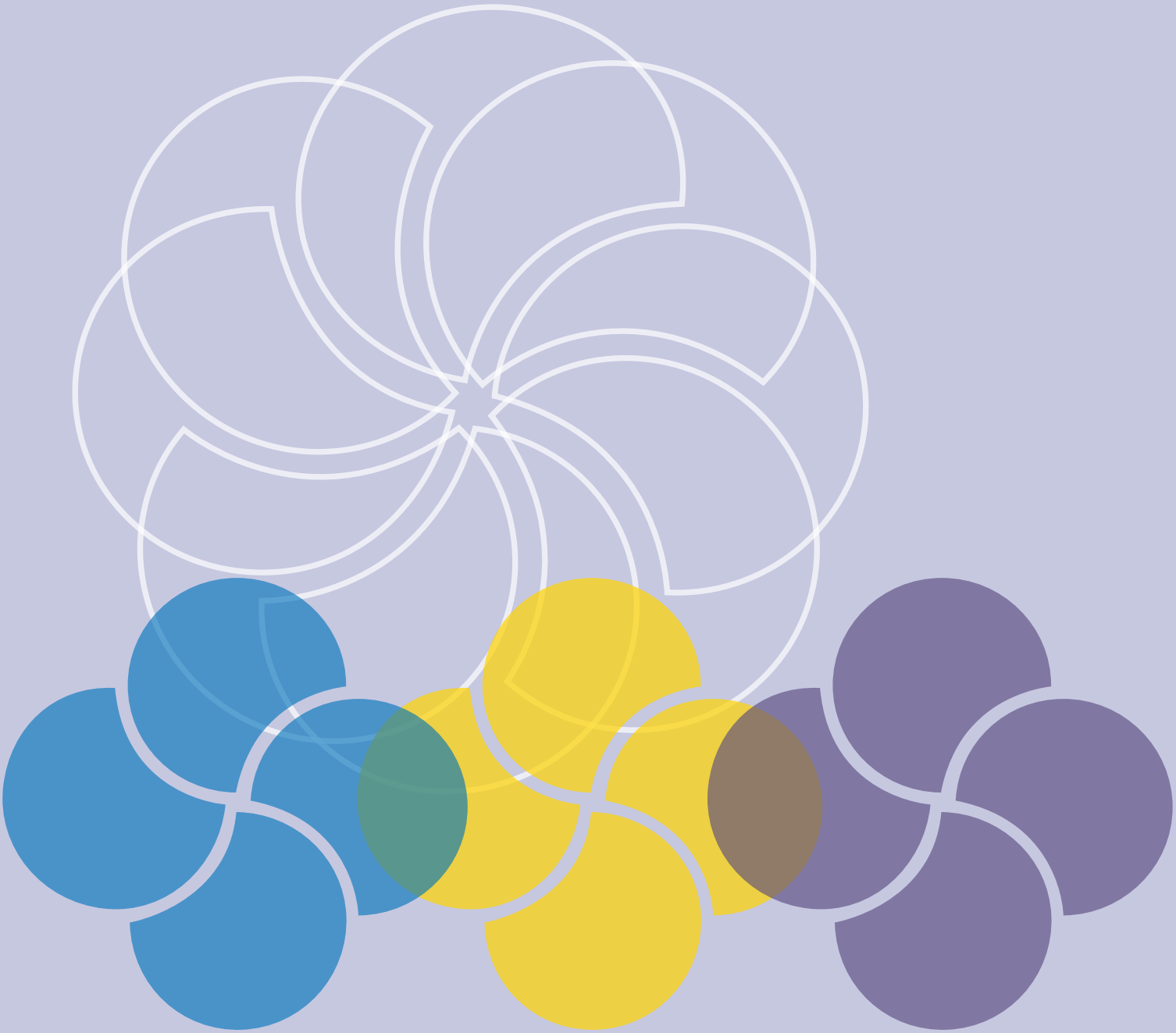
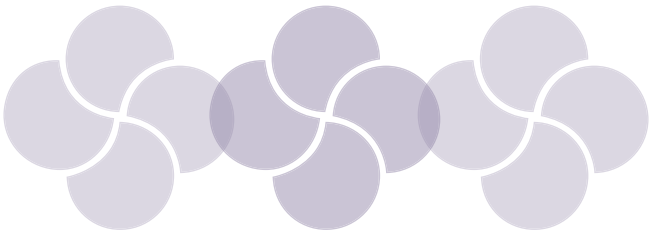
Monitoring human rights in contraceptive services and programmes



World Health Organization

Monitoring human rights in contraceptive services and programmes

World Health Organization Department of Reproductive Health and Research, including the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)



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Monitoring human rights in contraceptive services and programmes

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Contents

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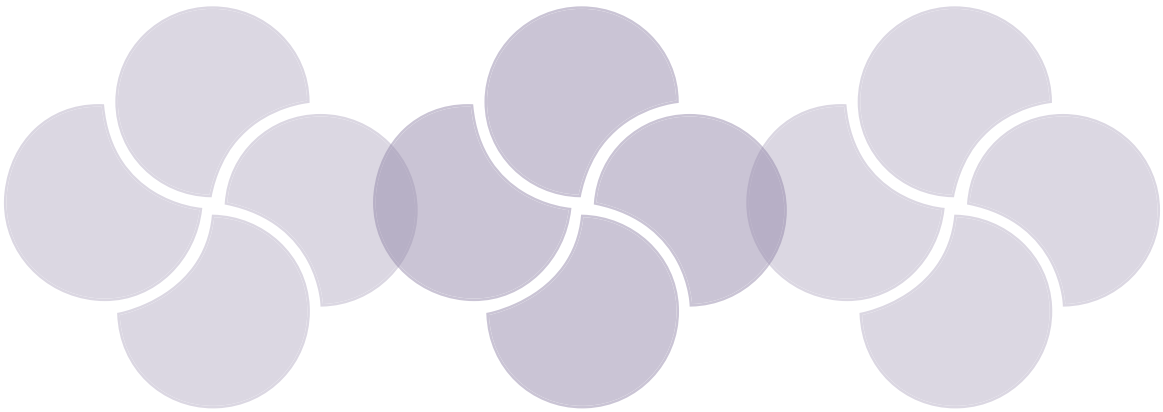

Acronyms and abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSE	comprehensive sexuality education
CSO	civil society organization
CYP	couple-years of protection
DHS	Demographic and Health Survey
EAG	expert advisory group
FP	family planning
FP2020	Family Planning 2020
HIV	human immunodeficiency virus
HRP	UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference on Population and Development (Cairo, 1994)
NCIFP	National Composite Index for Family Planning
NGO	nongovernmental organization
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive summary

This tool for Monitoring human rights in contraceptive services and programmes contributes to the World Health Organization's (WHO's) ongoing work on rights-based contraceptive programmes. This work builds directly on WHO's 2014 Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators[1] and the 2015 publication Ensuring human rights within contraceptive service delivery implementation guide by the United Nations Population Fund (UNFPA) and WHO. [2]

With advice from an expert advisory group, indicators were identified and an analytic framework developed to assess indicators commonly used in the field of contraception for their sensitivity to human rights – as a key step in developing a human rights-based approach to monitoring and evaluation of contraceptive services and programmes.

Drawing on relevant human rights principles and standards, and informed by the above-mentioned 2014 and 2015 publications, the analytic framework for assessing indicator sensitivity to human rights was developed and used to analyse and prioritize each of the indicators included in this tool. A short list of 41 commonly-used indicators was selected from a larger group, and each of these was reviewed using the analytic framework to determine its ability to shed light on relevant human rights concerns. Ultimately this process led to prioritization of a set of 20 indicators for immediate consideration. These 20 indicators are presented in the body of this tool and a set of worksheets provided, grouped into eight categories. The remaining 21 indicators are listed in an annex, similarly grouped among the eight categories.

This tool is intended for use by countries to assist them in strengthening their human rights efforts in contraceptive programming. The tool uses existing commonly-used indicators to highlight areas where human rights have been promoted, neglected or violated in contraceptive programming; gaps in programming and in data collection; and opportunities for action within the health sector and beyond, including opportunities for partnership initiatives.

We trust this tool will prove to be an asset to all who are working to ensure the quality of contraceptive information and services, and that it will serve to uphold the dignity and rights of all who access and use these services.

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1 Available at: http://who.int/reproductivehealth/publications/family_planning/contraceptive-programmes-hr-analysis/en/

2 Available at: http://apps.who.int/iris/bitstream/10665/158866/1/9789241549103_eng.pdf

Introduction

It is now well recognized that expanding access to contraceptive services and improving health outcomes require services to be delivered in ways that respect, protect and fulfil the human rights of everyone who seeks and uses them (1). The World Health Organization (WHO) is committed to the mainstreaming of gender, equity and human rights, and also works to develop evidence-based norms, standards and tools for scaling up equitable access to quality care and services within a rights- and gender-based framework (2).

Traditionally, many of the indicators used to evaluate contraceptive programmes have been those that monitor contraceptive use rates, efficacy and effectiveness, availability and security (e.g. stock-outs). While these indicators provide useful information, they are generally seen as limited in their capacity to assess many critical rights-related issues. For example, couple-years of protection (CYP) is an indicator 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 the reported quantity of contraceptives dispensed. This indicator provides information on the availability of commodities, but it does not provide information on whether the contraceptive methods on offer are of quality, accessible and acceptable to all intended beneficiaries, nor does it highlight any legal, policy, system or individual inequalities that may exist in relation to access or use (3). This tool aims to identify and address such gaps.

Data collected and analysed using this tool can help to:

- identify where and how rights are respected, protected and fulfilled in programming efforts, and
- identify gaps that exist in programming and data collection, as well as areas where the indicators used do not sufficiently capture rights-related concerns.

The information gained through the application of this tool can be used to build capacity for research, programming, measurement and accountability, and may help to propel the reconfiguration of health management information systems, to boost related investments and to foster the political will needed to ensure meaningful attention is given to human rights concerns in existing contraceptive programmes.

Development of the tool

Under the guidance of WHO, the tool was developed by a multidisciplinary research team with expertise in human rights and health, an expert advisory group (EAG) representing diverse organizations to guide the research and provide feedback.

With the input of the EAG, over 200 indicators commonly used in the field of contraception were identified, and an analytic framework was developed to assess these indicators for their sensitivity to human rights. The analytic framework was informed by WHO's 2014 publication, Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators (3). Using this framework, the research team reviewed all data sources and conducted independent analyses of the indicators.

Using the results of these analyses, each indicator was then prioritized on the basis of whether it drew attention explicitly or implicitly to one, some or all of the identified human rights principles or standards. A set of 85 indicators that were determined to be most sensitive to human rights were selected for in-depth analysis from among the initial list of 200. These 85 indicators encompassed a combination of quantitative, qualitative and policy-level information relevant to the topics addressed.

The 85 selected indicators were subsequently organized by the eight categories identified in the 2015 publication Ensuring human rights within contraceptive service delivery implementation guide by the United Nations Population Fund (UNFPA) and WHO (hereafter referred to as the UNFPA–WHO Implementation guide) (2). These indicators

were then presented to a broader audience for review and discussion at a technical consultation. Participants came from diverse backgrounds, including practitioners, researchers, academics and policy-makers, and they were collectively asked to review the methodology and preliminary findings of the work. As a result of this meeting, the list of 85 indicators was further reduced to a short list of 41 indicators considered to be most sensitive to human rights principles and standards and therefore appropriate to be included in this tool. From this short list, in turn, just 20 indicators were ultimately prioritized based on field-test results; scope; the rights addressed; the mix of quantitative, qualitative and policy-level information relevant to the topic they address; and feasibility of use. It should be noted that many of the indicators included were tweaked at the technical consultation, and therefore there may be slight variations in the wording and proposed methods of data collection for the indicators provided in this tool compared to what can be found in the original data sources.

Target audience

The tool is addressed to programme managers, monitoring and evaluation specialists, and staff of government bodies and civil society organizations (CSOs) involved with family planning services at national and provincial levels. It is intended for use by organizations involved in the planning, implementation and/or evaluation of contraceptive programmes and interventions, adding value to subnational and national reporting systems, as well as global initiatives.

Following human rights principles, the process of using the tool is participatory in nature, involving engagement with a variety of stakeholders. Such a process has the advantage that multiple perspectives generate broad-based support, consensus and ownership of prioritized actions. The initiation of the tool is intended to be led by the ministry of health (MOH) or other project initiator, with technical assistance from WHO and/or other partners familiar with human rights (1).

Organization of the tool

The body of the tool (provided in this publication) includes worksheets for collecting information on the 20 indicators that were prioritized from among the full set of 41 indicators. These 20 indicators were identified for immediate consideration through the extensive process described above (see Development of the tool).

The organization of the tool after this introductory section is as follows.

- A list of the 20 prioritized indicators grouped into eight categories.
- Eight sections – one for each of the eight categories (see the numbered list below) – each of which includes:
  - a description of the content of the category;
  - an informational table containing the prioritized indicators, a link to each indicator source, suggested approaches to data collection, and human rights determined to be explicitly or implicitly addressed by the indicator;
  - worksheets for each of the indicators within the category, including questions to guide users through analysis of each indicator with respect to human rights sensitivity and data quality;
  - suggested "Additional issues for consideration" within each category; and
  - a place for a summary write-up of all indicators within the category.
- Annex 1 – listing the additional 21 indicators, also grouped according to the eight categories.
- Annex 2 – containing detailed instructions on how to use and fill out the worksheets provided in each category.
- Annex 3 – providing definitions of the human rights principles and standards used within this tool.

The eight categories used to organize all 41 indicators (20 addressed in the body of the tool and

21 in Annex 1) are categories commonly used in the provision of primary health care and contraceptive information and services linked to human rights norms and standards, as identified in the UNFPA–WHO Implementation guide (2015) (2). This tool utilizes these same eight categories to ensure consistency amongst the various WHO products and publications on contraception and human rights.

Eight categories:

1. Ensuring access for all
2. Commodities, logistics and procurement
3. Organization of health-care facilities, outreach and integration
4. Quality of care
5. Comprehensive sexuality education
6. Humanitarian context[1]
7. Participation by potential and actual users of services
8. Accountability to those using services (2).

Interpretations of the human rights principles and standards used in this analysis are consistent with international human rights documents, international consensus documents, recommendations made to states by human rights treaty monitoring bodies and the Human Rights Council, as part of ensuring "no one is left behind" in accessing and using contraceptive services. Substantive definitions for each of the human rights principles employed can be found in Annex 3.

How to use this tool

Overall, the work required to complete the tool and proceed with the relevant follow-up steps is organized into three phases:

Phase 1: Initiating the process
Phase 2: Tool implementation, analysis and initial review
Phase 3: Reporting, dissemination and planning for action.

Each phase consists of a number of steps, which are described in more detail below.

Phase 1: Initiating the process

Establishing the national project team who will implement the tool

In any given country, the project may be initiated by the MOH with technical assistance from WHO and/or other partners familiar with human rights, or by a national human rights institution, parliamentarian forum, or other concerned body. A national project team can be established and include designated staff from the MOH, WHO (and other partner agencies) and nongovernmental organizations (NGOs), as well as health researchers, national experts and human rights lawyers, as needed. The national project team can facilitate the convening of meetings to adapt the instrument to the national context, oversee data compilation and analysis, prepare the final report, help disseminate the results and support implementation of prioritized actions (1).

Engaging the researchers

The MOH or other initiator of the project should arrange a contract for the work with researchers and human rights lawyers, as appropriate, who ideally have some independence from the government. Their role will be to assist in the adaptation of the instrument to the local context, collect information, analyse it, help facilitate the national stakeholder workshop and help prepare the final report (see further information in Phase 3 below). The researchers should regularly inform the rest of the national project team about the progress made (1).

Phase 2: Tool implementation, analysis and initial review

Tool implementation and analysis

The following steps should be undertaken.

1. Review the 20 prioritized indicators to determine those most relevant to your

1 The category "Humanitarian context" is included in this tool even though there are currently no indicators associated with it, as none were found that met the standards for inclusion.

context in each of the eight categories. If any of the 20 prioritized indicators do not align with the national or subnational context in which the tool is being implemented, refer to the list of 21 additional indicators included in Annex 1 to determine other indicators that may be of use. The final instrument for national use should contain approximately 20 indicators, organized according to the eight categories.

2. Read through Annex 2, which explains how to use the worksheets for each category and includes tips on how to collect and summarize the relevant data.
3. Identify and collect data sources for each prioritized indicator in each category. Note that data sources will vary depending on the indicator but should include, to the extent possible, not only standard quantitative, qualitative and policy data, but also information appearing in peer-reviewed and grey literature, including NGO reports.
4. Use the indicator worksheets provided to work through all the questions, which have been provided to help determine the human rights sensitivity of each indicator, noting the strengths and limitations from both a human rights and data perspective. Consult Annex 3 as needed for clarification about relevant human rights concepts.
5. Aggregate responses in each of the eight categories should include a summary of indicator worksheet findings (Worksheet summary) and a section on additional issues suggested for consideration, with attention to both programme strengthening and data strengthening.

Workshop presentation and initial review of findings

After the data compilation and analysis have been completed, a workshop with the full national project team should be held to explain the analysis methodology and to present and discuss the main findings from the completed worksheets across the eight categories. Responses to the worksheet questions (within and across categories) should be separately collated and discussed to identify strategies to improve programming from a rights perspective, as distinct from those necessary to strengthen data capacity at national and subnational levels. Agreement should be reached as to where rights issues are adequately addressed, where rights remain to be respected, protected and fulfilled in programming efforts, and where gaps exist – i.e. where indicators do not sufficiently capture rights concerns (1).

Phase 3: Reporting, dissemination and planning for action

Workshop for review of findings with national stakeholders

The final phase of the process involves the participation of national stakeholders in a workshop to review the findings of the analysis and the recommendations, and to draw up an action plan (1).

Generic action points captured through the workshop proceedings should include attention to:

- issues that are well addressed and need to be sustained;
- capacity of health workers and others involved in service provision and data monitoring to ensure adequate consideration of human rights in the provision of contraceptive information and services, including training and other related needs identified through this exercise;
- laws, policies, programmes, protocols, guidelines, etc., that require modification based on human rights concerns identified through this exercise; and
- data and indicator gaps, as well as inadequacies in health information systems, which remain to be addressed in order to support robust data gathering and monitoring of human rights in contraceptive programmes.

The final report

- The results of the analysis and the agreed recommendations should be summarized in a final report with a focus on prioritized actions, and this should be published and presented to a wider audience. The report should include the following sections.
- Introduction – brief background information on the state of human rights as relevant to contraceptive information and services in the country.
- Methods – a brief explanation of the methodology used and acknowledgement of any gaps and limitations of the review.
- Findings – a summary of the findings, including agreement as to where rights are adequately considered, and where they remain to be respected, protected and fulfilled in
- contraceptive programming efforts, as well as any gaps in the data and indicators.
- Action plan – presentation of agreed-upon prioritized actions, and identification of relevant stakeholders to implement them (1).

Public dissemination

Disseminating the final report gives stakeholders an opportunity to promote accountability and action by sharing their collective findings and recommendations with colleagues and the broader public (1).

Follow-up actions

Follow-up will require sustained commitment, financial resources and political will, ultimately contributing to national-level achievement of the highest attainable standard of health for all (1).

Indicators to support monitoring of human rights in contraceptive services and programmes

Category 1: Ensuring access for all

1. Are there laws/regulations/policies that guarantee access to contraceptive services and information without spousal or parental/guardian authorization/notification and without age limitation?
2. Existence of national laws and regulations, and national/subnational policies or strategic plans that regulate equitable and affordable access to quality contraceptive services and information
3. Does the government ensure that access to contraceptive information and services is not impeded by the claim of conscientious objection by a health-care provider or pharmacist?

Category 2: Commodities, logistics and procurement

4. Existence of a national contraceptive security strategy that recognizes the needs of young people and other underserved populations, and extends commodity security to the private and NGO sectors
5. Method mix: Number of health-care facilities offering at least one short-term, one long-term and one emergency contraceptive method (at least one of these must be a dual-protection method, e.g. condom or vaginal ring), as well as one permanent method (at secondary- or tertiary-level facilities, according to national policy)
6. Percentage of health-care facilities experiencing stock-outs of contraceptive(s), by method offered, on the day of assessment

Category 3: Organization of health-care facilities, outreach and integration

7. Contraceptive service-delivery points
8. Obstacles encountered by unmarried youth (and other populations) while seeking contraceptive services
9. Contraceptive prevalence rate (CPR)
10. Unmet need for family planning (FP)

Category 4: Quality of care

11. Informed choice (index)
12. Health-care facilities meeting quality-of-care standards
13. Are there national laws, regulations or policies regulating female or male sterilization?
14. Contraceptive user satisfaction with services

Category 5: Comprehensive sexuality education

15. Percentage of sexually active young people who used a condom at first/last sex

Category 6: Humanitarian context

No indicators currently available in this category.

Category 7: Participation by potential and actual users of services

16. Whether the decision to use contraception or not use contraception has been the woman's decision (woman alone or woman with her partner)
17. Is there a system in place that encourages dialogue and communication between users and service providers/health officials about service availability, accessibility, acceptability and quality?

Category 8: Accountability to those using services

18. Are there grievance-redress mechanisms for sexual and reproductive health (SRH) services in this country? If yes, describe these mechanisms. - At what levels do they function? - How accessible are these mechanisms to marginalized sections of the population? - What is known about the effectiveness of these mechanisms?
19. Existence of a legal and normative framework that protects the human rights of individuals to have control over and decide freely and responsibly on matters related to reproduction, free of discrimination, coercion and violence
20. Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (e.g. age, marital status, ability to pay) or by coercion (including inappropriate use of incentives to clients or providers)?

Category 1: Ensuring access for all

Most human rights principles and standards are relevant to ensuring access for all. For example, the human rights principle of non-discrimination obliges countries to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital or family status, sexual orientation, gender identity, health status, place of residence, economic or social situation, and this includes in relation to access and use of contraceptive information and services. Countries must strive to eliminate all forms of discrimination and to promote equality by ensuring that all people have access to the information and services they need. Another right that is particularly relevant to "ensuring access for all" is the right to make informed decisions about health care, including contraceptives. That is, in order to make an informed decision about safe and reliable contraception, comprehensive information, counselling and support should be accessible and acceptable to all people, including, for example, people with disabilities, indigenous peoples, ethnic minorities, people living with HIV, transgender and intersex people.

Table 1. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 1: Are there laws/regulations/policies that guarantee access to contraceptive services and information without spousal or parental/guardian authorization/notification and without age limitation?	1) Center for Reproductive Rights and UNFPA – *Reproductive rights: a tool for monitoring state obligations* 2) *Women's Major Group – Indicator proposals*	This indicator requires compiling legal and policy information from readily available sources, including ministry of health (MOH), ministry of justice (MOJ) and nongovernmental organizations (NGOs), as relevant.	• Non-discrimination • Availability • Accessibility • Acceptability • Privacy and confidentiality • Informed decision-making • Participation • Accountability
Indicator 2: Existence of national laws and regulations, and national/ subnational policies or strategic plans that regulate equitable and affordable access to quality contraceptive services and information	MEASURE Evaluation Population and Reproductive Health (PRH) Project – Family Planning and Reproductive Health Indicators Database	This indicator requires compiling health, legal and policy information from readily available sources, including MOH, MOJ and NGOs, as relevant.	• Non-discrimination • Availability • Accessibility • Quality • Accountability
Indicator 3: Does the government ensure that access to contraceptive information and services is not impeded by the claim of conscientious objection by a health-care provider or pharmacist?	Center for Reproductive Rights and UNFPA – *Reproductive rights: a tool for monitoring state obligations*	This indicator requires compiling health, legal and policy information from readily available sources, including MOH, MOJ and NGOs, as relevant.	• Accessibility • Quality • Accountability

Worksheet 1. Key questions and responses for each indicator

Indicator 1. Are there laws/regulations/policies that guarantee access to contraceptive services and information without spousal or parental/guardian authorization/notification and without age limitation?	
Key questions	**Responses, sources and explanatory notes**
Are there any laws/regulations/policies that explicitly guarantee access to contraceptive services and information without: a) spousal authorization? ☐ **Yes** ☐ **No** b) parental/guardian authorization/notification? ☐ **Yes** ☐ **No** c) age limitation? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
In what year(s) were these laws/regulations/policies enacted? Do they cover a specific time period? ☐ **Yes** ☐ **No** If yes, please specify.	
Are relevant laws/regulations/policies publicly available and easy to access? ☐ **Yes** ☐ **No**	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do these laws/regulations/policies state that contraceptive services and information should be made **available** without: a) spousal authorization? ☐ **Yes** ☐ **No** b) parental/guardian authorization/notification? ☐ **Yes** ☐ **No** c) age limitation? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies address the accessibility of contraceptive services and information without: a) spousal authorization? ☐ **Yes** ☐ **No** b) parental or guardian authorization/notification? ☐ **Yes** ☐ **No** c) age limitation? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

Do these laws/regulations/policies address ensuring the acceptability of contraceptive services and information to users without: a) spousal authorization? **Yes** **No** b) parental/guardian authorization/notification? **Yes** **No** c) age limitation? **Yes** **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies address ensuring the provision of contraceptive services and information without discrimination, on the basis of: a) spousal authorization? **Yes** **No** b) parental/guardian authorization/notification? **Yes** **No** c) age limitation? (Y/N) Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies address privacy and confidentiality of users (i.e. explicit provisions that personal health information should be kept private and confidential between providers and clients) in the context of contraceptive services and information without: a) spousal authorization? **Yes** **No** b) parental/guardian authorization/notification? **Yes** **No** c) age limitation? **Yes** **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies ensure informed decision-making (i.e. explicit provisions for health information and education to be provided to clients) in the context of contraceptive services and information without: a) spousal authorization? **Yes** **No** b) parental/guardian authorization/notification? **Yes** **No** c) age limitation? **Yes** **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

Do these laws/regulations/policies address participation of users in the design or implementation of contraceptive services and information without: a) spousal authorization? ☐ **Yes** ☐ **No** b) parental/guardian authorization/notification? ☐ **Yes** ☐ **No** c) age limitation? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies address the need to reach specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? ☐ **Yes** ☐ **No** If yes, which populations/inequalities? Provide a summary and cite key provisions of any identified laws/regulations/policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws/regulations/policies promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with non-discrimination law? ☐ **Yes** ☐ **No**	
Indicator 2. Existence of national laws and regulations, and national/subnational policies or strategic plans that regulate equitable and affordable access to quality contraceptive services and information	
Key questions	**Responses, sources and explanatory notes**
Are there: a) national laws and regulations ☐ **Yes** ☐ **No** b) national/subnational policies ☐ **Yes** ☐ **No** c) strategic plans ☐ **Yes** ☐ **No** that regulate equitable and affordable access to quality contraceptive services and information? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws and regulations, national/subnational policies and/or strategic plans. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
In what year(s) were these national laws and regulations, national/subnational policies and/or strategic plans enacted? Do they cover a specific time period? ☐ **Yes** ☐ **No** If yes, please specify.	
Are relevant national laws and regulations, national/subnational policies and/or strategic plans publicly available and easy to access? ☐ **Yes** ☐ **No**	

What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do these national laws and regulations, national/subnational policies and/or strategic plans state that quality contraceptive services and information should be made available? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws and regulations, national/subnational policies and/or strategic plans. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws and regulations, national/subnational policies and/or strategic plans address the accessibility of quality contraceptive services and information? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws and regulations, national/subnational policies and/or strategic plans. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws and regulations, national/subnational policies and/or strategic plans address the provision of quality contraceptive services and information without discrimination? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws and regulations, national/subnational policies and/or strategic plans. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws and regulations, national/subnational policies and/or strategic plans address the need to reach specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers, or others? ☐ **Yes** ☐ **No** If yes, which populations/inequalities?	
Do these national laws and regulations, and national/subnational policies or strategic plans promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? ☐ **Yes** ☐ **No**	
Indicator 3. Does the government ensure that access to contraceptive information and services is not impeded by the claim of conscientious objection by a health-care provider or pharmacist?	
Key questions	**Responses, sources and explanatory notes**

Are there any laws, policies or regulations that ensure that access to contraceptive information and services is not impeded by the claim of conscientious objection by a health-care provider or pharmacist? **Yes** **No** Provide a summary and cite key provisions of any identified laws, policies or regulations. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
In what year(s) were these laws, policies or regulations enacted? Do they cover a specific time period? If yes, please specify.	
Are relevant laws, policies or regulations publicly available and easy to access? **Yes** **No**	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Are there any laws, policies or regulations that address the **accessibility** of contraceptive information and services in cases of claims of conscientious objection by a health-care provider or pharmacist? **Yes** **No** Provide a summary and cite key provisions of any identified laws, policies or regulations. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws, policies or regulations address the **quality** of contraceptive information and services in cases of claims of conscientious objection by a health-care provider or pharmacist? **Yes** **No** Provide a summary and cite key provisions of any identified laws, policies or regulations. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws, policies or regulations address access for specific populations that have been documented as vulnerable (such as adolescents, unmarried youth, sex workers or others) in cases of claims of conscientious objection by a health-care provider or pharmacist? **Yes** **No** If yes, which populations/inequalities? Provide a summary and cite key provisions of any identified laws, policies or regulations. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these laws, policies or regulations promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? **Yes** **No**	

Additional issues for consideration

Consider whether the location and timing of services, the physical infrastructure and human resources take into account: (i) gender-based barriers to access that women face; (ii) the special needs of disadvantaged groups (e.g. those with low literacy, those with physical disabilities, members of linguistic and ethnic minorities).

- Review how different types of health-care providers – such as midwives, pharmacists, traditional medical practitioners, community health workers, female village health workers and volunteer agents — are accredited to deliver contraceptive information and services.
- Review whether steps have been taken to reduce gender-based and other barriers to contraceptive access, such as:
  - planning clinic timings that are convenient for women;
  - ensuring availability of women health-care providers;
  - taking steps to minimize waiting time;
  - having clear signs in the clinic stating days and times when services are available;
  - ensuring that rooms have signage so that clients can easily identify where to go;
  - having a help desk in the reception area with a facilitator who assists clients in negotiating the systems and procedures within health-care facilities (this facilitator should be able to communicate in the language of marginalized and minority communities);
  - ensuring there are separate rooms for women who want privacy for consultation and counselling;
  - ensuring privacy and confidentiality for all who seek contraceptive services, including those who are unmarried, sexually active adolescents, etc.;
  - making available a process by which marginalized and minority communities can provide input into the set-up of services and feedback on the services received.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 2: Commodities, logistics and procurement

Several human rights principles and standards are relevant to commodities, logistics and procurement. Access to a secure, reliable and steady supply of a broad range of modern contraceptive commodities without discrimination is an essential part of health care to many people: couples and individuals wishing to space the births of their children; women who would die in childbirth but whose lives could be saved if unintended pregnancy is prevented; adolescents too young to be parents; people in need of protection from HIV and sexually transmitted infections (STIs). Another rights-related principle that is particularly pertinent to commodities, logistics and procurement concerns their availability. Specifically, any service-delivery point (including those that are community-based) that provides contraceptive services should have a sufficient quantity of a broad range of contraceptive methods available, so that no individual or couple goes away without the contraception they want. As part of this core obligation, countries should ensure that the commodities listed in national formularies are based on the *WHO model list of essential medicines*, which guides the procurement and supply of medicines in the public sector (4).

Table 2. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 4: Existence of a national contraceptive security strategy that recognizes the needs of young people and other underserved populations, and extends commodity security to the private and NGO sectors	United States Agency for International Development (USAID) contraceptive security indicators	USAID's contraceptive security indicator "Is there a contraceptive security or reproductive health commodity security strategy or is contraceptive security explicitly included in a country strategy?" provides data that can be found at the same link. (This indicator requires using these data along with further review of health, legal and policy information from readily available sources, including ministry of health, ministry of justice and NGOs, as relevant.)	• Non-discrimination • Availability • Accessibility • Accountability
Indicator 5: Method mix: Number of health-care facilities offering at least one short-term, one long-term, one emergency contraceptive method (at least one of these must be a dual-protection method, e.g. condoms or vaginal ring), as well as one permanent method (at secondary- or tertiary-level facilities, according to national policy)	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS Service Delivery Assessment Survey Results or DHS Stat Compiler (Demographic and Health Survey [DHS] Service Provision Assessment Survey)	• Availability • Acceptability • Quality
*Ind*icator 6: Percentage of health-care facilities experiencing stock-outs of contraceptive(s), by method offered, on the day of assessment	Family Planning 2020 (FP2020) – *The National Composite Index for Family Planning (NCIFP): a new FP2020 measurement tool*	The data can be found at: http://www.familyplanning2020.org/microsite/measurement-hub/data-downloads (This webpage provides links to the FP2020 Commitment to Action: Measurement Annex 2015, the NCIFP results and the DHS factsheets by country. These may provide some, if not all, country-level data on some of the NCIFP indicators.)	• Availability • Accessibility • Accountability

Worksheet 2. Key questions and responses for each indicator

Indicator 4. Existence of a national contraceptive security strategy that recognizes the needs of young people and other underserved populations, and extends commodity security to the private and NGO sector	
Key questions	**Responses, sources and explanatory notes**
Is there a national contraceptive security strategy? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions. Note any restrictions. Provide information, if available, on whether it is actually implemented.	
In what year(s) was the strategy enacted? Does it cover a specific time period? ☐ **Yes** ☐ **No** If yes, please specify.	
Is the strategy publicly available and easy to access? ☐ **Yes** ☐ **No**	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Does the strategy extend commodity security to the private and NGO sector? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the strategy state that contraceptive commodities should be **available** to all, including young people and other underserved populations? (Y/N) Provide a summary and cite key provisions of any identified laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the strategy address the **accessibility** of contraceptive commodities for all, including young people and other underserved populations? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

Does the strategy address the need to ensure contraceptive commodities are provided without **discrimination** for all, including young people and other underserved populations? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the strategy address and attempt to reach specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? ☐ **Yes** ☐ **No** If yes, which populations? Provide a summary and cite key provisions of any identified laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the strategy promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with non-discrimination law? ☐ **Yes** ☐ **No**	

Indicator 5. Method mix: Number of health-care facilities offering at least one short-term, one long-term, one emergency contraceptive method (at least one of these must be a dual-protection method, e.g. condom or vaginal ring), as well as one permanent method (at secondary- or tertiary-level facilities, according to national policy)

Key questions	Responses, sources and explanatory notes
Are there data collected on this indicator? ☐ **Yes** ☐ **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected routinely? ☐ **Yes** ☐ **No**	
Are the data easy to access? ☐ **Yes** ☐ **No**	
What are the most recently available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Do the data collected on this indicator address the availability of each type of contraceptive method noted as relevant to method mix? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	

Do the data collected on this indicator address the **accessibility** of each type of contraceptive method noted as relevant to method mix? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **quality** of each type of contraceptive method noted as relevant to method mix? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect quality to the extent possible. If not, could the data be further disaggregated to reflect quality? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator consider the method mix available to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations?	
Do the data collected on this indicator reflect user perspectives in relation to the available method mix? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with **non-discrimination** law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	
Indicator 6. Percentage of health-care facilities experiencing stock-outs of contraceptives, by method offered, on the day of assessment	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are these data collected routinely? **Yes** **No**	
Are these data easy to access? **Yes** **No**	
What are the most recently available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	

Do the data collected on this indicator address the availability of the different contraceptive methods on offer? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **accessibility** of different contraceptive methods on offer? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator consider the implications of stock-outs for specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? ☐ **Yes** ☐ **No** If yes, which populations?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of users experiencing stock-outs)? ☐ **Yes** ☐ **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with **non-discrimination** law (i.e. do the disaggregated data shed light on the implications of stock-outs for people who fall into categories protected under national non-discrimination law (sex, race, etc.])? ☐ **Yes** ☐ **No**	

Additional issues for consideration

- Determine if the full range of contraceptives is included in the national essential medicines list, in accordance with the WHO model list of essential medicines (4). Ensure that emergency contraceptive commodities are included.
- Conduct regular monitoring of contraceptives distribution and stocks – with attention to stock-outs and method mix – at all levels of service-delivery points. Work towards putting in place a robust supply chain management system to ensure that at least five types of methods are available everywhere, taking into account provider capacity and health-care facility quality.
- Review whether information, forecasting, procurement and supply chain for contraceptives have been created or updated to ensure a steady supply of methods, in both the private and the public sector. If not, initiate a process whereby this can be undertaken, including the establishment of a logistics management and information system (LMIS).
- Support the establishment of coordination mechanisms with partners.
- Support capacity-building of logisticians, supply chain managers and specialists in forecasting and procurement.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 3: Organization of health-care facilities, outreach and integration

Various human rights principles and standards are relevant to the organization of health-care facilities, outreach and integration. For example, international human rights law requires that health-care facilities, commodities and services be accessible to everyone. This includes physical and economic accessibility, as well as access to information. Human rights bodies have called on countries to eliminate the barriers people face in accessing health services including, among other things, high fees for services, distance from health-care facilities and the refusal by health-care providers to provide some services to certain populations. Also particularly relevant to the organization of health-care facilities, outreach and integration from a rights perspective is the availability of facilities, goods and services. That is, functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity and be of adequate quality.

Table 3. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 7: Contraceptive service-delivery points	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS Service Delivery Assessment Survey Results or DHS Stat Compiler (Demographic and Health Survey [DHS] Service Provision Assessment Survey)	• Availability
Indicator 8: Obstacles encountered by unmarried youth (and other populations) while seeking contraceptive services	*European Journal of Contraception and Reproductive Health Care*. "Access to contraceptive services among unmarried young people in the north-east of China"	Data for this indicator may be collected through community-based surveys, focus groups or key informant interviews. Sources may include ministry of health, ministry of justice, NGOs and peer-reviewed publications, as relevant.	• Non-discrimination • Availability • Accessibility • Acceptability • Quality • Informed decision-making • Privacy and confidentiality • Participation • Accountability
Indicator 9: Contraceptive prevalence rate (CPR)	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS All Surveys by Country or DHS Stat Compiler (DHS Household Survey Data)	• Non-discrimination • Availability • Accessibility
Indicator 10: Unmet need for family planning (FP)	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS All Surveys by Country or DHS Stat Compiler (DHS Household Survey Data)	• Non discrimination • Availability • Accessibility

Worksheet 3. Key questions and responses for each indicator

Indicator 7. Contraceptive service-delivery points	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected *routinely*? **Yes** **No**	
Are these data easy to *access*? **Yes** **No**	
What are the *most recently* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do the data collected on this indicator address the **availability** of contraceptives at service-delivery points? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator shed light on specific populations and/or inequalities (i.e. do the data collected recognize specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. the lived experience of users with respect to contraceptive service-delivery points)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with **non-discrimination** law (e.g. do disaggregated data shed light on access or use of contraceptive service-delivery points for categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	
Indicator 8. Obstacles encountered by unmarried youth (and other populations) while seeking contraceptive services	
Key questions	**Responses, sources, and explanatory notes**
Are there data collected on this indicator? **Yes** **No**	
If yes, are the data collected *routinely*? **Yes** **No**	

Are the data easy to *access*? ☐ **Yes** ☐ **No**	
What are the *most recently* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do the data collected on this indicator address how these obstacles affect the **availability** of contraceptive services for unmarried youth and other populations? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address how the obstacles affect the **accessibility** of contraceptive services for unmarried youth and other populations? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address how these obstacles affect the **acceptability** of contraceptive services for unmarried youth and other populations? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect acceptability to the extent possible. If not, could the data be further disaggregated to reflect acceptability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address how the obstacles affect the **quality** of contraceptive services for unmarried youth and other populations? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect quality to the extent possible. If not, could the data be further disaggregated to reflect quality? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address how these obstacles impact **privacy and confidentiality** in the context of seeking contraceptive services by unmarried youth and other populations? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect privacy and confidentiality to the extent possible. If not, could the data be further disaggregated to reflect privacy and confidentiality? If there are no data relating to this, this gap should be noted.	

Do the data collected on this indicator address how these obstacles impact **informed decision-making** in the context of contraceptive services by unmarried youth and other populations? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect informed decision-making to the extent possible. If not, could the data be further disaggregated to reflect informed decision-making? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address how these obstacles impact **participation** by unmarried youth and other populations in seeking contraceptive services? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect participation to the extent possible. If not, could the data be further disaggregated to reflect participation? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator recognize the needs of young people and other underserved populations (i.e. do the data collected reflect the needs of specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations, and in what ways?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of these obstacles for users)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	
Indicator 9. Contraceptive prevalence rate (CPR)	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected *routinely*? **Yes** **No**	
Are the data easy to *access*? **Yes** **No**	
What are the most recently available data that pertain to this indicator? What *year* are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	

Do the data collected on this indicator address the **availability** of contraceptives? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **accessibility** of contraceptives? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator provide a focus on specific populations and/or inequalities (i.e. do the data collected include attention to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of users in using contraceptives)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	
Indicator 10. Unmet need for family planning (FP)	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected *routinely*? **Yes** **No**	
Are the data easy to *access*? **Yes** **No**	
What are the *most recently* available data that pertain to this indicator? What *year* are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	

Do the data collected on this indicator address the **availability** of FP as it affects unmet need? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **accessibility** of FP as it affects unmet need? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address **discrimination** in the context of contraceptive programmes as it affects unmet need? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect non-discrimination to the extent possible. If not, could the data be further disaggregated to reflect non-discrimination? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator provide a focus on specific populations and/or inequalities (i.e. do the data collected include attention to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. does it explicitly reflect the lived experience of users as it impacts unmet need)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with **non-discrimination** law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	

Additional issues for consideration

- Examine what is known about unmet need for contraception, focusing on: practical barriers to access; the reasons for discontinuation of methods; and the potential demand for different methods, depending on the age and risk-factors of the population.
- Map the different models for service delivery, including health-care facility-based, community-based, mobile, referral, and social franchising models, including the costs of all such services. Examine how the market for contraceptive services is structured and identify the extent to which different providers serve various population segments.
- Consider service-delivery protocols and clinical guidelines and make a note if any need to be revised.
- Review whether there are existing outreach services to reach out to underserved populations, and whether they provide a full range of contraceptive services, including access to follow-up, management of side-effects and other kinds of ongoing care.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 4: Quality of care

Many human rights principles and standards are relevant to quality of care. For example, studies show that where people feel they are receiving good-quality care, contraceptive use is higher, and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them. 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 an appropriate constellation of services (including follow-up) available in the same locality and provided without discrimination. A right that is particularly relevant to quality of care concerns informed decision-making. That is, individuals have the right to be fully informed about the information and services available to them. Respecting autonomy in decision-making requires that any counselling, advice or information that is provided by health workers or other staff should be non-directive, enabling individuals to make decisions they consider best for themselves. People should be able to determine their preferred method of contraception, based on reliable information, and taking into consideration the range of social and other factors they consider relevant. The principle of autonomy, expressed through free, full and informed decision-making, is a central theme in medical ethics, it should be noted, and is embodied in human rights law.

Table 4. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 11: Informed choice (index)	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS All Surveys by Country or DHS Stat Compiler (Demographic and Health Survey [DHS] Household Survey Data)	• Informed decision-making
Indicator 12: Health-care facilities meeting quality-of-care standards	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS Service Delivery Assessment Survey Results or DHS Stat Compiler (DHS Service Provision Assessment Survey Inventory Questionnaire)	• Acceptability • Quality
Indicator 13: Are there national laws, regulations or policies regulating female or male sterilization?	WHO – *Reproductive, maternal, newborn and child health and human rights: a toolbox for examining laws, regulations and policies*	This indicator requires compiling legal and policy information from readily available sources, in particular ministry of health, ministry of justice and NGOs, as relevant.	• Non-discrimination • Acceptability • Informed decision-making • Participation • Accountability
Indicator 14: Contraceptive user satisfaction with services	WHO – *Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators*	The data can be found at: DHS Service Delivery Assessment Survey Results or DHS Stat Compiler (DHS Service Provision Assessment Client Exit Interviews)	• Acceptability

Worksheet 4. Key questions and responses for each indicator

Indicator 11. Informed choice (index)	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected routinely? **Yes** **No**	
Are the data easy to access? **Yes** **No**	
What are the *most recently* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Are data collected in ways that address **informed decision-making**? **Yes** **No** If yes, in what ways?	
Do the data collected on this indicator provide a focus on specific populations and/or inequalities (i.e. do the data collected include attention to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of users)? **Yes** **No** If yes, which users, and in what ways?	
Do the data collected on this indicator shed light on informed choice for categories protected under national **non-discrimination** law (i.e. sex, race, etc.)? **Yes** **No**	
Indicator 12. Health-care facilities meeting quality-of-care standards	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected *routinely*? **Yes** **No**	
Are the data easy to *access*? **Yes** **No**	

What are the *most recently* available data that pertain to this indicator? What *year* are the data from?	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Do the data collected on this indicator address the **acceptability** of health-care facilities meeting quality of care standards to all who use them? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect acceptability to the extent possible. If not, could the data be further disaggregated to reflect acceptability? If there are no data relating to this, the gap should be noted.	
Do the data collected on this indicator include attention to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives in using health-care facilities meeting quality of care standards (i.e. do the data explicitly reflect the lived experience of users)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	
Indicator 13. Are there national laws, regulations or policies regulating female or male sterilization?	
Key questions	**Responses, sources and explanatory notes**
Are there national laws, regulations or policies regulating *female* sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented. Are there national laws, regulations or policies regulating male sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

In what year(s) were these national laws, regulations or policies enacted? Do they cover a specific time period? ☐ **Yes** ☐ **No** If yes, please specify.	
Are relevant national laws, regulations or policies publicly **available** and easy to access? ☐ **Yes** ☐ **No**	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Do these national laws, regulations or policies address the **acceptability** of regulating female sterilization? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented. Do these national laws, regulations or policies address the **acceptability** of regulating male sterilization? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws, regulations or policies address **discrimination** as it pertains to regulation of female sterilization? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented. Do these national laws, regulations or policies address **discrimination** as it pertains to regulation of male sterilization? ☐ **Yes** ☐ **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

Do these national laws, regulations or policies address **informed decision-making** as it pertains to female sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented. Do these national laws, regulations or policies address **informed decision-making** as it pertains to male sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws, regulations or policies address **participation** of affected communities as it pertains to regulation of female sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented. Do these national laws, regulations or policies address **participation** of affected communities as it pertains to regulation of male sterilization? **Yes** **No** Provide a summary and cite key provisions of any identified national laws, regulations or policies. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Do these national laws, regulations or policies provide a focus on specific populations and/or inequalities (i.e. do they address regulation of sterilization as concerns specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** If yes, which populations/inequalities?	
Do these national laws, regulations or policies promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? **Yes** **No**	
Indicator 14. Contraceptive user satisfaction with services	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** If yes, provide existing numerator and denominator.	
If yes, are the data collected *routinely*? **Yes** **No**	

Are the data easy to *access*? ☐ **Yes** ☐ **No**	
What are the *most recently* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do the data collected on this indicator address the **acceptability** of contraceptive services in the context of user satisfaction? ☐ **Yes** ☐ **No** If yes, in what ways? Include attention to existing disaggregated data that reflect acceptability to the extent possible. If not, could the data be further disaggregated to reflect acceptability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator provide a focus on specific populations and/or inequalities (i.e. do the data collected include attention to specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? ☐ **Yes** ☐ **No** If yes, which populations/inequalities?	
Do the data collected on this indicator explicitly reflect the lived experience of users with respect to satisfaction with services? ☐ **Yes** ☐ **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? ☐ **Yes** ☐ **No**	

Additional issues for consideration

- Assess whether laws, regulations, policies, guidelines and protocols related to the provision of contraceptive information and services:
  - state explicitly and upfront that no person shall be forced against his/her will to accept contraception, or to accept a specific method of contraception;
  - prohibit the offering of incentives or disincentives to the client or to the health-care provider/facility for adoption of a specific method of contraception;
  - protect persons from marginalized groups (e.g. low-income, minority communities, people living with HIV, persons with disabilities) from being forced or coerced, including through the use of monitoring and client feedback mechanisms, such as spot-checks, comment boxes, mystery client, client exit interviews;
  - include modalities of informed decision-making, including gender-based dimensions such as attention to whether it is the woman who is making the decision (without pressure from her husband/partner or other parties), and facilitating informed decision-making for young people;
  - provide for appropriate and adequate information to be supplied to users about follow-up visits, timings and procedures.
- Determine whether health workers have been trained in:
  - how to ensure that users, including adolescents, can make an informed choice, including choosing to accept or not to accept a contraceptive method, without imposing their own views or using coercion (i.e. provider bias);
  - power dynamics both within families and between providers and clients;
  - ways in which gender-based inequalities may affect informed decision-making (e.g. in settings where couples are jointly counselled for family planning, providers need to be conscious of the unequal power relations between male and female partners, and ensure that men do not control the decision-making process such as by responding to questions that were directed at the woman) and how to determine whether an individual counselling session for the girl/woman would be a better option.
  - safeguarding the privacy of individuals and maintaining confidentiality of their medical records, with particular attention to adolescents, whose privacy is often not safeguarded.
- Assess if strict instructions exist about how to keep medical records confidential, and in what circumstances they may be revealed, with the client's consent.
- Assess whether contraceptive protocols and guidelines exist for different levels of health-care facilities and providers for follow-up visits, management of side-effects and referrals for contraceptive services.
- Assess whether contraceptive protocols and guidelines explicitly mention the user's right to request removal of long-acting contraceptives, such as the intrauterine device (IUD) and implants, and whether protocols exist for referral in case removal cannot be safely carried out in the facility providing insertion services.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 5: Comprehensive sexuality education

Several human rights principles and standards are relevant to comprehensive sexuality education (CSE). For example, 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 (SHR), including effective contraceptive methods. In addition to counselling by trained personnel, this requires the provision of CSE, 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 live with their sexuality in a positive and a responsible way.

Table 5. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 15: Percentage of sexually active young people who used a condom at first/last sex	MEASURE Evaluation PRH – Family Planning and Reproductive Health Indicators Database	The data can be found at: http://www.cpc.unc.edu/measure/our-work/family-planning (To see if data are available for your country, see "Publications" for any reports that may have been produced.)	• Availability • Accessibility • Acceptability

Worksheet 5. Key questions and responses for each indicator

Indicator 15. Percentage of sexually active young people who used a condom at first/last sex	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No** Are the data collected focused on: a) first sex? **Yes** **No** b) last sex? **Yes** **No** c) both? **Yes** **No**	
If yes, are the data collected *routinely*? **Yes** **No**	
Are the data easy to *access*? **Yes** **No**	
What are the *most recently* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do the data collected on this indicator address the **availability** of condoms for sexually active young people? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **accessibility** of condoms for sexually active young people? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **acceptability** of condoms for sexually active young people? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect acceptability to the extent possible. If not, could the data be further disaggregated to reflect acceptability? If there are no data relating to this, this gap should be noted.	

Do the data collected on this indicator provide a focus on specific populations of sexually active young people (i.e. do the data collected include that from specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others)? **Yes** **No** In particular, is the information disaggregated to reflect any differences between females and males in responding to the above? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of sexually active people)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	

Additional issues for consideration

- Consider whether existing CSE programmes:
  - build capacity to strengthen curricula and provide teacher training;
  - conduct situation assessments and work to strengthen both in-school and out-of-school programmes;
  - initiate public debate about CSE, taking steps to ensure that training of health workers includes knowledge about the CSE curriculum;
  - promote the training of educators in CSE for school-based health programmes.
- Review national policies to establish whether CSE is included in none, one, some or all of the following: national HIV laws and policies; national population and reproductive health laws and policies; national youth laws and policies; national education laws and policies; national laws and policies that address gender inequality and gender-based violence.
- Assess whether laws and policies present obstacles and, where appropriate, advocate for the removal of legal, regulatory and social barriers to ensuring access to scientifically accurate, realistic, non-judgemental information about SRH for adolescents and young people.
- Determine whether a multisectoral approach that links health, education and youth sectors with CSE programmes also ensures that there is availability of and referral to youth-friendly services, including SRH.
- Determine the extent of existing efforts to reach out-of-school youth with CSE, in collaboration with NGO partners, particularly to reach the most vulnerable young people – married girls, children and adolescents with disabilities, pregnant adolescents, adolescents living with HIV, sexually exploited youth, etc. – who can more easily be engaged in non-school settings.
- Determine the government's level of financial commitment to CSE.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 6: Humanitarian context

Most all human rights principles and standards are relevant to access and use of contraception in humanitarian contexts. Of note, in crisis settings (emergencies, wars and refugee camps) there is often a lack of access to sexual and reproductive health (SRH) services, including contraception. Yet affected populations have a particular need for these services. Access to contraceptive methods, particularly emergency contraception, and access to prophylaxis for STIs and HIV are of paramount importance to safeguard women's health.

Table 6. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
No indicators currently available in this category.			

Worksheet 6. Category 6: Humanitarian context

Indicator	
Key questions	Responses, sources and explanatory notes
No indicators currently available in this category.	

Category 7: Participation by potential and actual users of services

Under international human rights law, countries have an obligation to ensure active, informed participation of individuals in decision-making that affects them, without discrimination, including on matters related to their health. They also have the obligation to ensure the meaningful participation of adolescents in all policies and programmes affecting their health. Non-discrimination is another right that is particularly relevant to participation by potential and actual users of services; this refers to the efforts made at the policy and programmatic levels to ensure the engagement of all affected communities without discrimination. In addition to the right to participation itself, several human rights principles and standards are relevant to participation by potential and actual users of services. Participation of affected populations in all stages of decision-making, implementation and monitoring of policies, programmes and services is a precondition for sustainable development and for reaching the highest attainable standard of health. 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.

Table 7. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 16: Whether the decision to use contraception or not use contraception has been the woman's decision (woman alone or woman with her partner)	*Women's Major Group* – *Indicator proposals*	The data can be found at: DHS All Surveys by Country or DHS Stat Compiler (Demographic and Health Survey [DHS] Household Survey Data)	• Non-discrimination • Availability • Accessibility • Acceptability • Informed decision-making • Participation
Indicator 17: Is there a system in place that encourages dialogue and communication between users and service providers/health officials about service availability, accessibility, acceptability and quality?	Family Planning 2020 (FP2020) – *National Composite Index for Family Planning (NCIFP): new FP2020 measurement tool*	The data can be found at: http://www.familyplanning2020.org/microsite/measurement-hub/data-downloads (This webpage provides links to the FP2020 Commitment to Action: Measurement Annex 2015, the NCIFP results and the DHS factsheets by country. These may provide some, if not all, country-level data on some of the NCIFP indicators.)	• Availability • Accessibility • Acceptability • Quality • Informed decision-making • Participation • Accountability

Worksheet 7. Key questions and responses for each indicator

Indicator 16. Whether the decision to use contraception or not use contraception has been the woman's decision (woman alone or woman with her partner)	
Key questions	**Responses, sources and explanatory notes**
Are there data collected on this indicator? **Yes** **No**	
If yes, are the data collected *routinely*? **Yes** **No**	
Are the data easy to access? **Yes** **No**	
What are the *most recent* available data that pertain to this indicator? What year are the data from?	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Do the data collected on this indicator address the **availability** of contraception to women alone and/or with a partner? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect availability to the extent possible. If not, could the data be further disaggregated to reflect availability? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **accessibility** of contraception to women alone and/or with a partner? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect accessibility to the extent possible. If not, could the data be further disaggregated to reflect accessibility? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address the **acceptability** of contraception to women alone and/or with a partner? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect acceptability to the extent possible. If not, could the data be further disaggregated to reflect acceptability? If there are no data relating to this, this gap should be noted.	

Do the data collected on this indicator address **non-discrimination** in the context of a woman choosing alone and/or with a partner whether or not to use contraception? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect non-discrimination to the extent possible. If not, could the data be further disaggregated to reflect non-discrimination? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address **informed decision-making** in the context of a woman alone and/or with a partner choosing whether or not to use contraception? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect informed decision-making to the extent possible. If not, could the data be further disaggregated to reflect informed decision-making? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator address **participation** in the context of a woman alone and/or with a partner choosing whether or not to use contraception? **Yes** **No** If yes, in what ways? Include attention to existing disaggregated data that reflect participation to the extent possible. If not, could the data be further disaggregated to reflect participation? If there are no data relating to this, this gap should be noted.	
Do the data collected on this indicator include consideration of a woman alone and/or with a partner who are part of specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations/inequalities?	
Do the data collected on this indicator reflect user perspectives (i.e. do the data explicitly reflect the lived experience of a woman alone and/or with a partner in choosing whether or not to use contraception)? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with **non-discrimination** law (i.e. do the disaggregated data shed light on categories protected under national non-discrimination law [sex, race, etc.])? **Yes** **No**	

Indicator 17. Is there a system in place that encourages dialogue and communication between users and service providers/ health officials about service availability, accessibility, acceptability and quality?	
Key questions	**Responses, sources and explanatory notes**
Is there a system in place that encourages dialogue and communication between users and service providers/health officials? **Yes** **No** If yes, what does this system look like (i.e. is there a physical and/or electronic space for discussion or where feedback can be provided or meetings held for this purpose)? How does it work? Indicate whether it addresses service: a) availability **Yes** **No** b) accessibility **Yes** **No** c) acceptability **Yes** **No** d) quality **Yes** **No** Provide a summary of this system and cite key components that are relevant to the above, if any.	
What *year* was the system established?	
Is information about the system easy to access? **Yes** **No**	
What alternative sources exist where relevant information can be obtained? (i.e. peer-reviewed articles, NGO reports, etc.)	
Is the system in place to encourage dialogue and communication **accessible** to both users and service providers/health officials (i.e. is the system located in a convenient space, is there a clear set of instructions and/or understanding of how to use it)? **Yes** **No** Provide a summary and cite key components that are relevant to the above, if any.	
Is the system in place to encourage dialogue and communication **acceptable** to both users and service providers/health officials? **Yes** **No** Provide a summary and cite key components that are relevant to the above, if any.	
Is the system in place to encourage dialogue and communication between users and service providers/health officials considered to be of **quality** (i.e. does the system work effectively)? **Yes** **No** Provide a summary and cite key components that are relevant to the above, if any.	

Does this system encourage **informed decision-making** (i.e. does this system address the need for or process by which health information and education are delivered)? **Yes** **No** Provide a summary and cite key components that are relevant to the above, if any.	
Does this system address **participation** (i.e. does this system address the need for or process by which users can participate in the design or delivery of health services)? **Yes** **No** Provide a summary and cite key components that are relevant to the above, if any.	
Does this system address and attempt to reach specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations/inequalities?	
Is the system set up to reflect user perspectives (i.e. were users involved in the design of this system and/or does it capture the lived experience of users)? **Yes** **No** If yes, which users, and in what ways?	
Does this system promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? **Yes** **No**	

Additional issues for consideration

- Determine if alternative relevant stakeholder processes exist (e.g. community-based users' committees; patient welfare committees in health-care facilities).
- If mechanisms for participation exist, find out the extent of participation by women, men and members of marginalized groups.
- Determine the level of investment in capacity-building, empowerment and participation of community organizations (civil society organizations, including grass-roots organizations, women's groups and other marginalized groups) that seek to ensure meaningful participation in policy and programme development.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Category 8: Accountability to those using the services

Various human rights principles and standards are relevant to accountability, in addition to the accountability principle itself. Countries have an obligation to align their legal, policy and programmatic frameworks and practices with international human rights standards, which includes attention to accountability mechanisms. Establishing effective accountability mechanisms is also intrinsic to ensuring that the agency, choices and rights of individuals are respected, protected and fulfilled. Effective accountability requires that individuals, families and groups, including women from vulnerable or marginalized populations, are aware of their rights with regard to sexual and reproductive health (SRH), and empowered to claim these rights. Participation is another right that is particularly relevant to accountability to those using services. 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. This extends to their participation in policy and programmes relevant to their access and use of contraceptive services.

Table 8. Indicators and sources

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
Indicator 18: Are there grievance-redress mechanisms for sexual and reproductive health (SRH) services in this country? If yes, describe these mechanisms. – At what levels do they function? – How accessible are these mechanisms to marginalized sections of the population? – What is known about the effectiveness of these mechanisms?	ARROW – *An advocate's guide: strategic indicators for universal access to sexual and reproductive health and rights*	This indicator requires compiling legal, policy and programmatic information from readily available sources, including ministry of health, ministry of justice and NGOs, as relevant.	• Non-discrimination • Availability • Accessibility • Acceptability • Quality • Privacy and confidentiality • Participation • Accountability
Indicator 19: Existence of a legal and normative framework that protects the human rights of individuals to have control over and decide freely and responsibly on matters related to reproduction, free of discrimination, coercion and violence	High-Level Task Force for the International Conference on Population and Development (ICPD) – *Indicators for a transformative, high-impact & people-centred 2030 Agenda for Sustainable Development: leading options for global, thematic, regional and/or national levels*	This is a proposed ICPD indicator, which is to be collected. Potential sources for this indicator include ministry of health, ministry of justice and NGOs, as relevant.	• Non-discrimination • Privacy and confidentiality • Participation • Accountability
Indicator 20: Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (e.g. age, marital status, ability to pay) or by coercion (including inappropriate use of incentives to clients or providers)?	Family Planning 2020 (FP2020) – *The National Composite Index for Family Planning (NCIFP): new FP2020 measurement tool*	The data can be found at: http://www.familyplanning2020.org/microsite/measurement-hub/data-downloads (This webpage provides links to the FP2020 Commitment to Action: Measurement Annex 2015, the NCIFP results and the Demographic and Health Survey (DHS) factsheets by country. These may provide some, if not all, country-level data on some of the NCIFP indicators.)	• Non-discrimination • Accessibility • Informed decision-making • Accountability

Worksheet 8. Key questions and responses for each indicator

Indicator 18. Are there grievance-redress mechanisms for sexual and reproductive health (SRH) services in this country? If yes, describe the mechanisms. - At what levels do they function? - How accessible are these mechanisms to marginalized sections of the population? - What is known about the effectiveness of these mechanisms?	
Key questions	**Responses, sources and explanatory notes**
Are there grievance-redress mechanisms for SRH services? ☐ **Yes** ☐ **No** At what levels do they function? Facility level/state or provincial level/national level? Provide a summary and cite key provisions, including restrictions, if any. Provide information, if available, on whether they are actually implemented.	
Are the data from these grievance-redress mechanisms collected *routinely*? ☐ **Yes** ☐ **No**	
In what year(s) were these grievance-redress mechanisms put in place?	
Are data on the effectiveness of the grievance-redress mechanism(s) easy to *access*? ☐ **Yes** ☐ **No**	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
What is known about the effectiveness of these mechanisms?	
Do the data collected on this indicator address the **availability** of these grievance-redress mechanisms (i.e. are data collected on how available or utilized these mechanisms are)? ☐ **Yes** ☐ **No** If yes, in what ways? Please summarize any relevant information.	
Do the data collected on this indicator address the **accessibility** of these grievance-redress mechanisms (i.e. are data collected on how accessible or utilized these mechanisms are)? ☐ **Yes** ☐ **No** If yes, in what ways? Please summarize any relevant information.	
Do the data collected on this indicator address the **acceptability** of these grievance-redress mechanisms (i.e. are data collected on the extent to which users or potential users find these mechanisms appropriate and useful)? ☐ **Yes** ☐ **No** If yes, in what ways? Please summarize any relevant information.	

Do the data collected on this indicator address the **quality** of these grievance-redress mechanisms (i.e. are data collected on the extent to which users or potential users find these mechanisms to function effectively)? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Do these mechanisms explicitly seek to ensure **non-discrimination** in who has access to these mechanisms? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Is **privacy and confidentiality** assured for people using these mechanisms? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Do these mechanisms address **participation** in explicit ways (i.e. do these mechanisms address the need for or process by which users participate in these accountability mechanisms)? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Are data collected on the use of these grievance-redress mechanisms by specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations?	
Do these grievance-redress mechanisms seek to reflect user perspectives? **Yes** **No** If yes, which users, and in what ways?	
Can the data collected on this indicator be disaggregated and investigated for potential accordance with non-discrimination law (i.e. do the disaggregated data shed light on categories protected under national **non-discrimination** law [sex, race, etc.])? **Yes** **No**	
Indicator 19. Existence of a legal and normative framework that protects the human rights of individuals to have control over and decide freely and responsibly on matters related to reproduction, free of discrimination, coercion and violence	
Key questions	**Responses, sources and explanatory notes**
Is there a legal and/or normative framework that protects the human rights of individuals to have control over and decide freely and responsibly on matters related to reproduction, free of discrimination, coercion and violence? **Yes** **No** Provide a summary and cite key provisions of any legal or normative frameworks. Note any restrictions. Provide information, if available, on whether they are actually implemented.	

If applicable, what *year* was this legal/normative framework established?	
Is this framework publicly available and easy to access? **Yes** **No**	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Does the framework explicitly state that individuals should have the right and control to decide freely and responsibly on matters related to reproduction without **discrimination**, coercion or violence? **Yes** **No** Provide a summary and cite key provisions of any legal or normative frameworks. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the framework address **privacy and confidentiality** (i.e. explicit provisions that personal health information should be kept private and confidential between providers and clients)? **Yes** **No** Provide a summary and cite key provisions of any legal or normative frameworks. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the framework address **informed decision-making** (i.e. explicit provisions for health information and education to be provided to clients)? **Yes** **No** Provide a summary and cite key provisions of any legal or normative frameworks. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the framework address **participation** (i.e. in the design or implementation of services, in contraceptive decision-making, other)? **Yes** **No** Provide a summary and cite key provisions of any legal or normative frameworks. Note any restrictions. Provide information, if available, on whether they are actually implemented.	
Does the framework address and attempt to ensure support for specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations, and in what ways?	
Does the framework promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? **Yes** **No**	

Indicator 20. Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (e.g. age, marital status, ability to pay) or by coercion (including inappropriate use of incentives to clients or providers)?	
Key questions	**Responses, sources and explanatory notes**
Does the government have mechanisms in place for reporting instances of denial of services on non-medical grounds (e.g. age, marital status, ability to pay)? **Yes** **No** Does the government have mechanisms in place for reporting instances of coercion (including inappropriate use of incentives to clients or providers)? **Yes** **No** Provide a summary and cite key provisions, noting any restrictions. Provide information, if available, on whether they are actually implemented.	
Are the data from these mechanisms collected *routinely*? **Yes** **No**	
If applicable, what year were the most recent mechanisms established?	
Are the data collected from these mechanisms easy to *access*? **Yes** **No**	
What alternative sources exist where relevant information can be obtained (i.e. peer-reviewed articles, NGO reports, etc.)?	
Has the government taken steps to ensure that any mechanisms in place are accessible to and usable by all without **discrimination**? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Has the government ensured the **accessibility** of these mechanisms (i.e. are these mechanisms well publicized, clear and convenient to access by all populations)? **Yes** **No** If yes, in what ways? Please summarize any relevant information.	
Do these mechanisms attempt to reach specific populations that have been documented as vulnerable, such as adolescents, unmarried youth, sex workers or others? **Yes** **No** If yes, which populations? In what ways?	
Do these mechanisms reflect user perspectives (i.e. is there explicit mention that users were involved in the design of the mechanisms and/or are they set up to explicitly reflect the lived experience of users)? **Yes** **No** If yes, which users, and in what ways?	
Do these mechanisms promote the collection of relevant data that are amenable to disaggregation and investigation for potential accordance with **non-discrimination** law? **Yes** **No**	

Additional issues for consideration

- Determine whether accountability, redress mechanisms and remedies exist in case of violation of policies, guidelines and protocols.
- Determine whether there is a grievance-redress policy in place to address complaints received. There should be systems in place to monitor enquiries and institute policy changes based on their findings, including connections to the criminal justice system, as appropriate.
- Identify whether there are mechanisms to publicly disseminate judicial and/or administrative remedies that address violations of health-related rights. (If there are, what dissemination mechanisms are used?)
- Determine what measures are in place to ensure that patients and health-care providers understand the implications of patients' rights charters and any legal remedies.
- Determine whether there are any established mechanisms, such as networks for regional health-care improvement, that are involved in oversight and monitoring of SRH and human rights in the country, and that work to hold providers and managers accountable.
- Determine whether there is a system for collecting and reporting on disaggregated data, which is essential for monitoring and evaluation.

Worksheet summary

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

References

1. Reproductive, maternal, newborn and child health and human rights: a toolbox for examining laws, regulations and policies. Geneva; World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/126383/1/9789241507424_eng.pdf, accessed 8 September 2017).
2. Ensuring human rights within contraceptive service delivery: implementation guide. Denmark: United Nations Population Fund, World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/158866/1/9789241549103_eng.pdf, accessed 8 Septmeber 2017).
3. Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/126799/1/9789241507493_eng.pdf, accessed 8 September 2017).
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Annex 1: List of additional indicators to support monitoring human rights in contraceptive services and programmes

Indicators 22, 25, 26 and 29 have been validated. The other indicators, shown in *italics*, have not been validated.

Category 1: Ensuring access for all

21. Does the national family planning plan include objectives to reach the poorest and most vulnerable groups with quality family planning information and services?
22. Existence of policies that enable the private sector to provide contraceptive information and services
23. Does the entire population have access to long-acting reversible contraceptive methods and their removal?
24. Are there national laws, regulations or policies regulating the manufacturing, importing, selling and publicizing of approved contraceptive methods?
25. What steps has the government taken to ensure the affordability of contraceptives, for instance by ensuring that a full range of contraceptive services are covered by public health insurance or available at no or low cost in public health-care facilities?

Category 2: Commodities, logistics and procurement

26. Are contraceptives (including at least one short-term, one long-term and one emergency contraceptive method) on the national essential medicines list?
27. Extent to which logistics and transport systems are sufficient to keep stocks of contraceptive supplies and related equipment available at all service-delivery points, at all times and at all levels (central, provincial, local)
28. Amount of government spending for contraceptives (if data are unavailable, a dedicated budget line for contraceptive commodity procurement)

Category 3: Organization of health-care facilities, outreach and integration

29. Existence of (additional) policies limiting or promoting access to family planning – regulations or policies that make it difficult for sub-populations to access effective family planning services (e.g. young people, unmarried people)

30. Rate of contraceptive discontinuation due to lack of access
31. Percentage of births that are reported as unintended

Category 4: Quality of care

32. Are family planning standard operating procedures (SOPs) in line with national guidelines and are they used for determining areas of need for quality improvement?
33. Percentage of women using contraception who participated in the decision to use contraception
34. Provider refers client if method unavailable
35. 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)
36. To what extent do service providers discriminate against sub-populations?
37. A system for quality assurance has been institutionalized
38. Percentage of contraceptive users reporting privacy

Category 5: Comprehensive sexuality education

No additional indicators in this category.

Category 6: Humanitarian context

No indicators in this category.

Category 7: Participation by potential and actual users of services

39. Contact of non-users with family planning providers
40. Does the national family planning policy/action plan include a mechanism that encourages and enables (and provides funding to support) meaningful participation of diverse stakeholders?

Category 8: Accountability to those using services

41. Are there mechanisms in place to address quality, including participatory monitoring or community-based/facility-based quality-improvement activities?

Annex 2: Worksheet manual

This annex provides instructions for completing the indicator worksheets in each of the eight categories. Specific descriptions of each step are presented within the context of how the worksheet prompts appear in the tool. Please review the annex in its entirety before commencing data collection and analysis.

Category X: Title of category

The first step is to read the content description of the category.

The category description appears here. Reading this will ensure familiarity with the rights-related context of the indicator(s) provided.

Table X. Indicators and sources

The next step is to review the indicators within the category to decide the appropriate indicators to analyse in your setting. [Note that alternate indicators are included in Annex 1, which can replace those presented in the body of the tool if they are found to be more relevant to your setting.] Please then review the informational table containing the indicators you have determined to be most relevant in each category. As indicated in more detail below, for each indicator the table contains a link to the indicator source, suggested approaches to data collection (and links to data sources), and human rights determined to be explicitly or implicitly addressed by the indicator.

Indicator	Indicator link	Suggested approaches to and links for data collection	Human rights principles and standards potentially addressed by this indicator
This column provides the number and wording of the indicator.	This column provides link(s) to sources where additional information about the indicator, and in some cases data collected on the indicator, can be found.	This column includes suggested approaches to data collection, including readily available sources where the data collected on the indicator can be found. Reviewing these suggested approaches to data collection should assist in compiling a list of resources and contacts that can provide the information needed to answer the questions asked in the worksheets.	This column lists the human rights principles and standards potentially addressed by this indicator, if any, based on previously conducted analyses. These rights inform the questions that are asked in the worksheets.

Worksheet X. Key questions and responses for each indicator

Now that you have determined which indicators will be analysed in each category, the sources where the indicator information can be obtained, and have compiled the requisite information, please move on to the worksheets for each of the indicators within the category. Please read through the questions within each worksheet in order to understand the range of questions being asked for each indicator, the research that will need to be conducted to answer each question, and how the questions relate to one another. The sources of information for each indicator should be compiled and readily available to reference prior to completing the worksheet; some sources may contain answers for multiple indicators. As indicated below, these worksheets include questions to guide users through analysis of each indicator with respect to human rights sensitivity and data quality.

Indicator X. The shaded row (or rows) of each worksheet provide the wording of the indicator.	
Key questions	**Responses, sources and explanatory notes**
This column contains the questions being asked in relation to each indicator. The first several questions are general questions (e.g. year of the most recent data), followed by questions that specifically focus on human rights principles and standards potentially measured by each indicator. Questions vary slightly depending on content and whether the indicator is quantitative, qualitative or policy-related.	This column provides blank space for your responses to the questions for each indicator. It is important to note relevant sources for the information supplied, and any explanatory notes that may be helpful for further analysis.

Once all of questions have been completed in each worksheet, please review the "Additional issues for consideration" section which follows.

Additional issues for consideration

This section comes after the worksheet in each category, and provides information and themes that should be considered in light of the answers given in the worksheets. It is important to note that these issues are relevant to the whole set of indicators in each category, not to specific indicators. Responses to these questions may point to strengths or gaps in programming and/or in the data collected by the indicators in each category.

Worksheet summary

Once the additional issues for consideration have been reviewed and taken into consideration, the final step in each category is to complete the worksheet summary.

Guided by the three questions in the worksheet summary tables, synthesize the answers from the worksheets into summaries. These should result in write-ups that can be built upon for future presentation at stakeholder workshops and for report writing, which will take place following the completion of all data collection and analysis.

Keep in mind when completing the summary tables that these are intended to provide a space to look at findings across the category as a whole. The category description at the top of each category section may be helpful in answering the summary questions below.

Please review findings of all indicators in this category. Consider the implications for contraceptive programming (e.g. What issues are adequately addressed from a human rights perspective? What areas need to be improved to ensure that rights concerns are sufficiently taken into account?) and suggest any follow-up actions.
Please review findings of all indicators in this category. Consider the strengths and limitations of existing data sources and systems (e.g. missing data, gaps in the type of information collected, additional data needs) and suggest any follow-up actions.
Based on review of responses to the above, please summarize key findings and action points.

Annex 3: Definitions of the human rights principles and standards used in this analysis

1. Non-discrimination

The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation *(1)*. This obligation in connection with the right to health means countries are to ensure the availability, accessibility, acceptability and quality of contraceptive services and information **without discrimination** *(2)*.

2. Availability of contraceptive information and services

Functioning health and health-care facilities, goods and services, as well as programmes, have to be **available** in sufficient quantity within the state *(3)*. The characteristics of the facilities, goods and services will vary depending on numerous factors, including the state's developmental level. Countries must, however, address the underlying determinants of health, such as provision of safe and potable drinking water, adequate sanitation facilities, health-related education, hospitals, clinics and other health-related buildings, and ensure that trained medical and professional personnel are receiving domestically competitive salaries. As part of this core obligation, countries should ensure that the commodities listed in national formularies are based on the WHO model list of essential medicines, which guides the procurement and supply of medicines in the public sector (3). A wide range of contraceptive methods, including emergency contraception, is included in the *WHO model list of essential medicines (2, 4)*.

3. Accessibility of contraceptive information and services

Under international human rights law, countries are required to ensure that health-care facilities, commodities and services are **accessible** to everyone. This includes physical and economic accessibility, as well as access to information *(3)*. Human rights bodies have called on countries to eliminate the barriers people face in accessing health services, such as: high fees for services; the requirement for authorization by spouse, parent/guardian or hospital authorities; distance from health-care facilities; and the absence of convenient and affordable public transport *(2, 5)*.

4. Acceptability of contraceptive information and services

All provision of health-care facilities, commodities and services must be **acceptable** to those who are their intended beneficiaries. They must be respectful of medical ethics and of the culture of individuals, minorities, peoples and communities; sensitive to gender and to life cycle requirements; and designed to respect confidentiality and to improve the health status of those concerned *(3)*. Countries should place a gender perspective at the centre of all policies, programmes and services affecting women's health, and should involve women in the planning, implementation and monitoring of such policies, programmes and services *(2)*.

5. Quality of contraceptive information and services

Fulfilment of human rights requires that health-care facilities, commodities and services be of good **quality**, including scientifically and medically appropriate. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation *(2, 3)*.

6. Informed decision-making

Respect for individual dignity and for the physical and mental integrity of each and every person who uses a health-care facility means also providing each person the opportunity to make reproductive choices autonomously (5, 6). The principle of autonomy, expressed through **free, prior, full and informed decision-making**, is a central theme in medical ethics, and is embodied in human rights law *(7)*. People should be able to exercise choice across a range of contraceptive options but also be free to refuse any and all options. In order to make an informed decision about their preferences with respect to safe and reliable contraceptive measures, comprehensive information, counselling and support should be made accessible for all people without discrimination, including young people, persons living with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people *(2, 8)*.

7. Privacy and confidentiality

The right to **privacy** means that individuals accessing health information and services should not be subject to interference with their privacy, and they should enjoy legal protection in this regard *(9)*. Sexual and reproductive health involves many sensitive issues that are not widely discussed within families or communities, and health workers are often entrusted with very personal information by their patients. **Confidentiality**, which implies the duty of providers to not disclose or to keep private the medical information they receive from patients and to protect an individual's privacy, has an important role to play in sexual and reproductive health *(2)*.

8. Participation

Under international human rights law, countries have an obligation to ensure active, informed **participation** of individuals in decision-making that affects them, including on matters related to their health (3). The Programme of Action of the International Conference on Population and Development (ICPD, 1994) reaffirmed this core principle in relation to sexual and reproductive health, stating that "the full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community" *(10)*. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) specifically requires countries to ensure that women have the right to participate fully and be represented in the formulation of public policy in all sectors and at all levels *(2, 11)*.

9. Accountability

Countries are accountable for bringing their legal, policy and programmatic frameworks and practices into line with international human rights standards (12). Further, effective **accountability** mechanisms are key to ensuring that the agency and choices of individuals are respected, protected and fulfilled, including when seeking and receiving health care. Effective accountability requires that individuals, families and groups, including women from marginalized populations, are made aware of their rights, including with regard to sexual and reproductive health, and are empowered to claim their rights *(2, 13)*.

References for Annex 3

1. United Nations Committee on Economic, Social and Cultural Rights (CESCR). General comment No. 20: Non-discrimination in economic, social and cultural rights (article 2, paragraph 2, of the International Covenant on Economic, Social and Cultural Rights). Adopted at the Forty-second session of the CESCR. Geneva: United Nations Economic and Social Council; 2009 (E/C.12/GC/20; http://www.refworld.org/docid/4a60961f2.html, accessed 8 September 2017).
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13. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. Report of the Office of the United Nations High Commissioner for Human Rights. Human Rights Council, Twentieth session. Geneva: United Nations General Assembly; 2012 (A/HRC/21/22; http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session21/A-HRC-21-22_en.pdf, accessed 8 September 2017).

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