



ICPD =

International Conference on
Population and Development
Beyond 2014



**ICPD Beyond 2014 Expert Meeting on Women's Health - rights,
empowerment and social determinants 30th September - 2nd
October, Mexico City**

**Discussion Note for the ICPD Beyond 2014
Conference on Human Rights: Meeting Human
Rights Norms for the Quality of Sexual and
Reproductive Health Information and Services**

Adrienne Germain

Background paper # 2b

1. Introduction

a. ICPD Commitments

The ICPD Programme of Action (POA) mandates that sexual and reproductive health (SRH) policies and programs respect, promote and fulfill human rights, particularly of women and of adolescents. Central commitments of the POA are propelled by two sets of human rights, as follows.

The first set of human rights help to create an enabling environment. The POA recognizes that the health, sexual life and reproductive decisions of individuals, particularly women and adolescents especially girls, are significantly affected by protection of their human rights, their socio-economic status and the wider environment. The POA therefore emphasizes gender equality and the empowerment of women and girls, including by ending child marriage and all other forms of gender-based violence, and also enacting and implementing laws, policies and actions to ensure girls' and women's rights to education, productive assets, employment, and political participation, among others.

The second set of rights focus on access to the means to secure and maintain sexual and reproductive health, namely comprehensive sexuality education, SRH information and SRH services. The POA requires promotion and protection of human rights and fundamental freedoms, as well as adherence to medical and public health ethics and technical standards, in the delivery of SRH services, education and information. Participants in the ICPD, particularly the global women's health and rights movement and other public health leaders, framed these requirements to redress and to end the poor quality of care and abuses of human rights and fundamental freedoms that have marred many national family planning and population programs worldwide.

Recognizing the various SRH issues that girls and women face over their lives, the POA (para 7.3) defines reproductive rights to include three elements: the right to decide whether, when and how many children to have, the right to access the means to do so, and the right to sexual and reproductive health, free of violence, coercion and discrimination. Para 7.6 of the POA describes an essential package of SRH services and mandates that they, along with sex education for adolescents, be universally available. WHO recognizes the SRH services as a "guaranteed minimum."¹ Human rights norms, medical ethics and technical standards encourage integration of these services with each other, directly or through effective referral as a fundamental element of quality of care. The POA also mandates "universal access to reproductive health", and ending severe inequities, based on income and other factors, in SRH outcomes.

¹ WHO, "Sexual and reproductive health: Core competencies in primary care", 2011

These two sets of human rights are, as all human rights are, interrelated and indivisible. This means that an enabling environment must exist in order for quality of care standards to be met fully and for all. This discussion note, however, was commissioned to reflect primarily on operationalizing the second set of rights, that is, human rights norms for the quality of SRH information, education and services.

b. Sources

This note is rooted in the seminal 1990 paper by Judith Bruce of The Population Council, “Fundamental Elements of the Quality of Care: A Simple Framework”, which focused on family planning services, the primary SRH interest of the time.² At the time, General Comment 14 (GC14) of the Committee on Economic, Social and Cultural Rights (CESCR) elaborating the right to health did not exist, and Bruce did not explicitly refer to human rights. Nonetheless, the six elements of her framework, which constitute key “domains” in which decisions must be taken, reflect certain human rights norms. For example, Bruce put the health and wellbeing of individuals, the “clients” of family planning programs, at the center and defined “constellation of services” as one of the domains. These services must address health needs that occur concurrently and also across much of the life cycle of individuals, especially women. The ICPD POA defined the core services to be contraception, safe abortion (where not against the law), maternity care, and prevention and treatment of sexually transmitted infections and HIV.

This discussion note also considers the guidance provided by UN treaty bodies, in particular the CESCR GC 14 on the right to health, the Children’s Rights Committee GC No.4 on adolescent health, the background paper for the conference, and the Declaration of the Bali Youth Forum. It also takes into account four significant, recent reviews of progress toward operationalizing and implementing the main elements of good quality care.³ These reviews assess available literature and contain bibliographies that together probably constitute a comprehensive inventory (at least in English) of what has been done to improve quality of care, primarily in family planning services.

The bibliographies imply a peak of interest in the late 1990s following Bruce’s paper and the ICPD, and then a trough until fairly recently. Brief perusal of the bibliographies, as well as the analysis by Askew and Brady, which is currently being updated and expanded, also suggest that many of the research and knowledge gaps identified by Bruce in 1990 have not yet been filled and that new research areas have emerged.

² Studies in Family Planning, Vol. 21, No.2, March/April 1990

³ WHO, “Quality of Care in the Provision of Sexual and Reproductive Health Services”, 2011; WHO, “Sexual and Reproductive Health: Core Competencies in Primary Care”, 2011; Futures Group and Engender Health, “Voluntary Family Planning Programs that Respect, Protect and Fulfill Human Rights: A Conceptual Framework”, draft for review at WHO consultation, 2013; Ian Askew and Martha Brady, “Reviewing the Evidence and Identifying Gaps in Family Planning Research: The Unfinished Agenda to Meet FP2020 Goals,” background document for the Family Planning Research Donor Meeting, December 2012, Washington, D.C., New York: Population Council, 2013

Significant progress, some documented in the published literature and others encountered in the author's 45 years of work, at country and global level, has occurred in a number of countries during the last two decades. Nonetheless, the author's continuing experiences with national programs, together with information from many other countries provided by networks of advocates for the sexual and reproductive health and rights of women and of adolescents and youth, indicate that avoidable shortfalls in the quality of SRH information and services, which were identified even before the ICPD, are still widespread. The current review of progress toward the ICPD POA, along with ongoing work to formulate a post-2015 global development agenda, offer unusual opportunities to redress the shortfalls and achieve SRH information, education and services for all that meet human rights norms.

2. Human Rights-based attributes of SRH information, education and services: availability, accessibility, acceptability and quality (AAAQ)

The right to the highest attainable standard of health requires that these four attributes be achieved for all without discrimination. (Note that "availability" includes affordability.) This section first acknowledges the characteristics of clients, then reviews duty bearers' obligation to provide good quality, and briefly describes the human rights attributes of quality.

a. Our Clients

The people who use or may potentially use SRH information and services are generally healthy and in the prime of life. They have the right to control what happens to their own bodies; to have control over their sexuality, including their sexual and reproductive health; and to have access to and use SRH services, education and information without any form of discrimination, violence or coercion by any source, including their families, health care providers and policy makers.

Earlier family planning programs focused on older, married women who had achieved their desired family size and women (especially in Africa, who were interested in spacing their births. Today, younger women must receive attention. Adolescent girls and the youngest women, especially those who live in poverty or without family support, face particularly intense risks and needs that vary by age, among other variables.

The 10-14 year olds are at risk of violence and sexual coercion, including marriage as children to older men, as well as intense gender inequalities in all aspects of their lives, but are not yet considered in most SRHR programs. Those who are 15-19 years old are beginning to receive more policy and program attention, with increasing recognition that, with preparation and investment, they can avoid risks and maintain their health, as they face decisions about sexual activity and marriage. The 20-24 year olds, both married and not, would also benefit from more

information, skills development and access to SRH services needed to maintain their health and enjoy fully their reproductive and sexual rights.

Yet, many, if not most, clients, especially adolescents and young women in the formative age groups, 10-14 and 15-19, face serious social risks and barriers when they try to access SRH information and use services. They commonly encounter judgment and intimidation by service providers, for example, experience or fear violence by their partners or parents, or do not know how to find accurate information. Such impediments affect their health (e.g., contraceptive side effects and failure rates), their personal security (e.g., threat of rejection or divorce, or violence, by partners and families), and their social standing (e.g., family hostility to giving birth in a health facility, judgmental treatment of sexually active adolescents by health care providers, expulsion of pregnant girls from school).

b. Our Obligation to Provide Good Quality Care

Governments, other key actors including private sector (commercial and NGO) health care providers, and other duty-bearers and stakeholders thus have even more than the usual obligation and responsibility to give priority to, and fully implement, information and service delivery standards that respect, protect and fulfill the human rights of their clients. Nonetheless, these standards have yet to be made explicit in SRH policies, or operationalized in the SRHR programs, of most countries and their international partners. They are not routinely used in the formulation of training and service delivery protocols or the content of SRH information, even though available evidence suggests that achieving quality standards improves the effectiveness of SRH information and services, and attracts people to use them.⁴

Further, quality of care often is addressed by the public health sector and by advocates only after extreme abuses of human rights and/or medical standards have occurred, abuses which can be prevented by appropriate planning and monitoring at all levels. Among many examples are the national contraceptive sterilization services in Bangladesh in the 1980s in which preventable deaths occurred from overdoses of anesthesia. Following criticism from donors, and withdrawal of some from the national program, the government appointed an investigation team that recommended reissuance of guidelines and direct, regular monitoring of services by senior, qualified managers; the high death rates ended with implementation of these revisions.

Despite similar experiences and long standing public controversy, in at least four states of India in 2012 and 2013, government sterilization “camps” and other

⁴ Askew and Brady, cited in Ref. 3 above; Anrudh Jain et al., “Evaluation of an intervention to improve quality of care in family planning programme in the Philippines”, Journal of Biosocial Sciences, Cambridge University Press, 2011; Jacqueline E. Darroch and Susheela Singh, “Trends in contraceptive need and use in developing countries in 2003, 2008 and 2012: an analysis of national surveys”, The Lancet, Vol. 381, Issue 9879, 18 May 2013

service sites failed to meet the most basic requirements of informed consent and medical standards, which has led to death, miscarriage and other severe health consequences, all of which could have been prevented by planning and supervision. Some of these cases are currently in the Indian courts.⁵ Egregious abuses, that could have been avoided with clear national policies and operational guidelines, have also occurred in many other places since the ICPD, including forced sterilization of women living with HIV and AIDS in southern Africa and of highly disadvantaged indigenous women in Peru.

As yet, specific mechanisms for redress of abuses in SRH services, inside the health sector or outside it in the courts or local government, exist in few places, are weak, and are least accessible or least likely to be used by those who are most likely to be abused. Further, they seem to be used only for the most extreme instances, namely preventable deaths or forced sterilization.

The following analysis emphasizes prevention of abuses and of poor quality care, by ensuring that human rights, public health and medical standards are fully implemented.

c. Human Rights Norms

As established by the CESCRC GC 14, health services and information should have the attributes of “availability, accessibility, acceptability and quality” (AAAQ), characteristics also embraced by medical ethics and public health standards. The AAAQ provides a high-level human rights framework for policy makers, practitioners and donors. Its implementation must be sensitive and responsive to the characteristics of its clients (such as age, gender, ethnicity, disability, among others), each of whom has different needs, resources and capacities. For example, what does the “acceptability” of particular contraceptive methods mean to a 14-year-old girl, as compared to a 25- or 40-year-old woman? AAAQ, including how they are specific to adolescents, are illuminated in the following box.

⁵ Among several local and international news stories see: <http://www.nydailynews.com/news/national/indian-women-dumped-field-sterilization-operation-article-1.1258314>; http://www.huffingtonpost.com/2013/02/07/mass-sterilization-india_n_2638490.html

Availability, Accessibility, Acceptability and Quality of Health Services

The Committee on Economic Social and Cultural Rights in its General Comment Number 14 on the right to the highest attainable standard of physical and mental health has defined four normative elements that apply to the right to health and all the underlying determinants of health. The Children's Rights Committee in its General Comment 4 on Adolescent Health has adapted these norms to adolescents:

States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:

(a) **Availability.** *Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;*

(b) **Accessibility.** *Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;*

(c) **Acceptability.** *While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;*

(d) **Quality.** *Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.*

This discussion note takes into account these four attributes of the right to health, but is organized by the primary areas of action that the health system can address and is responsible for. Actions in these six areas help to deliver more than one of the AAAQ attributes, and significantly expand the GC14 definition of "quality".

3. Practical actions by the health sector to meet AAAQ in SRH information, education and services

SRH information, education and services are delivered in various ways and combinations within and across countries: as vertical initiatives focused on one service such as family planning; as an integrated package of two or more services; and as a mix of the two. While a comprehensive package is the goal defined by the POA, most services, especially in low and middle income-countries, remain vertical or combine two services, often for special client groups such as women living with HIV and AIDS.

a. Focus on Family Planning

This section begins with and focuses substantially on family planning for several reasons:

- **Resurgent interest** in, and funding for, contraceptive services (e.g., FP2020) provides a major opportunity to institutionalize practices and deliver information and services that meet human rights norms, as well as medical ethics and public health standards.
- **Abuses such as contraception, sterilization or abortion without knowledge and consent, as well as disability and death** because of poor clinical care, continue in many places.
- **Other abuses are even more common**, including breaches of privacy and confidentiality, shortages of supplies and other management problems that obstruct access to services and choices among contraceptive methods, provider biases and disrespectful interaction with clients, and inadequate information especially about contraceptive side effects, all of which have been shown to **contribute to high rates of discontinuation and nonuse**.
- **Severe inequities in access and discrimination against certain groups**, including adolescents, the unmarried, and people marginalized by disability, ethnicity and other characteristics, have not yet been rectified.
- **Nonetheless, contraceptive services** are particularly important because they are very often, though not always, the **first or only SRH service that women can access**, especially disadvantaged women in countries with weak health systems and limited resources.

In addition, family planning (contraceptive) information and service programs must modify virtually all aspects of their work, including planning, implementation, monitoring and evaluation, to meet the needs of increasingly diverse clients. Clients today and in future include not only married women who wish to stop childbearing after having their desired number of children, but also many other groups, such as young married couples who want to postpone their first birth; young married women, in countries such as Bangladesh, who now have their desired number of children by age 25 and need contraceptive protection for decades;⁶ adolescents who begin sexual activity before marriage, especially as age at marriage rises, and who want to avoid both pregnancy and sexually transmitted infections but are not yet thinking about having a “family”, let alone “planning” one; girls or women who have unprotected sex or are raped and need emergency contraception; among many others.

Finally, recognizing the increasing prevalence of sexually transmitted infections (STIs) and the continuing HIV and AIDS epidemic, family planning information and services must give male and female condoms higher priority and also give more weight to assisting girls and women to consider the risks of sexually transmitted

⁶ For example, John Cleland and Iqbal H. Shah, “The contraceptive revolution: focused efforts are still needed”, *The Lancet*, Vol.381, May 11, 2013

infections and HIV when deciding what contraceptives to use. STIs not only harm women's own health (e.g., HPV infection leads to cervical cancer) and compromise their fecundity, but also affect child survival, as they are a significant cause of miscarriage, stillbirth, low birth weight and congenital defects.

Meeting the needs and protecting the right to the highest attainable standard of health of these highly diverse women and girls,⁷ as mandated in the POA and the CESC GC14, requires not only expanded and improved information for clients, including comprehensive sexuality education for all adolescents, but also training and supervision of health care workers to provide supportive counseling and clinical services, and adjustments in the mix of contraceptive methods made available, among others.

Meeting the needs of diverse clients, achieving human rights-based information and services, and eliminating inequities also requires modification of the indicators used to estimate "unmet need" and to measure "results" or programme "success". For example, one of the most common measures of the results of family planning programs is "couple years of protection" (CYP), which, like most other family planning measures, tracks the contraceptives, not the people using them. CYP and other measures, often required by donors, dispose program planners, managers and funders to favor longer acting methods and sterilization, which have high intrinsic CYPs. These common measures subvert human rights norms that require that clients have an unbiased choice among the widest possible range of contraceptives.⁸

b. Elements of Good Quality Information and Services

This section reorganizes the six elements of the Bruce framework and adds elements, in order to indicate how governments and other actors in the health sector can achieve AAAQ in the provision of SRH information, education and services, a core dimension of their human rights obligations to respect, protect and fulfill reproductive rights. Basic means to achieve universal fulfillment of reproductive rights, without discrimination and with the protection and fulfillment of reproductive rights were mandated by the 1994 ICPD, and subsequent intergovernmental agreements have elaborated their meaning.

For example, following up ICPD POA para 8.25, the 1999 key actions for the further implementation of the ICPD POA (para 63 iii) says that governments should train and equip health service providers and take other measure to ensure that, where abortion is legal, it is safe and accessible. Another example is the recognition by the

⁷ This discussion note focuses on information and services for women and girls as the primary clients of SRHR programs, without which they, unlike men and boys, cannot fully enjoy their other human rights. Provisions for men, boys and those of diverse gender identities are beyond the scope of this paper, but should be carefully developed by others.

⁸ Anrudh Jain and Judith Bruce, "A reproductive health approach to the objectives and assessment of family planning programs," pp 193-210 in Gita Sen et al., eds., *Population Policies Reconsidered: Health Empowerment and Rights*, Harvard University Press, 1994.

2013 57th Commission on the Status of Women that SRHR information, education and services need to incorporate actions to prevent and mitigate persistent high levels of violence and sexual coercion against women and girls.

Adoption and full implementation of the elements discussed below are required, at a minimum.⁹ Although countries will prioritize and design actions to fit their national constraints and circumstances, to fulfill their human rights obligations, all states, supported by their partners especially in the UN system, must review, adapt and implement policy and operational frameworks that include the elements below, as a matter of priority. Where resources are not sufficient to undertake comprehensive actions, states have the obligation of progressive realization. This obligation requires an explicit strategy with clear and time-bound targets and benchmarks, and focused monitoring, in order to achieve the full content of the right to health progressively for all, with priority for those who are most vulnerable and disadvantaged.

Six action elements necessary to achieve quality that meets human rights norms are suggested below, with an indication of their relationships to Bruce's foundational framework and to AAAQ:¹⁰

- i. **Widest possible range of choices** among contraceptive methods (Bruce includes; addresses all of AAAQ);
- ii. **Decent facilities, and equipment and commodities** that are adequate to sustain good quality services and information (Bruce does not cover; addresses availability and accessibility);
- iii. **Training and supervision of service providers** (encompasses Bruce's elements, "information", "technical competence", "interpersonal client-provider relations" and "client follow-up"; addresses availability, accessibility, and quality);
- iv. **Essential package of integrated SRH services** as agreed originally in the ICPD POA, para 7.6 (Bruce's "constellation of services"; not addressed by AAAQ);
- v. **Outreach and communications** to those with "unmet need for family planning" who want to avoid pregnancy but are not using modern contraception (Bruce does not include; addresses all of AAAQ);
- vi. **Quality assurance mechanisms, monitoring, redress** for individuals and mechanisms to remedy policy failures as well as to prevent and correct discrimination in access and other abuses (Bruce does not discuss; addresses GC14 requirement).

⁹ Jane Cottingham, Adrienne Germain, Paul Hunt, "Use of human rights to meet the unmet need for family planning", *The Lancet*, Vol. 380, 14 July 2012

¹⁰ The elements below are relevant to those parts of government, other institutions and organizations and persons that set policies and budgets for, and that deliver, health information, education and services. They do not cover actions that other parts of government need to take to meet human rights obligations to provide an enabling legal and policy environment for the exercise and protection of sexual and reproductive rights and fundamental freedoms.

These six action elements are elaborated below.

i. Widest possible range of contraceptive methods:

At minimum, methods that work in different ways, not just several versions of the same type of method (e.g. multiple brands or dosages of hormonal pills, or several kinds of IUDs), must be made available so that women and girls can choose the type of method that is best for their circumstances at that time. Circumstances that clients and providers need to consider include frequency of sexual intercourse, need to protect against sexually transmitted infections and HIV, need to protect fecundity and for how long, partner support (or not), among others. Research shows that most women use several different contraceptive methods during their fertile years, often for quite short periods. Respecting each woman's and girl's right to choose freely the method that is best for her at a particular time requires governments, the private (commercial and NGO) sector, and international agencies and donors to:

- Plan for, procure and deliver at minimum: one barrier method (preferably male and female condoms, the only existing contraceptive method that also protects against STIs including HIV); one short and one longer acting hormonal method (e.g., one oral pill type, plus an injectable or an implant); emergency contraception (see below); one long-acting, non-hormonal method (IUD); and, where health system capacity allows or can be developed, both male and female sterilization.
- Assume, for the purposes of commodity procurement and staff training, that the universe of clients includes a significant proportion who will want to switch methods: Twenty years ago and today, research shows that as many as 35-40 percent of contraceptive users discontinue use of their method within 6-12 months for reasons related to the quality of care, far more than those who discontinue in order to get pregnant¹¹ and either do not know about, or are not supported by service providers to choose, an alternative method.
- Assume that a significant portion of girls and women will need access to emergency contraception for various reasons, including contraceptive failure, non-use, and sexual coercion and rape.
- Align contraceptive projections and procurement with the characteristics and contexts of both current and likely new users of contraception, while aiming to maximize the number of types of methods under prevailing resource constraints: For example, a country program currently serves primarily married women with children who want to space or end childbearing, and provides mainly longer acting hormonal methods and sterilization. When that country decides to serve adolescents and youth who

¹¹ Cleland and Shah 2012, footnote 6 above, citing John Bongaarts and Judith Bruce, 1995; Sian Curtis, et al., "Contraceptive discontinuation and unintended pregnancy: An imperfect relationship", International Perspectives on Sexual and Reproductive Health, Vol. 37, No. 2, June 2011

are not married or who are newly married, the current contraceptive mix will have to be expanded to include, for example, male and female condoms as well other methods to meet clients' preferences. Another country has provided only temporary methods but finds through surveys that many women or couples want to end, not space, births. This country needs to add commodities and skilled personnel for male and female contraceptive sterilization, as well as condoms to provide continuing protection against STIs and HIV.

Decisions about contraceptive mix, particularly contraceptive sterilization, IUDs and hormonal implants, must be carefully calibrated with the capacities of the health system and the skills of service providers to ensure the highest quality clinical care (see section *iii* below).

ii. Decent Facilities, Adequate Equipment and Commodities

Facilities do not have to be elaborate or expensive but must be designed, renovated and managed to:

- Provide privacy and confidentiality, which means, at minimum, separate screened space and seating for client-provider interaction and service provision, with special provisions for adolescents;
- Maintain the required standards of cleanliness, toilets, running water, equipment sterilization, etc.,
- Provide simple seating for clients and their companions in waiting areas that are protected from the elements, especially where waiting time tends to be long;
- Procure, store, track and maintain necessary equipment, contraceptives and other SRH commodities required to meet technical standards of care and to provide choices for clients;
- Facilitate use of services through such means as clinic hours that take into account the hours that women and adolescents are able to go to services; management and administrative initiatives to reduce waiting times; home visits and community-based providers who can resupply methods; and so on;
- Modify infrastructure and management practices to meet the particular requirements of groups commonly excluded from SRH services, such as people living with disabilities or who speak different languages, who are marginalized due to various social and personal characteristics (e.g., sex workers or indigenous people), and people unable to pay for services, among others.

Achieving the CECSR GC14 attribute of accessibility requires wide distribution of facilities and/or transportation to reach distant facilities. It further requires that services be affordable. Various strategies are being tried in different countries to

meet each of these requirements. No one approach can meet the particular characteristics and constraints of all countries, but all countries need to take concrete steps to make services and information physically and geographically accessible and affordable, especially for those who are disadvantaged.

iii. Training and supervision of family planning and other SRH service providers:

Synchronous with the above standards for contraceptive choices and well designed and managed facilities, SRH service providers must be trained, equipped and supervised to:

- Understand, respect and protect every client's rights to privacy, dignity and confidentiality at all times in all SRH services, regardless of characteristics such as age, marital status, education and income, ethnicity and race, language, or occupation, among others.
- Provide full and accurate information, including in writing as well as through media accessible to those who do not read, on all the contraceptive methods and other SRH services being offered, as well as those that are available by referral. This information must be in forms that are accessible and understandable to different groups, not only adult women but also adolescent girls, boys and men, with diverse cultural or language backgrounds, disability or other special characteristics;
- Support the client's choice, rather than promote a particular method or methods; abide by the country's eligibility standards for access to and choices among contraceptive methods, not impose their own (such as sterilizing women living with HIV and AIDS, ethnic minorities or those living with disabilities, among others, without their knowledge or fully informed and free consent; or refusing to provide services to young couples or to unmarried persons); where law or policies restrict or exclude certain groups from services and information, provide services and information to the maximum extent possible in line with human rights norms and medical standards; ensure that providers and program managers understand and abide by regulations on conscientious objection and, where these are insufficient or do not exist, take action to initiate and improve them so as to protect the clients' human rights;
- Ensure the client's fully informed and free consent to use a contraceptive method and other SRH services, giving special attention to clients who may not be accustomed to making choices, such as adolescent girls;
- Establish training, service delivery, and supervision protocols and procedures so that eligibility criteria and other clinical standards for contraceptive and other SRH services are met, and so that SRH service providers have the technical skills to provide safe contraceptive services, including skills required to remove contraceptive implants and IUDs on demand, provide male and female sterilization, and deliver other SRH services including maternity care and skilled attendance at birth, safe

abortion, prevention, diagnosis and treatment of STIs, and prevention of violence against women and girls as well as services and referrals for survivors of violence;

- Reiterate and provide additional information on the contraceptive method or the SRH service chosen so that the client understands how to use the method or what to expect and how to prepare for other SRH services; knows what side effects, as well as benefits, she can expect or might experience, for how long and how to manage them; is encouraged return for follow-up, including to switch contraceptive methods if she decides she does not like the one she has.
- Maintain accurate, confidential records on each client's contact information, relevant medical history, contraceptive method selection and use, and use of other SRH services, in order to provide continuing care and follow-up;¹²
- Ascertain the client's need for financial assistance for contraception and other SRH services, and act effectively on this information using all appropriate channels, which will vary by country and even within countries;
- Design and implement approaches to staff supervision, performance evaluation and remuneration that reflect, and help providers to achieve, these requirements.

iv. Essential Package of Integrated SRH Services

The ICPD POA urged governments and their partners to develop the capacities and allocate the resources required to provide the essential sexual and reproductive health services package. Countries are at various stages of developing their capacity to deliver integrated services, and vertical programs to deliver the various components, such as family planning, are more common than not. Vertical programs of good quality to deliver just one of the services are appropriate and acceptable, provided they are designed and delivered with a high priority commitment and progressive actions to achieve integrated services, preferably at each service delivery point, but at least by effective referral.

Enabling effective access to the full package of SRH services requires the government, various stakeholders and different types of service providers to collaborate and coordinate, at a minimum, to:

- Train and provide necessary information to providers to effectively refer clients to other SRH services;
- Assess and eliminate legal, administrative, policy and other barriers to integration of services; for example, at least one donor does not allow their HIV and AIDS programs funds to be used to purchase condoms delivered by family planning programs; in many countries, the national AIDS control program is structurally and administratively separate from other SRH

¹² This standard is related to, but not the same as, collecting "service statistics" which follow the services rather than the client

services even though their clients need those other services; in still other countries, family planning and maternal health services are in different divisions or even different ministries.

- Facilitate provision of multiple services in selected sites in order to learn the most effective ways to proceed with integration, including actions needed to meet the particular needs and constraints of groups who are discriminated against or disadvantaged by age, disability, race and ethnicity, place of residence, marital status, HIV status, gender identity and sexual identity, or any other status.

v. Outreach and communication

Accessibility of services and information, as defined in GC14, includes affordability and physical access (see *b. ii* above) and non-discrimination. This section deals primarily with access to accurate and objective information delivered without bias or discrimination of any kind, especially to those who have “unmet need for family planning” (defined as women who want to avoid pregnancy, STIs and HIV, but are not using condoms or other modern contraception).

The history of national family planning programs shows that special attention is required to ensure that information, public education and communications, and field worker training and assignments are designed to support free and informed decisions about contraception, rather than to “persuade”, “motivate” or even coerce contraceptive selection or use. Outreach information and communications messages should:

- Provide full and accurate information about contraceptive choices, and other sexual and reproductive health services, in ways that enable individuals and couples, particularly those who are disadvantaged, to access services easily, and to make independent and free decisions about their childbearing and health care (e.g., in addition to explaining particular contraceptives or services, indicate where they can be obtained, when, and with what requirements, such as fees);
- Promote understanding of the need for protection against both unintended pregnancy and HIV and STIs.
- Avoid gender and other stereotypes, and promote equality, especially gender equality, including women’s autonomy in SRH decision-making and zero tolerance for all forms of violence against women and girls.
- Tailor messages, language and other characteristics to communicate effectively with those who are marginalized due to income, education, age, marital status, occupation, disability, language, ethnicity and race, among others (e.g., much has been learned about effective – and ineffective – ways to communicate with younger and older adolescents).

Until now, typical communications, including those prepared and promoted by international technical agencies, have typically emphasized promotional content rather than the client-centered approach described above. For example, in a December 2012 Policy Brief, “Designing and Implementing High-Quality Voluntary Family Planning Programs”, the Population Council lists the following as one of seven best practices:

*“Family planning programs must build in a robust communications component to **convey the benefits** of contraception and **motivate** people to adopt family planning when they would like to avoid pregnancy” (author’s emphasis, not the Council’s).*

While reaching all women and adolescents should be the goal, reaching adolescent girls, especially those 10-14 and the younger end of the 15-19 year range, requires specific planning, training of staff and investments in outreach appropriate to local circumstances. In most countries, few if any community health workers or clinical facilities serve girls, whether married or not, especially those who are disadvantaged, such as those not in school; working; or living in poverty with only one or no parent, on the street or with an abusive employer, or with an older husband and in-laws. Such teenage girls are often at the highest risk of sexual coercion and violence, and the worst SRH outcomes.

In recent years, in highly diverse countries, the Population Council, UNFPA and others have produced a strong body of programmatic experience and evidence demonstrating that community-based programs (“platforms”) for girls can effectively engage and empower young girls living in these circumstances, helping them achieve their sense of identity, voice and ownership of their bodies; acquire knowledge and skills to protect their health; practice exercising their rights; avoid risky situations; and access health services.¹³ By comparison, evaluations of “peer education” programs show that they are expensive and not very effective especially for girls. The reasons include inappropriate design (e.g., many “peer educators” are young men in their 20s) and also the fact that these “peers” provide limited information and must be backed up by trained and accessible adults).

Within the overall concept of outreach, several types of inducements have been used over the decades to “encourage” contraceptive use, such as payments of various kinds to “acceptors” and/or providers, especially for longer acting or permanent contraceptive methods. The ICPD POA disallows the following practices:

- National or local level targets to increase the number of “contraceptive users” based on demographic goals, rather than on the obligation to protect and fulfill individuals’ reproductive rights and achieve their sexual and reproductive health;

¹³ Jessica Sewall-Menon et al., “The cost of reaching the most disadvantaged girls: Programmatic evidence from Egypt, Ethiopia, Guatemala, Kenya, South Africa, and Uganda,” Technical Report, The Population Council, 2012

- Payments (“incentives”), in cash or kind, to providers for the number of (specified) contraceptive methods supplied or accepted, or for “clients recruited”;
- Incentives to clients, including remuneration for time and travel so substantial that people living in poverty would be unable or unlikely to say no; and payments or in kind transfers for taking a certain method even if they otherwise would not choose that type of contraception, or any contraception at all.

vi. Quality Assurance mechanisms, monitoring and redress:

To ensure the full implementation of the above standards, and to prevent and respond to abuses, governments and other duty bearers and stakeholders need to develop and sustain, on a priority basis, a variety of institutionalized mechanisms, procedures, tools and partnerships to:

- Set goals for programmes and services in line with human rights norms and medical standards, and design evaluation indicators, for staff performance and for overall program accomplishments, which monitor performance in line with human rights norms. To date, governments and their development partners have been most interested in the quantities of contraceptive methods delivered by programs, not by continuation rates or client satisfaction with their contraceptive method and their ability to achieve their reproductive intentions.¹⁴ An example is “couple years of protection” (CYP), discussed above. Even “extended use effectiveness”, which is better than CYP, tracks the methods not the clients. Further, analyses of monitoring data commonly do not disaggregate by age, income and other characteristics that are vital for understanding which groups are missed and whether biases in service delivery are occurring.

The HARI (Helping Individuals Achieve their Reproductive Intentions) Index is the only human-rights-based metric designed to date. It measures whether people avoided severe reproductive health problems and whether they achieved their reproductive intentions, as well as tracking whether people got the contraceptive methods they wanted. The index has recently been tested by its creator using panel data from Peru.¹⁵ While this method requires further application and refinement for use with limited data, it shows the way toward the client-centered evaluation of staff and program performance.

- Monitor, at appropriate intervals, both public and private services (providers, facilities, commodities, communications and outreach), as well as

¹⁴ Anrudh Jain, “Implications for evaluating the impact of family planning program with a reproductive health orientation”, *Studies in Family Planning*, Vol.32, No. 3, September 2001

¹⁵ Anrudh Jain, see footnote 14.

overall systems, to promote and enable system-wide adherence, without discrimination, to all the human rights attributes and medical standards discussed above. Effective means for direct monitoring of quality of care include staff supervision protocols and observation of providers' work; well-kept client records; periodic review, especially at the facility and local management level, of patterns of contraceptive acceptance by method which can reveal such problems as provider bias, and assessments of patterns in the use of other SRH services that tend to be over- or under-used, such as delivery by caesarian section; analysis of each client's overall contraceptive continuation, not just her continuing use or discontinuation of a particular method; unannounced "spot checks" of facilities by quality control officials, "mystery clients" and the like. All such assessments should disaggregate and analyze information on clients by age, and marital status, with particular attention to adolescents, and give focused attention to the treatment of clients who have been discriminated against or are disadvantaged by age or income, disability, race, ethnicity, HIV status, or any other status.

One common assessment tool is "exit interviews" with family planning clients, which are not useful unless very carefully designed. For example, the common question to clients, "Are you 'satisfied' with the services or information?", commonly elicits a nonspecific affirmative response unless follow-up questions are asked, and clients can be afraid of retaliation if they answer candidly. The Population Council has also produced resources for services to conduct self-assessments.¹⁶

- Respond quickly and effectively to correct problems and shortfalls in quality and equity. National human rights protection systems –including courts, national human rights institutions, parliamentary commissions and administrative mechanisms of the Executive – can address policy failures and specific human rights abuses in SRHR services and programmes. It seems, however, that the engagement of these mechanisms is neither widespread nor systematic. Cases are likely underreported because, among other reasons, too few people know their rights, including their right to legal protection, and are justifiably skeptical that legal mechanisms will function. While a systematic review has not been done of attention paid by these mechanisms to shortfalls in quality of care, it appears that they deal only with extreme abuse such as death or severe disability that results from poor care, or contraceptive sterilization or abortion without knowledge and/or consent, particularly of highly vulnerable girls and women who are disadvantaged by poverty, HIV and AIDS status, disability or other factors. In regard to broad inequities in access to quality sexual and reproductive health services and information, by income quintiles and other factors, this author

¹⁶ Janet Bradley, "Using COPE to improve quality of care: The experience of the national family planning association of Kenya", *Quality/Calidad/Qualite*, No. 9, 2005

knows of no human rights mechanisms that assess and address policy, planning and delivery failures.

- Review laws and policies, amend them as needed, and assess the implications of new or proposed policies to remove barriers to the achievement of the human rights, and medical ethics and technical standards, discussed above.
- Support and collaborate with civil society, including associations of health professionals, women, and young people, as well as human rights organizations, so that they can engage with governments and other influential actors during design, implementation, monitoring and evaluation of SRH information, education and services, and can hold all actors accountable for achieving the standards listed above, through such participatory methods as social auditing, follow-up surveys of clients, public hearings and direct advocacy, among other means.

4. Questions to Guide Discussion at the July Conference

- The CESCRC GC14 established four attributes of human rights-based health services and information: Availability, accessibility (including affordability), acceptability, and quality (AAAQ). Specific criteria for decision-making have not yet been agreed for realization of these human rights norms, especially in conditions of financial and human resource shortages. Do the six action elements described in this note cover the main actions needed to achieve AAAQ? What is missing? What should be revised or removed?
- What are the “non-negotiables” in this framework, especially for conditions of financial and human resource shortages? Can we agree that the six action elements, and certain aspects of them, are the minimum needed to achieve quality that meets human rights norms?
- What has been the experience with adopting national standards for quality of care as framed by AAAQ and the action elements elaborated here? To what degree is the minimum threshold covered in national standards consistent with the criteria laid out in this paper?
- What has been the experience with quality assurance mechanisms, including reporting requirements, for assessing and redressing failures to provide quality care that meet AAAQ? What investments should be made in external

evaluation and in redress mechanisms, as compared to the programme's own self-monitoring and corrective mechanisms?

- Can current monitoring and evaluation data and techniques be used to ascertain whether clients achieve their reproductive intentions without incurring severe health problems, and specifically the extent to which programs have assisted their clients to protect their sexual and reproductive health and achieve their reproductive intentions? If not, how can they be modified to so?
- Some have long argued that, “the best is the enemy of the good” (that is, high quality care means services for fewer people while lower quality services can serve more people). Is this a real trade-off and, if so, how can it be resolved?
- What are the most important research needs?