

# Ensuring human rights within contraceptive programmes

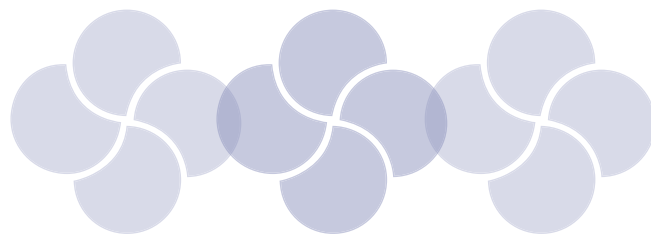
**A human rights analysis of  
existing quantitative indicators**



**World Health  
Organization**



Ensuring human rights within  
contraceptive programmes:  
a human rights analysis of existing  
quantitative indicators



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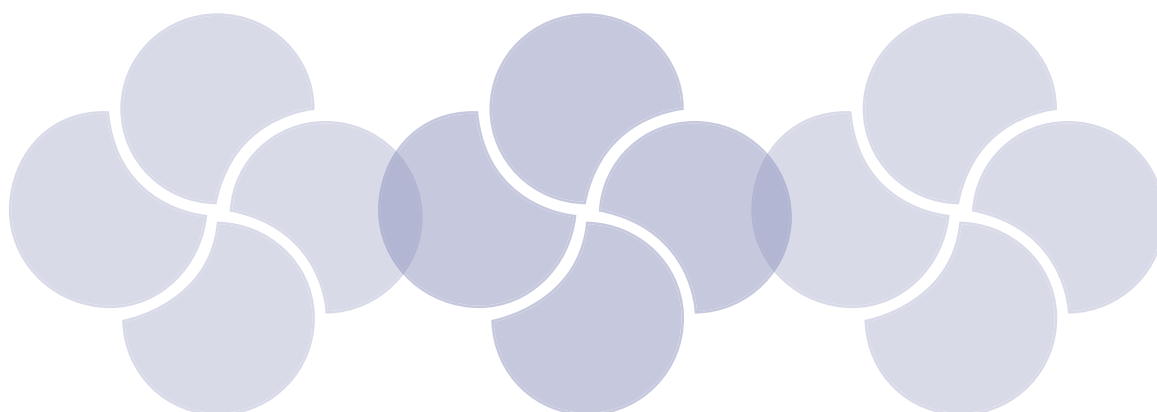
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## Acronyms and abbreviations

AAAQ	availability, accessibility, acceptability and quality
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CPR	contraceptive prevalence rate
DHS	Demographic and Health Survey
FFS	Fertility and Family Survey
HIV	human immunodeficiency virus
HMIS	health management and information system
IAG	Indicator Advisory Group
ICPD	International Conference on Population and Development
IUD	intrauterine device
MICS	Multiple Indicator Cluster Survey
RHS	Reproductive Health Survey
SRH	sexual and reproductive health
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization







## Executive summary

Contraceptive information and services are fundamental to the health and rights of all individuals. The latest estimates indicate that 222 million women and adolescent girls have an unmet need for modern contraception, and the need is greatest where the risks of maternal mortality are highest. Rapid scale-up of contraceptive programmes will be essential to reducing unmet need for information and services. The commitment to human rights in the delivery of sexual and reproductive health (SRH) services articulated at the International Conference on Population and Development (ICPD) in 1994 must not be compromised by the pressure for rapid scale-up.

Accountability is central to ensuring that health and human rights standards are respected, protected and fulfilled. In the context of human rights, accountability refers in part to the state's requirement to fully comply with its obligations under all international and regional human rights treaties to which it is a party. Accountability provides individuals with assurance and evidence of how their government has fulfilled its relevant human rights obligations. It is also the mechanism by which the government explains and justifies the steps it has taken. Redress is incorporated into this process. Given the complexity of the health sector and its importance to the fulfilment of rights in the delivery of contraceptive information and services, multiple transparent and independent accountability mechanisms are needed.

Monitoring and evaluation help to ensure effective delivery of services and contribute to accountability by providing information on progress towards the fulfilment of rights obligations. However, despite an international commitment to public health policies and programmes that are based on human rights principles, indicators for monitoring the promotion or violation of rights in health programmes remain fairly novel. While human rights indicators have been used to monitor some specific issues related to health, and health indicators have been used to draw attention to some rights issues, a systematic, transparent system does not yet exist that explicitly links human rights and health concerns, and then determines their combined impact on the effectiveness and outcomes of health policies and programmes.

This work represents a first step towards bridging this gap, by providing a methodology for identifying existing quantitative indicators that can be used in a rights analysis of contraceptive programmes, and a set of 12 prioritized indicators (see below). This 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.

## Prioritized quantitative indicators

1.	Contraceptive prevalence rate (CPR)
2.	Unmet need for family planning
3.	Informed choice
4.	Contraceptive service delivery points
5.	Contraceptive method mix
6.	Contraceptive users reporting privacy
7.	Contraceptive user satisfaction with services
8.	A system for quality assurance has been institutionalized
9.	Facilities meeting quality of care standards
10.	Contact of non-users with family planning providers
11.	Contraceptive discontinuation due to lack of access
12.	Ratio of the percentage of demand satisfied by a modern method in the poorest wealth quintile (Q1) to the percentage in the wealthiest quintile (Q5) –Q1:Q5

# I. Introduction

## Contraceptive programmes and human rights

The ability of women to choose whether or not to reproduce, to have access to full and accurate information, and to choose their preferred method of contraception (and when to use it) is fundamental to the life and health of women and their families (1, 2). But the latest estimates indicate that 222 million women and adolescent girls have an unmet need for modern contraception, and the need is greatest where the risks of maternal mortality are highest (3). In the least developed countries, 6 out of 10 individuals who do not want to get pregnant, or who want to delay the next pregnancy, are not using any modern method of contraception (3). Unmet need for contraception is highest among the most vulnerable in society, including adolescents, the poor, those living in rural areas and urban slums, and internally displaced people.

As defined in the Programme of Action that resulted from the International Conference on Population and Development (ICPD) in Cairo in 1994, reproductive health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (4, Paragraph 7.2). In the two decades since the ICPD, millions more women have been able to have fewer children and to start their families later in life. Still, many are unable to exercise their right to access the contraceptive method they wish and end up having more children than they intend. Unintended pregnancies threaten the lives and well-being of women and adolescent girls, by harming their health and undermining their opportunities to create a better life for themselves and their families, resulting in economic hardship (5).

Women’s autonomy in the context of family planning means being able to choose whether or not to reproduce, having access to full and accurate information, and choosing their preferred method of contraception and when to use it. This requires realization of rights both inside and outside the health system. Measures are needed to address, community dynamics, stereotypes and power structures that impair access to contraceptives for girls and women. Specific attention is needed to any coercive practices that may exist in service delivery, such as restricted choices among contraceptive methods, denial of services, forced pregnancies, forced abortions and forced sterilization. Measures needed to ensure that women are treated as active agents, not as passive beneficiaries, are often missing.

Human rights bodies, including the Committee on the Elimination of Discrimination Against Women (CEDAW), have frequently expressed concern over women’s lack of access to contraceptive services and information in all regions of the world. The Committee has identified several obstacles to accessing contraception and has urged States to address them. These obstacles include: cost; lack of medical insurance coverage; legal obstacles; discrimination on the basis of marital status; and coercion that prevents women from being able to choose freely a form of contraception (18).

Contraceptive programmes are the service delivery mechanism for both information and services. These programmes provide contraceptive information, commodities and services at the local, national and regional levels. Rapid scale-up of contraceptive programmes will be essential to reducing unmet need for information and services. At the same time, the commitment to human rights in the delivery of sexual and reproductive health (SRH) services articulated at the ICPD in 1994 must not be compromised by the pressure for rapid scale-up. The ICPD Programme of Action articulated a clear vision of the relationships among population and development issues and individual well-being. It emphasized that reproductive health and human rights, as well as women’s empowerment and gender equality, must be the cornerstones of population and development programmes (4). The call for attention to human rights resulted in part from past abuses

of human rights in contraceptive programmes. The application of numeric targets to contraceptive programmes in the 1960s and 1970s led to violations of human rights in some instances, with documented cases of users who were denied access to needed services, uninformed or even forced to receive a particular contraceptive method.

The ICPD replaced a demographically driven approach to family planning with one that is based on human rights and the health needs, aspirations and circumstances of each individual. According to the ICPD Programme of Action:

[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (4, Paragraph 7.3).

The right to the highest attainable standard of health lies at the heart of the link between health and human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity (6, 7). The service delivery aspect of the right to health is most commonly articulated by considerations of availability, accessibility, acceptability and quality of services (commonly referred to as AAAQ). However, rights in relation to health also incorporate the underlying determinants of health, and explicit consideration of these underlying factors is critical in order to adequately address the interactions between rights and contraceptive information and services. These underlying determinants include a wide range of socioeconomic factors that affect each person's ability to lead a healthy life, including access to food and nutrition, housing, safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment – all of which

are themselves human rights (7). The right to health was first articulated in the Constitution of the World Health Organization (WHO) in 1946. Subsequently, it was enshrined in several binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, as well as in many national constitutions. Over 80% of the world's nations have ratified the International Covenant on Economic, Social and Cultural Rights.

Accountability is central to ensuring that health and human rights standards are respected, protected and fulfilled. In the context of human rights, accountability refers to the state's requirement to fully comply with its obligations under all international and regional human rights treaties to which it is a party. Accountability, as relates to contraceptive programmes and the right to health, is the process that provides individuals with assurance and evidence of how their government has fulfilled its relevant human rights obligations. It is also the mechanism by which the government explains and justifies the steps it has taken. Redress is incorporated into this process. Given the complexity of the health sector and its importance to the fulfilment of rights, multiple transparent and independent accountability mechanisms are needed.

### Monitoring and evaluation of health programmes: the role of indicators

Monitoring and evaluation help to ensure effective delivery of services and contribute to accountability by providing information on progress towards the fulfilment of rights obligations. Indicators are indirect measures of a defined outcome. Their purpose is to enable monitoring of programme performance and impact, in relation to programme implementation and goals. Monitoring is a process of comparison, across populations, geographical areas or time, to highlight differentials or to detect changes over time in the existing situation (8); this process includes regular assessment of whether these gaps are narrowing and whether the changes are bringing the reality closer to the goals. Programme objectives are typically based on goals defined at the national or international level.

However, despite an international commitment to public health policies and programmes that are based on human rights principles, indicators for monitoring rights in health programmes remain fairly novel. While human rights indicators have been used to monitor some specific issues related to health, and health indicators have been used to draw attention to some rights issues, a systematic, transparent system is still needed to explicitly link human rights and health concerns, and then determine their combined impact on the effectiveness and outcomes of health policies and programmes (9).

Traditionally, the indicators used to evaluate contraceptive programmes have been those that monitor contraceptive efficacy, availability and security (e.g. stock-outs). While existing indicators do provide useful information about the health outcomes they measure, they have limited capacity to assess the critical rights-related issues that are associated with contraceptive use. For example, couple-years of protection (CYP) is an indicator that is commonly used to estimate the impact of contraceptive programmes. CYP provides an estimate of the protection provided by contraceptive services during a one-year period, based on measurements of the quantity of contraceptives dispensed. Although this indicator provides information on availability of commodities, it does not provide information on whether the contraceptive methods are accessible and acceptable to all individuals, nor does it provide any indication of the quality of services.

### **Identifying quantitative indicators that can help to ensure human rights in contraceptive programmes**

No single existing indicator can adequately provide meaningful information on all of the health and human rights standards that are relevant to all aspects of contraceptive programmes. A set of indicators, including some of those already in existence and others not yet developed, will be necessary to provide a detailed understanding of the extent to which human rights are respected in the delivery of contraceptive information and services. A human rights perspective could best be captured

by an analysis that combines quantitative, qualitative and policy indicators.

Since quantitative indicators are generally used to capture what is occurring at the national programme and service levels, this group of indicators was selected as the starting point for this work. The programme level is not only where the need for monitoring and guidance is greatest, but often serves as a basis for related monitoring efforts at the subnational level, as well as at the regional and global level.

This report is part of WHO's ongoing work on rights-based contraceptive programmes; it represents a modest contribution to this area with a specific focus on a rights-based analysis of key existing quantitative indicators of contraceptive programmes. The Methods section of this report describes the procedures that were followed to identify, evaluate, select and review a set of existing quantitative indicators that can provide information on the realization of human rights in the context of contraceptive programmes. The Results section defines and describes the selected indicators and their links to human rights. The Discussion section provides further analysis of each indicator, from the perspective of nine health and human rights standards, including identification of gaps where development of new indicators is urgently needed to comprehensively monitor health and human rights considerations in relation to contraceptive programmes.

It is hoped that this report will contribute to the development of a more comprehensive strategy for monitoring the interaction between health outcomes and rights realization in the context of contraceptive service delivery.

### **The importance of data disaggregation to ensure non-discrimination in services**

In the international human rights system, there is a strong demand for statistical information that goes beyond national averages to reveal the most marginalized or vulnerable population groups and to help measure inequality and discrimination. Disaggregation of data – for example, by sex, age group and wealth quintile – is essential for

extracting meaningful information on rights from a dataset relating to health indicators, and helps to ensure that discrimination and exclusion are not masked by national averages (10). Generally, international human rights experts have encouraged the disaggregation of data on the basis of factors that have been afforded legal protection against discrimination. A non-exhaustive list of these grounds includes: sex, age, economic and social situation, race, colour, language, religion, political or other opinion, national or social origin, property, birth, disability, health status, nationality, marital and family status, sexual orientation and gender identity, and place of residence. While the practical relevance and the feasibility of data disaggregation need to be appropriately addressed in each case, disaggregation of data can help with the design, adaptation, implementation and monitoring of initiatives intended to advance human rights, and it also contributes to the detection of related human rights problems, such as direct or indirect discrimination.

Non-discrimination in services is a basic human right. To date, however, most data is not disaggregated on different grounds of discrimination. At a minimum, it is recommended that data be disaggregated by: age (including 10–14, 15–19 and 20–24 years, for issues that affect young people), marital status, nulliparity, wealth quintile, and place of residence (i.e. rural versus urban), as well as geographic or administrative regions that differ in terms of socioeconomic characteristics. Additional factors to be used as a basis for disaggregation of data should be considered based on conditions in each country. Disaggregation of data is a fundamental part of using the indicators detailed here, as this allows examination of the experience of different groups involved with or affected by a contraceptive programme. Careful consideration of the appropriate level of disaggregation will be necessary in each different context, to ensure that the experience of vulnerable groups in accessing contraceptive information and services is captured. Equally, it is important to consider the context when reviewing and analysing disaggregated

data; for example, lower contraceptive use among rural women may be a reflection of higher fertility preferences rather than a reflection of differential access to services. In many cases, disaggregated data provide the first-step for identifying issues that could potentially indicate underlying rights-related problems, but further research and qualitative analysis may be needed to support any conclusions about rights fulfilment or the existence of human rights violations or discrimination.



## II. Methods: identification, evaluation, selection and review of quantitative indicators

While many quantitative indicators exist to assess contraceptive programmes (e.g. couple-years of protection [CYP], contraceptive prevalence rate [CPR], etc.), no health indicators were identified by the IAG that explicitly included human rights in their design and use. A review of the literature indicated that no validated quantitative health indicators currently exist that pay explicit attention to human rights within contraceptive service delivery programmes. To meet this need, WHO convened an Indicator Advisory Group (IAG) of experts in rights, contraception and indicator methodology (see *Annex A*).

To meet the urgent need for monitoring of rights at the programme level, the decision was made to begin this work by prioritizing a systematic evaluation of existing quantitative indicators. The IAG was tasked with developing and implementing a process to evaluate existing indicators for their ability to monitor rights at the programme level. Based on the results of this indicator evaluation process, the IAG was expected to subsequently develop a short list of prioritized indicators that could serve as the basis for assessing the realization of rights at the programme level. Future work will focus on identification of existing qualitative and policy indicators, to supplement this quantitative set, to monitor human rights in contraceptive programmes. Then the development of new indicators (quantitative, qualitative or policy), with human rights explicitly considered in their creation, will be considered.

### Identification of relevant health and human rights standards

International human rights standards and principles require states to fulfil their obligations to take legislative, policy and other measures to give effect to such rights in the area of health services and programming, including in contraceptive service delivery (11). Therefore, the IAG started by identifying the recommendations made to states

– by human rights treaty monitoring bodies and through international consensus documents – that are relevant to specific human rights and how those rights may be affected by the provision of contraceptive information and services (*Annex C*).

In line with WHO guidelines on human rights and contraception, and drawing from internationally recognized rights and principles as applied to contraceptive information and services (*Annex C*), Nine health and human rights principles and standards were identified (12). These include considerations of availability, accessibility, acceptability and quality (AAAQ) as relates to the provision of contraceptive information and services, as well as considerations of non-discrimination, informed choice, privacy and confidentiality, participation and accountability, given the importance of all these factors in the provision of contraceptive information and services (*Box 1*). The health and human rights content of these principles and standards, and what they imply for the different stakeholders responsible for the provision of services, is described in the rationale at the beginning of each sub-section in *Section IV*.

#### Box 1. Health and human rights principles and standards in relation to the provision of contraceptive information and services (12)

- Availability
- Accessibility
- Acceptability
- Quality
- Non-discrimination
- Informed decision-making
- Privacy and confidentiality
- Participation
- Accountability

### Identification, evaluation and selection of quantitative indicators

Next, the IAG searched for relevant existing quantitative indicators. Existing quantitative indicators were considered to be those currently

in use by large monitoring efforts, such as the Millennium Development Goals, and indicators used by the Commission on Information and Accountability in Women's Health, as well as indicators used by validated surveys (e.g. Demographic and Health Surveys [DHS], Program, Performance Monitoring and Accountability 2020 [PMA2020] surveys) and other readily available sources (health management information systems [HMIS] and national programme statistics).

Through this process, the IAG identified 40 indicators that could potentially be used to bring attention to rights concerns in relation to the identified health and human rights standards (*Box 1*).

Each of the 40 identified indicators was evaluated for their explicit or implicit linkages with human rights and for overall quality and feasibility. A scoring matrix for assessing the quality of the indicators was developed, inspired by the matrix used by the Joint United Nations Programme on HIV and AIDS (UNAIDS) (*see Annex B*) (13). This process included a systematic evaluation of any linkages between the identified indicator and human rights (*Box 2*).

In this way, the IAG evaluated and organized the indicators based on human rights and health principles and standards. Application of the process outlined in *Annex B* resulted in the reduction of the list of indicators from 40 to 12.

### **Box 2. Assessing the ability of indicators to measure rights outcomes**

1. Is there an explicit link between the indicator and human rights? (yes/no)
2. Is there an implicit link between the indicator and human rights? (yes/no) If yes, cite the relevant human right(s) linked to the indicator.
3. What human rights principles and standards are measured by this indicator? (give examples)
4. Does this indicator lend itself to disaggregation by factors that have been afforded legal protection against discrimination? (yes/no)? If yes, according to what criteria?
5. Can this indicator be combined in analysis with another indicator to yield a description that draws attention to a human rights principle or standard? (yes/no) If yes, describe.

## **Review and feedback**

The process for evaluating the 40 identified quantitative indicators and the resulting short list of 12 selected indicators were presented for review and input at a WHO and partners technical consultation in April 2013, on "Ensuring and monitoring human rights in contraceptive programmes." Participants provided feedback in both plenary and small-group sessions. There was general agreement on the need to improve existing health indicators, the need for a mix of quantitative, qualitative and policy indicators, as well as the need to develop new measures to adequately monitor rights realization within contraceptive programmes. It was recognized that this would require investment in the development of indicators, as well as in the infrastructure used for data collection. Some participants expressed concern that none of the 12 indicators are qualitative; none of them directly capture the user's voice. Additionally, it was noted that none of the 12 indicators cover policy and structural issues, although these are key areas for assessment. The recommendation for WHO to continue this work – to include both qualitative and policy indicators – was made. Participants noted the urgent need to develop indicators that measure empowerment or individual agency as well as quality of care. Lastly, emphasis was placed on the urgent need for future work to develop methods to capture the needs and barriers faced by non-users of contraceptive services.



### III. Results: presenting a set of 12 quantitative indicators

The section presents the 12 quantitative indicators selected from among the 40 that were initially identified and evaluated using the process described in the Methods section.

This set of indicators represents a first step in providing information relevant to the realization of human rights in contraceptive programmes. An awareness of an indicator's inherent limitations is crucial to ensuring its effective use and interpretation. How an indicator is designed, how the data are collected and how the findings are interpreted and shared are all relevant from a rights perspective (9). It should be noted that, in addition to technical limitations affecting specific indicators, all 12 indicators are also limited in that they were not specifically designed to assess human rights considerations. Furthermore, this set of indicators does not yet include any qualitative or policy indicators.

The 12 indicators are presented and defined in *Table 1*, as they are commonly used in the field. The first column gives the formal name of the indicator. The second column suggests likely sources

for obtaining the data that are needed to calculate the indicator (e.g. surveys, HMIS and/or interview data). The next two columns define the numerator and denominator to use when calculating each indicator, while the final column on the right-hand side details key technical limitations. As indicators may have different names or uses, we also indicate this where possible. In *Section IV*, we present how these existing quantitative indicators can be used in a rights analysis. The limitations of these indicators from a rights perspective are also described in *Section IV*.

*Table 2* presents an analysis of the linkages between each of the 12 indicators and each of the 9 health and human rights standards listed in *Box 1*. To ensure that human rights are comprehensively monitored, there is a need to capture all 9 of these dimensions. *Table 2* demonstrates where the indicators succeed and fail in capturing different health and human rights principles and standards.

*Table 3* presents additional data on how each of these 12 indicators maps to the identified health and human rights principles and standards. The answers to the five evaluation questions listed in *Box 2* were used to form an analysis of the explicit and implicit linkages between each indicator and the human rights standards, as well as an assessment of the feasibility of using each indicator for the purposes of monitoring and evaluating human rights in the context of the provision of contraceptive information and services.

**Table 1. Prioritized quantitative indicators: description, definition and limitations**

Indicator	Indicator source	Numerator	Denominator	Technical limitations
<b>1. Contraceptive prevalence rate (CPR)</b>	Household surveys such as: DHS, MICS, FFS, RHS, PMA2020 survey	Number of women aged 15–49 who are currently using a modern or traditional method of contraception  This indicator is sometimes limited to women using a modern contraceptive (i.e. modern contraceptive prevalence rate).	Number of women aged 15–49	<ul style="list-style-type: none"> <li>• There is no consistent definition across data sources of what is meant by “currently using” a method of contraception.</li> <li>• Differences in survey design and implementation, as well as in survey questions, can affect the comparability of the data, e.g. the range of contraceptive methods included and/or the time frame used to assess prevalence may differ.</li> <li>• Many survey samples do not include unmarried women or those in a nonconsensual union, thus underestimating the use of contraception. In this case, the limits of the indicator should be specified, e.g. CPR in married/in union women.</li> </ul>

**Table 1. Prioritized quantitative indicators: description, definition and limitations**

Indicator	Indicator source	Numerator	Denominator	Technical limitations
<b>2. Unmet need for family planning</b>	Household surveys such as: DHS, MICS, FFS, RHS, PMA2020 survey	<p>Number of women aged 15–49 who are at risk of pregnancy (i.e. they are married or unmarried and sexually active, and fecund) and who desire to limit or postpone childbearing but are not using contraception</p> <p>This indicator is sometimes defined as unmet need for modern contraception, in which case women using less-effective traditional methods of contraception are not included in the numerator.</p>	Number of women aged 15–49	<ul style="list-style-type: none"> <li>• There is no consistent definition across data sources of what is meant by “currently using” a method of contraception.</li> <li>• Differences in survey design and implementation, as well as in survey questions, can affect the comparability of the data, e.g. the definition of fecundity, the characteristics of the base population and/or the time frame used to assess sexual activity and desired postponement of childbearing may differ.</li> <li>• Many survey samples do not include unmarried women or those in a nonconsensual union, thus underestimating the unmet need for contraception.</li> </ul>
<b>3. Informed choice</b>	Household surveys such as: DHS, PMA2020 survey	<p>Among current users of modern contraceptive methods who adopted their current method in the last 5 years:</p> <p>a. Number who were informed about the possible side-effects of the method</p> <p>b. Number who were informed what to do if side-effects were experienced</p> <p>c. Number who were informed of other methods that could be used for contraception</p> <p>Among women who were sterilized in the 5 years preceding the survey:</p> <p>d. Number who were informed that they would not be able to have any more children.</p>	<p>All current users of modern contraception who adopted their current method in the last 5 years</p> <p>*For question specific to sterilization, the denominator is limited to sterilized women.</p>	<ul style="list-style-type: none"> <li>• This indicator is subject to courtesy bias (social desirability) and differences in cultural expectations and interpretation.</li> <li>• The four components of the indicator can be shown separately or combined into an index.</li> </ul>

**Table 1. Prioritized quantitative indicators: description, definition and limitations**

Indicator	Indicator source	Numerator	Denominator	Technical limitations
<b>4. Contraceptive service delivery points</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment, HMIS data	Number of contraceptive service delivery points in the defined catchment area	Population of the catchment area.	<ul style="list-style-type: none"> <li>• This indicator merely captures the ratio of service delivery points to the population of the defined catchment area. This indicator is designed to capture fixed service facilities and so may underestimate coverage where services are provided by community health workers, through mobile outreach, through pharmacies or other private sector distribution channels.</li> <li>• This indicator does not measure capture the extent to which facilities provide a range of method options or whether a site has the necessary resources to provide quality services.</li> </ul>
<b>5. Contraceptive method mix</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment, HMIS data	Number of facilities offering at least 1 short-term, 1 long-term, 1 permanent and 1 emergency method of contraception in a defined catchment area	Number of contraceptive service delivery points in the defined catchment area	<ul style="list-style-type: none"> <li>• Some surveys do not routinely include information on emergency contraception.</li> <li>• As with indicator No. 4 (the companion indicator), this indicator does not measure whether a site has the necessary resources to provide quality services; e.g. it does not provide information on fluctuations in availability due to commodity stock-outs or unavailability of providers.</li> <li>• This indicator may underestimate access where services are provided by community health workers or through mobile outreach services.</li> </ul>
<b>6. Contraceptive users reporting privacy</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment (Client exit interviews)	a. Number of contraceptive service users reporting “no problem” with visual and auditory privacy	Number of individuals using contraceptive services who completed the exit interview	<ul style="list-style-type: none"> <li>• This indicator is subject to courtesy bias (social desirability) and differences in cultural expectations and interpretation.</li> </ul>
	DHS Service Provision Assessment (Provider observations)	b. Number of contraceptive providers who ensured visual and auditory privacy, and assured user orally of confidentiality	Number of providers observed	<ul style="list-style-type: none"> <li>• This indicator is subject to courtesy bias (social desirability) and differences in cultural expectations and interpretation.</li> </ul>

**Table 1. Prioritized quantitative indicators: description, definition and limitations**

Indicator	Indicator source	Numerator	Denominator	Technical limitations
<b>7. Contraceptive user satisfaction with services</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment (Client exit interviews)	Number of contraceptive service users who report being “very satisfied” or “more or less satisfied” with services	Number of contraceptive service users who completed the exit interview	<ul style="list-style-type: none"> <li>This indicator is subject to courtesy bias (social desirability) and differences in cultural expectations and interpretation.</li> </ul>
<b>8. A system for quality assurance has been institutionalized</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment, PMA2020 survey	Number of contraceptive service facilities where a formal mechanism for quality assurance is in place	Number of contraceptive service facilities	<ul style="list-style-type: none"> <li>This indicator provides information on whether a system is in place, but not on whether it is in use or produces results.</li> </ul>
<b>9. Facilities meeting quality of care standards</b>	Service delivery assessment surveys such as: DHS Service Provision Assessment (Inventory questionnaire), facility-level surveys, PMA2020 survey	Number of contraceptive service facilities that meet quality of care standards	Number of contraceptive service facilities	<ul style="list-style-type: none"> <li>This indicator does not include an explicit definition of quality or quality standards.</li> </ul>
<b>10. Contact of non-users with family planning providers</b>	Household surveys such as: DHS, PMA2020 survey	Number of non-users who were provided contraceptive information by a community health worker or when visiting a health facility (within a specified period of time)	Number of non-users within the specified period of time	<ul style="list-style-type: none"> <li>This indicator does not provide information on the quality of the information/counselling received nor on the reasons for non-use, such as pregnancy intention.</li> </ul>
<b>11. Contraceptive discontinuation due to lack of access</b>	Household surveys such as: DHS, PMA2020 survey	Number of episodes of discontinuation reported as being due to lack of access in the 5 years preceding the survey	Number of episodes of discontinuation in the 5 years preceding the survey	<ul style="list-style-type: none"> <li>This indicator does not provide information on whether an individual was able to switch to an alternate method that is acceptable.</li> </ul>

**Table 1. Prioritized quantitative indicators: description, definition and limitations**

Indicator	Indicator source	Numerator	Denominator	Technical limitations
<b>12. Ratio of the percentage of demand satisfied by a modern method in the poorest wealth quintile (Q1) to the percentage in the wealthiest quintile (Q5) – Q1:Q5</b>	Household surveys such as: DHS, PMA2020 survey	Number of women currently using a modern method of contraception:  a. within wealth index quintile 1 (Q1, the poorest 20%)  b. within wealth index quintile 5 (Q5, the wealthiest 20%)	Number of women at risk of pregnancy who do not wish to become pregnant in the next 2 years:  a. within wealth index quintile 1 (Q1, the poorest 20%)  b. within wealth index quintile 5 (Q5, the wealthiest 20%)	<ul style="list-style-type: none"> <li>• This is calculated from the CPR and from unmet need and is thus subject to the same limitations as those indicators (Nos. 1 and 2).</li> <li>• This indicator can be calculated from data collected by DHS based on the percentage of demand satisfied, reported by wealth quintile.</li> </ul>

CPR: contraceptive prevalence rate; DHS: Demographic and Health Survey; FFS: Fertility and Family Survey; HMIS: health management and information system; MICS: Multiple Indicator Cluster Survey; PMA2020: Performance Monitoring and Accountability 2020; RHS: Reproductive Health Survey





Table 3. Indicator linkages with health and human rights principles and standards

Indicator	Is there an explicit link between the indicator and human rights? (yes/no)	Is there an implicit link between the indicator and human rights? (yes/no; cite rights)	What health and human rights principles and standards* are measured by this indicator? (give examples)	Does this indicator lend itself to disaggregation by factors that have been afforded legal protection against discrimination? (yes/no; cite factors)	Can this indicator be combined in analysis with another indicator to yield a description that draws attention to a health and human rights principle or standard? (yes/no; describe)	
1	Contraceptive prevalence rate (CPR)	No	Yes	<ul style="list-style-type: none"> <li>• Availability</li> <li>• Accessibility</li> <li>• Non-discrimination</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Availability (1,2,4,5)</li> <li>• Accessibility (1,2,4,5,11)</li> <li>• Non-discrimination (1,2,12)</li> </ul>
2	Unmet need for family planning	No	Yes	<ul style="list-style-type: none"> <li>• Availability</li> <li>• Accessibility</li> <li>• Non-discrimination</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Availability (1,2,4,5)</li> <li>• Accessibility (1,2,4,5,11)</li> <li>• Non-discrimination (1,2,12)</li> </ul>
3	Informed choice	Yes; informed decision-making	Yes	<ul style="list-style-type: none"> <li>• Informed decision-making</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Acceptability (3,5,6,7,9)</li> </ul>
4	Contraceptive service delivery points	No	Yes	<ul style="list-style-type: none"> <li>• Availability</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Accessibility (1,2,4,5,11)</li> <li>• Non-discrimination (1,2,12)</li> </ul>
5	Contraceptive method mix	No	Yes	<ul style="list-style-type: none"> <li>• Availability</li> <li>• Quality</li> <li>• Acceptability</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Availability (1,2,4,5)</li> <li>• Quality (5,8,9)</li> <li>• Accessibility (1,2,4,5,11)</li> </ul>
6	Contraceptive users reporting privacy	No	Yes	<ul style="list-style-type: none"> <li>• Privacy and confidentiality</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Acceptability (3,5,6,7,9)</li> <li>• Informed decision-making (1,3,6)</li> </ul>
7	Contraceptive user satisfaction with services	No	Yes	<ul style="list-style-type: none"> <li>• Acceptability</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Acceptability (3,5,6,7,9)</li> </ul>
8	A system for quality assurance has been institutionalized	No	Yes	<ul style="list-style-type: none"> <li>• Quality</li> <li>• Accountability</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Quality (5,8,9)</li> <li>• Accountability (8)</li> </ul>
9	Facilities meeting quality of care standards	No	Yes	<ul style="list-style-type: none"> <li>• Quality</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Quality (5,8,9)</li> </ul>
10	Contact of non-users with family planning providers	No	Yes	<ul style="list-style-type: none"> <li>• Participation</li> </ul>	Yes	No
11	Contraceptive discontinuation due to lack of access	No	Yes	<ul style="list-style-type: none"> <li>• Accessibility</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Accessibility (1,2,4,5,11)</li> </ul>
12	Ratio of the percentage of demand satisfied by a modern method in the poorest wealth quintile (Q1) to the percentage in the wealthiest quintile (Q5) – Q1:Q5	No	Yes	<ul style="list-style-type: none"> <li>• Non-discrimination</li> <li>• Accessibility</li> </ul>	Yes	Yes: <ul style="list-style-type: none"> <li>• Non-discrimination (1,2,12)</li> </ul>

\*The identified health and human rights principles and standards include: Availability, Accessibility, Acceptability, Quality, Non-discrimination, Informed decision-making, Privacy and confidentiality, Participation and Accountability.



## IV. Discussion: using existing quantitative indicators for a human rights analysis

In this section, we present an analysis of the proposed quantitative indicators and assess their capacity to provide useful information about the promotion or violation of human rights in contraceptive programmes. There are nine sub-headings in this section, one for each of the nine health and human rights principles and standards identified as a basis for inclusion of the indicators (see *Box 1*, in the Methods section). The majority of the 12 selected indicators appear more than once, as they are discussed in connection with each standard to which they were mapped (for a summary of this mapping, see the standards and the mapped indicator numbers listed at the top of each column in *Table 2*).

Under each sub-heading, first the “health and human rights rationale” is presented, to provide an overarching explanation

of the topic and its relationship to contraceptive information and services. The rationale provides a substantive discussion of the concepts that the indicators need to capture in this area. This rationale is intended as a comprehensive description of the health and human rights principles and standards for monitoring purposes. Within each subsection, it is intended that the indicators be looked at together, no one indicator will alone provide the necessary information. It is further acknowledged, that the proposed quantitative indicators do not adequately cover each domain: a combination of quantitative, qualitative and policy indicators is needed to comprehensively monitor each standard. The proposed quantitative indicators are a first step towards achieving this.

Following the rationale, under each of the nine health and human rights principles and standards, there is a list of the indicators (or sometimes only one indicator) that map to that standard, and a description of how each indicator can be analysed to provide rights information (“analysis and interpretation”) as relevant to this topical area. Finally, recognizing the limitations

of relying on existing quantitative indicators for monitoring rights standards, in the Gaps section the limitations of the presented indicators (from a rights perspective) and the need for additional complementary indicators is highlighted.

It should be noted that the definitions and full technical information on these indicators is presented in *Table 1* (Results section), including sources for the data, the numerator and denominator for calculating the indicator, and any specific technical limitations.

### Availability of contraceptive information and services

#### Health and human rights rationale

A core state obligation in connection with the right to health is to ensure the availability, accessibility, acceptability and quality of services. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the state. The characteristics of the facilities, goods and services will vary depending on numerous factors, including the state’s developmental level. They must, however, address the underlying determinants of health, such as provision of safe and potable drinking water, adequate sanitation facilities, hospitals, clinics and other health-related buildings, and trained medical and professional personnel receiving domestically competitive salaries.

As part of this core obligation, states 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 (14, 15). A wide range of contraceptive methods, including emergency contraception, is included in the core list of essential medicines (15).

In many low- and middle-income countries, however, contraceptives such as condoms (male and female), oral contraceptives, intrauterine devices (IUDs), hormonal injectable contraceptives, implants and emergency contraception, are lacking or not available, owing to inadequate laws and policies, inefficient systems of supply and logistics management, or low or absent funding. Lack of availability may also result

from ideology-based policies regarding the range of medicines or services (16). For example, in some countries emergency contraception is not available on the false grounds that it causes abortion (17).

### Indicators

- Contraceptive prevalence rate (CPR)
- Unmet need for family planning
- Contraceptive service delivery points
- Contraceptive method mix

### Analysis and interpretation

#### *Indicators: Contraceptive prevalence rate and Unmet need for family planning*

These are two indicators of health, population, development and women's empowerment. CPR also serves as a proxy measure of availability of reproductive health services that are essential for meeting many of the Millennium Development Goals, especially those related to child mortality, maternal health, HIV/AIDS and gender equality. CPR can be reported by method to give a sense of the availability (or lack thereof) of different methods. Indicators like these often do not capture the availability of a range of contraceptives or availability for unmarried women, therefore limiting the scope of analysis from a health and human rights perspective.

Unmet need for family planning provides a measure of women's ability to achieve their desired family size and birth spacing. It also provides an indication of the success of reproductive health programmes in addressing demand for services. Unmet need complements the CPR by indicating the additional extent of need to delay or limit births. As an indicator, unmet need for family planning helps determine how well a country's health system and social conditions support the ability of women to realize their stated preference to delay or limit births.

Unmet need tends to be lower in places where preferences for large families remain high. However, over time as preferences change some populations experience increased demand for contraception that outpaces the ability of services to scale up to meet the demand. In such instances – particularly

when CPR is low initially – it is possible that unmet need for family planning may increase rather than decrease when CPR increases. This illustrates why these indicators, and the set as a whole, need to be analysed and interpreted together.

A common approach is to use the data to calculate the percentage of demand satisfied by (modern) method use. The numerator of this combined indicator is the number of women aged 15-49 currently using a (modern) method of contraception (same numerator as CPR) and the denominator is the number of women aged 15-49 who are at risk of pregnancy who desire to limit or postpone childbearing but are not using a (modern) contraceptive (same numerator as Unmet need for family planning) plus the number of modern method users.

#### *Indicators: Contraceptive service delivery points and Contraceptive method mix*

Contraceptive service delivery points provides an estimate of physical availability of services: the number of service delivery points in a defined catchment area. This can be useful when assessing the geographical distribution of services. However, this indicator is limited as it provides no information about what is available at these existing centres. Contraceptive method mix is an indicator that provides an additional level of detail about sites offering contraceptive services: the proportion of sites that offer at least one of each type of contraceptive method (short-term, long-term, permanent and emergency).

Jointly, these indicators facilitate assessment of some aspects related to availability of contraceptive services and information. With regard to non-discrimination, these indicators primarily provide information on the geographic availability and coverage of contraceptive services and information.

### Gaps

As highlighted in the rationale, the health and human rights consideration of *availability* in the context of contraceptive information and services includes different elements to ensure that the full range of methods (as determined by the *WHO model list of essential medicines*) are available in the country.

While the indicators identified here could provide an analysis of the extent to which contraceptives are available in a country, they do not reflect *what* specific contraceptives are available. This is particularly important in relation to contraceptive methods such as condoms (male and female), oral contraceptives, IUDs, hormonal injectable contraceptives, implants and emergency contraception, which are often not available due to laws, policies, absence of funding, poor planning or negligence. These indicators are also limited in that they do not capture the inequalities in availability of contraceptives, which is essential to a human rights analysis.

## Accessibility of contraceptive information and services

### Health and human rights rationale

International human rights law requires health-care facilities, commodities and services to be accessible to everyone without discrimination. This includes physical and economic accessibility, as well as access to information (14, Paragraph 12[b]). Human rights bodies have called on states to eliminate the barriers people face in accessing health services, such as high fees for services, the requirement for preliminary authorization by spouse, parent/guardian or hospital authorities, distance from health-care facilities, and the absence of convenient and affordable public transport (18, Paragraph 21).

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 (SRH), including effective contraceptive methods (14, Paragraph 11). This requires counselling on SRH by trained personnel (18) and 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 (14, 19–20). In schools, such education should be mandatory and provided routinely at various ages and levels of education (21–24). Inadequate counselling tools and services, limited or no sexuality education within or outside of schools, and no or incorrect information about the safety and effectiveness of contraceptives (19) all hinder individuals' ability to make informed decisions.

The fulfilment of human rights obligations requires that health commodities, including contraceptives, be physically accessible and affordable for all (14). The goal of universal health coverage is to ensure that all people can obtain the health services they need without suffering financial hardship caused by paying for them (25). Services must be within safe physical reach for everyone, including for marginalized populations (14). They should be affordable, whether they are privately or publicly provided, and poorer households should not be burdened disproportionately with health expenses, including with the cost of contraceptives, in comparison to richer households. This applies to both low- as well as high-income countries where some sectors of the population do not have access to these services and information (3). Programmes therefore need to be established to address these financial barriers, including health insurance schemes, and other budgetary and economic measures to make contraceptives and other health services affordable (14, 18). Free or affordable sexual and reproductive health care – including contraceptive information and services – must be provided to persons with disabilities (26).

Adolescents in many countries lack adequate access to contraceptive information and services that are necessary to protect their sexual and reproductive health (18, 27). Human rights bodies have called on states to strictly respect adolescents' rights to privacy and confidentiality, including with regard to advice and counselling on health matters (28–30) and to ensure youth-friendly, confidential reproductive health care, including contraceptive services, for adolescents from different socioeconomic backgrounds (14, 18, 31). Adolescents' best interests and their evolving capacities need to be systematically considered, and appropriate SRH services should be available and accessible to

them without necessarily requiring parental or guardian authorization by law, policy or practice (18, 29, 30, 32, 33).<sup>1</sup>

In crisis settings there is often a lack of access to SRH services, meanwhile affected populations have a particular need for these services because of increased exposure to sexual violence. Access to contraceptive methods, particularly emergency contraception, and also to safe abortion, is of paramount importance to safeguard women's health (34).<sup>2</sup>

Experience in a variety of different settings has shown that integrating contraceptive information and services into other SRH services has the potential for increasing accessibility of such services. For example, integrating HIV services and maternal health services is cost-effective and contributes to improving overall family health (35). Within the context of abortion and post-abortion care services, all women should be offered comprehensive contraceptive information, counselling and services, to help increase effective use of contraceptive methods and reduce the rate of repeat abortions (36, p. 52; 37).

International, regional and national human rights bodies have frequently emphasized that states should not restrict women's access to health services or to clinics that provide those services on the grounds that women do not have third-party authorization or because they are unmarried, or simply because they are women (18, Paragraph 14).

Requirements for third-party authorization to receive contraceptive information and services are a significant barrier faced by women in many countries. Not only do such requirements violate the right to privacy they are a breach of confidentiality, as well as deny women autonomy in their decision-making; for these any other reasons, these requirements deter women from seeking the health services they need.

Women's access to contraceptive information and services may be jeopardized by health-care providers' refusal to provide services due to conscientious objection. In the context of contraceptive services, this is usually manifested in a provider's refusal to issue a prescription for contraceptives, or a pharmacist's refusal to dispense or sell contraceptives, especially emergency contraceptives. While international human rights law protects the right to freedom of thought, conscience and religion, it also stipulates that the freedom to manifest one's beliefs in the professional sphere is not absolute and might be subject to limitations that are necessary to protect the rights of others, including the right to access reproductive health care (38, Article 18; 39). Human rights bodies have consistently called on states to regulate the practice of conscientious objection in the context of health care, to ensure that patients' health and rights are not in jeopardy (18, 40). Some human rights bodies have explicitly addressed conscientious objection in the context of contraceptive service provision, stating that where women can only obtain contraceptives from a pharmacy, pharmacists cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products (39).

1 Best interests of the child: According to the Committee on the Rights of the Child, "in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (33, Article 3).

2 Evolving capacities of the child: "In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. ... States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion" (30, Paragraph 31).

## Indicators

- Contraceptive prevalence rate
- Unmet need for family planning
- Contraceptive service delivery points
- Contraceptive method mix
- Contraceptive discontinuation due to lack of access

## Analysis and interpretation

### *Indicators: Unmet need for family planning and Contraceptive prevalence rate*

These are two indicators of health, population, development and women's empowerment. CPR serves as a proxy measure of access.

Unmet need for family planning provides a measure of women's ability to achieve their desired family size and birth spacing. It also provides an indication of how accessible services are. Unmet need complements the CPR by indicating the additional extent of need to delay or limit births. However, not all unmet need exists due to a lack of availability; other factors, including fear of side-effects, personal or family opposition, and religious prohibition, are often cited as reasons for non-use of contraception.

### *Indicators: Contraceptive service delivery points and Contraceptive method mix*

Examining data on these indicators, which are reported for service facilities within defined catchment areas, can provide information on geographical barriers to contraceptive access, as well as disparities in access to a range of methods.

### *Indicator: Contraceptive discontinuation due to lack of access*

This indicator provides information on the number of individuals who discontinue contraception due to issues with access. This complements the data from the other four indicators in this section. While this indicator captures the percentage of individuals who report that they discontinued contraception due to issues with access, it is limited because it does not identify on what grounds, which limits the scope of analysis in relation to accessibility.

Taken together, the five indicators analysed in this section jointly facilitate analysis of accessibility, providing information related to physical accessibility and non-discrimination in terms of access to contraceptive services and information.

## Gaps

The health and human rights consideration of *accessibility* in the context of contraceptive services and information seeks to ensure that everyone has

access to the contraceptive services and information they require. This includes access in terms of non-discrimination, affordability, physical accessibility, and access to information regarding contraceptives. While the five indicators identified here seek to capture access to contraceptives at an aggregate level, they do not provide an analysis of these and other access issues.

Furthermore, these indicators do not measure other barriers to access to contraceptives, such as conscientious objection, provider bias, third-party authorization requirements, or other costs, such as transport or user fees, which can severely impair individual access to contraceptive services and information in some countries.

## Acceptability of contraceptive information and services

### Health and human rights rationale

All health-care facilities, goods and services must 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 (14, Paragraph 12[c]). States should ensure a gender perspective is at the centre of all policies, programmes and services and should involve women in the planning, implementation and monitoring of such policies, programmes and services.

Contraceptive information should include the likely benefits and potential adverse effects of proposed methods and available alternatives (18, Paragraph 20). 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 (41). WHO Medical's Eligibility Guidelines provide information about health risks, side-effects and benefits that are specific to methods and to user characteristics. Counselling about how to manage side-effects and information about options for switching to other methods is therefore crucial to helping women who wish to control their fertility.



## Indicators

- Informed choice
- Contraceptive method mix
- Contraceptive users reporting privacy
- Contraceptive user satisfaction with services
- Facilities meeting quality of care standards

## Analysis and interpretation

### *Indicator: Informed choice*

Informed choice is measured using data collected from current users of modern contraceptive methods who adopted the current method within the five years preceding the survey, and it captures four separate measures: (a) the percentage who were informed about the side-effects of the method, (b) the percentage who were informed what to do if side-effects were experienced, (c) the percentage who were informed of other methods that could be used for contraception, and (d) specifically among women who were sterilized within the five years preceding the survey, the percentage who were informed that they would not be able to have any more children.

The data for this set of indicators can be used to estimate the level of informed decision-making and of user awareness about contraceptive side-effects, both of which are core components of acceptability. While the indicator has several features aimed at capturing informed choice, it does not include details regarding the nature of the information provided to users or users' understanding of that information.

### *Indicator: Contraceptive method mix*

A range of methods is a core component of contraceptive acceptability. This indicator provides information on the availability of a range of methods.

### *Indicator: Contraceptive users reporting privacy*

Visual and auditory privacy are important for informed decision-making and acceptability of services. The indicator only captures the privacy and confidentiality requirement in a limited way, by looking at it in context of visual and auditory privacy while a user is meeting with a provider. It does not capture confidentiality requirements and other aspects, such as data protection.

### *Indicator: Contraceptive user satisfaction with services*

This indicator provides a simple measure of the acceptability of services from the user's perspective. It can be calculated using data from client exit interviews, such as those performed for the DHS Service Provision Assessment, during which users are asked if they are satisfied with services, and a "yes" or "no" response is recorded. The indicator does not seek to capture the reasons for these responses and is thus a limited assessment tool for user satisfaction.

### *Indicator: Facilities meeting quality of care standards*

Quality is essential to the acceptability of services. This indicator evaluates facility performance against established quality standards. The indicator supports a limited assessment of the number of users who receive contraceptive information and services that meet the expected quality standards. It does not provide details regarding the nature of the services or information.

Acceptability is a complex construct. A joint analysis of these indicators helps in conducting a limited analysis of acceptability, based on the components measured by these indicators. These indicators can also support efforts to link the acceptability dimension related to health and human rights to other dimensions, such as quality and accessibility.

## Gaps

Acceptability is aimed at ensuring that contraceptive services and information are respectful of medical ethics and are also culturally appropriate, in terms of being respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. The indicators analysed here do not capture acceptability components such as those related to gender and life-cycle requirements, which are key to the measurement of acceptability. Further, these indicators also do not seek to capture cultural expectations and interpretations that could influence individual decision-making, and therefore the acceptability of contraception information and services.

## Quality of contraceptive information and services

### Health and human rights rationale

The fulfilment of human rights requires that health-care facilities, commodities and services be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation (14, Paragraph 12[d]).

In the provision of contraceptive information and services, studies show that where people feel they are receiving good quality care, contraceptive use is higher (42–45), and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them (46, 47). 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 trained health workers; provider–user relationships based on respect for informed choice, privacy and confidentiality; and the appropriate constellation of services (including follow-up) available in the same locality (48).

Anyone seeking contraceptive information and services has the right to be fully informed, by appropriately trained personnel, of their options in relation to agreeing to treatment or participation in research, including the likely benefits and potential adverse effects of proposed procedures and available alternatives (4, Paragraph 20). WHO Medical's Eligibility Guidelines provide information about health risks, side-effects and benefits that are specific to methods and to user characteristics. States have been called upon to expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communication and counselling skills (4, Paragraph 7.23[d]), and training on issues of human rights and gender-based violence (18, Paragraph 31[f]). This is in line with WHO guidance on core competencies for the provision of sexual and reproductive health care (49).

### Indicators

- Contraceptive method mix
- A system for quality assurance has been institutionalized
- Facilities meeting quality of care standards

### Analysis and interpretation

#### *Indicator: Contraceptive method mix*

This indicator is a proxy measure for quality. Availability of a range of modern contraceptive methods to choose from is a core component of quality in contraceptive service delivery.

#### *Indicator: A system for quality assurance has been institutionalized*

This indicator measures institutional commitment to quality. The indicator gives the proportion of all contraceptive service facilities where a formal mechanism for quality assurance is in place. It does not provide details regarding the level of service quality the mechanism seeks to assure.

#### *Indicator: Facilities meeting quality of care standards*

This indicator allows monitoring at the facility level of specific standards, and success in achieving them.

This set of indicators provides information on some elements of quality of care, such as the availability of a choice of contraceptive methods, technically competent providers, evidence-based information and services, the provider-user interaction and follow-up care for management of side-effects or removal of a long acting method. These indicators can support a limited analysis of quality based on information about choice among a wide range of contraceptive methods, the existence of a quality assurance mechanism and the status of the facilities with respect to quality of care standards.

### Gaps

Quality of care is a key health and human right consideration for contraceptive information and services. Quality care in relation to contraceptives includes: provision of a choice of methods; information and counselling for users; technical competence and adherence to clinical standards; good interpersonal relations; continuity of care; and appropriate

constellation of services (50). These indicators identified do not capture all of these elements of quality of care.

## Non-discrimination with the provision of contraceptive information and services

### Health and human rights rationale

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 (51).

Discrimination poses a serious threat to SRH for many people (6). The legal or social restrictions on women's and girls' access to contraceptive information and services affect their ability to take decisions regarding their sexual and reproductive health and lives, are a manifestation of discrimination on the basis of sex, and often contribute to poor physical and mental health. People who live in rural areas may not have access to the same SRH services as people in urban areas, thus facing discrimination because of their place of residence. Discrimination on the grounds of age or other status is manifested through, for instance, the fact that adolescents may be denied services at family planning clinics because of their age, and others may be denied health services because they are HIV-positive. Some individuals suffer discrimination on multiple grounds, e.g. gender, race, marital status, socioeconomic status and health status (51).

Furthermore, people (particularly women) from indigenous and minority groups, people with disabilities, people living with HIV, sex workers and drug users, as well as transgender and intersex individuals, for example, have been subject to involuntary, coerced and forced contraceptive practices. In some parts of the world, women and men are given coercive economic incentives to undergo sterilization; this primarily impacts the poor. Such practices reflect multiple forms of discrimination, have a significant impact on health, and are a violation of human rights law.

As part of their human rights commitments, states must strive to eliminate all forms of discrimination and to promote equality by ensuring that vulnerable groups have access to information and services (18). All individuals have the right to decide the number and spacing of children and the right to found a family on an equal basis (11, Article 16[e]; 49). State family planning policies should not be discriminatory or compulsory (52). Laws, regulations and policies, including those related to contraceptive information and services, should not be discriminatory and should aim at eliminating stereotypes and discriminatory attitudes that lead to forced and coercive practices (11, 18, 26, 28, 51, 53, 54, 55).

### Indicators

- Contraceptive prevalence rate (CPR)
- Unmet need for family planning
- Ratio of the percentage of demand satisfied by a modern method in the poorest wealth quintile (Q1) to the percentage in the wealthiest quintile (Q5) – Q1:Q5

### Analysis and interpretation

#### *Indicators: Unmet need for family planning and Contraceptive prevalence rate*

These are two indicators of health, population, development and women's empowerment. CPR also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the Millennium Development Goals, especially those related to child mortality, maternal health, HIV/AIDS and gender equality.

Unmet need for family planning provides a measure of women's ability to achieve their desired family size and birth spacing. It also provides an indication of the success of reproductive health programmes in addressing demand for services. Unmet need complements the CPR by indicating the additional extent of need to delay or limit births. As an indicator, unmet need for family planning helps determine how well a country's health system and social conditions support the ability of women to realize their stated preference to delay or limit births.



In some instances – particularly when CPR is low initially – it is possible that unmet need for family planning may increase rather than decrease when CPR increases. This occurs when demand for contraception increases in a population where contraceptive supply cannot keep up.

**Indicator: Ratio of the percentage of demand satisfied by a modern method in the poorest wealth quintile (Q1) to the percentage in the wealthiest quintile (Q5) – Q1:Q5**

This indicator compares the difference in the proportion of need for contraception that is unmet between the lowest and the highest wealth quintiles. It is a measure of equity and affordability of services. The indicator only captures discrimination based on wealth quintiles but does not capture discrimination on other grounds.

The numerator of this combined indicator is the number of women aged 15-49 of the relevant wealth quintile who are currently using a (modern) method of contraception and the denominator is the number of women aged 15-49 of the same wealth quintile who are at risk of pregnancy who want to limit or postpone childbearing (whether or not they are using a contraceptive method).

The indicators identified here jointly provide an aggregate analysis of population access to contraceptives and any discrimination on the basis of wealth that the population groups experience in terms of access to contraceptives.

### Gaps

Non-discrimination in the provision of contraceptive services and information requires that contraceptives must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination. The indicators identified here only measure aggregate coverage of contraceptive services and compare the highest and lowest wealth quintiles in terms of access, but they do not seek to measure different elements of discrimination. Disaggregation of data for these and other indicators based on other factors that have been afforded legal protection against discrimination could provide more information.

## Informed decision-making

### Health and human rights rationale

Showing respect for individual dignity and for the physical and mental integrity of a person includes giving each person the opportunity to make autonomous reproductive choices (18, Paragraph 22; 9, Article 16; 26, Articles 12 and 23). The principle of autonomy, expressed through free, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law (56). People should be able to choose contraception but also to refuse it. 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 people with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people (49).

Respecting autonomy in decision-making requires that any counselling, advice or information that is provided by health workers or other support staff should be non-directive, enabling individuals to make decisions that are best for themselves. People should be able to choose their preferred method of contraception, taking into consideration their own health and social needs (57–59).

Individuals have the right to be fully informed by appropriately trained personnel. Health-care providers have the responsibility to convey accurate, clear information, using language and methods that can be readily understood by the user, together with proper, non-coercive counselling, in order to facilitate full, free and informed decision-making (18, Paragraph 11.3; 54, Paragraph 22; 60). The information provided to people so that they can make an informed choice about contraception should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and should enable comparison of various contraceptive methods. Censoring, withholding or intentionally misrepresenting information about contraception can put health and human rights in jeopardy (14). Clear guidelines should be available concerning the requirement of “informed consent” (61).

## Indicators

- Contraceptive prevalence rate (CPR)
- Informed choice
- Contraceptive users reporting privacy

## Analysis and interpretation

### *Indicator: Informed choice*

Informed choice is measured using data collected from current users of modern contraceptive methods who adopted the current method within the five years preceding the survey, and it captures four separate measures: (a) the percentage who were informed about the side-effects of the method, (b) the percentage who were informed what to do if side-effects were experienced, (c) the percentage who were informed of other methods that could be used for contraception, and (d) specifically among women who were sterilized within the five years preceding the survey, the percentage who were informed that they would not be able to have any more children. A composite measure or index of informed choice can be created from these four rates, to support an analysis of how well informed current users of modern contraception are.

### *Indicator: Contraceptive prevalence rate*

It is informative to analyse data on informed choice together with data on CPR. For example, if CPR were to increase, and informed choice decreased, this could indicate coercive practices.

### *Indicator: Contraceptive users reporting privacy*

Furthermore, interpreting CPR and informed choice in the context of user-reported privacy can provide information about whether lack of privacy influences informed decision-making and/or CPR.

A joint analysis of these three indicators can provide an illustration of what information is available to users to facilitate their decision-making about contraception, and also about what visual and auditory privacy exists. These indicators also jointly provide information regarding the influence these considerations have on decision-making by users and on contraceptive prevalence.

## Gaps

Informed decision-making is central to health and human rights considerations in relation to contraceptive services and information. While the indicators under this section seek to capture the considerations related to informed decision-making in a limited way, they do not measure the nature and quality of the information and services or aspects related to autonomy in decision-making. Furthermore, the existing indicators do not measure the safety and reliability of contraceptive services, how comprehensive the information is, or the availability of counselling and support for marginalized groups, including people with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people.

## Privacy and confidentiality in provision of contraceptive information and services

### Health and human rights rationale

The right to privacy means that individuals should not be subject to interference with their privacy, and they should enjoy legal protection in this respect (38, Article 17). Sexual and reproductive health involves many 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 keep secret or 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. If people feel that confidentiality and privacy are not guaranteed in the health-care environment, they may decide not to seek services (18, Paragraph 12[d]), thus jeopardizing their own health and potentially that of others. This is often the case for vulnerable groups such as adolescents (28, Paragraph 20). Privacy is also key to protecting the sexual and reproductive health of groups who are stigmatized on the basis of their sexuality, sexual identity or sexual practices, such as gay, lesbian, bisexual, transgender and intersex people, sex workers, as well as because their behaviours or actions fall outside the law.

In line with human rights commitments, and in order to promote the health and development of all, states are urged to strictly respect the right to privacy and confidentiality, including with respect to advice and counselling on sexual and reproductive health matters (29, Paragraph 11). Health-care providers have an obligation to keep medical information confidential, both written records and verbal communications. Such information may only be disclosed with the consent of the user.

The right to access information regarding one's health includes access to medical records. All persons are entitled to know what information has been collected about their health (61, Article 10). Where individuals cannot access their medical records, this may make it hard for them to get information about their health status or to receive a second opinion or follow-up care. This can have an effect on not only restricting individual's access to follow-up care, but also to their ability to access remedies in cases of violation of their human rights (62).

### Indicators

- Contraceptive users reporting privacy

### Analysis and interpretation

#### **Indicator: Contraceptive users reporting privacy**

This indicator tracks both the user's reported experience of privacy (both visual and auditory) and the observed number of contraceptive providers who ensured visual and auditory privacy, and assured the user of confidentiality in relation to counselling sessions and physical examinations. Its strength is that it incorporates the user's perspective, and does not merely record whether a private space for counselling is available (an available space may not be used). This is a quantitative indicator that provides important information about users' experience of privacy and confidentiality related to contraceptives services and information.

### Gaps

Privacy and confidentiality in the provision of contraceptive information and services should ideally include a range of guarantees including access to information, data protection and others, as highlighted in the rationale. The presently available quantitative indicator only addresses the aspect of the physical (visual and auditory) privacy of a user during a visit. Additionally, the information available by using this indicator is often subject to bias and cultural differences in interpretation. Further work is needed to develop indicators on structural and policy measures, including on aspects related to data protection and access to information.

## Participation

### Health and human rights rationale

It has been recognized that participation of affected populations in all stages of decision-making and implementation of policies, programmes and services is a precondition for sustainable development and the highest attainable standard of health (63, 64). 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 (65, 66). For example, there is evidence of an association between women's participation and improved health and health-related outcomes (65). Where women's participation in policy-making 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 (66).

Under international human rights law, states have an obligation to ensure active, informed participation of individuals in decision-making that affects them, including on matters related to their health (14, Paragraph 17). The ICPD Programme of Action reaffirms this core principle in relation to SRH and states 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" (4, *Principle 4*). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically requires states 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 (67).

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 (65, 68).

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 (68).

### Indicators

- Contact of non-users with family planning providers

### Analysis and interpretation

#### *Indicators: Contact of non-users with family planning providers*

This indicator provides the proportion of all non-users who had either been visited by a contraceptive worker or spoken with a health worker at a health-care facility about contraceptive methods during the 12 months preceding the interview. Although limited in its purview, this measure gives us information about how

likely it is that women who are not using contraception will have had interaction with a contraceptive service provider, and thus it also provides information about the availability of contraceptive information and services in the community, outside of the facility. This information is helpful for an analysis of interaction between users and providers, a key component to participation of users in contraceptive decision-making process. This indicator is the only quantitative indicator identified that spoke to the experience of the non-user of contraceptive services.

### Gaps

In terms of measuring participation from a human rights perspective, this indicator is extremely limited. It provides only a narrow, indirect assessment of participation and does not capture essential aspects related to individual agency and participation in relation to decision-making regarding their sexual and reproductive health, such as user involvement in design, implementation and monitoring of contraceptive services and information. A more robust measure is urgently needed, which would include qualitative assessment of a user's ability to engage in programme design and management. An indicator that evaluated the accountability of the programme to the community, such as through the presence of redress mechanisms, could also contribute to monitoring participation.

## Accountability

### Health and human rights rationale

Accountability guides states in putting their legal, policy and programmatic frameworks and practices in line with international human rights standards (69). 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 SRH and empowers them to claim these entitlements (68).

International human rights law requires states to ensure effective accountability mechanisms, including monitoring and evaluation, and availability of effective processes for remedy and redress, and to ensure participation of a wide range of stakeholders in the development and implementation of laws, policies and programmes (18, 64).

Effective monitoring of health care requires a functioning health management information system, civil registration system and availability of disaggregated data. A strong capacity to collect data on women's health is essential in each country, in order to determine where investments should be focused and whether progress is being made (10). Within a human rights framework, monitoring requires the use of a range of indicators, not all of which are quantitative or directly related to the health sector (70). Wherever possible, the disaggregation of information on the basis of age, marital status, nulliparity, wealth quintile, and place of residence (i.e. rural versus urban), as well as geographic or administrative regions is essential for ensuring non-discrimination and equity, and as a basis for affording due protection to vulnerable and marginalized groups (10). All persons subjected to human rights violations have a right to an effective remedy and to reparation.

Remedies take a variety of forms including: restitution (i.e. re-establishing a situation as it was before a violation took place); rehabilitation (i.e. medical or psychological care or social or legal services); compensation (i.e. payment for any financially assessable damage); satisfaction (i.e. acknowledgement of a breach, an apology, etc.); and guarantees of non-repetition (i.e. legislation, organizational improvements, etc.) (51). Some of these measures primarily assist individual victims of violations, while others are more directed at the general population, to facilitate proactive protection of human rights. Depending on the situation, full reparation may require a combination of these measures (14, 71–73). In all cases, remedies should be accessible, affordable, timely and effective. This will require adequate funding, capacity-building and ensuring that mechanisms are in place with the necessary mandate to provide remedies (68).

Accountability is achieved through a variety of processes and institutions, which vary from country to country and may involve both national and international mechanisms and multiple forms of review and oversight, including, administrative, social, political and legal. Examples of these processes and institutions include courts, national human rights institutions, professional disciplinary proceedings, international and regional human rights bodies' state reporting processes, and individual complaint mechanisms. Civil society participation in the development and monitoring of laws and policies, including budgets and use of public funds, is an important element of accountability (68).

While it is primarily the state's obligation to respect, protect and fulfil human rights with regard to the provision of contraceptive information and services, it is important to note that, in addition to their obligations to guarantee the right to contraceptive information and services in their own country, donor countries also have a responsibility to promote and protect human rights in relation to contraceptive information and services through international assistance and cooperation. The same is true of other development partners (68, 74).

### Indicators

- A system for quality assurance has been institutionalized

### Analysis and interpretation

#### ***Indicator: A system for quality assurance has been institutionalized***

This indicator measures organizational commitment to quality assurance.

From a management perspective, the following six items are essential to developing a composite score of commitment to quality assurance:

- evidence of integration of quality assurance into the organization's mission and strategy;
- evidence of integration of quality assurance into the organization's plans and budget;
- evidence of the availability of quality standards or protocols;

- evidence of performance/provider adherence to standards;
- mechanisms for obtaining user feedback relating to quality;
- mechanisms for collecting provider perspectives on quality.

While this is primarily an indicator applicable to the quality of contraceptive services provided, it is also helpful for analysis of the accountability dimension since this indicator provides information on the existence of a monitoring mechanism to assess quality of contraceptive services.

### **Gaps**

Effective, transparent and accessible monitoring, accountability and redress mechanisms, at the national and international levels, in relation to the public and private health sectors, are essential to a health and human rights approach. While this indicator measures an organization's commitment to quality assurance, it does not speak to most elements of accountability. In order to assess accountability, there should be indicators to evaluate each step of the accountability process (monitor, review, remedy).



## V. Conclusions and next steps

Monitoring and evaluation of contraceptive programmes is critical to ensuring accountability, both in terms of achieving health outcomes and fulfilling human rights obligations. A key limitation to ensuring that contraceptive programmes respect, protect, and fulfil human rights obligations has been the absence of indicators to monitor rights-related outcomes. This document provides a small, but important first step towards bridging this gap.

As described in this report, first a list of health and human rights principles and standards was drawn from internationally recognized human rights as applied to contraceptive service delivery. These standards have served as part of a set of criteria for the systematic evaluation and selection of existing relevant quantitative indicators. Next, the resulting set of 12 indicators was analysed to illustrate how these existing quantitative indicators can be used to capture information relevant to a health and human rights analysis. Most importantly, however, this report identifies the remaining gaps, highlighting rights-related concerns that we are currently not able to adequately monitor in the context of contraceptive programmes.

It is hoped that, while not comprehensive, use of these standards and indicators as proposed will contribute to development of a comprehensive strategy for monitoring the interaction between health outcomes and rights realization in the context of contraceptive service delivery. A comprehensive approach to monitoring rights will require several initiatives. First, existing data collection systems must be strengthened, to allow for more frequent data collection, including administration of service provision assessment surveys and client exit interviews. Good quality data that capture different aspects of service provision are essential for monitoring. Second, all nine health and human rights principles and standards must be adequately assessed in order to comprehensively monitor human rights. Thirdly, a human rights perspective could best be captured with a combination of quantitative, qualitative and policy indicators. This will require identification of existing qualitative and policy indicators to supplement the quantitative indicators reported here. Lastly, the creation of new indicators (quantitative, qualitative and/or policy) may be needed to address any remaining gaps in coverage of the nine identified areas.

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## Annex B. Indicator methodology

### Evaluating indicators for feasibility and quality in monitoring rights in contraceptive programmes

**Step 1:** Discuss what are the rights issues in contraceptive programmes- what are the priorities for monitoring to ensure that rights are protected and respected?

**Step 2:** Does this indicator provide information relevant to the programme level, and specific to programme outcomes?

**Step 3:** Consider ability of indicator to measure outcomes, using rights or health and human rights principles and standards:

1. Is there an explicit link between the indicator and human rights? (yes/no)
2. Is there an implicit link between the indicator and human rights? (yes/no) If yes, cite the relevant human right(s) linked to the indicator.
3. What human rights principles and standards are measured by this indicator? (give examples)
4. Does this indicator lend itself to disaggregation by factors that have been afforded legal protection against discrimination? (yes/no)? If yes, according to what criteria?
5. Can this indicator be combined in analysis with another indicator to yield a description that draws attention to a human rights principle or standard? (yes/no) If yes, describe.

**Step 4:** Feasibility and quality of indicator (from UNAIDs)

1. Does this indicator measure performance against contraceptive policy/programme strategy or an international commitment? (yes/no)
2. Is it clear how data from this indicator can be used for programmatic decision making? (yes/no)
3. Is there a consensus amongst technical experts that this indicator should be monitored? (yes/no)
4. Does this indicator reliably measure what is intended to be measured?
5. Is the indicator fully defined?\* (yes/no)
6. Are systems available to allow this indicator to be measured? (yes/no)
7. Are adequate human and financial resources available to allow this indicator to be measured? (yes/no)
8. Has the indicator been field tested or used in practice (yes/no)

\*To be fully defined, an indicator should have: Title and definition, Purpose and rationale, Method of measurement, Data collection method, Measurement frequency, Data disaggregation, Guidelines for interpretation and use, Strengths, weaknesses and challenges and Sources of further information

**Step 5:** Considering the indicators as a set, are all identified health and human rights principles and standards covered adequately?

## Appendix C International human rights relevant to contraceptive information and services

Human Right	Recommendations to States
<b>The Right to Consent to Marriage and to Equality in Marriage</b>	<ul style="list-style-type: none"> <li>• Ensure the right to “freely to choose a spouse and to enter into marriage only with their free and full consent” (1).</li> <li>• Remove any requirements for spousal consent in order to access family planning services (2).</li> </ul>
<b>The Right to Education</b>	<ul style="list-style-type: none"> <li>• “Family planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling” (3).</li> <li>• Ensure women’s rights “to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (4).</li> <li>• Provide “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning” (5).</li> </ul>
<b>The Right to Equality and Non-Discrimination</b>	<ul style="list-style-type: none"> <li>• 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” (6).</li> <li>• Ensure that states “take all appropriate measures to eliminate discrimination against disadvantaged women regarding access to health care, including family planning information, counselling, and services” (7).</li> <li>• Ensure that states “report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women’s access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport” (8).</li> <li>• “Ensure access to quality health care services” [including family planning], for all women, including adolescent girls, which are delivered in a way that “ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives” (9).</li> <li>• Ensure “the equal participation of women and men in all areas of household responsibilities, including family planning” ... “should be promoted and encouraged by governments” (10).</li> </ul>

Human Right	Recommendations to States
<b>The Right to Health</b>	<ul style="list-style-type: none"> <li>• “Develop and implement programmes that provide access to sexual and reproductive health information and services, including for adolescents” (11).</li> <li>• Ensure the availability, accessibility, acceptability and quality of family planning information and services (12).</li> <li>• [Ensure that available family planning methods] “provide accessible, complete, and accurate information about various family planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases” (13).</li> <li>• Ensure that “health facilities, goods and services [including family planning] must be accessible to all, especially the most vulnerable or marginalized sections of the population in law and in fact without discrimination on any of the prohibited grounds” (14).</li> </ul>
<b>The Right to Information and Freedom of Expression</b>	<ul style="list-style-type: none"> <li>• “Ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice” (15).</li> <li>• Provide accessible, comprehensive information on family planning to make options clear to individuals. . . “In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention” (16).</li> </ul>
<b>The Right to Liberty and Security of Person</b>	<ul style="list-style-type: none"> <li>• Ensure that “no one shall be subjected to arbitrary or unlawful interference with privacy, family, home or correspondence”, [including in decisions relating to family planning] (17).</li> <li>• Ensure “no one shall be subjected . . . to unlawful attacks on his honour and reputation” [for any decisions pertaining to family planning] (18).</li> </ul>
<b>The Right to Life</b>	<ul style="list-style-type: none"> <li>• Ensure “the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance” (19).</li> </ul>
<b>The Right Not to be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment</b>	<ul style="list-style-type: none"> <li>• “Ensure that measures are taken to prevent coercion in regard to fertility and reproduction” (20).</li> <li>• Ensure the “right to make decisions concerning reproduction” [including family planning] free of discrimination, coercion and violence, as expressed in human rights documents“ (21).</li> </ul>
<b>The Right to Participate in the Conduct of Public Affairs and the Right to Free, Active and Meaningful Participation</b>	<ul style="list-style-type: none"> <li>• Ensure free, active and informed participation of individuals in decision-making related to family planning . . . “Reproductive health care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization, and evaluation of services” (22).</li> <li>• Ensure that “special efforts [are] made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning . . .” (23)</li> </ul>



Human Right	Recommendations to States
<b>The Right to Privacy</b>	<ul style="list-style-type: none"> <li>• Ensure that “accessibility of information [will] not impair the right to have personal health data treated with confidentiality” [including information pertaining to family planning] (24).</li> <li>• Ensure that “all health facilities, goods and services [including family planning] are “designed to respect confidentiality and improve the health status of those concerned” (25).</li> <li>• “The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services” (26).</li> </ul>
<b>The Right to Decide the Number and Spacing of Children</b>	<ul style="list-style-type: none"> <li>• Ensure the “same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (27).</li> <li>• Ensure that “Compulsory sterilization or abortion” [pertaining to family planning does not occur as it] “adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children” (28).</li> <li>• Ensure that “decisions to have children or not, while preferably made in consultation with spouse or partner, must not” ... “be limited by spouse, parent, partner or Government” (29).</li> </ul>
<b>The Right to be Free from Practices that Harm Women and Girls</b>	<ul style="list-style-type: none"> <li>• “Ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence” (30).</li> </ul>
<b>The Right to be Free from Violence</b>	<ul style="list-style-type: none"> <li>• Ensure that states “take appropriate and effective measures to overcome all forms of gender-based violence,” [including sexual violence and all other forms of violence pertaining to family planning] (31).</li> <li>• Ensure “the enactment and effective enforcement of laws and the formulation of policies, including health care protocols” [and family planning programs] “to address violence against women and abuse of girl children and the provision of appropriate health services” (32).</li> <li>• “Undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights (33).</li> </ul>

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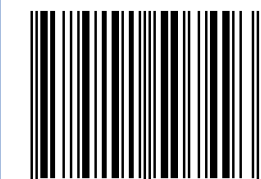
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