in Latin America to establish an intercultural and human rights-centred approach to sexual and reproductive health. In Plurinational State of Bolivia and Ecuador, UNFPA collaborated with the constitutional reform processes that led to the recognition of sexual and reproductive rights and the right to intercultural health. UNFPA is providing and promoting technical assistance for designing or adapting intercultural reproductive health policies and norms, as the reports of Bolivia (Plurinational State of), Ecuador, Guatemala, Mexico, Panama and Peru demonstrate. This assistance is helping to implement culturally tailored reproductive health models in hospitals and communities, in emergency obstetric care units, and primary health care clinics at national and subnational levels. New reproductive health models need to be supported so they may continue to

address the high maternal mortality ratio and unmet need for family planning within indigenous peoples communities.

Source: Cline, R. (ed). 2010. *Promoting Equality, Recognizing Diversity: Case Stories in Intercultural Sexual and Reproductive Health Among Indigenous People in Latin America*. Panama City, UN Population Fund.

### **A tool to facilitate informed contraceptive decision-making**

WHO's *Decision-making Tool for Family Planning Clients and Providers* was adapted to the Iranian setting. Providers in 52 urban and rural public health facilities in four selected and representative provinces of Iran (Islamic Republic of) were trained to use the tool. Pre- and post-intervention data showed that use of the tool significantly improved the quality of information provided to clients, client's choice of contraceptive method, and client satisfaction with family planning services.

Source: Farrokh-Eslamlou H, Aghlmas S, Eslami M, Homer CS. 2014. Impact of WHO's decision-making tool for family planning clients and providers on quality of family planning services in Iran. *Journal of Family Planning and Reproductive Health Care*, 40(2):88-95.

## Resources

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UNFPA. 2014. *Engaging Men and Boys: A Brief Summary of UNFPA Experience and Lessons Learned*. New York: UN Population Fund. Available from: <http://www.unfpa.org/resources/engaging-men-and-boys-brief-summary-unfpa-experience-and-lessons-learned>. Accessed 3 December 2014.

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WHO Global Code of Practice on the International Recruitment of Health Personnel. Available from [http://www.who.int/hrh/migration/code/WHO\\_global\\_code\\_of\\_practice\\_EN.pdf](http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf). Accessed 28 November 2014.

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*Adolescent-Friendly Health Services*. Geneva: World Health Organization. Available from: [http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf?ua=1). Accessed 12 July 2014.

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Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning* 1220; 21:61-91.

For a comprehensive resource that provides guidance on how to enhance client skills for making contraceptive choices, see: *Comprehensive Counseling for Reproductive Health: an Integrated Curriculum. Trainers' Manual*. New York: EngenderHealth. 2003. Available from: [http://www.engenderhealth.org/files/pubs/counseling-informed-choice/ccrh\\_tm.pdf](http://www.engenderhealth.org/files/pubs/counseling-informed-choice/ccrh_tm.pdf). Accessed 3 December 2014.

For further guidance on follow-up services, management of side-effects and referrals, see:

*COPE for Reproductive Health Services: a Toolbox to Accompany the COPE Handbook*. New York: EngenderHealth; 2003. Available from: [http://www.engenderhealth.org/files/pubs/qj/toolbook/cope\\_toolbook-a.pdf](http://www.engenderhealth.org/files/pubs/qj/toolbook/cope_toolbook-a.pdf). Accessed 3 December 2014.

For guidance on a human rights-based and gender-responsive approach to quality of care, see:

Germain A. Meeting human rights norms for the quality of sexual and reproductive health information and services. Discussion paper presented at the International Human Rights Conference: ICPD Beyond 2014. June 26 2013.

For guidance on diagnostics to identify quality gaps from a gender and rights perspective, see:

IPPF/WHR. 2002. *Manual to Evaluate Quality of Care from a Gender Perspective*. New York: IPPF/WHR. Available from: [www.ippfwhr.org/sites/default/files/files/QoC\\_gendermanual\\_EN.pdf](http://www.ippfwhr.org/sites/default/files/files/QoC_gendermanual_EN.pdf). Accessed 26 November 2014.

For facility-based actions to improve quality of sexual and reproductive health care including family planning (from a gender and rights perspective) see:

Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning* 1220; 21:61-91. Available from: <http://www.popcouncil.us/pdfs/councilarticles/sfp/SFP212Bruce.pdf>. Accessed 3 December 2014.

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## 5. Comprehensive sexuality education and information (Accessibility)

In order to make informed decisions about sexuality and reproduction, all individuals — without discrimination — need access to good-quality, evidence-based and comprehensive information on sexuality and sexual and reproductive health, including effective contraceptive methods [2]. In addition to counselling by trained personnel, this requires the provision of comprehensive sexuality education, which should be provided both within and outside of schools and must be evidence-based, scientifically accurate, gender sensitive, free of prejudice and discrimination, and adapted to young people’s level of maturity, to enable them to deal with their sexuality in a positive and a responsible way [2].

Note: Although classified under “accessibility” in the WHO guideline, for the purposes of implementation, comprehensive sexuality education is given a separate category as it is a fundamental, cross-cutting category to be addressed by many actors beyond the health and health service provision sector.

**The provision of scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition. (Recommendation 3.1)**

### Key considerations for policymakers and programme managers

- Sexuality education, defined as an age-appropriate, culturally relevant approach to fostering knowledge including about sex and relationships by providing scientifically accurate, realistic, non-judgemental information, 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. The right to sexuality education is grounded in universal human rights — including the right to education and to

health — as established in numerous international agreements, such as the Convention on the Rights of the Child; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination against Women; and the Convention on the Rights of Persons with Disabilities.

- The term “comprehensive” in relation to sexuality education indicates that this approach is rights-based and promotes gender equality and will encompass the full range of information, skills and values to enable children and young people to develop a positive view of their sexuality in the context of their emotional and social development, and exercise their human rights as they make decisions about their sexual and reproductive health. Comprehensive sexuality education goes beyond a focus on the prevention of pregnancy and disease to embrace a holistic and positive vision of sexuality and sexual behaviour, and enables children and young people to acquire accurate information, explore and nurture positive values and attitudes, and develop life skills.
- Evidence from a range of countries indicates that information, knowledge and skills about sexuality and sexual health imparted through comprehensive sexuality education can improve sexual health outcomes, including through delayed sexual debut, reduction in unintended pregnancies, and increased use of condoms or other forms of contraception. Furthermore, a new review of evaluation studies has found that comprehensive sexuality education curricula that emphasize critical thinking about gender and power are far more effective than conventional “gender-blind” programmes at not only reducing STIs and unintended pregnancy, but also at reducing intimate partner violence,

transforming gender norms and advancing gender equality more broadly, and empowering young people as global citizens who can advocate for their own rights [40].

## Action points

1. Initiate meaningful participation processes  to:

1.1. Strengthen CSE programme quality by:

- (a) Building capacity in order to strengthen curricula and provide teacher training.
- (b) Conducting situation assessment and developing top priorities for action for strengthening both in-school and out-of-school programmes.
- (b) Initiating public debate about CSE; taking steps to ensure that training of health workers includes knowledge about the CSE curriculum; and looking for strategic “entry points” in schools to build the case for sexuality education (see UNESCO, 2012 (Resources)).
- (c) Promoting the training of educators in CSE for school health programmes.

1.2. Strengthen policies and advocate for sexuality education that is comprehensive and that reaches young people both in and outside of school:

- (a) Review the following national policies to establish whether comprehensive sexuality education (CSE) is included: national HIV laws and policies; national population and reproductive health laws and policies; national youth laws and policies; national education laws and policies; national laws and policies that address gender inequality and gender-based violence. If none or only one include comprehensive sexuality education, advocate for the inclusion of such a component, and initiate a process whereby CSE is included.
- (b) Assess whether laws and policies present obstacles and, where appropriate, advocate for the removal of legal, regulatory and social barriers to ensuring access of scientifically

accurate, realistic, non-judgemental

information about sexual and reproductive health for adolescents and young people.

- (c) Assess the potential for engaging in education reform and school health policies (e.g. drawing on the WHO Global School Health Initiative/ health promoting schools ([http://www.who.int/school\\_youth\\_health/gshi/en/](http://www.who.int/school_youth_health/gshi/en/))).
- (d) Assess the proportion of schools that provides CSE. If less than complete coverage, explore ways to expand coverage.
- (e) Advocate for a multisectoral approach that links health, education and youth sectors with CSE programmes to ensure availability of and referral to youth-friendly services, including sexual and reproductive health.
- (f) Promote ways of reaching out-of-school youth with CSE, in collaboration with NGO partners, particularly to reach most vulnerable young people — married girls, children with disabilities, pregnant adolescents, adolescents living with HIV, sexually exploited youth, etc. — who can more easily be engaged in non-school settings.
- (g) Advocate for financial commitment to CSE by the government.

1.3 Enhancing protective social factors:

- (a) Assess the extent to which CSE is given in a safe learning environment (see UNFPA 2010 (Resources)) and support government ministries to develop, train personnel, enforce, and evaluate policies and mechanisms to ensure safe learning environments which would focus on:
  - zero tolerance for sexual harassment, sexual relations, or physical abuse of learners by educators (or other adults charged with responsibility for young people);
  - regulations (backed with training, enforcement, and ombudsman systems to provide youth and families a safe place to report) to identify and report child abuse;

- adequate and appropriate adult supervision of out-of-classroom recreational activities, especially those involving girls;
  - reinforcing these efforts through explicit attention on safe schools within curricula.
- (b) Build on and reinforce long-term relationships with government and civil society partners to foster links between leaders of CSE programmes, other public initiatives, quality youth-friendly health services, and social institutions (including NGOs and technology/ media-based education programmes) that may address specific problems or foster changes in social norms.

1.4. Support monitoring and evaluation of CSE efforts through:

- (a) Formative research including to inform an evidence-based rationale for policy and programme priority setting.
- (b) Routine monitoring to assess the quality of CSE programmes and their reach.
- (c) Support to rigorous studies including quantitative surveys, and direct classroom (or group) observation, to measure changes beyond self-reported contraceptive and condom use.<sup>1</sup>
- (d) Support to rigorous evaluations that measure changes in STIs, unintended pregnancy, empower to reject sexual coercion, or other ultimate programme goals.

<sup>1</sup> This includes critical thinking skills, gender norms and girls' agency; knowledge of rights; intent to delay pregnancy; tolerance of sexual diversity and for the rights of PLWHIV; connectedness to school; sexual debut and activity; experience or perpetration of IPV, sexual coercion; girls' participation in safe spaces programmes; boys perception of sexuality and relationships; quality of interactions with mentors and teachers. Seek financial resources for at least one rigorous, quantitative evaluation of a rights-based, gender-focused CSE programme.

## Examples

### Colombia's comprehensive sexuality education programme to promote rights, gender, citizenship and critical thinking

Since 2008, with the support of UNFPA, the Colombia Ministry of Education has been implementing a programme aimed at delivering quality education to support sustainable development and foster citizenship capacities of young people. It is now transversal, continuous, and taking place both inside and outside the formal educational system. The programme is built on four essential elements: (1) to take a positive view of sexuality; (2) to support individual autonomy, responsibility and enjoyment; (3) to promote and achieve gender equality; and (4) to advance human rights. The programme also stresses the importance of the pedagogic methods that foster critical thinking.

After six years of implementation, Colombia's programme for sexuality education and building citizenship — Programa de Educacion para la Sexualidad y Construccion de Ciudadania (PESCC) — has expanded to 71 out of 94 Education Departments. It has consolidated conceptual and pedagogic programme frameworks and relevant operational processes such as institutional strengthening, knowledge management, and social mobilization and communications. Through Law 1620 (2013) and in line with PESCC, a National System of School Coexistence was created to ensure inclusion in the education system of training in human rights, sexuality education, and the prevention and mitigation of school based violence. This new law includes the conceptual and operational guidelines developed by PESCC.

The teachers' education strategy has been implemented through various methods. Pedagogic practices in sexuality education are included during the initial training for teachers, and online courses have been developed for public servants in the education, health and protection sectors. Through an intersectoral effort, a "pedagogic suitcase" has been developed, which includes guides, materials and tools for working with adolescents and youth on PESCC topics. The training process in the use of

these materials was being implemented in 2014. In addition, an external evaluation of PESCC is taking place in order to measure the programme's effects on students, teachers' pedagogic practices and the school environment.

During the 2010 Global Meeting on Comprehensive Sexuality Education, speakers from the Colombian Ministry of Education reflected on lessons learned that are still valid:

- Implementing comprehensive sexuality education in the education system is not easy and requires ongoing effort to build support for it over many years. It is essential to build a receptive external environment through communication and social mobilization efforts. And it is crucial to build receptive environments within schools that favour human rights and gender equity and engender trust and participation.
- At the school level, it is necessary to build institutional support within the schools. This requires building a multisectoral team within the school and developing an operational plan that fits within the larger institutional context. The plan must include monitoring and evaluation.
- The integration of sexuality education into different subjects in the curriculum, a transversal approach, has been found to be most effective.
- The process of building capacity is a continuous one, requiring preparation for sexuality education to be integrated into pre-service teacher training at different levels, as well as conducted by NGOs to those already in schools.
- Sustainability requires partnerships — across sectors of government, within communities and with civil society actors. Of primary importance is building links between the health and education sectors at all levels, particularly at the local level.
- It is not sufficient to work only within schools. A variety of programmes is needed, leading

to a cumulative impact. Broad alliances and collaborations among sectors and among various stakeholders — including local policymakers, parents, community leaders and the media — are essential.

Source: UNFPA. 2010. Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health. A Report on an International Consultation to Review Current Evidence and Experience. Bogota, Colombia: UN Population Fund.

### **Restless Development is reaching out-of-school youths in Sierra Leone with SRH sensitization and education**

Restless Development — a youth-led NGO — has volunteer peer educators (VPEs) that live and work in placement communities away from home for 8 months. During that time they are responsible for delivering SRH and life-skills training to both in- and out-of-school youths, as well as working with other community structures (e.g. traditional and religious leaders, and youth leaders) to ensure the community receives maximum benefit from the programme. As well as delivering SRH and life skills lessons each week in primary school and junior secondary school classrooms, the VPEs establish Teenage Mothers Clubs (TMC), where girls who have given birth and dropped out of school meet to support each other, learn about pregnancy and contraception, and conduct advocacy to in-school girls within their communities about the benefits of delaying pregnancy. The VPEs also establish youth-friendly resource centres (YFRCs), which contain resources (books, posters, and games) to engage young people in the community. The YFRC are safe, non-judgemental environments where young people can ask questions and find out about SRH issues, obtain condoms, and receive advice from VPEs. The VPEs also engage in advocacy on behalf of out-of-school youths, often with their parents or their teachers. This is particularly the case with young people who have fallen in with local 'gangsters' and been thrown out of the house, who decide they want to return to school but do not know how to

approach their families. With VPE intervention there is a strong history of family reintegration and returning to school. Restless Development usually works with communities for 3 years, building the capacity and understanding of the community leaders, teachers and youths. After 3 years the structures developed (YAC, TMC, YFRC) are embedded in the social fabric of the community, and continue to operate without the support of VPEs, ensuring that the VPE programme makes a sustainable difference.

Source: External Evaluation Report of Sierra Leone's Youth Reproductive Health Programme (2007–2012) <http://restlessdevelopment.org/file/external-evaluation-restless-development-sierra-leone-srh-programme-2007-2012-pdf>

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## 6. Humanitarian context (Crisis settings)

(See also Section 3, Organization of health facilities)

In crisis settings (emergencies, wars, and refugee camps) there is often a lack of access to SRH services. Yet affected populations have a particular need for these services. Access to contraceptive methods, particularly emergency contraception, and also to safe abortion and prophylaxis for STIs and HIV, is of paramount importance to safeguard women's health (WHO, UNFPA et al. 2012 (Resources)).

**Special efforts should be made to provide comprehensive contraceptive information and services to displaced populations, those in crisis settings and survivors of sexual violence, who particularly need access to emergency contraception. (Recommendation 3.4)**

### Key considerations for policymakers and programme managers

In crisis settings there is often a lack of access to sexual and reproductive health services, yet affected populations have a particular need for these services because contraceptive users are cut off from their normal sources of supply, and because of increased exposure to sexual violence. Access to prophylaxis for sexually transmitted infections including HIV, to contraceptive methods, particularly emergency contraception, and also to safe abortion, is of paramount importance to safeguard women's health (see WHO et al. 2012 (Resources)). Offering comprehensive contraceptive services in humanitarian settings has many benefits, such as:

- allowing families to time, space, and limit their pregnancies
- helping prevent unwanted pregnancy and unsafe abortion
- contributing to the reduction of maternal mortality

- enabling more efficient post-crisis recovery, development, and economic stability
- helping prevent the transmission of HIV and other STIs.
- In humanitarian settings, **childbearing risks are compounded**, due to increased exposure to forced sex, and reduced availability of and sensitivity to adolescent sexual and reproductive health services. At the same time, adolescents and women in humanitarian settings will have **similar rights and needs** and desire for sexual and reproductive health information and services as their peers in non-crisis settings.
- Emergency contraception can be used following unprotected intercourse, contraceptive failure, incorrect use of contraceptives, or in cases of sexual assault. The emergency contraceptive pill regimen recommended by WHO is one dose of levonorgestrel 1.5 mg, taken within five days (120 hours) or unprotected intercourse (WHO 2013 (Resources)).
- In the humanitarian context, a multisectoral response should take into account the fact that the need for SRH services does not end with the immediate crisis, but must continue and anticipate the cyclical nature of such crises.

### Action points

1. Initiate a stakeholder process  to:

1.1. Assess whether providers in the humanitarian setting are trained to deal with individuals who have been raped, to provide both STI/HIV prophylaxis and contraceptive information and services in this context, and to use current guidelines on sexual and reproductive health. If they are not, arrange for provider training, consulting in particular the WHO

guide on the clinical management of rape survivors (2004; Resources). 

1.2. Conduct a rapid needs assessment  to establish:

- (a) the demand for and access to contraception;
- investigate community and cultural beliefs and attitudes towards contraception
  - gather information on contraceptive prevalence by methods
  - assess potential providers' contraception provision competencies
  - verify availability of supplies and continuity of supplies
  - determine availability and functionality of existing facilities.
- (b) the extent of sexual violence in this setting. (See UN Action against Sexual Violence in Conflict, 2008 (Resources).)

Based on the findings of these assessments, advocate for appropriate training and supplies to be provided urgently.

1.3. Ensure the availability of supply and distribution for reproductive health kits (see Inter Agency Field Manual on Reproductive Health in Humanitarian Settings (2010; Resources)).

1.4. Identify whether there are legal or policy provisions preventing the availability of emergency contraception (EC) to the general population. If so, advocate for an exception to be made to those in humanitarian settings, and arrange to include EC as a part of the Minimum Initial Services Package. Initiate a process to have EC included on the national essential medicines list. (See also Section 2, Commodities and procurement.)

2. Advocate for a multisectoral response, including referral systems, to helping survivors of gender-based violence.

## UNFPA and humanitarian response

UNFPA has been involved in humanitarian action since the 1994 Cairo International Conference on Population and Development. In 2005, UNFPA became a full member of the United Nations Inter-Agency Steering Committee and started contributing to emergency responses around the world. UNFPA responds in emergencies through capacity building and human resources provisions. During emergencies, UNFPA works with service providers to implement the Minimum Initial Service Package (MISP), delivering key reproductive health services in emergency situations. The Fund also works with camp managers to ensure that refugees are safe through increased attention to their protection needs, that the dignity of women and girls is preserved through the provision of dignity kits, and that basic reproductive health services and psychosocial support are available and accessible.

### Resources

For guidelines on how to set up and implement family planning services in humanitarian settings, refer to:

Inter Agency Working Group on Reproductive Health in Crises. 2010. *Inter Agency Field Manuals on Reproductive Health in Humanitarian Settings*. Available from: [http://www.who.int/reproductivehealth/publications/emergencies/field\\_manual\\_rh\\_humanitarian\\_settings.pdf](http://www.who.int/reproductivehealth/publications/emergencies/field_manual_rh_humanitarian_settings.pdf). Accessed 26 November 2014

And the companion guide:

UNFPA and Save the Children. 2009. *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: a Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York: UNFPA. Available from: <http://eeca.unfpa.org/publications/adolescent-sexual-and-reproductive-health-toolkit-humanitarian-settings>. Accessed 3 December 2014.

For additional information on provision of EC in humanitarian settings, refer to:

Emergency Contraception for Conflict-affected Settings: a Reproductive Health in Conflict Consortium Distance Learning Module. Available from: <https://www.k4health.org/toolkits/rh-humanitarian-settings/emergency-contraception-conflict-affected-settings-reproductive>. Accessed 9 July 2014.

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UNFPA. 2008. *Interagency Reproductive Health Kits for Crisis Situations: a Manual*. 4th Edition. New York: UN Population Fund. Available from: [http://www.who.int/maternal\\_child\\_adolescent/documents/interagency/en/](http://www.who.int/maternal_child_adolescent/documents/interagency/en/). Accessed 3 December 2014.

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WHO. 2013. *Responding to Intimate Partner Violence and Sexual Violence against Women. WHO Clinical and Policy Guidelines*. Geneva: World Health Organization. Available from: [http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1). Accessed 12 July 2014.

## 7. Meaningful participation by potential and actual users of services

Participation of affected populations in all stages of decision-making, implementation and monitoring of policies, programmes and services is a precondition for sustainable development and the highest attainable standard of health [37,38]. Evidence shows that laws, policies and programmes better reflect the needs and perspectives of affected populations when members of these populations take part in their development, thus helping to secure improvements in health outcomes and the quality of health care [41,42]. For example, where women's participation in policymaking is guaranteed, a gender perspective tends to be more fully integrated into public policy, and the health system is more responsive to women's needs [36].

Under international human rights law, countries have an obligation to ensure active, informed participation of individuals in decision-making that affects them, including on matters related to their health [2]. They also have the obligation to ensure the meaningful participation of adolescents in all policies and programmes affecting their health [43].

**Communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring. (Recommendation 8.1)**

### Key considerations for policymakers and programme managers

- Participation can range from communities coming together to plan strategies to address local priorities, to the delivery of community-based responses for SRH, or social movements advocating for national policy change. Participation also includes the active involvement of individuals, communities or community-based organizations in the design, implementation, management or

evaluation of their community health services or systems, including in matters relating to their sexual and reproductive health [44,45].

- To ensure that programmes and policies meet their needs, adolescents must be heard and must contribute to the planning, implementation, monitoring and evaluation of services. Adolescents are a force for their own health and for the health of their families and communities. They are actors for social change, not simply beneficiaries of social programmes. Their participation needs to be advocated for and facilitated [46].
- People should be seen as active agents who are entitled to participate in decisions that affect their sexual and reproductive health. The criteria and evidence for prioritizing actions must be transparent and subject to public scrutiny. Power differentials based on literacy, language, social status or other factors — which may exclude those who are most affected by the decisions taken, such as women and girls — should be redressed to promote meaningful participation [45].

### Action points

1. Initiate a dialogue with all relevant stakeholders, including community leaders that influence contraceptive use.
2. Initiate, as part of this dialogue, a stakeholder process to:
  - 2.1. Examine whether the family planning policy/ programme guidelines specify the creation of mechanisms for regular participation and consultation (e.g. community-based users' committees; patient welfare committees in health facilities).

2.2. If not, advocate with policymakers and health programme managers the need for doing so, referring to human rights principles and examples of best practices.

2.3. If mechanisms for participation exist, find out the extent of participation by women, men and members of marginalized groups. Fixing specific quotas for the inclusion of women and members of marginalized groups will help ensure their inclusion. Ensure those mechanisms cover public participation throughout the continuum of programme design, implementation, management and monitoring, and include the possibility of client/user feedback to be incorporated into programme improvement.

**3.** Invest in capacity-building, empowerment and participation of community organizations (civil society organizations including grass roots organizations, women's groups and other marginalized groups) to ensure meaningful participation and to monitor programmes and be able to influence policy.

### Example

#### **Mechanisms for participation in programme implementation**

'Stronger Voices for Reproductive Health' was a Project in Geita District of United Republic 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 per cent to 80 per cent. The proportion of women engaging in discussions with health-care providers to improve quality of care increased from 3 per cent to 20 per cent during the project period.

Source: UNFPA and Harvard School of Public Health. *UNFPA at Work. Six Human Rights Case Studies*. New York: United Nations Population Fund 2008.

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*A Guide to Action for Community Mobilization and Empowerment Focused on Postabortion Complications: Facilitator's Manual*. New York: The RESPOND Project/EngenderHealth; 2010. Available from: [http://respond-project.org/pages/files/6\\_pubs/curricula-manuals/COMMPAC-Facilitator-Manual-May2010.pdf](http://respond-project.org/pages/files/6_pubs/curricula-manuals/COMMPAC-Facilitator-Manual-May2010.pdf). Accessed 26 November 2014.

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## 8. Accountability to those using services

Countries have an obligation to put their legal, policy and programmatic frameworks and practices in line with international human rights standards [11]. Establishing effective accountability mechanisms is also intrinsic to ensuring that the agency and choices of individuals are respected, protected and fulfilled. Effective accountability requires that individuals, families and groups, including women from vulnerable or marginalized populations, are aware of their rights with regard to sexual and reproductive health, and empowered to claim these [12].

**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. (Recommendation 9.1)**

**Evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur. (Recommendation 9.2)**

**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. (Recommendation 9.2 bis)**

**Key considerations for policymakers and programme managers**

- Evaluation and monitoring require that there be functioning data-collection and analysis systems. Monitoring can reveal the portion of all use for each method (and thus the extent that choice is really happening), and possible bias towards provision of particular methods (e.g. LARCs) will show up in any skewing of the proportions.
- The involvement of communities in the ensuring that health services are accountable to them is key. Where mechanisms for their involvement have been tried, such as the use of “report card” for obtaining and integrating client/user feedback, services have been found more responsive, more acceptable and health outcomes have improved. (See example below.)
- Mistreatment or violations of people’s human rights may occur in the context of contraceptive services; complaints may not be taken seriously and there may be an absence of remedy or redress. This is particularly the case for individuals who are already marginalized in some way, such as the poor, adolescents, migrants, persons living with disabilities, indigenous peoples, people living with HIV, sex workers, transgender and intersex individuals. The existence of mechanisms for addressing such grievances is a key part of human rights-based provision of services. Generally speaking, the more decentralized are such mechanisms the better their access for marginalized populations.
- Results-based financing 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” [45]. Examples include conditional-cash transfers to clients; and incentives paid to providers for meeting targets. Evidence on the effects of result-based financing suggests that there are many downsides to the approach, including a focus on quantity rather than quality of services, and an increase in inequity by rewarding users, providers and facilities that are better able to meet conditionalities or targets set by the programme [46]. Both these are in conflict with human rights standards and principles.

- Public-private partnerships and private actors are playing an increasingly prominent role in the framing and delivery of health services. It is therefore essential that accountability mechanisms are also in place for the private sector, so that all individuals may enjoy their rights in relation to contraceptive information and services.

## Action points

1. Initiate a stakeholder process  to:

1.1. Examine whether there is a grievance redress policy in place requiring enquiry and corrective action to address complaints received. There should be a system in place to monitor these enquiries and institute policy changes based on their findings. The system should have connections to the criminal justice system in instances of human rights abuse.

1.2. Examine whether there are mechanisms at the central and district levels to track financial commitments and allocations, and report leakages and delays in the procurement, supply and management systems as they apply to contraceptives. 

1.3. Identify whether there are mechanisms to:

- publicly disseminate judicial and/or administrative remedies that address violations of health-related rights (if so what dissemination mechanisms are used?).
- ensure that patients and health providers understand the implications of patients' rights charters and other legal remedies.

1.4. Examine whether there are any established mechanisms, such as networks for regional health-care improvement, that are involved in oversight and monitoring of sexual and reproductive health and human rights in the country, and that can hold providers and managers accountable. If so, examine how this oversight might be better facilitated. If not, advocate for the establishment of a system for

collecting and reporting on disaggregated data, as essential for monitoring and evaluation. 

1.5. Examine the role of private actors in the delivery of health services for sexual and reproductive health, including contraceptives, such as by pharmaceutical companies, private commodities and device manufacturers, insurance companies and private service providers, and assess whether there are any mechanisms to hold them accountable to both users of services and the government.

Depending on the answers to these points, initiate a process whereby improvements in effectiveness of mechanisms can be made.

- Promote the idea of social/community accountability mechanisms and facilitate their effective functioning through capacity-building initiatives that increase awareness about sexual and reproductive health and rights; and through deliberate inclusion of traditionally excluded sections of the population.
- If results-based financing has been adopted in sexual and reproductive health services, support research to study its effects on citizens' rights to contraceptive information and services, and especially on quality of care, equity and non-discrimination.

## Example

### Citizens' report card on health services

In many Latin American countries civil society groups are preparing 'report cards' on public services that provide feedback from citizens on the quality and coverage of public services including health services. 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 that 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.

The report card has put health services problems on the public agenda, and facilitated advocacy by civil society groups for transparency accountability and better access and delivery of health-care services. Perhaps the best indicator of success of the report card initiative is that it has been replicated in a number of other cities in Colombia and in the rest of Latin America.

Source: Chacón FG. *Ella Policy Brief: citizen participation in evaluating health services: the Latin American experience, ELLA (Evidence and lessons from Latin America)*. Lima (Peru): Practical Action Consulting; 2012.

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Expanding access to contraceptive services and improving health outcomes require services to be delivered in ways that respect, protect and fulfil the human rights of everyone who seeks, or uses contraceptive information and services.

This implementation guide for ensuring human rights within contraceptive service delivery is a companion document to the WHO guidelines on *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. This implementation guide sets out core minimum actions that can be taken at different levels of the health system, and provides examples of implementation of the recommendations in the WHO guidelines.

This guide is addressed to midlevel policymakers and programme managers/implementers involved with family planning service provision in all settings.



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