



VOLUNTARY FAMILY PLANNING PROGRAMS THAT RESPECT, PROTECT, AND FULFILL HUMAN RIGHTS

A Conceptual Framework

AUGUST 2013 (Updated April 2014)



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August 2013 (Updated April 2014)

CONTENTS

Acknowledgments	iv
Executive Summary	v
Abbreviations	viii
I. Introduction	1
II. Human Rights and Health and the Foundation for Voluntary, Rights-Based Family Planning	3
Human Rights and Health	3
The Foundation for Voluntary and Human Rights-Based Family Planning	3
The Range of Violations of Reproductive Rights and Contraceptive Choice	4
III. Human Rights-based and Public Health Programming	6
IV. Programming Voluntary, Rights-based Family Planning	8
Applying Human Rights to Voluntary Family Planning in Practice	10
V. The Framework for Voluntary, Right-based Family Planning	12
Development and Purpose of the Framework	12
Components of the Framework	14
Review of Supportive Evidence and Tools	15
Inputs and Activities	18
<i>Country Context</i>	18
<i>Policy Level</i>	18
<i>Service Level</i>	20
<i>Community Level</i>	22
<i>Individual Level</i>	23
Outputs	24
Outcomes and Impacts	26
VI. Summary and Recommendations	27
Annex 1. Treaties, Declarations, and Conventions Establishing Reproductive Rights	29
References	34
Glossary of Terms	43

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EXECUTIVE SUMMARY

At the 2012 London Family Planning Summit, world leaders committed to reaching 120 million new users of family planning by 2020, an effort now known as FP2020. At the same time, relevant stakeholders began reviewing progress made at 20 years following the International Conference on Population and Development (ICPD), as well as considering a post-2015 Millennium Development Goals development agenda. The demonstrated political will and promised funding for these initiatives offer an extraordinary opportunity to transform family planning programs around the world, but also represent a great challenge. Amidst the positive response to FP2020, some civil society organizations expressed concerns that the numeric goal of reaching 120 million new users could signal a retreat from the human rights-centered approach that underscored the 1994 ICPD.

Achieving the goal of reaching millions of women and men worldwide with voluntary family planning services that respect and protect human rights will take concerted and coordinated efforts among diverse stakeholders over the next decade and beyond. It will also take a new programmatic approach that has the support of both the public health and human rights communities. The principle of voluntarism has been a long-standing cornerstone of international support for family planning; and the need to respect, protect, and fulfill an expanded list of reproductive rights has been articulated, particularly since the 1994 ICPD.

Emergence of a New Conceptual Framework for Voluntary, Human Rights-Based Family Planning

This paper presents a new conceptual framework, designed to serve as a pathway to fulfilling both the FP2020 goal and governments' commitments to the provision of voluntary family planning programs that respect, protect, and fulfill human rights. The framework answers the key question, **"How can we ensure public health programs oriented toward increasing voluntary family planning access and use respect, protect, and fulfill human rights in the way they are designed, implemented, and evaluated?"** The framework defines what such a program looks like, taking into consideration the broad context in which programs operate as well as the essential programmatic elements at the policy, service, community, and individual levels. By applying human rights laws and principles to family planning program and quality of care frameworks, this new framework brings what have traditionally been parallel lines of thought together in one construct to make the issue of rights in family planning concrete. The framework also shows that taking a human rights-based approach and a public health-based approach can be mutually reinforcing if programming is based on reaching both public health and human rights outcomes.

Drawing from and combining elements from relevant existing frameworks, in addition to rights documents as distilled by Erdman and Cook (2008), the **Framework for Voluntary, Family Planning Programs that Respect, Protect, and Fulfill Human Rights**

- Describes key family planning program elements in terms of rights, incorporating public health and human rights principles.
- Offers a practical approach to operationalizing reproductive rights in the development, implementation, and monitoring and evaluation of voluntary family planning (FP) programs.
- Links program inputs and activities to public health and human rights outcomes and impact.
- Highlights how countries can invest in and make further progress toward the realization of rights as an inherent part of supporting comprehensive, high-quality FP programming.

The framework is intended to assist policymakers, program managers, donors, and civil society at the **policy, service, community, and individual levels** with program design, implementation, and monitoring and evaluation. It is designed as a logic model, linking **inputs and activities** with **outputs, outcomes, and impacts**. Specifically, it

- Includes the inputs required at the policy, service, community, and individual levels to achieve the desired public health and human rights outcomes and impacts.
- Situates these four levels within the country context that affects both the supply of and demand for family planning.
- Shows how the four levels support the right to reproductive self-determination; sexual and reproductive health services, information, and education; and equality and nondiscrimination.
- Links the current focus on quality of care in FP programming to the concepts of availability, accessibility, acceptability, and quality.
- Reflects the principles of public health and human rights programming.
- Applies to all phases of the program life cycle (i.e., needs assessment, planning, implementation, monitoring and evaluation, scale-up, and sustaining).
- Presents the importance of accountability mechanisms for the effective redress of rights violations and handling of alleged or confirmed vulnerabilities.
- Promotes the agency of individuals to make reproductive health choices that are free from discrimination, violence, and coercion.

While comprehensive, not all aspects of the framework need to be implemented in their entirety by all organizations. Some organizations may focus on the supply side and others on the demand side of family planning programming. Some work at the service delivery level, while others specialize in programming at the community level. Others may work to affect policy change. Likewise, donors may decide which aspects of the programming their mandates and strategies support. But, by having a comprehensive, systems view, all actors can see how their programming contributes to meeting the needs of women and men for voluntary, human rights-based family planning. Gaps in the system can also be identified.

The framework is supported by reviews of available evidence and tools that could help operationalize such programming. The full findings of these reviews can be found in two accompanying papers (Rodriguez et al., 2013; Kumar et al., 2013).

Application of the Framework and Recommended Next Steps

The following actions are recommended to progress toward securing and safeguarding family planning programs that respect, protect, and fulfill human rights:

- **Foster additional dialogue** at the global and country levels to facilitate discussions around the critical issues of expanding access to family planning—particularly to underserved population groups—and respecting, protecting, and fulfilling human rights.
- **Use the conceptual framework as a guide for country programming and donor assistance under FP2020.**
 - Disseminate the conceptual framework both at the country and global levels, including *providing access to the framework and associated evidence and tools in a web-based platform*, to facilitate its use.

- Support additional review of the conceptual framework by stakeholders at national/subnational and global levels to continue the discussion on its use to guide programming and its adaptation to country contexts.
- **Further document and evaluate rights-based approaches** to fill the gaps in our knowledge about human rights-based programming and to evaluate both human rights outcomes and public health outcomes.
- **Develop guidance and tools to apply the framework** in programming to facilitate its use at the country level and through donor support.
- **Update and expand the accompanying reviews of evidence and tools** to ensure inclusion of all relevant material so that programs have access to the most relevant and up-to-date information for programming.
- **Identify a comprehensive set of indicators** to support the framework, including for all the various levels at which family planning programs function. Have the relevant FP2020 working groups identify a comprehensive set of structural, process, and outcome indicators that monitor and evaluate a rights-based approach to family planning.
- **Foster innovation in rights-based, public health approaches and additional investment in interventions** that are explicitly rights-based. Focus particularly on additional interventions to strengthen individual empowerment, community participation, and capacity building.

ABBREVIATIONS

AAAQ	availability, accessibility, acceptability, and quality
AFP	Advance Family Planning (project)
AIDS	acquired immune deficiency syndrome
DFID	(UK) Department for International Development
FP	family planning
HIV	human immunodeficiency virus
HMIS	health management information system
HR	human right(s)
ICPD	International Conference on Population and Development
IGWG	Interagency Gender Working Group
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
NGO	nongovernmental organization
OHCHR	(United Nations) Office of the High Commissioner for Human Rights
PH	public health
QA	quality assurance
QI	quality improvement
Rs	rights
RH	reproductive health
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
UNCESCR	United Nations Committee on Economic, Social, and Cultural Rights
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WHO	World Health Organization
WHO/RHR	World Health Organization/Reproductive Health and Research

I. INTRODUCTION

Background

The global community has an extraordinary opportunity to transform family planning programs around the world. This opportunity comes as a result of the 2012 London Summit on Family Planning, where more than 150 world leaders, international agencies, civil society organizations, foundations, and the private sector from donor and developing countries committed resources to reach an additional 120 million women and girls with voluntary family planning services by 2020. The summit “underscored the importance of access to contraceptives as both a right and a transformational health and development priority” (Bill & Melinda Gates Foundation and DFID, 2012: 1). The program to meet this goal is now known as FP2020.

“When I travel and talk to women around the world, they tell me that access to contraceptives can often be the difference between life and death. Today is about listening to their voices, about meeting their aspirations, and giving them the power to create a better life for themselves and their families.”

Melinda Gates, co-chair of the Bill & Melinda Gates Foundation at the London Family Planning Summit, July 11, 2012

The London Family Planning Summit capped more than a decade of efforts to bring renewed attention to family planning. The 20-year anniversary of the landmark 1994 International Conference on Population and Development (ICPD) is approaching, and the world is looking beyond the current Millennium Development Goals (MDGs) framework to a post-2015 development agenda. ICPD positioned family planning within a broad context of reproductive health and human rights. In the foreword to the 2012 *State of World Population* report, “By Choice, Not by Chance,” Babatunde Osotimehin, Executive Director of the United Nations Population Fund (UNFPA)

wrote that, “the right of the individual to freely and responsibly decide how many children to have and when to have them has been the guiding principle in sexual and reproductive health, including family planning for decades” (UNFPA, 2012). Both ICPD and the MDGs now include goals and targets related to universal access to reproductive health, including family planning. The MDG framework added universal access to reproductive health as a target in 2007.

Other efforts have included the 2001 Istanbul conference, “Meeting the Reproductive Health Challenge: Securing Contraceptives, and Condoms for HIV Prevention,” which resulted in the establishment of the Reproductive Health Supplies Coalition (www.rhsupplies.com); “Reposition Family Planning” (USAID, n.d./a) and “Advance Family Planning” (AFP, n.d.) initiatives; and the development of a family planning goal for 2015 that supports MDG-5b (Ross and Stover, 2010). In addition, international family planning conferences were held in 2009 and 2011, and a third is scheduled for November 2013—all signaling increased global visibility for family planning.

Amidst the positive response to FP2020, including a civil society declaration signed by more than 1,000 organizations worldwide, some civil society organizations expressed concerns that the numeric goal of reaching 120 million new users of contraception by 2020 could signal a retreat from the human rights-centered approach that underscored the 1994 ICPD (Girard, 2012; Khosla, 2012; Krishnan, 2012). Concern was raised that the FP Summit goal could also lead to a focus on services for urban groups who may already have access to services, at the expense of marginalized women, men, and young people who are more costly to reach but who may face more financial, social, or other barriers preventing them from accessing such services. These concerns emphasized the need to focus on reproductive rights, with strong accountability systems in place to ensure that programs offer voluntary family planning services based on human rights laws and principles. Reaching the goal of the FP2020 Summit will need “interventions to be

implemented in ways that improve health, and [will need to ensure] that efforts to reach national and international targets...do not result in the neglect or violation of human rights” (Gruskin et al., 2007: 452–453).

A focus on reaching more women with contraceptives will not negate the broader reproductive health and rights focus of ICPD; instead, it will draw attention and resources to family planning, a key component of reproductive health that has received insufficient attention and resources for nearly two decades. In fact, the Business Plan for the Summit notes that FP2020’s implementation will align with the principles of the ICPD (see Box 1).

The need for renewed attention to family planning has been highlighted, resources have been pledged, and political will is high, offering what Kingdon (1984) identified as a window of opportunity for transformational change. Taking advantage of this opportunity will require bringing together diverse stakeholders—representing family planning, reproductive health, human rights, and public health—to harness relevant approaches to programming and create the conditions for achieving the FP2020 goal (120 million new voluntary family planning users) in ways that guarantee choice and respect, protect, and fulfill human rights.

Box 1. Family Planning and Sexual Reproductive Health and Rights in the London FP Summit

“The Summit and its follow-up will align fully with the broader SRHR [sexual reproductive health and rights] framework established by the [ICPD] almost 20 years ago. The Summit will have a strong focus on equity and rights and will emphasise freedom of access to a range of contraceptives for married and unmarried women, marginalized communities, and adolescents.”

London Summit on Family Planning, 2012: 2

Forging of a New Conceptual Framework

The principle of voluntarism has been a long-standing cornerstone of international support for family planning; and the need to respect, protect, and fulfill an expanded list of reproductive rights has been articulated, particularly since 1994. Yet, few attempts have been made to link voluntarism and human rights into a comprehensive operational framework to guide family planning policies and programs. This paper represents a response to this need and thus includes the following:

- A discussion of human rights and how they relate to reproductive health and family planning
- Relevant history of the family planning and reproductive health and rights movements, including the legacy of ICPD as it relates to moving forward with FP2020
- A new framework designed to support voluntary family planning programs that respect, protect, and fulfill rights
- Recommended actions for facilitating the operationalization of integrated public health and human rights approaches in family planning programming

The framework’s development was supported by a review of the history of the family planning movement and discussions with experts. Systematic reviews were carried out of literature/the evidence base for voluntary, human-rights based family planning and of tools to undertake such programming.¹ The conceptual framework was reviewed by more than 150 people from 25+ countries through a series of in-person and web-based consultations and the World Health Organization (WHO) consultation on rights-based family planning held in April 2013. Ultimately, it is hoped that this effort and the resulting framework can contribute to implementation of the FP2020 program.

¹ See the two accompanying papers in this series, *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Evidence* (Rodriguez et al., 2013) and *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Tools* (Kumar et al., 2013).

II. HUMAN RIGHTS AND HEALTH AND THE FOUNDATION FOR VOLUNTARY, RIGHTS-BASED FAMILY PLANNING

Human Rights and Health

Human rights are those rights to which people are entitled to by virtue of being human beings. “Human rights are universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements, and human dignity” (OHCHR, 2006: 1). Human rights include civil, political, economic, social, and cultural rights and are rooted in international treaties that have the status of international law. The 1948 UN Universal Declaration of Human Rights articulated a broad range of rights, and treaties—such as the International Covenant on Economic, Social, and Cultural Rights, which guarantees the right to the highest attainable standard of health, and the International Covenant on Civil and Political Rights—identify legally binding human rights.

Under human rights law, governments, as duty-bearers, are responsible for facilitating the achievement of better health of their populations (rights-bearers) through “respecting, protecting, and fulfilling rights (i.e., not violating rights, preventing rights violations, and creating policies, structures, and resources that promote and enforce rights)” (Gruskin et al., 2007: 450).

The content and meaning of the **right to the highest attainable standard of health** has been set out most clearly by the UN Committee on Economic, Social, and Cultural Rights (UNCESCR), the body of independent experts that monitors implementation of the International Covenant on Economic, Social, and Cultural Rights by its States parties. The committee publishes its interpretation of the content of human rights provisions in the form of general comments on thematic issues. In 2000, it published General Comment No. 14 on the right to the highest attainable standard of health (Article 12 of the international covenant). The section on the normative content of Article 12 provides details of **four “interrelated and essential” elements** of the right to the highest attainable standard of health: **availability, accessibility, acceptability, and quality.**

Taken together, these elements form a valuable basis for identifying both government and service provider obligations to respect, protect, and fulfill the right to the highest attainable standard of health. The extent to which programs make their services available, accessible, and acceptable and of the highest attainable level of quality as defined in General Comment No. 14 will be directly proportionate to the extent to which they can claim to respect, protect, and fulfill the human right to the highest attainable standard of health. The array of human rights instruments can be used not only to hold governments accountable, but also to guide policies and programs—whether in the public, not-for-profit, or private sectors—to ensure available, accessible, acceptable, and high-quality information and services (Cottingham et al., 2010; Cottingham et al., 2012). More detail on the treaties, declarations, and conventions establishing reproductive rights is found in Annex 1.

The Foundation for Voluntary and Human Rights-Based Family Planning

The foundation for voluntary and human rights-based family planning can be traced to the 1968 International Conference on Human Rights, which included in its proclamation that “parents have a basic human right to decide freely and responsibly the number and spacing of their children” (UN, 1968: 4). This right was reaffirmed at three subsequent international population conferences in Bucharest in 1974, Mexico in 1984, and Cairo in 1994 (Singh, 2009).

The landmark International Conference on Population and Development, which took place in Cairo in 1994, affirmed that

...reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; and the right to attain the highest standards of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (UNFPA, 1994, Programme of Action para. 7.3).

Erdman and Cook (2008: 535) list **three broad categories of reproductive rights** under which family planning falls:

1. **Rights to reproductive self-determination** (right to bodily integrity and security of person and the rights of couples and individuals to decide freely and responsibly the number and spacing of their children)
2. **Rights to sexual and reproductive health services, information, and education** (including right to the highest attainable standard of health)
3. **Rights to equality and nondiscrimination** (right to make decisions concerning reproduction free of discrimination, coercion, and violence)

“Reproductive rights refer to the composite of human rights that protect against the causes of ill health and promote sexual and reproductive wellbeing.”

Erdman and Cook, 2008: 532

Others include the rights to privacy and life to this list (Cottingham et al., 2012) and note that a range of other rights, such as the right to education—while not reproductive rights per se—are also considered human rights and indivisible, greatly affecting reproductive health and fertility. For more detail on the process of forging the consensus on reproductive health and rights at the 1994 ICPD and the Cairo Consensus at 20, see Annex 1.

The Range of Violations of Reproductive Rights and Contraceptive Choice

“By focusing only on blatant violations—such as sterilization without consent—human rights methodologies also can miss subtler but more widespread and persistent violations of human rights.”

Jacobson, 2001: 56

As rights violations related to reproductive health have tended to focus on some egregious cases—such as forced abortion in China, forced sterilization in India, Peru, and more recently among HIV-positive women—more subtle forms of rights violations have been missed (Barot, 2012). Some programs or providers pressure or coerce clients into using family planning methods they do not want, while others create barriers that prevent individuals from obtaining and using methods they desire. Some of these factors are

subtle and some are overt. While coercion gets the most attention, all conditions that compromise a woman’s right to make a free and informed choice violate rights (EngenderHealth/RESPOND Project, 2013). Inadequate supplies of safe and effective contraceptives, the myriad barriers women face in accessing contraception, and poor-quality services are also related to human rights violations (Cottingham et al., 2012).

As the experts who participated in a consultation, *A Fine Balance: Contraceptive Choice in the 21st Century*, in September 2012, observed, improving the quality of family planning services, including counseling, is important but is not sufficient to ensure women are empowered to exercise their rights and choices. They observed that, ideally, the individual making reproductive health and family planning decisions should be supported by the health system and by social networks, as well as be protected by the policy and legal context (EngenderHealth/RESPOND Project, 2013).

Furthermore, while there is no “right” contraceptive method mix, the range of methods available and their accessibility contribute to contraceptive use (Ross and Hardee, 2012). Programs that offer a limited choice of methods cannot really be said to offer a full choice. To support reproductive rights, programs should be more client-focused than method-focused; and design, implementation, and monitoring of programs should incorporate client voices and the client perspective. Decisions on which methods to invest in should be based on method attributes that matter to clients (WHO, 1994). Client rights can be reinforced through routine monitoring and evaluation that incorporates clients’ views on the choices they are offered and the quality of services provided (EngenderHealth/RESPOND Project, 2013).

III. HUMAN RIGHTS-BASED AND PUBLIC HEALTH PROGRAMMING

Programming to achieve the FP2020 goal will require the integration of public health and human rights approaches. The challenges of doing so and the tensions between the approaches are not new (Mann et. al. 1999; PATH, 2001; Seltzer, 2002; Yamin, 2004; Sinding, 2007). Jacobson (2001: 55) notes that, “Traditional public health and human rights approaches are based on different conceptual frameworks and use different methodologies, with seemingly different implications for programs. Each of these approaches has to be rethought and reconciled on a practical level to promote rights-based health programs.” Public health focuses on improving the health of populations or providing the most good to the most people, whereas human rights focus on individuals. And yet, the ethical principles of public health do not compromise or violate rights. The **three standard ethical principles of public health programming** include

- **Beneficence**—the obligation to maximize benefits and minimize harms
- **Equity**—distributing the benefits and burdens of actions fairly
- **Autonomy**—defending the right of persons to self-determination and protecting those with impaired autonomy (Shelton, 2001: 15–16)

“The underlying assumption is that in a human rights approach individual rights are protected at all costs....Yet a rights-based approach does not privilege protection of individual rights over the public good.”

Gruskin and Loff, 2002: 1880

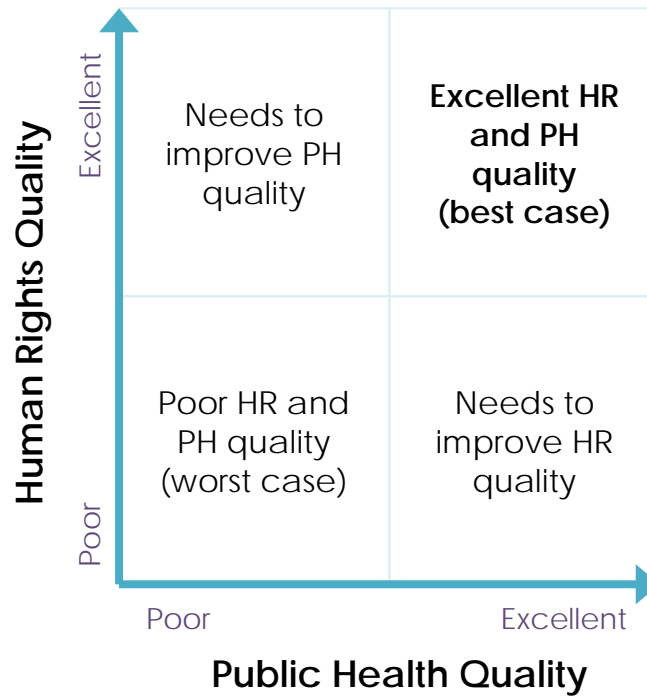
“In trying to make the world a better place, there are merits to using both the public health approach and the rights-based approach. Although we look at the world through different lenses, we must look for ways to harmonize our efforts.”

Shelton, 2001: 22

In fact, taking a human rights-based approach and a public health-based approach can be mutually reinforcing if programming is based on reaching both public health and human rights outcomes. Figure 1 provides a framework for assessing the quality of both public health and human rights in programming (International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights, 1999, cited in

WHO, 2001). Although it is sometimes sanctioned to promote public health over human rights, the goal for family planning should be ensuring that programs are aligned with both public health and human rights; this is particularly important given the early history of imposing family planning to meet demographic goals, as discussed above. “The introduction of human rights into public health is not about the imposition of any preordained result, but about the processes and their application toward maximum public health gains” (Gruskin and Loff, 2002: 1880).

Figure 1: The Quality of Human Rights and Public Health in a Program



Source: International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights, 1999; cited in WHO, 2001.

Both human rights-based and public health programming are developed and implemented on the premise of achieving results. Results-based management (of attention to inputs, outputs, outcomes, and impact) can be considered the program management vehicle, with the program designed, implemented, and monitored based on human rights law and principles, including ensuring participatory processes and mechanisms for accountability (OHCHR, 2006; WHO, 2001).

IV. PROGRAMMING VOLUNTARY, RIGHTS-BASED FAMILY PLANNING

The right of individuals and couples to decide freely and responsibly the number and spacing of their children and to access the information and means to do so was first operationalized through international support for adherence to voluntary family planning. The principle of voluntarism has been integrated into all U.S. government assistance for family planning (Ravenholt, 1968; US Congress, 1968; USAID, 1982; USAID, n.d./b; Donaldson, 1990; Bongaarts and Sinding, 2009; Barot, 2012). For example, the U.S. Agency for International Development (USAID), which has been the largest international funder of family planning assistance for more than a half century (Robinson and Ross, 2007), notes that its assistance is guided by **principles of voluntarism and informed choice**:

- People have the **opportunity to choose** voluntarily whether to use family planning or a specific family planning method.
- Individuals have **access to information** on a wide variety of family planning choices, including the benefits and health risks of particular methods.
- Clients are **offered**, either directly or through referral, **a broad range of methods and services**.
- The **voluntary and informed consent** of any clients choosing sterilization is **verified** by a written consent document signed by the client (USAID, n.d./b).

The movements to focus on quality of care (Jain, 1989; Bruce, 1990; Lynam et al., 1993; Rama Rao and Mohanam, 2003; Jain et al., 2012), which started in the 1980s and gained widespread acceptance in the 1990s and beyond, galvanized family planning and continue to set the tone for programming. The Maximizing Access and Quality Initiative sought to address access to care and quality of care and reduce unnecessary medical barriers to family planning (see Box 2). All of these initiatives were situated within public health programming approaches and sought to adhere to the right of individuals and couples to decide freely and responsibly the number and spacing of their children and to access the information and means to do so. Addressing quality of care is necessary but not sufficient to ensure that rights are respected, protected, and fulfilled within programs, but it does directly address one of the four key elements of the right to the highest attainable standard of health, namely quality. This element and the other three—availability, accessibility and acceptability—are further defined in Chapter 5 of this paper.

Box 2. Access, Quality, and Medical Barriers to Family Planning

"Access to family planning, quality of care, and medical barriers to services are key factors in the adoption of contraceptive care. Access helps determine whether the individual makes contact with the family planning provider, while quality of care greatly affects the client's decision to accept a method and the motivation to continue using it. Medical barriers are scientifically unjustified policies or practices...that inappropriately prevent clients from receiving the contraceptive method of their choice or impose unnecessary process barriers to access to family planning services."

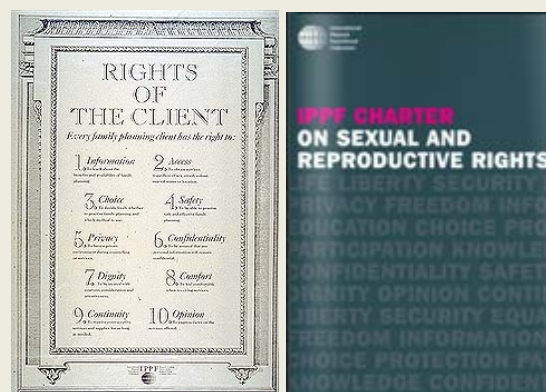
Bertrand et al., 1995: 64

To operationalize the landmark Bruce/Jain framework for Quality of Care, using quality improvement approaches, a number of tools were developed (Katz et al., 1993; Kols and Sherman, 1998), such as COPE (EngenderHealth, 2003), Situation Analysis (Miller et al., 1997), and the Quick Investigation of

Quality (MEASURE Evaluation, 2001), among many others. The International Planned Parenthood Federation (IPPF) articulated a list of 10 rights of the client (see Box 3), which providers have to apply to offer high-quality care (Huezo and Diaz, 1993). The SEATS II Project, among others funded by USAID, had as its purpose “to expand the development of, access to, and use of [high-] quality family planning and reproductive health services in currently underserved populations” (SEATS, 2000: xi). The notion of scaling up quality of care in family planning helped shape the ExpandNet framework for scaling up innovative practices (Simmons et al., 2002; www.expandnet.net). The Population Council published a series, *Quality/Calidad/Qualite*, among numerous reports on quality of care meetings, studies, and country experiences. Experience in promoting quality of care was a prevalent topic in discussions at ICPD (Singh, 2009).

Following ICPD, family planning and reproductive health have been considered in a broader array of reproductive rights (UNFPA, 1994; IPPF, 1996; Jacobson, 2000; DFID, 2004; Eager, 2004; Erdman and Cook, 2008; UNFPA, 2008; UNFPA, 2012; Cottingham et al., 2010; Cottingham et al., 2012). Since the ICPD, some other donors have adopted the reproductive health and rights framework in their programming. In 2010, the UK’s Department for International Development (DFID) published its framework of results for improving reproductive, maternal, and newborn health in the developing world (DFID, 2010). DFID (n.d.) notes that its vision “is a developing world where all women are able to exercise choice over the size and timing of their families, where no woman dies giving birth, and where all newborns survive and thrive.”

Box 3. IPPF’s Rights of the Clients Poster and Charter of Sexual and Reproductive Rights



There have also been initiatives to promote equity and ensure that gender is integrated into and addressed in reproductive health programming, including family planning. In recent years, equity in family planning has been measured through the analysis of service availability and use by wealth quintiles (Gwatkin et al., 2007; Ortayli and Malarcher, 2010; USAID | Health Policy Initiative, 2009; Saunders et al., 2010; Foreit et al., 2011; PATH, 2012). Since 1997, the USAID Interagency Gender Working Group (IGWG)² has been supporting the integration of gender into development programs and has produced a number of reports, studies, and tools (see <http://www.igwg.org/about.aspx>). For example, one study—undertaken with support from the IGWG’s Gender, Access, and Quality of Care Task Force and the Maximizing Access and Quality Initiative—assessed the intersection between gender, access to care, and quality of care in reproductive health programs in India, Guatemala, and Kenya (Hardee, 2005). Two other assessments commissioned by the IGWG focused on the impact of integrating gender into programming on reproductive health outcomes (Boender et al., 2004; Rottach et al., 2009). Integrating gender into HIV/AIDS programming by addressing inequitable gender norms is also relevant for family planning (Pulerwitz et al., 2006; Verma et al., 2008; Gay et al., 2012).

² The Interagency Gender Working Group (IGWG), established in 1997, is a network comprising nongovernmental organizations, the United States Agency for International Development (USAID), cooperating agencies, and the Bureau for Global Health of USAID. The IGWG collaborates with multilateral organizations, including WHO.

The United Nations has an organization-wide commitment to human rights. UNFPA's programming framework is reflected in its 2008 document, *Sexual and Reproductive Health Framework: A Reality for All* (UNFPA, 2008). The WHO also supports sexual and reproductive health. "The vision of WHO/RHR [Reproductive Health and Research] is the attainment by all peoples of the highest possible level of sexual and reproductive health. It strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected and all women and men, including adolescents and those who are underserved or marginalized, have access to sexual and reproductive health information and services" (WHO/RHR, n.d.). The IPPF published a Charter of Sexual and Reproductive Rights 1996 and reissued it in 2003. Foundations such as the Ford Foundation and Open Society Foundation also proactively support reproductive rights.

Applying Human Rights to Voluntary Family Planning in Practice

While governments have legal obligations to respect, protect, and fulfill human rights, taking a human rights-based approach to family planning can help ensure that human rights values and concepts are infused into all aspects of programming (Cottingham et al., 2012). Box 4 highlights the distinction between the legal requirements of governments related to human rights and taking a human rights-based approach to programming. In such programming, attention is given not only to health outcomes, but also to how programs are implemented.

While there is no one definition of a **human rights-based approach**, taking such an approach for family planning includes the following (OHCHR, 2006; Gruskin, et al., 2007; UNFPA, 2010):

- *Analyzing the inequalities* related to family planning and reproductive health and the laws and policies under which programs take place
- Ensuring that the plans, policies, and programs are *anchored in a system of rights and corresponding obligations* established by international law and that they integrate core *human rights principles* such as *participation, accountability, nondiscrimination, and empowerment*
- Working toward *equitable* service delivery
- Focusing on key elements of the right to health—*availability, accessibility, acceptability, and quality* when defining standards for provision of services
- *Empowering people* themselves—especially the most marginalized—to *participate* in policy formulation and hold accountable those who have a duty to act

What does applying human rights to voluntary family planning programs mean in practice? Cottingham et al. (2012) have concluded that, from a human rights perspective, to achieve universal access to contraceptive information and services, the **legally required priorities** include the

- Establishment of concrete national and subnational plans that enable universal access
- Removal of legal and regulatory barriers
- Continuous supply of high-quality reproductive health commodities, including the widest possible range of safe and effective contraceptives

Box 4. Describing a Human Rights-based Approach

"In recent years, two distinct but complementary approaches have evolved. The first is a **legal approach**. This uses human rights standards, the formal system of international human rights law, to emphasize legal obligations to respect, protect and fulfill rights. The second is a broader **development-centered approach**. This draws from the standards and principles of human rights and demands adherence to 'good development practices' such as participation and inclusion."

DFID, 2005: 2

- Employment of appropriately skilled and supervised health workers who respect privacy and confidentiality, provide full and accurate information, and ensure free and informed consent
- Maintenance of high-quality facilities
- Removal of financial barriers to access
- Establishment of effective monitoring and accountability mechanisms to check that human rights and other commitments are kept

Box 5 illustrates that the principles outlined in the Business Plan for the FP Summit reflect taking such a human rights-based approach.

Box 5. Principles to Support the Goal of Reaching 120 Million Additional Women by 2020

- Protection of the human rights of women and girls, including through policies and mechanisms to ensure informed choice of a broad range of high-quality, safe, effective, acceptable, and affordable contraceptive methods; nondiscrimination, and assurance that women and girls are fully informed and not coerced by any means.
- Integration of family planning within the continuum of care for women and children (including HIV-related services); and development of mechanisms that address barriers to access to affordable and high-quality information, supplies, and services for family planning, yet are adaptable and can be expanded to meet a broader set of unmet health and development needs of women and children.
- Universal access to voluntary contraceptive information, services, and supplies, within the context of integrated programmes to achieve sexual and reproductive health and rights and the health-related MDGs.
- Equity in policies and program design and implementation, such as the removal of policy and financial barriers and the development of public and private delivery mechanisms, so that the poorest and most vulnerable women and girls have ready access to affordable, high-quality family planning information, supplies, and services.
- Empowering women to decide whether and when they wish to become pregnant as well as how many children they wish to have.
- Participatory development of country plans based on consultations with, and the views of, all stakeholders, especially poor and marginalised girls and women.
- Strong partnerships among and between a broad base of stakeholders—community, governments, political leaders, civil society organisations (including faith-based organisations), the private sector, donors, and multilaterals—to help ensure high-quality service delivery, outreach to more disadvantaged groups, [the] building [of] community support, and programme accountability to the people served.
- Commitment to results, transparency, and accountability to ensure countries and the global community track progress towards results, as well as [to] monitoring and assessing [the] protection of human rights and the extent to which the poor and marginalised women and adolescent girls are reached.

London Summit on Family Planning, 2012: 5

V. THE FRAMEWORK FOR VOLUNTARY, RIGHT-BASED FAMILY PLANNING

Development and Purpose of the Framework

To fully understand what a voluntary, rights-based family planning program should include and how to effectively implement it, a team of staff and consultants from Futures Group, EngenderHealth, and the Bill & Melinda Gates Foundation³ drafted a conceptual framework as a way to clearly illustrate how voluntarism and human rights can be mutually reinforcing in family planning programs. Drawing from and combining elements from relevant existing frameworks,⁴ in addition to rights documents as distilled by Erdman and Cook (2008), this new **Framework for Voluntary, Family Planning Programs that Respect, Protect, and Fulfill Human Rights** was developed to

- Describe key family planning program elements in terms of rights, incorporating public health and human rights principles.
- Offer a practical approach to operationalizing reproductive rights in the development, implementation, and monitoring and evaluation of voluntary family planning programs.
- Link program inputs and activities to public health and human rights outcomes and impact.
- Highlight how countries can invest in and make further progress toward the realization of rights as an inherent part of supporting comprehensive, high-quality FP programming.

The framework is intended to assist policymakers, program managers, donors, and civil society at the policy, service, community, and individual levels with program design, implementation, and monitoring and evaluation through bridging the “chasm between theory and practice...in translating human rights norms into concrete programming guidance applicable in diverse policy contexts and national circumstances” (Arbour, in OHCHR, 2006: 3). The framework attempts to define the desired impact and provides a systems pathway to achieve it. As such, it helps to answer the following key questions:

- What needs to be done—and be in place—to ensure that a family planning program is voluntary and respects, protects, and fulfill human rights? (inputs and activities)
- What does a voluntary family planning program that respects, protects, and fulfills rights look like? (outputs)
- What are the desired effects of a voluntary family planning program that respects, protects, and fulfills rights? (outcomes)
- What is hoped to be achieved by implementing a voluntary family planning program that respects, protects, and fulfills rights? (impact)

³ The team included expertise in global and country family planning programs, policy, monitoring and evaluation, reproductive rights, and gender. The expertise was augmented by reviews from a range of stakeholders at the global, regional, and national levels.

⁴ The key frameworks reviewed included the family planning quality of care framework (Bruce, 1990), the rights of clients and needs of providers (Huezo and Dias, 1993), the Choices in Family Planning: Informed and Voluntary Decision Making and the SEED Assessment Guide for Family Planning (EngenderHealth, 2003 and 2011).

Considerations

By applying human rights laws and principles to family planning program and quality of care frameworks, this new conceptual framework brings what have traditionally been parallel lines of thought together in one construct to make the issue of rights in family planning concrete. The focus on rights and the focus on informed and voluntary family planning programs clearly overlap. The Bruce/Jain Quality of Care Framework (Bruce, 1990) and the IPPF Rights of the Clients and Needs of Providers (Huezo and Diaz, 1993) are notable examples of this link. The framework includes voluntarism and rights language to show the compatibility of the approaches.

The inclusion of human rights in family planning also calls attention to the need for mechanisms that support accountability and redress for violations of rights. As such, this framework highlights the importance of systems that monitor and account for rights violations, including the right to decide freely and without discrimination the number and spacing of children.

The framework encourages approaching family planning through a holistic, client-centered, and health systems view, addressing factors that affect human rights and the choice and use of family planning. It also considers the country and global contexts in which family planning programs operate. Further, it reflects the current context of health programming, focusing on promoting universal healthcare through health systems strengthening rather than vertical programming. While vertical programs are easier to put in place, they are found to be less effective than health systems with the financial and human capacity to deliver essential integrated services.

Universal healthcare cannot be achieved without addressing disparities among populations, especially those marginalized and disadvantaged populations—for example, youth, people living with HIV, migrant workers, displaced persons, or those caught in armed conflict, among others—who often have poor access to healthcare services. Human rights approaches work to address such disparities, and thus, taking a human rights approach to the provision of family planning, as part of sexual and reproductive health programs, will help to secure universal access to services that respect, protect, and to the extent possible, fulfill human rights.

The framework reflects recent discourse on the social determinants of health (WHO, n.d.), which were clearly articulated by ICPD. Sen (2010: 143) has noted that ICPD “recognized that people can make free and responsible choices about how, when, and how many children they will have only if they can determine how, when, and under what conditions they can have sex, cohabit, or marry, and if these decisions are free from coercion and violence and are made with full adult autonomy and agency. ICPD acknowledged the centrality of power relations based on age and gender.”

Note that the framework does not address abortion-related activities; the definition of family planning used here is consistent with the ICPD’s definition, which states (Paragraph 8.25) that there is a need to “deal with the health impact of unsafe abortion as a major public health concern” and that “In no case should abortion be promoted as a method of family planning.”

Components of the Framework

The framework (see Figure 2) is designed as a logic model, linking **inputs** and **activities** with **outputs** and the **outcomes** and **impacts** determined for FP2020.⁵ It

- Includes the inputs required at the **policy, service, community, and individual levels** to achieve the desired public health and human rights outcomes and impact
- Situates these four levels within the country context that affects both the supply of and demand for family planning
- Shows how the four levels support the three broad categories of reproductive rights (Rs):⁶
 - Rights to reproductive self-determination
 - Rights to sexual and reproductive health services, information, and education
 - Rights to equality and nondiscrimination
- Links the current focus on quality of care in FP programming to the elements of AAAQ:⁷
 - Availability
 - Accessibility
 - Acceptability
 - Quality
- Reflects the principles of public health and human rights programming:
 - Public health—beneficence, equity, autonomy
 - Human rights—participation, accountability, nondiscrimination, empowerment, and link to international treaties
- Applies to all phases of the program life cycle (i.e., needs assessment, planning, implementation, monitoring and evaluation, scale-up, and sustaining)
- Presents the importance of accountability mechanisms for the effective redress of rights violations and handling of alleged or confirmed vulnerabilities
- Promotes the agency of individuals to make reproductive health choices that are free from discrimination, violence, and coercion

The framework clearly depicts the need for program planners to think beyond what happens during client provider interactions to the effects of the policy and resource environment (does it support or hinder choice and method access and clients' rights?) as well as community factors (do sociocultural and gender norms support clients' right and ability to make autonomous FP decisions?). It guides systematic thinking that includes and goes beyond what happens at the service delivery point to consider whole programs, not just individual services.

While comprehensive, not all aspects of the framework need to be implemented in their entirety by all organizations. Some organizations may focus on the supply side and others on the demand side of family planning programming. Some work at the service delivery level, while others specialize in programming

⁵ Groups working on the outcomes and impacts associated with FP2020 and with the indicators and the monitoring and evaluation systems to measure them include the Monitoring and Accountability Working Group and the Rights and Empowerment Working Group.

⁶ See Erdman and Cook, 2008 for more information on these categories.

⁷ See the "Outputs" section of this chapter for a definition and discussion of these AAAQ terms.

at the community level. Others may work to affect policy change. Likewise, donors may decide which aspects of the programming their mandates and strategies support. But, by having a comprehensive, systems view, all actors can see how their programming contributes to meeting the needs of women and men for voluntary, human rights-based family planning. Gaps in the system can also be identified.

Review of Supportive Evidence and Tools

In the course of developing the framework, the team conducted (1) a literature review of current evidence for voluntary rights-based family planning to identify practices that promote a rights-based approach to achieving public health and rights outcomes and (2) a review of available tools that could help operationalize a voluntary rights-based approach. Until this work, no systematic review of rights-based family planning existed, and as such, there was a need to search for evidence and tools that could support and elaborate the components of the framework. The team synthesized the findings according to the framework's components and four levels, helping to identify the key actions or factors for family planning programs to implement or consider.

The literature review concentrated on relevant interventions, evaluations, and case studies to help achieve a better understanding of what elements are needed for a successful voluntary, rights-based family planning program. Because there is no existing definition of a rights-based approach to family planning, evidence related to rights-based programming is limited. Therefore, the review cannot be considered exhaustive but rather a good starting point for continued research. The questions guiding the search strategy included

1. How can we ensure public health programs oriented toward increasing access and use of family planning are voluntary and respect and protect rights in the way they are designed, implemented, and evaluated?
2. What works to promote voluntary, rights-based family planning? Or what rights-based interventions or tools increase family planning demand and/or access (service delivery)?
3. What evidence exists to support a rights-based approach to family planning?

The literature search (databases, individual websites, hand-search) aimed to find references to

1. Any “principles” of reproductive rights and empowerment (might include “approaches”)
2. “Tools” or “approaches” that can be used in family planning programs that support reproductive rights and empowerment
3. “Intervention studies” in family planning programs

The findings from the review of 350 documents were categorized into the four levels according to the conceptual framework: policy, service, community,⁸ and individual. In summary, the findings revealed some key actions/interventions needed to ensure that

- *Policy level*—the conditions of governance (especially political commitment) and accountability (especially to the community) support family planning programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services).

⁸ The team's review at the community level focused on community participation, as an exhaustive review of the rich literature on community participatory approaches, community empowerment, and community capacity building in health was outside the scope of this review.

- *Service level*—the elements of quality of care (quality, accessibility, availability, and acceptability) guide programming to adhere to the highest standard of care and thus protect inherent human rights principles (especially in the areas of method mix, technical competence, and service integration).
- *Community level*—the political, financial, and social environments are supported by the effective participation of diverse community groups (especially youth) in all aspects of family planning policy and program development, implementation, and monitoring (especially in the areas of policy making, funding, and societal norms and equity).
- *Individual level*—the various contexts in which an individual lives allow the person to exercise his or her rights (especially in the areas of behavior, knowledge, access to information and services, and empowerment).

The main inputs and activities identified at each level are reflected in the framework. See the accompanying paper in this series, *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Evidence*, for details on the approach, search strategy, and evidence reviewed by level, including identified knowledge gaps) (Rodriguez et al., 2013).

The review of available FP-related tools concentrated on those that could help operationalize components of a voluntary, rights-based approach to family planning. The search strategy focused on experience with or evaluations of the tools. Three hundred and fifty resource documents were reviewed and of those, 150 were categorized into the same four categories of the framework—policy, service, community, and individual—plus a fifth, cross-cutting (associated with all four levels), and then further categorized by type:

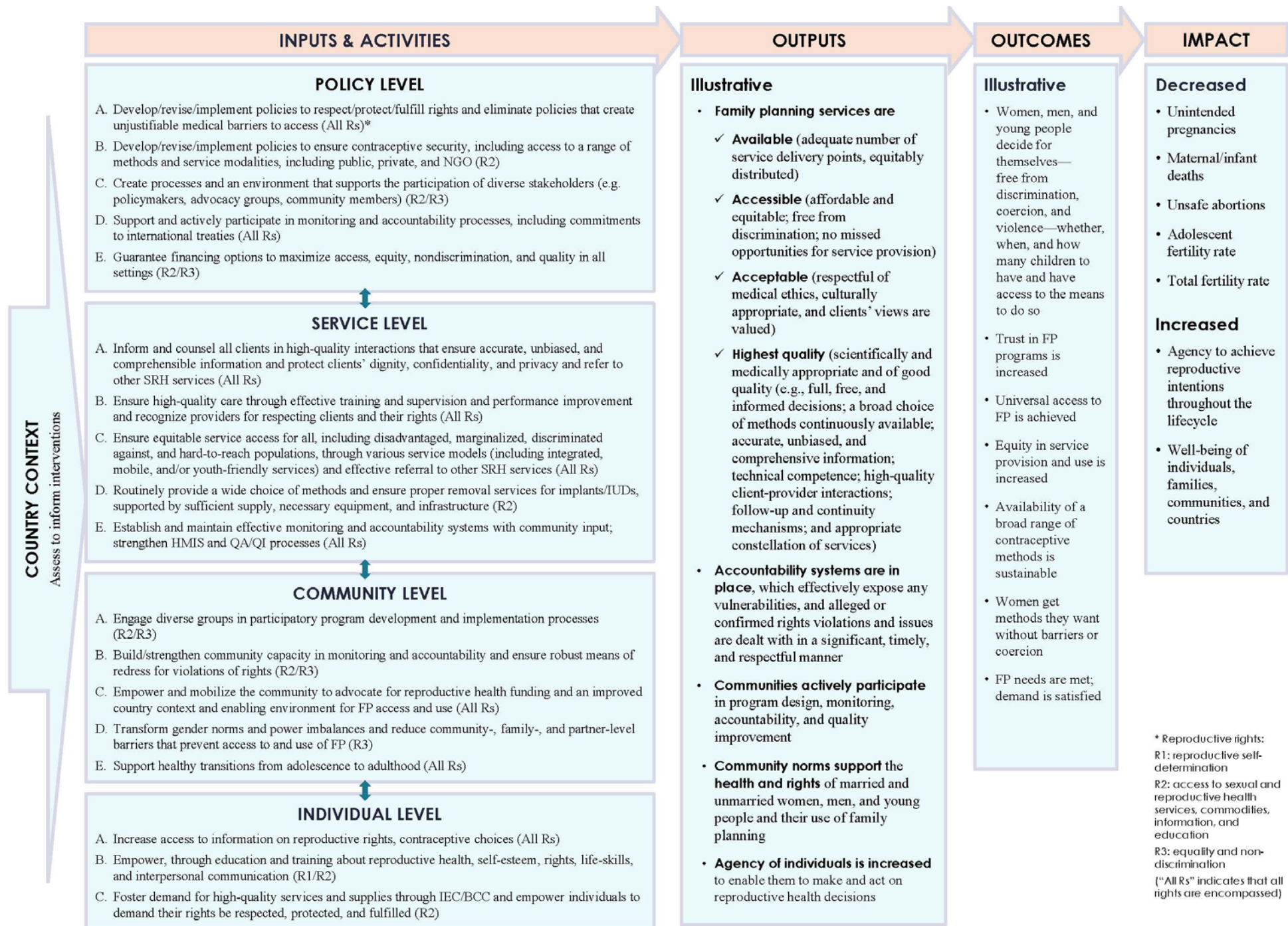
- Training
- Assessment
- Framework
- Methodology
- Implementation
- Job aid

Of the total 150 tools included, 29 percent explicitly focused on human rights or reproductive rights, but this does not mean the remaining documents showed a lack of support for human or reproductive rights (references were sometimes implicit). The review showed that

- More evaluation is needed to determine a tool’s potential or comparative effectiveness as a tool for operationalizing family planning programs that respect, protect, and fulfill rights.
- A gap exists in many tools and indicators to monitor and ensure accountability.
- Most tools focus more broadly on quality of care and not specifically on empowerment or client rights.

See the accompanying paper in this series, *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Tools*, for details on the resource documents reviewed and the findings (by category and type) (Kumar et al., 2013).

Figure 2. Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights



Inputs and Activities

Country Context

The framework recognizes that family planning programs are affected by a country's political, social, cultural, and economic environments. It is important to assess this overall context and to both work within it and seek to change aspects of it to promote and implement voluntary family planning programs that respect and protect rights. The value of such an analysis is that the process itself, as well as the analysis and recommendations that it yields, can be helpful in securing an increased understanding of the need for collaboration across disciplines and sectors in order to identify and reduce barriers to universal access to sexual and reproductive health and rights, particularly for vulnerable groups.

The key actions at this level are to

- Assess the overall country and global context—within which voluntary, human rights-based family planning is situated—and use the findings to inform interventions at all levels, including interventions related to marginalized and vulnerable populations:
 - **Overall country governance**, including the World Bank's six dimensions of overall governance—accountability and voice, political stability and support, rule of law/regulatory quality, government effectiveness, power relationships and dynamics, and control of corruption⁹
 - **Health governance**, including government stewardship for health (e.g., health systems strengthening through the establishment of health systems building blocks) and family planning/reproductive health
 - **Financing/resources**, including the availability of funding at national and local levels for health, reproductive health, and family planning
 - **Health policy environment**, including those policies related to family planning (e.g., safe motherhood policy, youth policy) and health status (e.g., maternal morbidity and mortality, infant mortality, child health status)
 - **Sociocultural context and gender norms**, including those affecting marginalized populations
 - **Diverse stakeholder participation**, including the engagement of civil society, communities, and public and private sector actors
 - **Adherence to global human rights agreements**, including in national laws and policies
 - **Global accountability** of donors and other global actors, including to country-level work
 - **National accountability mechanisms** in place, including the means of redress for violations of rights for government as duty-bearer to respect, protect, and fulfill human rights (e.g., treaty monitoring bodies, human rights tribunals, national courts), including accountability for private actors and for international assistance

Policy Level

Supportive policy has been identified as one of 10 elements of successful family planning programming (Richie and Salem, 2008). Policy making—while of course necessary but not sufficient to ensure

⁹ Good governance is defined by high rankings in these dimensions (<http://info.worldbank.org/governance/wgi/index.asp>). Governance includes the activities carried out by elected and appointed governmental bodies such as parliaments, ministries, and regulatory agencies. Governance also goes beyond these to include private firms, civil society advocacy organizations, community groups, and private individuals.

voluntary, rights-based family planning—is a complex process that involves a range of actors with differing demands and priorities (Walt et al., 2008; Buse et al., 2010). National policies, laws, operational guidelines, strategic plans, and other policy-related instruments—within not only the health sector but other sectors—establish how countries address family planning issues and whether they do so in ways that respect, protect, and fulfill rights. For example, in Latin America and Africa, ministers of health and education signed and adopted declarations that committed their governments to taking action on providing sexuality education—all through a human rights frame (Cottingham et al., 2012).

The policy level includes those actions or factors that influence policies—and thus the enabling environment—that affect equitable access and treatment; adequate resources; good governance; and management and accountability to ensure the availability, accessibility, acceptability, and quality of FP information and services:

Create an enabling environment for family planning programs

- A. Develop/revise/implement policies to respect/protect/fulfill rights and eliminate policies that create unjustifiable medical barriers to access (All Rs)**
- Develop laws and policies that ensure that family planning services are sufficiently available; physically and economically accessible to all people without discrimination; acceptable—respectful of culture and confidentiality; and of the highest possible quality
 - Protect women’s reproductive health and human rights
 - Support the promotion of gender equity and women’s autonomy in realizing their reproductive rights
 - Support prevention of harmful practices (e.g., child marriage, gender-based violence, female genital cutting) and knowledge of the rights violations and harms caused by such practices
 - Ensure equitable access to services for all groups (e.g., without discrimination in respect of ethnicity, age, income level)
 - Ensure the highest standard of reproductive health and address the contributors to poor sexual and reproductive health (SRH)
 - Eliminate unjustifiable access barriers (e.g., client eligibility criteria) or policies that contain method-specific or performance-based targets or incentives that have the effect of being coercive in practice
 - Set service standards and enable task shifting and task sharing and facilitate access to a wide range of safe and effective contraceptive methods
 - Protect privacy in service delivery settings
 - Promote the provision of comprehensive sex education and access to family planning (within SRH) information
 - Increase access to information on reproductive rights to provide choices and a sense of entitlement to high-quality services (R2)
- B. Develop/revise/implement policies to ensure contraceptive security, including access to a range of methods and service modalities, including public, private, and NGO (R2)**
- Follow through on implementation of the WHO List of Essential Medicines
 - Ensure a steady supply of a variety of contraceptives, supplies, and equipment
 - Ensure that relevant ministries and donors collaborate in budgeting for RH supplies
 - Build the capacity for procurement and data collection systems to track health and supply needs
 - Establish an effective supply chain and procurement system, including through a monitoring system that enables all partners to monitor stock outs and improve the distribution system

- Collaborate with research institutions, manufacturers, service delivery organizations, and potential users to develop safe, effective, and acceptable contraceptive technologies that meet individuals' needs
- C. Create processes and an environment that supports participation of diverse stakeholders (e.g., policymakers, advocacy groups, community members)—including government/public sector actors at the national and decentralized levels; civil society organizations, including women's groups and human rights groups at the national and community levels; poor, vulnerable, and marginalized people and other key populations; community and religious leaders; private sector actors; and related sector actors—to (R2/R3)**
- Contribute to setting priorities and standards for FP policies/programs
 - Advocate for family planning in reform processes
 - Monitor policies and programs (see bullet D)
 - Respond to voices and demands of poor/vulnerable groups
 - Assess and address environmental factors that create barriers to family planning use
- D. Support and actively participate in monitoring and accountability processes, including commitments to international treaties (All Rs)**
- Ensure adequate monitoring and evaluation systems and data (e.g., disaggregated by age, sex) to facilitate a timely monitoring and accountability process
 - Monitor action and follow up on commitments and concluding observations from international human rights treaties (e.g., the Convention Eliminating All Forms of Discrimination against Women or CEDAW)
 - Support civil society organizations and others (e.g., women's group and key populations) to monitor government policies and performance on FP issues, including quality of care
 - Ensure that the government monitors the quality of service delivery and family planning uptake
 - Establish or strengthen accountability mechanisms/human rights mechanisms to address violations of rights (including discrimination or coercion); create a means to redress violations; and apply rights-monitoring tools (equity audits)
 - Monitor budgetary appropriations to ensure that reproductive healthcare is covered
- E. Guarantee financing options to maximize access, equity, nondiscrimination, and quality in all settings (R2/R3)**
- Ensure national and donor resources and financing mechanisms to implement policies to expand coverage of family planning services and ensure access to a wide range of methods and services by all (including poor/vulnerable groups)
 - Identify and reform financing plans that can eliminate barriers to achieving access to FP services, commodities, and supplies
 - Ensure a budget line item for FP commodities, equipment, supplies, and services

Service Level

Providing clients with high-quality services that meet reproductive health needs and respect, protect, and fulfill rights will appropriately focus significant attention on service delivery. As noted in this paper, the conceptual framework draws from, and links, key existing frameworks, most notably, the Fundamental Elements of Quality of Care (Bruce, 1990), IPPF's rights of clients and needs of providers (Huezo and Diaz, 1993), and IPPF's charter of reproductive rights (IPPF, 1996). Most evidence and tools identified in the systematic review undertaken for this paper relate to the service delivery level.

The service level includes all modalities of service delivery, including public, private, and NGO; clinic- and community-based; static and mobile, and social marketing, among others. At the service delivery level, the framework considers those actions or factors that influence the capacity of the health system to make voluntary family planning services available, accessible, and acceptable and of high quality (that meet clients' rights and providers' needs) within both facilities and communities.

Provide equitable, high-quality family planning information, services, and supplies

- A. Inform and counsel all clients in high-quality interactions that ensure accurate, unbiased, and comprehensible information and protect clients' dignity, confidentiality, and privacy and refer to other SRH services (All Rs)**
 - Routinely counsel all clients and respect and protect their right to make autonomous decisions about whether to use family planning and what method to use
 - Protect clients' privacy and confidentiality
 - Address gender-based violence and establish linkages with broader gender-based violence programming
- B. Ensure high-quality care through effective training and supervision and performance improvement and recognize providers for respecting clients and their rights (All Rs)**
 - Provide adequate training, supervision, and resources to providers (including technical knowledge and skills and rights awareness) to ensure technical competence and reduce bias, stigma, and discrimination
- C. Ensure equitable service access for all, including disadvantaged and marginalized, discriminated against, and hard-to-reach populations, through various service models (including integrated, mobile, and/or youth-friendly services) and effective referral to other SRH services (All Rs)**
 - Ensure access, including for women and girls living with HIV, women and girls living in conflict and humanitarian crises, the poor, rural dwellers
 - Provide services at the facility and community levels
 - Integrate FP with HIV and maternal, neonatal, and child health services as appropriate
- D. Routinely provide a wide choice of methods and ensure proper removal services for implants and IUDs, supported by sufficient supply, necessary equipment, and infrastructure (R2)**
 - Routinely offer a wide choice of methods to all clients, without discrimination, to meet the full range of client preferences and reproductive intentions
 - Ensure reliable, sufficient inventories of supplies, instruments, and working equipment, plus the infrastructure necessary to maintain the uninterrupted delivery of high-quality services
 - Ensure that supply chain management training is in place at the central, district, and local levels
- E. Establish and maintain effective monitoring and accountability systems, with community input; and strengthen HMIS and QA/QI processes (All Rs)**
 - Ensure that respecting and protecting rights is built into performance monitoring and accountability indicators, procedures, and practices
 - Engage communities in program monitoring and establish a client feedback mechanism
 - Establish mechanisms to investigate rights vulnerabilities and to redress violations

Community Level

Community participation in health programs has been emphasized since the Alma Ata declaration in 1978, and it is a central tenant of human rights-based approaches to development programs, as articulated in the UN Common Understanding, adopted in 2003 (HRBA Portal, n.d.). There are two primary reasons behind community participatory approaches: (1) to use resources from the community to offset costs and increase sustainability and (2) to empower communities to be more active in health and development projects so that people have a greater degree of self-determination and are better able to manage their own lives (Wallerstein, 1993). Zackus and Lysack (1998: 2) describe the latter approach to community participation:

“Community participation in health ... may be defined as the process by which members of the community (a) develop the capability to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and manage organizations in support of these efforts; and (d) evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis. Community participation is therefore a strategy that provides people with a sense that they can solve their problems through careful reflection and collective action.”

Community participation—whether directed toward program development, monitoring, accountability, or advocacy—may contribute most substantially to the acceptability of family planning programs and the ability of programs to gain traction in traditionally hard-to-reach populations (Rifkin, 2003). While a focus on the service delivery level is essential, it is not sufficient to ensure that clients have a choice of methods that meet their needs and have access to the methods they want. It also does not reach potential clients in communities in which sociocultural barriers to FP use or to autonomous decision making prevent women from exercising their right to contraceptive information and services.

At the community level, the framework considers those actions and factors that empower communities to (1) participate in the development and implementation of the policies and programs designed to serve them; (2) hold policymakers and service providers accountable; (3) adapt norms and customs; and (4) enhance community knowledge of human rights and of family planning in order to facilitate the respect, protection, and fulfillment of community members’ rights to high-quality, voluntary FP information and services.

Ensure equitable participation/engagement in policy and program development, implementation, and monitoring

A. Engage diverse groups in participatory program development and implementation processes (R2/R3)

- Encourage and support civil society participation, including women’s groups and human rights groups at the national and community levels; poor, vulnerable, and marginalized people, youth, and other key populations; and community and religious leaders in the design, implementation, and monitoring of policies and service programs
- Ensure a representative approach by identifying underrepresented groups and addressing factors that impede their participation in the program development process

B. Build/strengthen community capacity in monitoring and accountability and ensure robust means of redress for violations of rights (R2/R3)

- Increase community literacy in human rights, monitoring, and accountability
- Establish an active process of engagement between the community and health system through negotiations to improve outcomes and to ensure that rights are respected, protected, and fulfilled

- Educate the community on mechanisms to ensure a high quality of care and voluntary, informed decision making
 - Ensure improved health outcomes through the monitoring of provider performance, the quality of services and facilities, and the availability of commodities and services
- C. Empower and mobilize the community to advocate for reproductive health funding and an improved country context and enabling environment for family planning access and use (All Rs)**
- Build/strengthen communities’ capacity to advocate for available, accessible, acceptable, and high-quality healthcare
 - Promote community and civil society participation in the mobilization of and decision making around local funding and budgets for health services
 - Foster advocacy to address social barriers to access, including barriers to reproductive health education
 - Increase overall awareness and support for reproductive rights, gender equity, and information and access for young people
 - Build awareness and support for the reproductive rights of vulnerable groups
- D. Transform gender norms and power imbalances and reduce community-, family-, and partner-level barriers that affect the realization of reproductive rights (R3)**
- Address community and other environmental factors that create barriers to FP use by changing relevant norms, attitudes, and behaviors and promoting self-determination in FP use at the community level
 - Engage gate keepers of the community—traditional, religious, or cultural leaders/individuals—in support of family planning
 - Engage men constructively in FP and SRH
- E. Support healthy transitions from adolescence to adulthood (All Rs)**
- Work with community leaders, parents, and adults who play significant roles in the lives of youth to build support for young people’s reproductive health and rights and access to high-quality FP services
 - Prepare girls and boys for adulthood by teaching hygiene, self-esteem, rights, life skills, etc.
 - Provide age appropriate education on reproductive health and rights to young people

Individual Level

Taking to heart “the right of individuals and couples to decide freely and responsibly the number and spacing of their children,” the individual is at the heart of a voluntary, human rights-based approach to family planning. With the realization that individuals can face significant challenges to exercising their reproductive rights, the individual level of the framework considers those actions and factors—including family, educational, religious, gender, and social norms—that influence the ability of individuals in a particular community to exercise their reproductive rights, including the right to voluntary FP information and services.

Enable individuals to exercise reproductive rights

A. Increase access to information on reproductive rights, contraceptive choices (All Rs)

- Support self-help groups and other networking and information sharing vehicles to spread information and provide support for attitude and behavior changes
- Increase individuals' knowledge about human rights, reproductive rights, and respectful, high-quality treatment within health facilities on the basis of equality and nondiscrimination
- Educate about changing contraceptive needs of women as they progress through their reproductive life cycle
- Fill knowledge gaps and correct myths about family planning

B. Empower, through education and training about reproductive health, self-esteem, rights, life-skills, and interpersonal communication (R1/R2)

- Improve partner communication and negotiation skills
- Promote gender equitable attitudes and behaviors
- Improve health literacy and communication skills
- Foster support of family members and other influential people for use of family planning

C. Foster demand for high-quality services and supplies through IEC/BCC and empower individuals to demand their rights be respected, protected, and fulfilled (R2)

- Educate vulnerable individuals about the programs that have been designed to serve them, such as voucher schemes or community-based service provision
- Engage men as partners in reproductive decision making without compromising women's autonomy to make decisions related to their sexual and reproductive health

Outputs

The inputs and activities in the framework emphasize a rights-based approach to voluntary family planning programming. Using a logic model framework facilitates linking the proposed activities to corresponding rights-based outputs and outcomes. It also lends itself to taking a systems view of family planning programs. Meadows (1999) includes the “goals of the system” as one of most important leverage points for transformational change of complex systems. This framework for voluntary, human rights-based family planning operationalizes actions that will help achieve both family planning and human rights goals, which need not be in opposition. Although the final family planning outcomes to be measured for FP2020 have yet to be named, the outputs of this framework lead to outcomes that move beyond traditional measures, such as the contraceptive prevalence rate, to measure factors that indicate the availability, accessibility, and acceptability of family planning and that emphasize accountability for quality and equity in programming.

Using a human rights framework highlights the obligation of duty bearers to promote available, accessible, acceptable, and high-quality family programs (AAAQ). AAAQ in family planning should be activity outputs at the policy and service levels. Whereas these obligations fall on governments, the framework indicates their relevance to service managers and providers to ensure that their services respect and protect rights. General Comment 14 of the U.N. Committee on Economic, Social, and Cultural Rights (UNCESCR, 2000) defines the terms:

- **Availability** refers to functioning public health and healthcare facilities, goods, and services, as well as programs available in sufficient quantity within the country.
- **Accessibility** has four components: nondiscrimination, physical accessibility, economic accessibility, and information accessibility.

- **Acceptability** implies that all health facilities, goods, and services must be respectful of medical ethics and culturally appropriate (i.e., respectful of the culture of individuals, minorities, peoples, and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned).
- **Quality** emphasizes that health facilities, services, and commodities must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The AAAQ was created to clarify the content and meaning of the right to the highest attainable standard of physical and mental health. The activity outputs related to increasing AAAQ in the context of family planning can be made more specific when the framework is used for program and policy development; only a few outputs are provided in the framework as examples.

The technical quality described in the General Comment can be further supported by the decades-long history within family planning, emphasizing high quality of care (Bruce, 1990). The concept of quality of care reinforces the rights to self-determination, information, and education by underscoring the importance of informed choice and the quality of the interpersonal interaction between clients and providers. In the context of family planning, the historical and ongoing emphasis on quality of care constitutes the Q element of AAAQ; therefore, the elements of quality of care for family planning are included in the outputs section of the framework to show their unique contribution to framing outputs and related indicators. The components of family planning quality of care include

- Women make full, free, and informed decisions about FP use
- Women have access to a choice of methods
- Information given to clients is accurate, unbiased, and comprehensive
- Providers have the technical competence to provide or refer clients for a range of methods
- Provider trainings reflect commitment to respecting, protecting, and fulfilling human rights, and supervisors reinforce training by rewarding service provider performance that respects, protects, and fulfills rights
- Providers have sufficient time and communication skills for high-quality client-provider interactions
- Follow-up and continuity mechanisms are in place to support continuous contraceptive use and method switching
- An appropriate constellation of services is available to support ease of access and overall reproductive health

Quality of care reinforces and expands on concepts such as availability and quality, but it does not emphasize equity to the degree that a human rights approach to family planning requires. By including both AAAQ and quality of care, the outputs of the framework are described in such a way that both issues of equity and quality are adequately reflected.

AAAQ and quality of care provide a comprehensive base for outputs related to the supply side and aspects of the country context for family planning programs and the enabling environment for individuals to exercise their reproductive rights. Additional outputs are expected from the community- and individual-level activities. Priority outputs that are adapted to the needs, concerns, and context of the community need to be determined at a local level. Overall, a program that incorporates community- and individual-level activities will promote a stronger enabling environment for family planning by addressing community-level barriers to family planning and stimulating demand for high-quality services. Outputs that describe community participation in developing and accessing programs, promoting

accountability mechanisms, engaging in advocacy, and meeting the needs of adolescents and disseminating information can be specified at the local level.

Ultimately, the desired outcome is that rights to (1) reproductive self-determination (right to bodily integrity and security of person and the rights of couples and individuals to decide freely and responsibly the number and spacing of their children); (2) rights to sexual and reproductive health services, information, and education (including right to the highest attainable standard of health); and (3) rights to equality and nondiscrimination (right to make decisions concerning reproduction free of discrimination, coercion, and violence) are respected, protected, and fulfilled. These rights are respected, protected, and fulfilled through working at the policy, service, community, and individual levels.

Determining what to measure to assess the impact of the framework's activities is crucial to identifying successful family planning programs. Measures and indicators should gauge progress toward achieving the goal of reaching 120 million new users but also recognize and reinforce program obligations to respect, protect, and fulfill rights throughout family planning programming by explicitly evaluating the extent to which they do that. Linking voluntary, rights-based activities to measurable outputs, outcomes, and impact increases accountability for programs to achieve results in a transformational way.

Outcomes and Impacts

Family planning programs contribute to a range of positive outcomes—both for individuals and societies. Over time, these outcomes have been used as three rationales for investment in family planning: individual empowerment, improved health and well-being of mothers and children, and a country's ability to plan and manage development. These rationales have also been described as human rights, health, and demographic rationales (Seltzer, 2002).

This conceptual framework describes a vision of success for voluntary, human rights-based family planning programs that embrace both human rights and health outcomes. Leading up to the 2012 London Summit, the health rationale was first emphasized and the human rights rationale was subsequently included. Yet, when women choose and use family planning services that respect and protect rights, there are additional benefits related to overall improved health and the ability to achieve wider national sustainable development goals. The outcomes will likely also provide benefits for countries to plan and manage development. Illustrative outcomes in the framework include, for example, increased trust in FP programs, achievement of universal access to FP, increased equity in service provision and use, sustainable availability of a broad range of contraceptive methods, and increased fulfillment of the demand for family planning. Illustrative impacts include a reduction in unintended pregnancies, decreases in maternal and infant deaths, a decrease in unsafe abortion, and a decrease in adolescent fertility. In addition, impacts include an increase in women's agency to achieve their reproductive intentions throughout the life cycle and an increase in the well-being of individuals, families, communities, and countries.

VI. SUMMARY AND RECOMMENDATIONS

Summary

The commitment of political will and funding made at the 2012 London Family Planning Summit, in addition to the current review of ICPD+20 and the MDG after 2015, offer an extraordinary opportunity as well as a great challenge. Achieving the goal of reaching millions of women and men worldwide with voluntary family planning services that respect and protect human rights will take concerted and coordinated efforts among diverse stakeholders over the next decade and beyond. It will also take a new programmatic approach that has the support of both the public health and human rights communities. This paper provides, through a conceptual framework, supportive evidence and tools, a pathway to fulfilling both the FP2020 service goal and governments' commitments to the provision of family planning programs that are consistent with and fulfill human rights.

Countries throughout the world are signatories to human rights treaties and conventions that have the status of international law and uphold reproductive rights. We contend that transformational programming with human rights values and norms at their core must be central to efforts to meet FP2020 goals. We maintain that human rights and public health outcomes are complementary, not contradictory, and that combining approaches leads to a strong enabling context for family planning and for rights of women and girls. The framework provides common ground for public health professionals and human rights activists to work together to expand access to family planning through services which, at the same time, respect, protect, and fulfill human rights in the way that they are designed, implemented, and evaluated.

While some programs have applied coercive tactics to reach demographic targets, the global reproductive health and family planning community has long embraced as a founding principle the right of individuals and couples to decide freely and responsibly the number and spacing of their children and the information and means to do so. Family planning programs have also focused attention on quality of care since the publication of the groundbreaking *Fundamentals of Quality of Care* in 1990. These two founding principles, linked with additional relevant human rights principles relevant to reproductive rights, provide a solid foundation for FP2020 programming moving forward.

The framework presented in this paper merges the elements of high-quality family planning and human rights into a unified construct that answers the question, "How can we ensure public health programs oriented toward increasing voluntary family planning access and use respect, protect, and fulfill human rights in the way they are designed, implemented, and evaluated?" This framework defines what such a program looks like, taking into consideration the broad context in which programs operate as well as the essential programmatic elements at the policy, service, community, and individuals levels. The conceptual framework is presented as a logic model that links inputs/activities with outputs, outcomes, and impact. Thus, the conceptual framework can be used in all phases of the program cycle, including assessment, design, implementation, and monitoring and evaluation.

Recommendations

Current conditions offer the chance to transform family planning programs and to reach those most vulnerable and in need of these life-altering services. We urge governments and donors to (1) embrace and support voluntary, human rights-based family planning programming with the support and engagement of civil society and (2) hold programs accountable for respecting, protecting, and fulfilling human rights. This approach offers the potential to close the gap between the rhetoric and the reality of reproductive rights, expanding equitable access to, and use of, high-quality family planning services that enable women and men to exercise their rights and achieve their reproductive intentions. The conceptual

framework presented in this paper is based on experience in family planning programming and promoting human rights and has been reviewed by a range of stakeholders worldwide. The following actions are recommended to progress further toward securing and safeguarding family planning programs that respect, protect, and fulfill human rights:

- **Foster additional dialogue** at the global and country levels to facilitate discussions around the critical issues of expanding access to family planning—particularly to underserved population groups—and respecting, protecting, and fulfilling human rights.
- **Use the conceptual framework as a guide for country programming and donor assistance under FP2020.**
 - Disseminate the conceptual framework both at the country and global levels, including *providing access to the framework and associated evidence and tools in a web-based platform*, to facilitate its use.
 - Support additional review of the conceptual framework by stakeholders at national/subnational and global levels to continue the discussion on its use to guide programming and its adaptation to country contexts.
- **Further document and evaluate rights-based approaches** to fill the gaps in our knowledge about human rights-based programming and to evaluate both human rights outcomes and public health outcomes.
- **Develop guidance and tools to apply the framework** in programming to facilitate its use at the country level and through donor support.
- **Update and expand the accompanying reviews of evidence and tools** to ensure inclusion of all relevant material so that programs have access to the most relevant and up-to-date information for programming.
- **Identify a comprehensive set of indicators** to support the framework, including for all the various levels at which family planning programs function. Have the relevant FP2020 working groups identify a comprehensive set of structural, process, and outcome indicators that monitor and evaluate a rights-based approach to family planning.
- **Foster innovation in rights-based, public health approaches and additional investment in interventions** that are explicitly rights-based. Focus particularly on additional interventions to strengthen individual empowerment, community participation, and capacity building.

ANNEX 1. TREATIES, DECLARATIONS, AND CONVENTIONS ESTABLISHING REPRODUCTIVE RIGHTS

Human rights treaties are important; unlike the consensus documents emerging from international conferences, such as ICPD, they have the status of international law, and countries that sign and ratify them thereby enter into legally binding obligations to bring their national legislation into line with them. Conference outcome documents add content and meaning to these human rights but are not binding on governments in the same way.¹⁰ Treaty monitoring bodies ensure that states are accountable for discharging their obligations to respect, protect, and fulfill the rights in treaties (OHCHR, n.d./a). Relevant treaties in respect of sexual and reproductive health and rights, including those related to family planning, are highlighted in Box 1.

ICPD took place in 1994; it was one of several important UN conferences on international development that applied human rights principles to its area of specialization, following on closely after the Vienna 1993 World Conference on Human Rights—which affirmed that women’s rights are human rights and successfully called for the creation of a new mechanism, the Special Rapporteur on Violence Against Women—and occurring the year before the 1995 Beijing Fourth World Conference on Women. As Cook et al. (2003: 148) have argued, these conferences, in particular the Cairo and Beijing conferences, “led to the recognition that the protection of reproductive and sexual health is a matter of social justice and that the realization of such health can be addressed through the improved application of human rights contained in existing national constitutions and regional and international human rights treaties.”

¹⁰ For a complete list of relevant treaties, conventions, and agreements relevant to reproductive health and rights, see UNFPA, 2012.

Box 1. Treaties, Declarations, and Conventions with Particular Relevance for Reproductive Health and Rights, Including Family Planning

Treaties (have the status of international law)

- International Covenant on Economic, Social and Cultural Rights (1966)
- International Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of all Forms of Racial Discrimination (1969)
- Convention on the Elimination of all forms of Discrimination Against Women (1979)
- Convention on the Rights of the Child (1989)

Conference Documents (add content and meaning to human rights)

- Tehran Conference on Human Rights (1968)
- World Population Plan of Action (1974, 1984)
- International Conference on Population and Development Programme of Action (1994)
- Fourth World Conference on Women Beijing Declaration and Platform for Action (1995)
- United Nations World Conference on Human Rights (1993)

Declarations (no legal status, but have “undeniable moral force and provide practical guidance to States in their conduct” [UNHCRH, n.d.]

- Universal Declaration of Human Rights (1948)
- Millennium Declaration (2000) and related Millennium Development Goals (2001), which included Target 5b (universal access to reproductive health) in 2007

For a more complete list of relevant treaties, conventions, and agreements related to reproductive health and rights, see UNFPA, 2012: 4–5. Also see OHCHR, n.d./b and n.d./c, for an explanation of the legal force of these instruments.

Forging the Cairo Consensus

The connection among human rights, reproductive health, and family planning, which came together in the 1990s, and ensured that ICPD *Programme of Action* was based on a comprehensive vision of sexual and reproductive health that upheld human rights, was hard-fought. ICPD emerged from agreements among coalitions to move forward with a common agenda that promoted human rights and repudiated targets (Hodgson and Watkins, 1997). The Cairo agenda was forged among diverse constituencies (Singh, 2009), including “feminists, public health professionals, development economists, demographers, environmentalists, faith communities, donors and governments” Riechenbach and Roseman (2009: 4). Women’s health and rights advocates¹¹ played a key role in the ICPD conference preparation process. These groups were influential in shaping the discourse on population, family planning, reproductive health, and women’s rights (Petchesky and Judd, 1998; CEDPA, 1995; Hodgson and Watkins, 1997; Ashford, 2001; Eager, 2004; IWHC, n.d.).

Aware that women’s right to decide whether and when to become pregnant was crucial for women’s ability to take control of other aspects of their lives, women’s health and rights activists were highly motivated to ensure that whatever program of action emerged from the Cairo conference would also mark

¹¹ This group included a range of positions on what should be tackled in Cairo and agreed to in the Programme of Action (see Hodgson and Watkins, 1997).

a rejection of some earlier family planning program approaches that included use of targets, incentives,¹² and disincentives—some of which were clearly coercive. Commonly cited examples were the imposition of forced sterilization in some states during the Emergency Period in the mid-1970s in India (Harkavy and Roy, 2007; Connolly, 2006) and the One-child Policy adopted in China in 1979, which included legally mandated numbers of children, use of birth control, and compulsory use of abortion to meet birth quotas (Winkler, 2002; Kaufman, 2003; Gu et al., 2007).

The extent to which coercive programs represented exceptions rather than the norm for family planning programs implemented in the 1970s and 1980s has been hotly debated (Warwick, 1982; Pillsbury, 1990; Finkle and McIntosh, 1994; Chauls, 1994; Hartmann, 1995; Bongaarts and Sinding, 2009; Connelly, 2008; Hardee et al., forthcoming). While Barot (2012:7) says that “history is overflowing with examples,” Bongaarts and Sinding (2009: 39) say that “only in rare cases, most notably in China and briefly in India, has coercion been used.” The history of the family planning movement includes both health and demographic rationales (Shiffman and Quissell, 2012).

From a human rights perspective, however, one human rights violation is significant and is a violation too many—the point was to find a way for the ICPD *Programme of Action* to characterize programs in such a way that ensuring that individual rights were respected, protected, and fulfilled was hard-wired into the way that programs were designed, implemented, monitored, and evaluated. ICPD also called for integrated programming (Sen, 2010) and a focus beyond the health sector on rights and empowerment of women.

Women’s health advocates and others were reacting against programs that had been driven by demographic objectives of reducing population growth, within which women were the “objects” rather than the “subjects” of programs (Dixon-Mueller, 1993; Jacobson, 2001; Eager, 2004). These programs were put in place in the context of growing concern in the 1960s and 1970s about rising population growth, which was crystallized in “The Population Bomb,” an influential book written by Paul Ehrlich in 1968 that warned of mass starvation of humans in 1970s and 1980s and advocated immediate action to reduce population growth. However, women’s health advocates argued that such programming had the effect of creating an association of family planning with imposing restrictions on, rather than increasing women’s agency with regard to their ability to make their own decisions about whether and when to have children. They argued that an exclusive focus on family planning—if that meant ignoring other issues that were clearly significant for female and male clients (e.g., the presence of some kind of discharge that might indicate a sexually transmitted infection, or ignoring a bruise that could indicate gender-based violence)—was not in the best interests of women. Cairo “shifted population policy away from fertility regulation and toward the notion of reproductive health, predicated on the exercise of reproductive rights and women’s empowerment” (Riechenbach and Roseman, 2009: 4).

The Cairo Consensus at 20

As the twentieth anniversary of Cairo approaches, it is important to assess perceptions of the “Cairo Consensus,” how the *Programme of Action* has been implemented, and the controversies that persist. As indicated above, women’s health advocates successfully argued for a comprehensive vision of sexual and reproductive health and rights within which family planning took its place among a range of other

¹² Note that the term “incentive” is used broadly, since “incentives” can be intended to encourage or induce a desired behavior, which is a subtle form of coercion. Some payments that are intended to remove access barriers, including reimbursement for lost wages or travel expenses, are also generally referred to as incentives. Not all payments are incentives, nor coercive. The key element is to discern the extent to which the existence or promotion of measure has compromised the extent to which the decision to use a family planning method was truly free.

interventions relevant to these issues, including sex education; sexually transmitted infection prevention, diagnosis, and treatment; prenatal, postnatal, and delivery care; among other interventions, including those beyond the health sector that promoted women’s empowerment. Yet, as Yinger et al. (2008:1) has noted, “the ICPD definition is so broad that it can be interpreted in a variety of highly politicized ways.” Abortion is among the contentious issues. Abortion is legal in some countries but not others, and advocacy and service delivery programming is supported by some donors and not others, has been among the most contentious issues.

Reichenbach and Roseman (2009: 7) observe that “when understood conceptually, ICPD has had much enduring success. Yet, when viewed operationally it faces serious challenges.” Some noted that the expanded focus on reproductive health and rights was difficult to translate into programming (Gillespie, 2004). Operationalizing ICPD has also been difficult because its broad scope transcends any one government agency, nongovernmental organization, or department within a donor organization. Furthermore, guidance on programming from a rights-based perspective, as distinguished from taking a quality of care approach, which was already underway, was not immediately available after ICPD.

Following ICPD, countries worked to implement the comprehensive vision of sexual and reproductive health and rights that was articulated in the 1994 ICPD *Programme of Action* (Ashford and Makinson, 1999; Pachauri, 1999; Hardee et al., 1999; Foreman and Ghosh, 2000; Haberland and Measham, 2002), and over the years, organizations have developed many tools, training curricula, and guidelines. During this time, however, global investment in reproductive health fell (Dennis, 2012; PAI, 2011; Osotimehin, 2012). Unfortunately, donor funding did not flow to such programs during the decades following Cairo; this was partly due to competing claims for the funding of HIV/AIDS prevention, care, and treatment programs and partly due to initiatives oriented toward making the journey through pregnancy and childbirth safer, which tended not to include broader reproductive health interventions, focusing instead on the important issues of antenatal care, skilled attendance at birth, and emergency obstetric care.

Furthermore, the political context changed dramatically after ICPD. Political changes in the United States during the era of President George W. Bush, during which the Mexico City Policy was revived in a format known as the “Global Gag Rule¹³,” and other restrictive rules and regulations were adopted, further restricting funding for family planning and reproductive health (Sinding, 2005). Since the United States was the largest donor of technical and program assistance for family planning over the past several decades, reduced funding from the US contributed to decreasing attention to reproductive health. The Obama administration has rescinded some of the earlier restrictive policies, and funding from the US government has risen.

Also, sexual reproductive health and rights remained a contentious topic after Cairo—to the extent that the goal of universal access to reproductive health was absent from the original list of MDGs (Crosette, 2005). After concerted effort, Target 5b—universal access to reproductive health, including contraceptive use and meeting unmet need for family planning—was added in 2007 under Goal 5 of the MDG on maternal health (ENRECA Health, 2012).

¹³ In the United States, the Helms Amendment, in force since 1973, has ensured that no US taxpayer dollars are spent on “abortion-related activities”; a category that is not limited to carrying out abortions, and can include, for example, increasing awareness of the public health impact of unsafe abortion. In 1984, the Reagan administration instituted the “Mexico City policy,” which stipulated that US funding was only available to organizations that did not spend any of their own resources from any other source on such funding. The policy was rescinded under the Clinton administration, reinstated under the GW Bush administration, and rescinded again during the Obama administration (see <http://populationaction.org/data-and-maps/global-gag-rule-timeline/>).

Reproductive Health vs. Family Planning

There are some who believe that the emphasis on sexual and reproductive health was detrimental to family planning programs. While few people doubted the importance of addressing reproductive health, reproductive rights, and women's empowerment issues, for some people, the comprehensive but relatively complex concept of sexual and reproductive health and rights emphasis embraced by ICPD had the effect of reducing the visibility and importance of family planning (Gillespie, 2004; Cleland et al., 2006; Bongaarts and Sinding, 2009; Yinger et al., 2008; Shiffman and Quissell, 2012), and some blamed the fall in funding for family planning on this shift of emphasis, which resulted in stalled fertility transitions (Bongaarts, 2006) in the face of persistent unmet need (Singh et al., 2012).

Jacobson (2001; 62) counters that "this group...often dismisses the call for comprehensive, integrated services as grossly unrealistic, arguing that a public health approach 'cannot do everything' and demands choosing strategic, cost-effective actions in the interest of increasing general health." More recently, Reichenbach and Roseman (2009: 15) noted that, "Some policy notables who previously embraced ICPD and reproductive health have called for a return to the good old days of family planning when success meant ensuring that couples had their contraceptive needs met" and that some year "to reduce provision of reproductive health services to the provision of family planning" (p. 11). Suzanne Ehlers, president of Population Action International, made a plea before the London FP Summit to end this unproductive sniping, saying:

"the age-old advocacy divide risks playing out here: the Summit promises a ton of new money for family planning, but places less focus on the over-arching agenda of sexual and reproductive health and rights. But is it all or nothing? Family planning contributes to the well-being of women, and helps fulfill the promise of planetary sustainability and economic growth. Not too shabby" (Ehlers, 2012).

Resolution of this controversy will be difficult; for advocates of the Cairo-endorsed, comprehensive vision of sexual and reproductive health and rights, it is self-evident that family planning is a critically important element of that vision, while some advocates for family planning believe that the expanded vision has resulted in a loss of focus. A healthy tension will certainly exist between those who have a public health perspective and those with a human rights perspective. Advocates of both welcome the resurgence of interest in family planning, with the former group urging an emphasis on voluntarism within programming that family planning advocates implicitly agree with; the challenge is to make that explicit in the way that programs are designed, implemented, and evaluated.

REFERENCES

- Advance Family Planning (AFP). (n.d.). *Advance Family Planning*. <http://www.advancefamilyplanning.org/toolkits/advancefp/about-4>. Accessed December 27, 2013.
- Ashford, L.S. (2001). New Population Policies: Advancing Women's Health and Rights. *Population Bulletin* 56(1). Washington, DC: Population Reference Bureau.
- Ashford, L.S., and Makinson, C. (1999). *Reproductive Health in Policy and Practice. Case Studies from Brazil, India, Morocco and Uganda*. Washington, DC: Population Reference Bureau.
- Barot, S. (2012). Governmental Coercion in Reproductive Decision Making: See It Both Ways. *Guttmacher Policy Review* 15(4): 6.
- Bertrand, J.T., Hardee, K., Magnani R.J., and Angle, M.A. (1995). Access, quality of care and medical barriers in family planning programs. *International Family Planning Perspectives* 1(2): 64–9, 74.
- Bill & Melinda Gates Foundation and UK Department for International Development (DFID). (2012). *Landmark Summit Puts Women at Heart of Global Health Agenda*. Press Release. <http://www.londonfamilyplanningssummit.co.uk/1530%20FINAL%20press%20release.pdf>. Accessed October 3, 2012.
- Boender, C., Santana, D., Santillán, D., Hardee, K., Green, ME., and Schuler, S. (2004). *The So What Report. A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes*. Washington, DC: Interagency Gender Working Group. http://www.prb.org/igwg_media/thesowhatreport.pdf. Accessed on February 17, 2013.
- Bongaarts, J. (2006). The Causes of Stalling Fertility Transitions. *Studies in Family Planning* 37(1): 1–16.
- Bongaarts, J., and Sinding, S. (2009). “A Response to Critics of Family Planning.” *International Perspectives on Sexual and Reproductive Health* 35(1): 39–44.
- Bruce, J. (1990). The Fundamental Elements of Quality of Care: A Simple Framework. *Studies in Family Planning* 21: 61–91.
- Buse, K., Lalji, N., Mayhew, S.H., Imran, M., and Hawkes, S.J. (2010). Political Feasibility of Scaling-up Five Evidence-informed HIV Intervention in Pakistan: A Policy Analysis. *Sexually Transmitted Infections* 85(Suppl II): ii37–ii42.
- CEDPA. (1995). *Cairo, Beijing and Beyond. A Handbook on Advocacy for Women Leaders*. Washington, DC: CEDPA.
- Chauls, D. (1994). Is the Indonesian Family Planning Program Coercive? Paper presented at the National Council for International Health, Washington, DC, June.
- Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., and Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*. 368(9549): 1810–1827.
- Cook, R.J., Dickens, B.M. and Fathalla, M.F. (2003). *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*. Oxford: Oxford University Press.

- Connelly, M. (2006). Population control in India: prologue to the emergency period. *Population and Development Review* 32(4): 629–667.
- Connelly, M. (2008). *Fatal Misconceptions*. Boston: Harvard University Press.
- Cottingham, J., Germain, A., and Hunt, P. (2012). Use of human rights to meet the unmet need for family planning. *The Lancet* 380(9837): 172–180.
- Cottingham, J., Kismodi, E., Hilber, A. M., Lincetto, O., Stahlhofer, M., and Gruskin, S. (2010). Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bulletin of the World Health Organization* 88(7): 551–555.
- Crossette, B. (2005). Reproductive Health and the Millennium Development Goals: The Missing Link. *Studies in Family Planning* 36(1): 71–79.
- Dennis, S. (2012). More Funding Needed for International Reproductive Health. *Policy and Issue Brief*. Washington, DC: Population Action International.
- Department for International Development (DFID). (2004). *Sexual and Reproductive Health and Rights. A Position Paper*. London: DFID.
- Department for International Development (DFID). (2005). *How to Reduce Maternal Deaths: Rights and Responsibilities*. London: DFID, Policy Division.
- Department for International Development (DFID). (2010). *Choices for women - planned pregnancies, safe births and healthy newborns: The Framework for Results for Improving Reproductive, Maternal and Newborn Health in the Developing World*. London: DFID.
- Department for International Development (DFID). (n.d.). *Reproductive, Maternal and Child Health*. <http://www.dfid.gov.uk/rmh>. Accessed January 10, 2013.
- Dixon-Mueller, R. (1993). *Population Policy and Women's Rights*. Boulder, CO: Praeger.
- Donaldson, PJ. (1990). *Nature Against Us. The United States and the World Population Crisis, 1965–1980*. Chapel Hill, NC: University of North Carolina Press.
- Eager, PW. (2004). *Global Population Policy: From Population Control to Reproductive Rights*. Wilmington, DE: University of Delaware Press.
- Ehlers, S. (2012). *Perspective on the London Family Planning Summit: Seeing the Forrest and Trees*. Blog Post, RH Reality Check. <http://www.rhrealitycheck.org/article/2012/07/10/forest-and-trees>. Accessed December 29, 2012.
- EngenderHealth. (2003). *COPE Handbook: A Process for Improving Quality in Health Services*. Revised Edition. New York: EngenderHealth.
- EngenderHealth. (2011). *SEED™ Assessment Guide for Family Planning Programming*. New York: EngenderHealth.

EngenderHealth/RESPOND Project. (2013). *A Fine Balance: Contraceptive Choice in the 21st Century*. Report from a USAID-funded RESPOND Project consultation held in Bellagio, Italy, September, 2012. New York: EngenderHealth, RESPOND Project.

ENRECA Health. (2012). Sexual Reproductive Health and Rights. In Defense of Life. A Background Document. Danish Research Network for International Health.
http://www.enrecahealth.dk/rhwg/upcoming_boks/Background_Doc_SRHR_2012.pdf/. Accessed December 29, 2012.

Erdman, J. N., and Cook, R. J. (2008). *Reproductive Rights*. *International Encyclopedia of Public Health*. Editor-in-Chief: Kris. Oxford, Academic Press: 532–538.

Finkle, J., and McIntosh, C.A. (1994). The New Politics of Population. Conflicts and Consensus in Family Planning. *Population and Development Review* 20(suppl).

Ford Foundation. (n.d.). *Sexuality and Reproductive Health and Rights*
<http://www.fordfoundation.org/issues/sexuality-and-reproductive-health-and-rights>. Accessed January 10, 2013.

Foreit, K., Barden-O’Fallon, J., Dietrich, J., Seck, C., and Sharma, S. (2011). Achieving Equity in Planning: Getting Beyond the Rhetoric. Presentation in Session 1.2.11 at the International Family Planning Conference: Dakar.

Foreman, S., and Ghosh, R. (2000). *Promoting Reproductive Health: Investing in Health for Development*. Boulder, CO: Lynne Rienner Publishers.

Gay, J., Croce-Galis, M., and Hardee, K. (2012). *What Works for Women and Girls: Evidence for HIV/AIDS Interventions*. 2nd edition. Washington DC: Futures Group, Health Policy Project.
www.whatworksforwomen.org.

Gillespie, D.G. (2004). Whatever Happened to Family Planning And, for That Matter, Reproductive Health. *International Family Planning Perspectives* 30(1): 34–38.

Girard, F. (2012). *Will the London Family Planning Initiative Measure Up?* Blog post. RH Reality Check. July 23. <http://www.rhrealitycheck.org/article/2012/07/20/will-london-family-planning-initiative-measure-up>. Accessed December 9, 2012.

Gruskin, S., and Loff, B. (2002). Do human rights have a role in public health work. *The Lancet* 360(9348): 1880.

Gruskin, S., Mills, E.J., and Tarantola, D. (2007). “History, principles, and practice of health and human rights.” *The Lancet* 370(9585): 449–455.

Gu, BC., Feng, W., Guo, ZG, and Zhang E. (2007). China’s local and national fertility policies at the end of the twentieth century. *Population and Development Review* 339(1): 129–147.

Gwatkin, D., Rutstein, S., Johnson, K., Suliman, E., Wagstaff, A., and Amouzou, A. (2007). *Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries: An Overview*. Country Reports on HNP and Poverty. Washington, D.C., World Bank.

Haberland, N., and Measham, D. Eds. (2002). *Responding to Cairo. Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York: Population Council.

Hardee, K., Agarwal, K., Luke, N., Wilson, E., Pendzich, M., Farrell, M., and Cross, H. (1999). Reproductive health policies and programs in eight countries: progress since Cairo. *International Family Planning Perspectives*, 25(Suppl): S2–9.

Hardee, K. (2005). *The Intersection of Gender, Access, and Quality of Care in Reproductive Services: Examples from Kenya, India, and Guatemala*. Washington, DC: Interagency Gender Working Group. http://www.prb.org/igwg_media/IntersectionOfGender.pdf. Accessed February 17, 2013.

Hardee, K., Rodriguez, M., and Harris, S. Forthcoming. “Achieving the London FP Summit Goal through Adhering to Voluntary, Rights-based Family Planning: What Can We Learn from Past Experiences with Coercion?”

Harkavy, O., and Roy, K. (2007). “Emergence of the India National Family Planning Program.” In Robinson, W. and J. Ross. Eds. 2007. *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*. Washington, DC: World Bank.

Hodgson, Dennis, and Watkins, Susan Cotts. (1997). Feminists and Neo-Malthusians: Past and Present Alliances. *Population and Development Review* 23(3): 469–523.

HRBA Portal. (n.d.). The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies. <http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies>. Accessed March 27, 2013.

Huezo, C., and S. Diaz. (1993). Quality of Care in Family Planning: Clients’ Rights and Providers’ Needs. *Advances in Contraception* 9(2): 129–139.

International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. (1999). “Public Health—Human Rights Dialogue.” Chapter 5 in Mann, J., S. Gruskin, MA. Grodin and GJ. Annas, Eds. 1999. *Health and Human Rights*, New York: Routledge.

International Planned Parenthood Federation (IPPF). (1996). *IPPF Charter on Sexual and Reproductive Rights*. London: IPPF.

International Women’s Health Coalition (IWHC). (n.d.). *The Women’s Coalition for ICPD*. http://www.iwhc.org/index.php?option=com_content&task=view&id=3366&Itemid=548.

Jacobson, J. (2001). Transforming Family Planning Programs: Towards a Framework for Advancing the Reproductive Rights Agenda. In PATH. 2001. *Reproductive Health, Gender and Human Rights: A Dialogue*. Washington, DC: PATH, pp. 53–65.

Jacobson, J. L. (2000). Transforming family planning programmes: towards a framework for advancing the reproductive rights agenda. *Reprod Health Matters* 8(15): 21–32.

Jain, A.K. (1989). Fertility Reduction and the Quality of Family Planning Services. *Studies in Family Planning*. 20(1): 1–16.

- Jain, A.K, RamoRao, S., Kim, J., and Costello, M. (2012). Evaluation of an intervention to improve quality of care in family planning programme in the Philippines. *Journal of Biosocial Science*. 44: 27–41.
- Katz, K., Hardee, K., and Villinski, M. (1993). *Quality of Care in Family Planning. A Catalog of Assessment and Improvement Tools*. Research Triangle Park, NC: Family Health International.
- Kaufman, J. (2003). The Myths and Realities of China’s Population Program. *Harvard Asia Quarterly*. Winter.
- Khosla, R. (2012). *Looking for Human Rights at the Family Planning Summit*. Blog post. *Livewire*. July 11. <http://livewire.amnesty.org/2012/07/11/looking-for-human-rights-at-family-planning-summit/>. Accessed December 9, 2012.
- Kingdon, J.W. (1984). *Agendas, Alternatives, and Public Policies*. Boston, MA: Longman.
- Kols, A.J., and Sherman, J.E. (1998). Family planning programs: improving quality. *Population Reports*. Series J, No. 47. Baltimore: Johns Hopkins School of Public Health, Population Information Program. November.
- Krishnan, S. (2012). *Highs and Lows at The London Family Planning Summit*. Blog post on ASAP. July 12. <http://asap-asia.org/blog/highs-and-lows-at-the-london-family-planning-summit/>. Accessed December 9, 2012.
- Kumar, J., Bakamjian, L., and Connor, H. (2013). *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Tools*. Washington, DC: Futures Group and EngenderHealth.
- London Summit on Family Planning. (2012). *London Summit on Family Planning, July 11, 2012*. June 14 version. <http://www.londonfamilyplanningsummit.co.uk/>. Accessed July 17, 2013.
- Lynam, P., McNeil Rabinovitz, L., and Shobowale, M. (1993). Using self-assessment to improve the quality of family planning clinic services. *Studies in Family Planning* 24(4): 252–260.
- Mann, J., Gruskin, S., Grodin, M.A., and Annas, G.J. (1999). *Health and Human Rights*. New York: Routledge.
- Meadows, Donella H. (1999). *Leverage Points: Places to Intervene in a System*. The Sustainability Institute. Vermont
- MEASURE Evaluation. (2001). Quick Investigation of Quality (QIQ). A User’s Guide for Monitoring Quality of Care in Family Planning. MEASURE *Evaluation* Manual Series, No. 2. Chapel Hill, NC: MEASURE Evaluation and the Monitoring and Evaluation Subcommittee of the Maximizing Access and Quality (MAQ) Initiative.
- Miller, R, Fisher, A, Miller, K. Ndhlovu, L, Maggwa, BN, Askew I, Sonogo, D., and Tapsoba, P. (1997). *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*. New York: Population Council.
- Office of the High Commissioner for Human Rights (OHCHR). (2006). *Frequently Asked Questions on a Human Rights-based Approach to Development Cooperation*. New York and Geneva: OHCHR.

Office of the High Commissioner for Human Rights (OHCHR). (n.d./a). Enhancing the human rights treaty body system. Harmonized guidelines on reporting to the treaty bodies. <http://www2.ohchr.org/english/bodies/treaty/CCD.htm>. Accessed December 29, 2012.

Office of the High Commissioner for Human Rights (OHCHR). (n.d./b). *International Law*. <http://www2.ohchr.org/english/law/>. Accessed February 17, 2013.

Office of the High Commissioner for Human Rights (OHCHR). (n.d./c). *Human Rights Bodies*. <http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx>. Accessed January 6, 2013.

Ortayli, N., and Malarcher, S. (2010). Equity analysis: identifying who benefits from family planning programs. *Studies in Family Planning* 41(2): 101–108.

Osoimehin, B. (2012). Family Planning Saves Lives Yet Investments Falter. *The Lancet*. Published online July 10, 2012. [http://dx.doi.org/10.1016/S0140-6736\(12\)60906-4](http://dx.doi.org/10.1016/S0140-6736(12)60906-4).

Pachauri, S. Ed. (1999). *Implementing a Reproductive Health Agenda in India: The Beginning*. New Delhi: Population Council.

PATH. (2001). *Reproductive Health, Gender and Human Rights: A Dialogue*. Washington, DC: PATH.

PATH. (2012). *Enhancing Equity and Sustainability of Public-Sector Family Planning*. Seattle: PATH. http://www.path.org/publications/files/RH_enh_equity_sustain_fp_fs.pdf. Accessed February 17, 2013.

Petchesky, R., and Judd, K. (1998). *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. New York: Zed Books.

Pillsbury, B. (1990). The Politics of Family Planning: Sterilization and Human Rights in Bangladesh. In Handwerker, WP. Ed. 1990. *Births and Power. Social Change and the Politics of Reproduction*. Boulder, CO: Westview Press, pp. 165–196.

Population Action International (PAI). (2011). *Trends in US Population Assistance*. <http://populationaction.org/articles/trends-in-us-population-assistance/>.

Pulerwitz, J., Barker, G., Segundo, M., and Nascimento, M. (2006). Promoting More Gender-equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy. Washington, DC: Horizons Program, Population Council.

Rama Rao, S., and R. Mohanam. (2003). The quality of family planning programs: concepts, measurements, interventions, and effects. *Studies in family planning* 34(4): 227–248.

Ravenholt, R. T. (1968). The A.I.D. population and family planning program—goals, scope, and progress. *Demography* 5(2): 561–573.

Reichenbach, L., and Roseman, M.J. (2009). *Reproductive Health and Human Rights: The Way Forward*. Philadelphia: University of Pennsylvania Press.

Richey, C., and Salem, M. (2008). Elements of Success in Family Planning Programming. Population Reports. I. Project. Baltimore, Johns Hopkins Bloomberg School of Public Health. Series J, No. 57.

- Rifkin, S. (2003). A framework linking community empowerment and health equity: it is a matter of CHOICE. *Journal of Health Population and Nutrition* 21(3): 168–180.
- Rottach, E., Schuler, S.R., and Hardee, K. (2009). *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. Washington, DC: Interagency Gender Working Group.
- Robinson, W., and Ross, J. Eds. (2007). *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*. Washington, DC: World Bank.
- Rodriguez, M., Harris, S., Willson, K., and Hardee, K. (2013). *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Evidence*. Washington, DC: Futures Group.
- Ross, J., and Hardee, K. (2012). Access to Contraceptive Methods and Prevalence of Use. *Journal of Biosocial Science*. Published online. doi:10.1017/S0021932012000715.
- Ross, J., and Stover, J. (2010). *Developing a Family Planning Goal for 2015 that Supports MDG-5b*. Washington, DC: USAID | Health Policy Initiative, Task Order 1, Futures Group.
- Saunders, M., Sethi, H., Jayachandran, A.A., and Sharma, S. (2010). *A Policy Response to Increase Access to Family Planning Services for the Poor in Jharkhand, India*. Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.
- SEATS. (2000). *Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery. Context & Case Studies*. Arlington, VA: John Snow, Inc. SEATS II Project.
- Seltzer, J., and Gomez, F. (1998). *Family Planning and Population Programs in Colombia 1965 to 1997, Population Technical Assistance Project [POPTECH]*. [2], xxii, 93, [40] p.: 40p.
- Seltzer, JR. (2002). The Origins and Evolution of Family Planning Programs in Developing Countries. *Population Matters*. Santa Monica, CA: RAND.
- Sen, G. (2010). Integrating family planning with sexual and reproductive health and rights: the past as prologue? *Studies in Family Planning* 41(2): 143–146.
- Shelton, J. (2001). “Women’s Reproductive Health: The Public Health Perspective.” In PATH. 2001. *Reproductive Health, Gender and Human Rights: A Dialogue*. Washington, DC: PATH.
- Shiffman, J., and Quissell, K. (2012). Family planning: a political issue. *The Lancet* 380(9837): 181–185.
- Simmons, R., Brown, J., and Diaz, M. (2002). Facilitating large-scale transitions to quality of care: an idea whose time has come. *Studies in Family Planning* 33(1): 61–75.
- Sinding, S. (2005). Why is funding for population activities declining? *Asia-Pacific Population Journal* 20(2): 3–9.
- Sinding, S. (2007). “Overview and Perspective.” Chapter 1 in Robinson, W. and J. Ross, Eds. *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*. Washington, DC: World Bank.

Singh, S., Darroch, J., Ashford, L., and Vlassoff, M. (2012). *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York: Guttmacher and UNFPA.

Singh, J.S. (2009). *Creating a New Consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women's Empowerment*. London: Earthscan.

United Nations (UN). (1966). *International Covenant on Economic, Social and Cultural Rights*. New York: United Nations.

United Nations (UN). (1968). *Final Act of the International Conference on Human Rights*. Teheran. 22 April—13 May 1968. New York: United Nations.

United Nations (UN). (1974). *World Population Conference. World Population Plan of Action*. 1974. Bucharest. New York: United Nations.

United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). (2000). *International Covenant on Economic, Social and Cultural Rights. Article 12, General Comment No. 14*. 2000. “The Right to the highest attainable standard of health.”
[http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En). Accessed March 23, 2013.

United Nations Population Fund (UNFPA). (1994). *Programme of Action of the International Conference on Population and Development*. New York: UNFPA.

United Nations Population Fund (UNFPA). (2008). *Sexual and Reproductive Health Framework a Reality for All*. New York: UNFPA.

United Nations Population Fund (UNFPA). (2010). *A Human Rights-based Approach to Programming/Practical Implementation Manual and Training Materials*. New York: UNFPA and Boston: Harvard School of Public Health.
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/hrba/hrba_manual_in%20full.pdf. Accessed December 29, 2012.

United Nations Population Fund (UNFPA). (2012). *By Choice, Not by Chance. State of World Population 2012*. New York: UNFPA.

UNHCR. (n.d.). *UNHCR Note on Refugee Claims Based on Coercive Family Planning Laws or Policies*. Geneva: UNHCR. <http://www.unhcr.org/refworld/pdfid/4301a9184.pdf>. Accessed on March 27, 2013.

United States Agency for International Development (USAID). (n.d./a). *Repositioning Family Planning*. http://transition.usaid.gov/our_work/global_health/pop/techareas/repositioning/index.html. Accessed December 27, 2012.

United States Agency for International Development (USAID). (n.d./b). *USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements*. http://transition.usaid.gov/our_work/global_health/pop/voluntarism.html. Accessed November 12, 2012.

United States Agency for International Development (USAID). (1982). *USAID Policy Paper on Population Assistance*. Washington, DC, USAID.

- United States Agency for International Development (USAID) | Health Policy Initiative. (2009). *Achieving EQUITY for the Poor in Kenya: Understanding the Level of Inequalities and Barriers to Family Planning Services*. Washington, DC: Futures Group.
http://www.healthpolicyinitiative.com/Publications/Documents/1247_1_Achieving_Equity_for_Poor_in_Kenya_brief_FINAL_acc.pdf. Accessed February 17, 2013.
- United States Congress. (1968). *Foreign Assistance Act of 1967, Title X*, Jan. 2, 1968. Washington, DC: US Congress.
- Verma, R., Pulerwitz, J., Mahendra, V., Khandkar, S., Singh, A., Das, S., Mehra, S., Nura, A., and Barker, G. (2008). *Promoting Gender Equality as a Strategy to Reduce HIV Risk and Gender-based Violence Among Young Men in India*. Horizons Final Report. Washington, DC: Population Council.
- Wallerstein, N. (1993). Empowerment and health: the theory and practice of community change. *Community Dev Journal* 28: 218–27.
- Walt, G., Shiffman, J., Schneider, H., Murray, SF., Brugha, R., and Gilson, L. (2008). Doing Health Policy Analysis: Methodological and Conceptual Reflections and Challenges. *Health Policy and Planning* 23(5): 308–317.
- Warwick, D. (1982). *Bitter Pills. Population Policies and Their Implementation in Eight Developing Countries*. Cambridge, UK: Cambridge University Press.
- Winkler, EA. (2002). Chinese reproductive policy at the turn of the millennium: dynamic stability. *Population and Development Review* 28(3): 379–418.
- Whaley, F. (2013). Catholics Mobilize to Defeat Philippine Politicians Who Backed Reproductive Law. http://www.nytimes.com/2013/01/30/world/asia/catholics-mobilize-after-setback-over-reproductive-law.html?_r=0. Accessed February 1, 2013.
- World Health Organization (WHO). (1994). *Contraceptive Introduction Reconsidered: A Review and Conceptual Framework*. Geneva: WHO, UNDP/UNFPA/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. WHO/HRP/ITT/94.1.
- World Health Organization (WHO/RHR). (2001). *Transforming Health Systems: Gender and Rights in Reproductive Health*. Geneva: WHO. WHO/RHR/01.29
- World Health Organization (WHO). (n.d.). *Social Determinants of Health*. http://www.who.int/social_determinants/en/. Accessed December 29, 2012.
- World Health Organization (WHO/RHR). (n.d.). *Sexual and Reproductive Health*. http://www.who.int/reproductivehealth/about_us/en/. Accessed January 10, 2013
- Yamin, A. E. (2004). Promising but elusive engagements: combining human rights and public health to promote women’s well-being. *Health and Human Rights* 8(1): 62–92.
- Yinger, N., Bradford, C., Sines, E., and Mbacke, C. (2008). An Essay on Adding Rights to the Measurement of Reproductive Health. Presented at a special meeting at the Population Association of America, New Orleans, April.
- Zackus, D., and Lysack, C. (1998). Revisiting community participation. *Health Policy Planning* 13(1):1–1.

GLOSSARY OF TERMS

Accountability:¹⁴ a distinctive, complex, and central feature of human rights. Accountability covers national and global levels and comprises three interconnected processes—monitor, review, and act—aimed at learning and continuous improvement. It links accountability for resources to results (i.e., the outputs, outcomes, and impacts they produce).

Coercion:¹⁵ contains elements of undue influence and duress and occurs when an individual is compelled to an act contrary to their will. It can be direct (e.g., physical force) or indirect (e.g., where a person is legally subjugated to another). For family planning, coercion has generally been considered to mean that individuals are compelled to use contraception or to have an abortion (although, according to the 1994 ICPD *Programme of Action*, abortion is not to be considered a method of contraception). A broader view of coercion suggests that individuals who lack access to safe and effective methods of contraception could be considered to be coerced into having more children than they might desire, thus violating their human right to have the number and spacing of children they desire and the information and means to do so.

Contraceptive choice:¹⁶ the fundamental right and ability of individuals to choose and access the contraceptive method that meets their needs and preferences.

Disadvantaged/vulnerable/marginalized groups:¹⁷ these terms are applied to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society. Examples might include unemployed people, refugees, and others who are socially excluded.

Discrimination:¹⁸ “any distinction, exclusion, or restriction made on the basis of sex, which has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field.”

Equality:¹⁹ “everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political, or other opinion, national, or social origin, property, birth, or other status.”

Equity (in health):²⁰ the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige.

¹⁴ Commission on Information and Accountability, Global Strategy. (2011). Final Report.

¹⁵ <http://legal-dictionary.thefreedictionary.com/coercion>, accessed on April 16, 2013;

<http://www.unhcr.org/refworld/pdfid/4301a9184.pdf>, accessed on April 16, 2013; and EngenderHealth/RESPOND Project. 2013. *A Fine Balance: Contraceptive Choice in the 21st Century*. Report from a USAID-funded RESPOND Project consultation held in Bellagio, Italy, September, 2012. New York: EngenderHealth, RESPOND Project.

¹⁶ EngenderHealth/RESPOND Project. (2013). *A Fine Balance: Contraceptive Choice in the 21st Century*. Report from a USAID-funded RESPOND Project consultation held in Bellagio, Italy, September, 2012. New York: EngenderHealth, RESPOND Project.

¹⁷ WHO. Health Impact Assessment, Glossary of Terms. Available at <http://www.who.int/hia/about/glos/en/index.html>.

¹⁸ United Nations, Department of Social and Economic Affairs, Division for the Advancement of Women. (n.d.). *Convention Eliminating All Forms of Discrimination Against Women*. Accessed on March 23, 2013, at <http://www.un.org/womenwatch/daw/cedaw/>.

¹⁹ United Nations. (1948). *Universal Declaration on Human Rights*. Accessed on March 23, 2013, at <http://www.un.org/en/documents/udhr/>.

Family planning client: an individual who freely seeks family planning services or counseling but does not necessarily become a user of a family planning method.

Family planning user: an individual who freely decides to obtain and use a family planning method.

Family planning program:²¹ is an entity (could be government, public/private, or NGO) providing contraceptive and reproductive health commodities or services for clients. It is a component of health services provision.

Gender equality:²² the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

Health system:²³ consists of all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. The WHO identifies “six essential building blocks,” which together make up a health system:

- *Health services.* “Good health services are those that deliver effective, safe, high-quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.”
- *Health workforce.* “A well-performing health workforce is one which works in ways that are responsive, fair, and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e., there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive, and productive).”
- *Health information system.* “A well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health systems performance, and health status.”
- *Medical products, vaccines and technologies.* “A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.”
- *Health financing.* “A good health financing system raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.”
- *Leadership, governance, stewardship.* This “involves ensuring strategic policy frameworks exist and are combined with effective oversight coalition building, the provision of appropriate regulations and incentives, attention to system design, and accountability.”

Human rights-based family planning: See Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Rights.

Informed choice:²⁴ is the process and outcome of an individual’s well-considered, voluntary decision (no coercion and no barriers) based on information, understanding, and options.

²⁰ Braveman, P., and S. Gruskin. (2002). “Defining equity in health.” *Journal of Epidemiology and Community Health*, 57(4).

²¹ Draft WHO Indicators Group document (unpublished).

²² Population Reference Bureau. “Glossary of Terms.” Available at <http://www.prb.org/Educators/Resources/Glossary.aspx>.

²³ WHO. (2007). WHO’s Framework for Action: Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes. Geneva: WHO. Page 3.

Policy:²⁵ Health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. Policy is also a dynamic process of problem identification, policy development, policy implementation, and policy monitoring and evaluation that involves many stakeholders.

Participation:²⁶ is the right of individuals and groups to participate in decision-making processes that may affect their development—seen as an integral component of any policy, program, or strategy developed.

Reproductive rights:²⁷ “the composite of human rights that protect against the causes of ill health and promote sexual and reproductive well-being.” Three components of reproductive rights include

1. Reproductive self-determination
2. Access to sexual and reproductive health services, commodities, information, and education
3. Equality and nondiscrimination

Rights-based approach:²⁸ aims to support better and more sustainable development outcomes by analyzing and addressing inequalities, discriminatory practices (de jure and de facto), and unjust power relations.

Right to health:²⁹ the ability to enjoy a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health. Essential elements of the right to health include

- *Availability.* Functioning public health and healthcare facilities, goods, and services, as well as programs, have to be available in sufficient quantity within the State party.
- *Accessibility.* Health facilities, goods, and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: nondiscrimination, physical accessibility, economic accessibility, and economic accessibility (affordability).
- *Acceptability.* All health facilities, goods, and services must be respectful of medical ethics and culturally appropriate (i.e., respectful of the culture of individuals, minorities, peoples, and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned).
- *Quality.* As well as being culturally acceptable, health facilities, goods, and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled

²⁴ EngenderHealth/RESPOND Project. (2013). *A Fine Balance: Contraceptive Choice in the 21st Century*. Report from a USAID-funded RESPOND Project consultation held in Bellagio, Italy, September, 2012. New York: EngenderHealth, RESPOND Project.

²⁵ WHO. (n.d.). Health Policy. http://www.who.int/topics/health_policy/en/. Accessed on April 16, 2013; and Hardee, K., L. Irani, MacInnis, R., and Hamilton, M. (2012). *Linking Health Policy with Health Systems and Health Outcomes: A Conceptual Framework*. Washington, DC: Futures Group, Health Policy Project.

²⁶ Gruskin, S., Bogecho, D., and Ferguson, L. (2010). “Rights-based approaches’ to health policies and programs: articulations, ambiguities, and assessment. *J Public Health Policy* 31(2): 129–45.

²⁷ Erdman, J. N., and Cook, R. J. (2008). *Reproductive Rights. International Encyclopedia of Public Health*. Editor-in-Chief: Kris. Oxford, Academic Press: 532–538. P. 532.

²⁸ “A Human Rights-Based Approach to Health.” Accessible at: http://www.who.int/hhr/news/hrba_to_health2.pdf.

²⁹ United Nations, Committee on Economic, Social and Cultural Rights (UNCESCR). (2000). International Covenant on Economic, Social and Cultural Rights. Article 12, General Comment No. 14. 2000. “The Right to the highest attainable standard of health.” [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En). Accessed March 23, 2013.

medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

State obligations (human rights obligations):³⁰

- *Respect*. Not to interfere directly or indirectly with the enjoyment of the right to health (e.g., refrain from limiting access to healthcare services or marketing unsafe drugs).
- *Protect*. Prevent third parties from interfering with the right to health (e.g., ensure that private companies provide safe environmental conditions for their employees and surrounding communities).
- *Fulfill*. Adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures to fully realize the right to health.

Stigma:³¹ is being devalued by individuals or communities on the basis of real or perceived health status, socioeconomic class, marital status, sex, disability, age, caste, ethnicity, or sexual orientation.

Voluntarism in family planning:³²

- People have the opportunity to choose voluntarily whether to use family planning or a specific family planning method.
- Individuals have access to information on a wide variety of family planning choices, including the benefits and health risks of particular methods.
- Clients are offered, either directly or through referral, a broad range of methods and services.
- The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client.

³⁰ WHO. Department of Ethics, Equity, Trade and Human Rights (ETH) Information, Evidence and Research (IER) and OHCHR, Human Rights and Economic and Social Issues Section & Millennium Development Goals Section. (n.d.). "A Human Rights-Based Approach to Health." Accessed on March 23, 2013, at http://www.who.int/hhr/news/hrba_to_health2.pdf.

³¹ Gruskin, S., and Ferguson, L. (2009). "Using indicators to determine the contribution of human rights to public health efforts." *Bull World Health Organ* 87(9): 714–9.

³² USAID. (2009). "USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements Voluntarism and Informed Choice." Available at http://transition.usaid.gov/our_work/global_health/pop/voluntarism.html.

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