Introduction to the programme assessment and planning package (stakeholder workshop)

The third component of the Human Rights-Based Approach to Family Planning: UNFPA Support Tool is a comprehensive package of materials for conducting a programme assessment and planning workshop. The workshop consists of three modules with a total of 14 sessions. Some sessions require handouts or slides. The workshop package also includes: *Slide presentation on HRBA to FP*; *Slide presentation on HRBA to FP and gender-transformative approaches* (Sessions 8 and 9); and *Model Concept Note and Preparation Checklist for UNFPA Country Offices*

	Session	Title	Handout
MODULE 1	1	Opening and introduction	Agenda (Annex 1)
	2	Human rights and sexual and reproductive health, including family planning	Matching Game and Answer Key
	3	The human rights-based approach to family planning (HRBA to FP)	Power Walk Character Cards and Facilitator Guide FP Vulnerabilities Grid Exercise
	4	Factors that support and factors that challenge human rights in family planning	Case Studies and Facilitator Guide
	5	Report-back and discussion	–
	6	What does an ideal HRBA to FP look like?	Brief: The Holistic Framework for Human Rights-Based Family Planning
MODULE 2	7	Assess your family planning programme through a human rights lens, identifying strengths, weaknesses and gaps relative to the ideal	Brief: The Holistic Framework Worksheet #1: Assessment Questionnaire
	8	Prioritize weaknesses and gaps, identify underlying challenges that are critical and feasible to address, and recommend actions	Brief: The Holistic Framework Worksheet #2: Prioritizing Challenges and Identifying Actions
	9	Set plan parameters	–
	10	Monitoring, evaluation and accountability of human rights in voluntary family planning programmes	–
MODULE 3	11	Formulate an action plan – Part 1	Worksheet #3: Developing an Action Plan
	12	Formulate an action plan – Part 2	–
	13	Action plan review and refinement	–
	14	A look ahead to implementation of action plan	Resources List

Matching Game: Stakeholder workshop for human rights-based family planning

Instructions: For each programme issue (left column), identify one or more human rights principle(s) that is affected. Note it in the right column.

Human rights principles

1. Availability
2. Accessibility
3. Acceptability
4. Quality
5. Privacy and confidentiality
6. Agency/autonomy/ empowerment
7. Accountability
8. Informed decision-making
9. Non-discrimination and equity
10. Participation

Programme issue	Principle number(s)
Example: National policy requires spousal consent for female sterilization and parental consent for minors who wish to obtain family planning information and services.	5, 6, 8
In a programme with results-based financing, providers are offered per case payments for each client who accepts an implant or an IUD, but not for pills or injectable contraceptive methods.	
Service delivery points are concentrated in urban areas. The rural poor have limited access to family planning information and services.	
Staff lack competence and confidence in delivering certain methods due to inadequate training and supervision.	
Due to a weak commodity logistics system, there are frequent stock-outs of contraceptive commodities, supplies and equipment at many sites.	
Providers try not to confuse poor, low literate or illiterate clients with too much information, especially about side effects. They steer them away from methods that require compliance.	
Providers criticize women for having more children than they can afford and tell them they are stupid for not using contraception earlier.	
Women have little autonomy. Husbands or mothers-in-law drive family planning decision-making.	
There is low rights literacy in the community.	
Social norms discourage sexual activity among unmarried youth.	

Matching Game: Stakeholder workshop for human rights-based family planning

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Service delivery points are concentrated in urban areas. The rural poor have limited access to family planning information and services.	2, 3, 9
Staff lack competence and confidence in delivering certain methods due to inadequate training and supervision.	4, 3
Due to a weak commodity logistics system, there are frequent stock-outs of contraceptive commodities, supplies and equipment at many sites.	3, 8
Providers try not to confuse poor, low literate or illiterate clients with too much information, especially about side effects. They steer them away from methods that require compliance.	4
Providers criticize women for having more children than they can afford and tell them they are stupid for not using contraception earlier.	4
Women have little autonomy. Husbands or mothers-in-law drive family planning decision-making.	6
There is low rights literacy in the community.	8, 10
Social norms discourage sexual activity among unmarried youth.	2, 8

Power Walk Facilitator Guide

Note: There are two sets of cards, please print and cut out the set most appropriate for your country and feel free to edit the characteristics to fit your country context, keeping in mind a balanced distribution of powerful to vulnerable characters (about 1:3 is good).

SET UP

- Print "Power Walk Character Cards" on paper. Cut out each card. There are two sets of cards, please use the set most appropriate for your country and feel free to edit the characteristics to fit your country context, keeping in mind a balanced distribution of powerful to vulnerable characters (about 1:3 is good).
- If your group is too small to use all of the cards provided, be sure to select a balanced distribution of powerful to vulnerable characters (about 1:3 is good).
- Locate an open space, indoors or outdoors. You will need enough space for powerful characters to take around 20 steps forward from their spot in the line. [Note: It is a more impressive exercise if those characters who answer "no" take one step backwards, but this usually requires a large open space, such as a football field or park.]

STEP 1: Make a line

- At the beginning of exercise, take everyone to the open space and give each participant a printed character card. Be sure that there is an approximate ratio of powerful to vulnerable characters (about 1:3 is good).
- Ask participants to form a straight line, facing forward.
- Say: "This line represents the Universal Declaration of Human Rights – Article 1: All human beings are born free and equal in dignity and rights."
- But development is a process that is inherently unequal…

STEP 2: Read yes/no statements

- Read aloud the statements that are written below. Read slowly in a loud voice, and repeat as needed. Ask participants to listen to the statements.
- Say: "If your character could answer 'yes' to the statement, take one step forward. If your character would likely answer 'no' or if unclear, remain in place."
- Once you have finished the questions, ask all participants to remain where they are.

LIST OF YES/NO STATEMENTS FOR POWER WALK

- I get to meet visiting government officials
- I can read newspapers regularly
- I have access to and time to listen to the radio
- I have access to micro credit
- I can speak in extended family meetings
- I have access to confidential counselling services
- I can negotiate condoms use with my partner
- I expect to go to secondary school
- I enjoy a healthy environment in my community
- I will not face discrimination or stigma when using public services
- I will be consulted on issues affecting health services in our community
- I can pay for treatment at a private hospital if necessary
- I eat at least two full meals a day
- My home and family are not vulnerable to natural disasters
- I sometimes attend workshops and seminars on development issues in my country
- I am not in danger of being sexually harassed or abused
- I could own a small business
- I can question the expenditure of public funds
- I get paid the at least the official minimum wage
- I have access to or can afford the legal counsel of a lawyer
- I have access to public financial information from the provincial government

STEP 3: Identify characters

- Ask participants at the front of the line to read out their characters, loudly and slowly. Who are they? Discuss: Why they are at the front?
- Ask participants at the back of the line to read out their characters, loudly and slowly. Who are they? Discuss: How did they feel as they watched all the others moving forward?
- Ask who is male, and who is female. Note: This outcome is pre-determined by the selection of character cards. Strategically, it will be important to have a majority of female characters at the back in order to demonstrate gender inequality.

STEP 4: Discussion

- Say: "I will refer back to where we started: The Universal Declaration of Human Rights states that all human beings are born free and equal in dignity and rights. What would you like to do next? Should we work with those that have advanced? With those that have regressed? Both? Should we hold people back?" Note: The message should be that we should not hold people back, but we cannot allow people to regress beyond the minimum guarantees that human rights provide. After all, human rights are minimum rules.
- Lead a discussion on how to reach the people at the back. Explain that because communities are very diverse (heterogeneous), it is important to make deliberate efforts to reach the poor and the marginalized, and especially the young. However, the rich and powerful (especially those at the very front of the line) will not have too much interest in helping the ones at the back. Ask: "How could human rights assist in mitigating the differences?"
- Ask what the outcome of the Power Walk exercise tells us about the way in which we should work during the process of country programme planning, implementation and evaluation.
- Ask what capacities the different people need in order to participate effectively or to listen to others.
- Summarize major takeaways from the Power Walk:
  - Development is not power neutral. Discrimination and elite capture are well known development realities.
  - Power-relations have a huge impact on who we are, and what we can be.
  - For those who are left behind, it is impossible to catch up without specific and targeted assistance.
  - Resources and capacities alone are not sufficient. The enabling environment is a fundamental determinant.
  - Given the political realities around power, an objective and neutral normative standard is needed in order to guide discussions.
  - The purpose of the human rights-based approach is to develop the capacities of those at the back so that they are able to enjoy their rights. The more rights they are able to exercise the more they will make it to the front.

Power Walk Character Cards

Note: There are two sets of cards, please print and cut out the set most appropriate for your country and feel free to edit the characteristics to fit your country context, keeping in mind a balanced distribution of powerful to vulnerable characters (about 1:3 is good).

Set 1

Male
University degree
Formal private sector job
Urban

Female
University degree
Works for the UN
Urban

Boy
With disabilities
Rural

Male
University degree
Ethnic minority non-dominant group

Female
Migrant worker
Living with HIV

Male
Secondary education
Urban

Female
No education
Urban

Female
No education
Formal private sector job
Urban

Girl
Secondary education
Urban

Female
With disabilities
Unemployed

Male
No education
Unemployed
Rural

Son of President
University degree
Member of ethnic dominant group
Urban

Female
No education
Unemployed
Refugee

Village elder
Secondary education
Member of ethnic dominant group

Female
Secondary education
Member of ethnic dominant group

Girl
Ethnic minority, non-dominant group
With disabilities
Rural

Male
Secondary education
Living with HIV
Rural

Female
Ethnic minority,
non-dominant group
Formal private sector job
Urban

Female
Secondary education
With disabilities
Formal private sector job

Female
No education
Migrant worker

Girl
Secondary education
Member of ethnic dominant group
Urban

Male
Unemployed
Refugee

Son of the President
Secondary education
With disabilities
Formal private sector job

Male
Migrant worker
University degree
Urban

Female
Ethnic minority, non-dominant group
Rural

Female
No education
Unemployed
Rural

Female
Refugee
Living with HIV
Urban

Male
Member of ethnic dominant group
Works for the UN

Set 2

Local councillor

Village chairperson

National operations director for big pharma company (male, aged 47)

Village health worker in a clinic without minimum sanitation standards (male)

Traditional birth attendant

School teacher, in a school with many orphans and other children made vulnerable by AIDS (female)

District health officer (male, aged 52)

Orphaned girl, aged 13

Grandmother caretaker of 9 children who have lost their parents to HIV

Minister of Health

Primary school boy, aged 12

Woman whose husband died from an AIDS-related illness, aged 30

Unemployed boy, aged 17

Provincial prosecutor

Minister of Education

Political party leader (male, aged 47)

National NGO director

Worker at a rubber plantation, earning US$ 50 per month (male)

UNFPA Country Representative

Local journalist (female, aged 26)

Director of a National TV Channel, (male, aged 47)

One of top 5 richest businessmen in the country (male, aged 37)

(Make your own)

Family Planning Vulnerabilities Grid Exercise

Instructions: Take a few minutes to think about some examples from your experience of coercion, barriers or poor quality in family planning programmes. Were they **overt** (easy to see) or **subtle** (less obvious)? Write them down in the appropriate box below. We will ask for volunteers to share your examples in the plenary.

	Overt (easy to see)	**Subtle** (less obvious)
Coercion	Example: Involuntary sterilization of ethnic minorities, poor women, people living with HIV	Example: Community/family pressure
Barriers	Example: Limited choice of methods available (e.g. not offered, stock-outs)	Example: Provider bias against specific method or group (i.e. young, unmarried clients)
Poor quality	Example: Harried or rude providers	Example: Provider bias regarding specific methods or client populations

Case Studies on Human Rights-Based Family Planning

Directions: Hand out this instruction sheet along with each case study.

Small group instructions:

In your small group, identify the human rights-related principles and standards that apply to family planning that are found in the case study. Check those that apply:

Human rights-related principles and standards that apply to family planning

1. Availability	2. Accessibility	3. Acceptability	4. Quality	5. Privacy and confidentiality
6. Informed decision-making	7. Non-discrimination and equity	8. Accountability	9. Participation	10. Agency/ autonomy/ empowerment

Discuss what factors in this case study support and what factors challenge the main character's human rights. Write individual factors on a sticky note or card.

For each factor you identify, determine whether it exists at the following programming level:

Programming level	Condition
Community	Supportive community and social and gender norms
Laws and policy	Enabling legal and policy environment
Service delivery	Quality information and services
Individual	Empowered and satisfied client

Select someone at your table to post and explain your notes during the report-back to the large group in a plenary session.

Case study #1: Bathsheba

Bathsheba lives in a remote, rural village. The village has a population of 1,225 whose health care needs are served by one public primary health care centre and one pharmacy. Access to services for modern contraception is limited to injectable methods. The health centre is staffed by two senior Community Health Education Workers (CHEWs). They have had basic training in family planning consisting of natural methods and short-term modern methods such as oral pills and condoms. They also have had some limited training in long-acting reversible contraceptive methods including injectables and implants. The supply of contraceptive commodities is unreliable, with periodic stock-outs of injectable methods over the last six months. They have very little in the way of client education materials. The few existing family planning posters and client leaflets are in the official majority langauge, though most of the women they serve speak only the local language. The supervisor from the district has been encouraging staff to promote implants as part of a campaign to increase the use of long-acting methods and improve the overall modern contraceptive prevalence rate (mCPR) by 20 per cent over the next two years. In addition to being effective, the supply of implants is more reliable than other methods.

Bathsheba is a 26-year-old mother of four children. She has three daughters and a son, and she lost another son to malaria. She has been using injectable contraceptives since her last child was born a year ago and is reasonably happy with the method. She had used oral contraceptives previously, but she tended to forget to take her pills. As a result, she experienced two unintended pregnancies, one of which she ended with an illegal abortion that had complications. Bathsheba's husband is a farmer who struggles to provide for his family. The couple wants to try for one more son, but they want to wait another year.

Bathsheba goes to the health care centre one day to get her three-month injection. She waits for an hour in the crowded waiting area and is finally called by the CHEW, who leads her into a small room and offers Bathsheba a seat. The CHEW greets her with a smile and asks why she has come. Bathsheba tells her she has returned for an injection. The CHEW frowns and says, "We have no injectables just now. We have run out. The new supplies have not arrived yet and I do not know when they will come."

The CHEW pauses as she notices concern register on Bathsheba's face. She thinks of the implant campaign. "I have another method that would be very good for you. It will protect you for a long time and you won't have to remember to do anything," she suggests.

Bathsheba asks what it is like. "Oh, it is very good. I can put it in today and you can leave without worry," the health worker says. "Put it in where?" Bathsheba asks. "I will examine you and leave it in your upper arm where it will stay until you want to have it removed," the CHEW tells her.

Bathsheba remembers hearing about a method that can move around in your body and cause harm to your health. She is afraid. "No. I don't want that. I will wait and come back when you have the injectable. I will come again soon." She says thank you and leave the health centre.

Case study #2: Grace

Grace lives in a small town. The local primary health care centre offers a range of services, including antenatal care, delivery care, immunization and treatment of minor ailments. The Community Health Officer has been setting monthly performance goals for child immunization and family planning. The health centre staff fear that they may be fired if they do not reach the performance goals.

Grace is a 15-year-old student. She lives with her widowed mother and three younger siblings. She has a boyfriend, Gambo, who is pressuring her to have sex. Gambo is six years older than Grace and has had several other girlfriends. Grace believes that he has been very good to her. He gives her things and has helped her family. Her mother strongly disapproves of sex before marriage and keeps urging her to wait until she is older before getting involved sexually. But Grace is afraid Gambo will leave her if she does not agree.

Grace's friend has told her about the primary health care centre where she can get family planning. One day, after a fight with Gambo about denying him sex, Grace decides to go to the clinic. She is nervous – afraid she will meet someone who knows her mother and afraid of what the health worker will do to her.

Grace enters the facility and takes a seat. She sits quietly and looks around the crowded waiting area. There are posters on the wall. One shows a diagram of different family planning methods. One warns about getting HIV from having sex. One is about Clients' Rights. There are leaflets on the counter, but Grace is too shy to stand up and take any.

While waiting for over an hour, Grace grows increasingly restless. She is considering leaving, but just then hears her name being called. She follows the nurse into a room where four other people are sitting and talking. The nurse seems rushed and unfriendly. She pulls out a form and starts asking Grace questions she is too embarrassed to answer in front of the others. Annoyed, the nurse asks her to speak up. Grace responds in a whisper. The nurse scolds her that she is too young to be having sex. Grace says that she has changed her mind. Ashamed and angry, she gets up and leaves the clinic. On her way home, she decides to have sex with Gambo that night without protection.

Case study #3: Lami

Lami lives in a large town where a general hospital is located. The hospital offers the full range of modern family planning methods and serves as a referral site for sterilization and for implant removal. The hospital management is prioritizing family planning due to funding received from an international donor organization to increase family planning use, with a focus on promoting long-acting reversible contraceptive methods. They have started a new programme that provides information and referral for women visiting different departments in the hospital. They have given the family planning staff refresher training and they have upgraded the family planning clinic.

Lami is 18 years old and has a baby daughter. She is the junior wife of a truck driver who is away much of the time. Lami knows that when he is not home with her or his other wife he stays with other women. He believes that family planning is against their religion. He wants his young wife to bear him as many children as God provides and hopes for sons. Lami had a difficult pregnancy that ended in a Cesarean delivery. While she is conflicted about going against her religion, she is very afraid of becoming pregnant again. She has been avoiding relations with her husband as much as possible since her daughter was born six months ago, but is running out of excuses and he is running out of patience with her. She has decided to obtain a family planning method she can hide from him.

Lami goes to the family planning clinic at the hospital. The recently renovated waiting room is clean and cheerful. The walls are lined with posters, showing different contraceptive methods. Before waiting very long, Lami is called by the nurse and is led into a small, private room where she is offered a seat. The nurse smiles and asks why she has come. Lami tells her she has never used contraception, but wants to start to use a method that will give her good protection against pregnancy and that she can keep secret from her husband. She has been pregnant once and experienced complications that she does not want to go through this again. The nurse tells her she could use oral pills, an injectable contraceptive or an IUD without her husband's knowledge or cooperation. There is also the implant, but he could detect this in her arm. The nurse tells her how each method works. Lami wants long-acting protection, so she chooses the IUD. The nurse tells her to come back when she has her next period to have one inserted. She gives her a leaflet about the method and sends her home.

Case study #4: Geeta

Geeta is a 28-year-old housewife with three daughters, aged 4, 3 and 6 months. Her last delivery was by Caesarian section. Feeling overwhelmed with the childcare responsibilities of three young children, she does not want to become pregnant in the foreseeable future. Now that she is weaning the baby, she is growing worried that this could happen. Her husband, still disappointed that the last child was a girl, is talking about trying again for her to bear him a son. Geeta is not ready, but she does not stand up to him. “If God wills,” she demurs. She wants to wait two or three years before planning another child. A friend has told her that an IUD would provide long-term protection against pregnancy, and that her husband would not even have to know she has one. Geeta decides that is what she wants.

Her husband takes her and the baby to the maternal and child health and family planning clinic for a well-baby check. He joins her to meet with the nurse. The nurse is friendly and kind. She confirms that the baby is on a good growth track. They talk about weaning and introducing food to the diet. She gives the baby the vaccination she is due for and reminds them of the schedule for her remaining inoculations. Then she turns to Geeta, “Is everything good with you?” Geeta smiles shyly. “No problem,” she says. The nurse then asks the couple what they are doing about family planning. Before Geeta can respond, her husband chimes in. “I had wanted a boy. We want to try again for a son,” he says.

The nurse engages with Geeta’s husband, smiling reassuringly. “Your wife is young and strong. Once the baby is weaned, her fertility will return. You can try whenever you like.”

Geeta sits frozen in silence. She is angry that the nurse did not ask what she wants, but is afraid to contradict both this authority figure and her husband. She leaves the clinic without contraception.

Case study #5: Rose and Doris

Rose lives in a small farming village. Things have been difficult in the rural village for the past several years, as the crops have been poor because of the drought. Most families live on subsistence farming and nutrition is generally poor. Rose's village is 25 km away from the nearest health centre and is connected by mainly dirt roads. A new health centre is being built near to Rose's village, but construction has stopped because funding has run out.

Rose is a 31-year-old mother of four children. Her youngest child is six weeks old. Her last pregnancy was difficult and she lost a lot of blood during labour and delivery. Rose is happy to have a healthy baby girl, but she is much more tired than she remembers being after her prior pregnancies, making it difficult to work on the family farm. Rose has decided she does not want to have any more children.

Doris, a Community Health Worker, is responsible for conducting home visits under the supervision of the local health centre's nurse-midwife. She received training several years ago about how to conduct health promotion activities, with a focus on maternal and newborn care. The training included a short module on family planning, consisting mainly of messages about the importance of spacing births and the use of the Lactational Amenorrhea Method (LAM). However, there has been no opportunity for refresher training. Things have been difficult at the health centre, as there has been constant staff turnover over the past few years and Doris is on her third supervisor in two years.

Rose receives a home visit from Doris for the six-week postnatal check-up. After conducting the physical check-up, Doris asks Rose about how breastfeeding is progressing and reviews the importance of maternal nutrition and hygiene. She also reviews the baby's immunization schedule. Rose raises the topic of family planning and asks Doris what she can do to stop having any more children. Doris tells Rose that she will be fine as long as she continues to breastfeed as this will protect her from getting pregnant. Rose is confused, as she became pregnant with her new baby while breastfeeding her toddler. Doris tells Rose that she thinks it is not good to use contraception while the baby is still breastfeeding as it might harm the baby's health. "It is very complicated; it is better if you come to the clinic to ask the nurse-midwife about what to do," Doris says. Rose is concerned, as she is not sure when that will be possible.

Case study #6: Josephine

This country has in place population and health policies that support equitable access to and voluntary use of contraception for all women and couples. Current government strategies include increasing funding to support the scale up of adolescent and youth responsive sexual and reproductive health services. Nevertheless, there remains a large gap between policy and implementation and funds and political will are lacking.

Josephine is a community nurse. During a recent outreach held in a rural district, she was approached by a local teacher from the secondary school. The teacher spoke of her worry about the rising number of pregnancies among teenage girls in the community. Many have stopped coming to class and she fears that they will drop out altogether. The teacher asked Josephine if there was anything she could do to help, as her efforts thus far have been met with resistance from parents and other school officials.

She shares the teacher's concern, but is afraid to raise the issue with those in charge at the health clinic. She is relatively new at the clinic and has observed staff turn away young girls and unmarried women despite the new policies about "leaving no one behind". She has also observed that clinic staff have poor morale. They complain about the lack of resources and take extended breaks to look at their mobile phones despite the long lines of clients waiting for services.

Josephine decided to gather her courage. She made a suggestion to set up a mechanism to obtain client feedback. The response from her colleagues was a firm no. "No. That is not how we do things here," they said. She plans to raise the issue with the District Supervisor on her next visit, although there has not been a supervisory visit for over a year.

THE HOLISTIC FRAMEWORK FOR HUMAN RIGHTS-BASED FAMILY PLANNING

UNFPA Technical Brief

Essential programme elements

The Holistic Framework for Human Rights-Based Family Planning depicts a vision for an ideal human rights-based family planning programme. This framework defines the essential elements that should ideally be in place at the various levels in the health-care system for a comprehensive family planning programme based in human rights. Such an ideal programme does not yet exist. It is an aspiration. Yet every programme is somewhere along the continuum that leads to this desired state.

The framework includes four programmatic levels:

COMMUNITY Supportive community and social and gender norms

LAWS & POLICY Enabling legal and policy environment

SERVICE DELIVERY Quality information and services

INDIVIDUAL Empowered and satisfied client

This comprehensive framework addresses both the supply side and demand side of programmes, and covers both the responsibilities of duty-bearers and the entitlements and protections of rights-holders. These levels do not operate in isolation but reinforce and contribute to each other.

Defining HRBA to FP

The first United Nations definition of the "human rights-based approach" (HRBA) was published by the UNDG Human Rights Working Group in 2003. This definition applies HRBA to the area of family planning (HRBA to FP). It derives from international human rights law and draws on UNFPA guidance.

A human rights-based approach to family planning is a conceptual framework and systematic process that:

- **Ensures States meet their obligations under international human rights law to respect, protect and fulfil human rights**
- **Ensures family planning programmes maintain a focus on key human rights-related principles and standards that apply to family planning**
- **Applies these principles and standards in all phases of programming, and at all levels of the programme**
- **Enables duty-bearers to meet their obligations and rights-holders to claim their rights.**

Duty-bearers are State actors who have an obligation to respect, protect and fulfil human rights and can be held accountable for their actions.

Rights-holders are every individual including every man, woman and child, of any race, ethnic group or social condition.

Human rights principles that apply to family planning


AAAQ – Availability, Accessibility, Acceptability, Quality


Non-discrimination and equality


Bodily autonomy and agency


Informed decision-making


Privacy and confidentiality

Accountability


Participation

HRBA to FP is consistent with programming best practices. It builds on familiar tenets of quality of care, but does not entail different programming processes. While it makes a focus on human rights explicit, it builds upon familiar tenets of quality of care and routine programming processes. The framework supports programming to affirm individuals' human rights, promote non-discrimination and equality, and leave no one behind. The commitment to leave no one behind is a central promise of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals. It is also central to the *UNFPA Strategy for Family Planning, 2022–2030: Expanding Choices – Ensuring Rights in a Diverse and Changing World*.

Applying a human rights-based approach ensures that people are at the centre of development programmes. The explicit goal of a family planning programme is to support individuals to enjoy their right to decide freely and responsibly the number, spacing and timing of their children as stated in the 1994 Programme of Action of the International Conference on Population and Development (para. 7.3). The framework lists key programmatic conditions and actions necessary to fulfil human rights as enshrined in international human rights law.

Purpose of the framework

- To foster understanding of what a human rights-based approach to family planning entails
- To enable stakeholders to compare existing programming with an ideal holistic human rights-based vision
- To shift the way people think about and go about their work, making human rights a more intentional, cross-cutting programmatic element
- To identify human rights-related problems that might otherwise be overlooked or receive insufficient attention.

Progressive realization is a key concept

The framework is guided by the human rights concept of "progressive realization" of human rights (CESCR General Comment No. 14). Progressive realization means that States have an obligation to move as expeditiously and effectively as possible towards the full realization of the right to health, even if resources are not sufficient for the right to be met immediately. Despite existing resource constraints, governments (duty-bearers) have an obligation to take action to continuously advance the protection and fulfillment of individuals' human rights.

Applying the framework

Any family planning programme can take the human rights-based approach. The framework applies to a wide range of settings – from smaller programmes with limited scope or geographic coverage to larger national programmes. The intended users of the framework are stakeholders responsible for designing, strengthening, monitoring and/or evaluating family planning programmes. It is relevant to national and sub-national government representatives, staff from development partners and technical assistance organizations, private sector partners, civil society and representatives of the community.

The elements of the framework provide a basis of comparison between the ideal and the status of the family planning programme under review. The framework details what should ideally be in place for each human rights-related principle that applies to family planning programmes at each level of the health-care system. Each level can be the focus of a comparison exercise. The framework can be used at any phase of the programming cycle from situation assessment, design and implementation to monitoring and evaluation.

The framework serves as a conceptual resource to establish a shared understanding of human rights-based family planning among a variety of stakeholders. It may be used as a stand-alone programmatic job aid. Consider incorporating the graphic into presentations or guidance documents for family planning programming. Consider referring to the graphic during the development of a project proposal or funding proposal for a human rights-based family planning intervention or broader sexual and reproductive health programme. The framework is the main component of the *Human Rights-Based Approach to Family Planning: UNFPA Support Tool*, where it is applied through a stakeholder workshop.

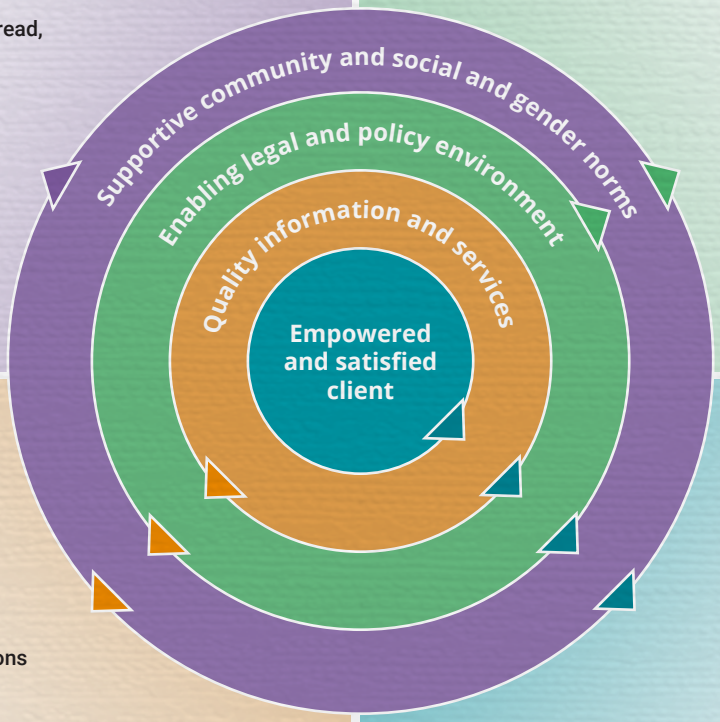
The holistic framework for human rights-based family planning

Community

Rights literacy is widespread, norms support informed decision-making and communities foster access to contraception

Laws and policy

National laws and policies ensure full and equal access to family planning and are supported by adequate budgets and sound institutions



Service delivery

A range of quality contraceptives are supplied by duty-bearers free from discrimination or access barriers, with redress for rights violations

Individual

Every individual rights-holder enjoys agency in decision-making, privacy, confidentiality and respectful care

Empowered and satisfied rights-holders who can exercise bodily autonomy are at the core of the framework.

They are surrounded by quality information and services, an enabling legal and policy environment, and supportive community and social and gender norms. When these conditions exist, it indicates that all of the human rights-related principles and standards that pertain to contraceptive information and services are being applied.

Human rights-based family planning programmes aim to achieve this goal:

"All couples and individuals have the basic right *to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so." (Principle 8)*

"It also includes their right to make decisions concerning reproduction ***free of discrimination, coercion and violence****." (para 7.3)*

Programme of Action, International Conference on Population and Development

Supportive community and social and gender norms

AGENCY/AUTONOMY/EMPOWERMENT

- Rights literacy is widespread
- Communities recognize that all people, everywhere, are entitled to human rights
- Marginalized individuals and communities, in particular women, adolescents and youth, are empowered to realize their sexual and reproductive health and rights
- Women, men and young people have knowledge of family planning
- Gender norms support women, adolescents and youth in making and acting upon their own informed family planning decisions
- The community supports healthy transitions from adolescence to adulthood
- Civil society is mobilized to advocate for policies, funding and programmes that support equitable access to quality family planning services

ACCESSIBILITY

- Affordable transportation links individuals to service delivery points
- Community-based distribution of contraceptives enhances access

ACCEPTABILITY

- The use of family planning by all population groups, including unmarried youth, is culturally acceptable and supported by community and religious leaders

PARTICIPATION

- Community members, including women from marginalized populations, adolescents and youth, are fully engaged in the formulation of policy affecting family planning service delivery and in monitoring programmes
- Health committees comprising community volunteers provide a critical link between service facilities and communities

ACCOUNTABILITY

- Community members, including adolescents and youth, participate in programme development and monitoring
- Social accountability mechanisms are in place, as are robust means of redress for rights violations

Enabling legal and policy environment

NON-DISCRIMINATION AND EQUALITY

- Laws and policies promote and protect access to quality contraceptive information and services and equal treatment for all
- The State guarantees that reproductive rights are respected, protected and fulfilled for all without discrimination of any kind

AVAILABILITY

- A national strategy and action plan on sexual and reproductive health and rights exist, are adequately resourced and are periodically reviewed and monitored through a participatory and transparent process
- Policy and legal frameworks facilitate regulated, quality self-care interventions*

ACCESSIBILITY

- No laws, policies or practices criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information
- Universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, is guaranteed, in particular for women and disadvantaged and marginalized individuals and communities
- Information and services are physically and economically within reach
- Comprehensive sexuality education is provided
- No third-party authorization, unjustifiable medical barriers or other restrictions exist
- Contraceptive security is assured
- Special efforts are made to reach displaced populations and those in crisis settings
- Post-abortion care and counselling are available for those who need it

ACCEPTABILITY

- A gender perspective is at the centre of all policies, programmes and services affecting women's health
- Services are culturally appropriate, youth-friendly and sensitive to gender and life cycle requirements

QUALITY

- State policies, programmes and practices regarding contraceptive goods and services are evidence-based, scientifically and medically appropriate, and in line with recent technological advances and innovations
- Facilities, services and commodities are medically appropriate and comply with approved service standards
- Medicines, equipment and technologies essential to sexual and reproductive health are provided, based on the WHO Model List of Essential Medicines

* Self-care interventions for sexual and reproductive health and rights to advance universal health coverage: 2023 joint statement by HRP, WHO, UNDP, UNFPA and the World Bank. Available at: www.unfpa.org/sites/default/files/resource-pdf/JointStatement_SelfCareInterventions-EN_0.pdf

INFORMED DECISION-MAKING

- The State has taken effective measures to prevent or eliminate laws, practices and policies that promote involuntary, coercive or forced contraception
- Individuals are empowered to make free, informed and responsible decisions without barriers, coercion or discrimination
- The principle of autonomy is protected by client counselling; by removing all third-party authorization requirements (e.g. parental, spousal or partner); and by eliminating non-medical eligibility criteria that create access barriers (e.g. minimum number of children required to obtain sterilization or IUD, or age or marital status requirements)
- Individuals are not subjected to incentives or policies that foster coercive provider practices, nor to non-medical eligibility criteria that create barriers to access
- All individuals and groups have access to comprehensive education and information on sexual and reproductive health that are non-discriminatory, non-biased and evidence-based, and that take into account the evolving capacities of children and adolescents

PRIVACY AND CONFIDENTIALITY

- Legal and professional regulations have been adopted to guarantee the confidentiality and privacy of individuals seeking contraceptive information and services

PARTICIPATION

- Women and youth participate fully and are informed and represented in the planning, implementation and monitoring of policies, programmes and services related to family planning

ACCOUNTABILITY

- The State is meeting its obligations under human right law to guarantee that reproductive rights are respected, protected and fulfilled for all without discrimination of any kind
- Legal, policy and programmatic frameworks are aligned with international human rights standards
- Effective monitoring and accountability mechanisms are in place at all levels to ensure that individuals' agency and choices are respected, protected and fulfilled and to redress rights violations
- Measures of programme success are rights-supportive and rights-related indicators are routinely monitored
- Systems and structures engage with national human rights institutions (NHRIs) to monitor State human rights obligations, oversee law enforcement, and engage with international human rights mechanisms to strengthen accountability for SRHR, including engaging in the Universal Periodic Review (UPR) and Treaty Bodies
- Individuals from all groups, including marginalized populations, are made aware of their rights
- The State has ensured administrative or judicial safeguards in instances where an individual is impermissibly denied access to a particular contraceptive method (including emergency contraceptives) or experiences violations of informed consent and other abuses around contraceptive access and use
- The State ensures access to effective and transparent remedies and redress, including administrative and judicial safeguards, for any violations of the right to sexual and reproductive health

Quality information and services

NON-DISCRIMINATION AND EQUALITY

- Quality information and services are provided equitably to all individuals without discrimination of any kind

AVAILABILITY

- A wide range of contraceptive methods is offered
- All contraceptives included in the National Essential Medicines List are made available, including male condoms, female condoms, oral contraception, injectable contraception, emergency contraception, IUDs (insertion and removal) and implants (insertion and removal)
- Both insertion and removal services for IUDs and implants are supported by adequate supply of commodities and equipment, competent staff and infrastructure
- An effective contraceptive security system prevents stock-outs

ACCESSIBILITY

- All people have access to comprehensive, unbiased, scientifically accurate information on sexual and reproductive health, including information regarding the full range of contraceptives, delivered in a manner that is understandable to all (considering age, language, age, ability, etc.), including public health campaigns
- Equitable service access is assured for all through various service models (static, mobile, integrated and youth-friendly models as well as effective referral) and convenient service delivery points ("leave no one behind")
- All contraceptive services are affordable
- No non-medical eligibility or third party consent requirements exist
- The widest range of service providers who can safely provide services is trained and authorized to do so
- Measures are in place to ensure sufficient numbers of trained and competent service providers in a range of settings (facility-based, community-based, mobile) to expand access to the full range of contraceptive methods, including emergency contraceptives and self-care interventions

ACCEPTABILITY

- Facilities, commodities and services are acceptable to intended beneficiaries
- Services are provided in an ethical, culturally respectful, confidential manner that includes being respectful of the culture of individuals, minorities, people and communities
- Individual preferences are respected

QUALITY

- Skilled medical personnel:
  - Provide safe and appropriate services that meet accepted standards
  - Provide approved and unexpired commodities and equipment
  - Provide clear and medically accurate information
  - Maintain infection protection and adequate sanitation
  - Protect all clients' dignity and treat all clients with respect
- Services and commodities are medically safe and provided respectfully in a clean and comfortable environment
- Special measures are taken to ensure that contraceptive information and services are provided in compliance with the human rights of marginalized groups, including adolescents, individuals with disabilities, sex workers, individuals living in remote areas, and individuals living in humanitarian settings
- Effective monitoring, supervision, quality improvement and health management information systems and logistics management information systems (HMIS/LMIS) systems are in place and supported by training

INFORMED DECISION-MAKING

- Individuals can choose from a wide range of contraceptive options
- All clients are informed and counselled to ensure they have accurate, unbiased and comprehensible information that includes common side effects, possible risks and whether or not the method protects against HIV and other sexually transmitted infections (STIs)
- Clients' right and ability to make their own choices is respected, protected and fulfilled
- Neither providers nor clients receive incentives for accepting or providing family planning or particular methods

PRIVACY AND CONFIDENTIALITY

- Providers protect individuals' privacy and do not disclose any personal or medical information they receive from clients

PARTICIPATION

- Mechanisms are in place to elicit input and feedback from clients and community members about service delivery

ACCOUNTABILITY

- Programme managers and health care workers have rights literacy
- As duty-bearers, they respect, protect and fulfil individuals' human rights
- Managers routinely monitor human rights in their programmes
- Effective mechanisms are in place to manage alleged and confirmed rights violations

Empowered and satisfied client

NON-DISCRIMINATION AND EQUALITY

- Every individual is treated the same without discrimination based on who they are, their age or their circumstances, or their sexual orientation or gender identity

AGENCY/AUTONOMY/EMPOWERMENT

- Every individual can make and act on their own family planning decisions in consultation with whomever they choose, without pressure or obstacles from the health care system, their partner or family

AVAILABILITY

- Every individual is offered a broad range of methods and services to choose from

ACCESSIBILITY

- Every individual has correct and understandable contraceptive information and can get services that are physically convenient (through static or mobile services, community-based distribution or effective referral), affordable and available when needed

ACCEPTABILITY

- Methods offered suit the individual's needs and preferences
- Services are respectful and culturally appropriate

INFORMED DECISION-MAKING

- Every individual can decide whether or not to use family planning and what method to use, based on accurate and complete information, including side effects

PRIVACY AND CONFIDENTIALITY

- Every individual receives information and services in a setting where no one can hear or observe client-provider interactions; records and information are not shared with anyone

PARTICIPATION

- Every individual can make their own informed family planning decisions and can provide input and feedback regarding how information and services are provided

ACCOUNTABILITY

- As rights-holders, individuals know and claim their human rights
- As rights-holders, individuals speak up if any of their rights are violated, and have access to redress

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Assessment Questionnaire

Identifying programmatic strengths, weaknesses and gaps from a human rights perspective

Human rights standards on contraceptive information and services

An estimated 257 million women who want to avoid or delay pregnancy are not using safe, modern methods of contraception.[1] During the first year of the COVID-19 pandemic, nearly 21 million women and girls lost access to contraception.[2] Human rights law establishes the right to determine the number and spacing of one's children and the right to the information and means to do so, including sexuality education and family planning services.[3]

Women and girls with an unmet need for family planning are those who want to stop or delay childbearing but are not using a modern method of contraception. This unmet need can result in violations of the rights to privacy, health, life, education, nondiscrimination and equality.[4] High unmet need for contraceptives is linked to numerous harms recognized under human rights law, including unsafe abortion[5]; maternal mortality and morbidity from higher-risk unplanned or closely timed pregnancies[6]; increased risk of HIV and other sexually transmitted infections (STIs); and infertility arising from STIs.[7] The failure to ensure legal and accessible emergency contraception for individuals who are victims of rape or other forms of sexual abuse is linked to physical and mental suffering, which may amount to ill-treatment.[8] Barriers to contraceptive information and services may be particularly acute for individuals from marginalized groups or living in certain settings, such as low-income individuals, individuals with disabilities, adolescents, ethnic and racial minorities, people living with HIV and individuals living in humanitarian settings.

Purpose: This questionnaire is meant to support the analysis of current programmes and policies.

Directions: The worksheet begins with an introduction to human rights standards on contraceptive information and services. Invite participants to reach the introduction and to utilize the references if they would like additional information. Next, the worksheet provides a list of key questions. Answer the questions using traffic lights standing for **Yes**, **Partially** and **No**. Examples of implementation provide practical actions.

In other instances, marginalized individuals may be subjected to coercive or forced contraceptive policies and practices, such as involuntary sterilization,[9] or may face harm through poor-quality contraceptive and sterilization procedures. Such practices violate numerous human rights and may rise to the level of torture or cruel, inhuman or degrading treatment.[10] Coercive policies and practices disproportionately affect members of vulnerable groups, such as poor people, people with disabilities, ethnic and racial minorities, and women living with HIV.[11] Gendered and other stereotypes about who "should" and "should not" reproduce may shape access to contraceptive information and services and may affect the risk of coercion. For example, the presumption that single women and adolescents should not be sexually active or the stereotype that women with disabilities are asexual may lead to these persons' exclusion from contraceptive-related policies and programmes. Intersex children may also be sterilized early in life due to misconceptions concerning their fertility and sexuality.

Human rights law and the Programme of Action of the International Conference on Population and Development (ICPD) recognize states' obligations to ensure that the full range[12] of good-quality, modern, and effective contraceptives, including emergency contraception, are available and accessible to everyone.[13] States are obligated to ensure that the use of contraceptives is voluntary, fully informed, and free from coercion and discrimination, and they should pay particular attention to groups who have been historically subject to coercive family planning practices such as Roma, persons with disabilities and women living with HIV.[14] States must also guarantee the right to seek, receive and disseminate contraceptive-related information; this includes providing access without discrimination to unbiased, comprehensive and evidence-based information and services for family planning and contraception, including to adolescents and youth.[15] Human rights law specifically establishes that emergency contraception, which can prevent pregnancy following unprotected sexual intercourse, should be available without a prescription[16], that such contraception should be free for victims of violence, including adolescents[17], and that special measures should be taken to ensure that it is available in conflict and postconflict zones.[18]

Key questions for monitoring compliance with human rights obligations

The questionnaire below provides a tool for assessing health system compliance with human rights obligations regarding contraceptive information and services.

About the traffic lights

Each "key question" is followed by a column with "traffic lights" standing for yes, partially and no. The traffic lights are intended to help users answer each question based on their country context.

Yes means that the country shows significant progress in this area. To this end, the user should further ask: How can we support the continuity of these efforts? Is there something we can do to ensure the institutionalization of these policies and approaches?

Partially means that there might be good progress, but there is more that could be done. To this end, the user should further ask: What gaps need filling? What can we contribute from our own entity or organization towards this goal?

No means that there is significant room for improvement. To this end, the user should further ask: What areas in particular need to be strengthened? What actors do we need to engage with to do this? What levels of action are needed, e.g. law and policy reform, capacity development, awareness raising and partnerships?

Directions: Answer the key questions yes / partially / no. Read the examples of implementation. Reflect on your answer and propose next steps. Worksheet 1 should be used alongside Worksheet 2.

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?
Are contraception-related facilities, goods and services provided in a manner that is respectful of medical ethics and culturally acceptable to all (including by being respectful of the culture of individuals, minorities, peoples and communities, and sensitive to gender and life-cycle requirements)?				In partnership with affected communities, provide training to health care providers to improve the accessibility of services to all individuals and cultures, including by raising awareness around the needs and cultures of marginalized groups and addressing dominant discriminatory stereotypes and norms that may undermine care. Ensure that civil society and other stakeholders play a central role in the development and monitoring of laws, policies and programmes on contraceptive information and services.	
Do all people have access to comprehensive, unbiased and scientifically accurate[19] information on sexual and reproductive health, including regarding the full range of contraceptives, in a manner that is understandable to all (considering age, language, ability, etc.), including comprehensive sexuality education and public health campaigns?[20] Is the content non-discriminatory and free from harmful stereotypes?				Develop and disseminate information and education materials on contraceptive information and services and related rights in the most common local languages, Braille, and adolescent-friendly formats. Work with education officials to develop a national curriculum on comprehensive sexuality education (CSE) that reflects the input of young people and includes contraceptive information and services. Develop communication campaigns to destigmatize contraceptive use and to dispel misconceptions and misinformation concerning contraception among providers and the public that create barriers to accessing services.[21]	

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?
Are sufficient numbers of health care providers adequately trained to provide information and counselling on the full range of contraceptive methods, including emergency contraceptives? Does the state ensure that access is not impeded by refusal to provide contraceptives or provide incomplete or biased information/ services based on conscience or beliefs by health care providers or pharmacists?[22]				Provide ongoing competency-based training to health care providers to ensure their capacity to provide counselling and services around the full range of contraceptives, including recent advancements and emergency contraception. Support the development and execution of quality-assurance processes in health care facilities to identify barriers in access, including refusal to perform abortion based on conscience where it is legal.	
Are state policies, programmes and practices regarding contraceptive goods and services evidence-based, scientifically and medically appropriate, and in line with recent technological advances and innovations?[23]				Support national and local health officials in the review of contraception-related policies and programmes to ensure the quality of the information presented and the inclusion of recent technological/digital advances and innovations.	
Have legal and professional regulations been adopted to guarantee the confidentiality and privacy of individuals seeking contraceptive information and services? [24]				Support national and local health offices in the design of health facilities that include private spaces for confidential counselling, examination and treatment and in the implementation of policies that clarify that counselling sessions and examinations should include only the patient, unless they request the presence of a spouse or another person.	

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?
Do legal and professional regulations respect autonomy and support informed consent, including by: > providing counselling; > removing all third-party authorization requirements (such as parental, spousal or partner consent)[25] and; > eliminating non-medically-based conditions for access to contraceptives, such as requiring a minimum number of children before allowing a woman to undergo surgical sterilization or intrauterine device insertion, or restricting access to contraceptives on the basis of age or marital status?				Partner with civil society to provide capacity-building and sensitization programmes for health officials, judges and legislators to raise awareness of human rights standards concerning third-party consent for contraceptive information and services, including for adolescents. Engage national and local health officials to develop robust protocols for informed consent, including tools to ensure comprehensive counselling and consent forms in multiple languages and formats (e.g. Braille and audio). Support law and health officials in ensuring that laws and policies on contraceptive information and services and other health care adopt a clear definition of meaningful, free, full and informed consent, and in ensuring the removal of non-medically-based conditions for access to contraceptives.	

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?
Are contraceptive-related facilities, goods, information, and services available as needed in the country, including in remote areas? Are contraceptive information and services physically accessible? Are contraceptive information and services affordable to all?[26]				Support health officials and civil society organizations in ensuring that the full range of contraceptive methods is readily available in public and private clinics, e.g. by supporting procurement and training of health workers, task-sharing where appropriate, and the modification of facilities to ensure accessibility for all. Support the integration of contraceptive information and services into primary health care and sexual and reproductive health care, including postpartum and post-abortion care. Engage with the drug regulation authority to ensure that all essential medicines (as recognized in the WHO Model List of Essential Medicines) for contraception, including emergency contraception, are legally permitted and available in practice.[27] Examine logistics and procurement policies to ensure the availability of goods and conduct regular monitoring of contraceptives distribution and stocks, with attention to stock-outs and method mix at all levels of service delivery. Review public insurance plans and budgeting processes to ensure the affordability of contraceptive services, including their inclusion in public health insurance schemes and their subsidization.	

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?
Are special measures being taken to ensure that contraceptive information and services are provided in compliance with the human rights of marginalized groups, including adolescents, individuals with disabilities, sex workers, individuals living in remote areas and individuals living in humanitarian settings? Are these groups and any other stakeholders able to participate in the development, planning, implementation and monitoring of family planning programmes and policies? Is data updated and disaggregated on grounds of identity and characteristics?				Support civil society organizations in advocating for and monitoring the delivery of quality contraceptive information and services and facilitating discussions between users (particularly those from marginalized groups) and service providers. Ensure that recent and reliable disaggregated contraception-related data is accessible to local advocates, and support them in using data to foster accountability. Work with national judicial academies and national human rights institutions to develop and implement capacity-building programmes on contraceptive information and services as a human rights concern.	
Has the state ensured administrative or judicial safeguards in instances where an individual is impermissibly denied access to a particular contraceptive method (including emergency contraceptives) or experiences violations of informed consent and other abuses around contraceptive access and use?[28]				Create awareness-raising campaigns and legal aid programmes to provide individuals who have been or may have been affected by coerced, forced or involuntary sterilization with information on the possibility of seeking administrative and judicial redress. Support the establishment of monitoring mechanisms for the prevention and documentation of forced, coercive and otherwise involuntary sterilization and for the adoption of corrective measures.	

Add any additional issues your group finds relevant.

Key questions	Yes	Partially	No	Examples of implementation	Why did you answer this way? How will you address this concern?

Source: This checklist is taken from a forthcoming joint UNFPA and Center for Reproductive Rights publication/toolkit on ensuring UHC for SRH services. This is an excerpt from the module on Contraceptive Information and Services.

Endnotes

1 In the UNFPA report, State of World Population 2022, the figure 257 million is based on 2010 estimates by the United Nations Department of Economic and Social Affairs (UN DESA) in the 2019 World Contraceptive Use. Recent data estimates have become available indicating unmet need is closer to 270 million as of 2019 (Kantorová et al).

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10 CEDAW Committee, *General Recommendation No. 35*, *supra* note 47, para. 18; Human Rights Committee, *General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, paras. 11, 20, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000) [hereinafter Human Rights Committee, *Gen. Comment No. 28*].

11 OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, WHO, *Eliminating Forced, Coerced, and Otherwise Involuntary Sterilization: An Interagency Statement* (2014). Available at www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf.

12 As defined by the WHO Model List of Essential Medicines. WHO, WHO Model List of Essential Medicines (21st List 2019). Available at www.who.int/publications/i/item/WHOMVPEMPIAU2019.06

13 ESCR Committee, *Gen. Comment No. 22*, *supra* note 5, paras. 13, 28, 45, 57, 62; Human Rights Committee, *Gen. Comment No. 36*, *supra* note 13, para. 8; CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 6, paras. 12(d), 17; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 34: The Rights of Rural Women, (63rd Sess., 2016)*, *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 38, 39(a), U.N. Doc. CEDAW/C/GC/34 (2016) [hereinafter CEDAW Committee, *Gen. Recommendation No. 34*]; Committee on the Rights of the Child, *General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health (Art. 24),* (62nd Sess., 2013), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 31, 70, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *Gen. Comment No. 15*]; CRC Committee, *Gen. Comment No. 20*, *supra* note 25, paras. 59, 63.

14 ESCR Committee, *Gen. Comment No. 22*, *supra* note 5, paras. 13, 45, 57; CEDAW Committee, *Gen. Recommendation No. 24, supra* note 6, paras. 17, 22.

15 *Programme of Action of the International Conference on Population and Development,* Cairo, Egypt, Sept. 5-13, 1994, para. 7.16, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter ICPD Programme of Action]; ESCR Committee, *Gen. Comment No. 22, supra* note 5, paras. 18-19, 41, 49(f).

16 CEDAW Committee, *Concluding Observations: Hungary,* para. 31(b), U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

17 CRC Committee, *Gen. Comment No. 15, supra* note 52, para. 70; CRC Committee, *Gen. Comment No. 20, supra* note 25, para. 59; CEDAW Committee, *Gen. Recommendation No. 35*, *supra* note 47, para. 40(c); ESCR Committee, *Gen. Comment No. 22, supra* note 5, paras. 13, 45, 57; CEDAW Committee, *Concluding Observations: Peru*, paras. 35-36, U.N. Doc. CEDAW/C/PER/CO/7-8 (2014); CRC Committee, *Concluding Observations: Costa Rica*, paras. 63-64, U.N. Doc. CRC/C/CRI/CO/4 (2011).

18 CEDAW Committee, *General Recommendation No. 30: Women in conflict prevention, conflict, and post-conflict situations*, *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 52(c), U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, Gen. Recommendation No. 30]; CEDAW Committee, *Concluding Observations: Central African Republic*, paras. 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).

19 By "scientifically accurate," this publication refers to objective international standards as determined by established authorities in the field of sexual and reproductive health, such as the World Health Organization.

20 ESCR Committee, *Gen. Comment No. 22, supra* note 5, paras. 18-19.

21 *Id.*, para. 41.

22 *Id.*, para. 14.

23 *Id.*, paras. 21, 47.

24 CEDAW Committee*, Gen. Recommendation No. 24*, *supra* note 6, para. 31(e).

25 *Id.*, para. 22.

26 ESCR Committee, *Gen. Comment No. 22, supra* note 5, paras. 12-17.

27 ESCR Committee, Gen. Comment No. 14, supra note 6, para. 43(d) (explaining that the provision of essential drugs, as defined by WHO, constitutes a core obligation of states parties in satisfying the right to health). The WHO Model List of Essential Medicines includes a full range of modern contraceptives. WHO, WHO Model List of Essential Medicines (21st List 2019). Available at: www.who.int/publications/i/item/WHOMVPEMPIAU2019.06.

28 Center for Reproductive Rights (2019). Breaking Ground 2020: Treaty Monitoring Bodies on Reproductive Rights. Available at: https://reproductiverights.org/wp-content/uploads/2020/12/Breaking-Ground-2020.pdf.

WORKSHEET #2

Prioritizing Challenges and Identifying Actions

Analysis of root causes of weaknesses, gaps and impediments

Purpose: The aim of Worksheet 2 is to prioritize the areas identified in Worksheet 1. Please use it alongside the previously completed checklist.

Review and ranking

Review the list of items you have identified as programme weaknesses or gaps in Worksheet #1. (This could also include strengthening what works.) List them under the corresponding **programming level**:

- Community
- Laws & policy
- Service delivery
- Individual

Rank them in priority from 1 to 3, with 1 meaning highest priority to be addressed first, down to 3, meaning lowest priority or not feasible to address in the short term. Considerations for ranking should include:

- Most critical issue
- Easiest/hardest to address
- Tensions or impediments that may create barriers to necessary action
- Necessary resources can/cannot be mobilized

Root cause

For each weakness and gap designated as priority 1 and 2, get to the underlying root cause(s) by conducting a simple root cause analysis to identify the fundamental source of the deficiency or impediment that you can do something about. A simple root cause analysis consists of asking “Why?” that condition exists. Complete the last (fourth) column in the table below to capture the outputs of your analysis.

Action plan

Finally, recommend actions to address each weakness and/or gap that was revealed in the root cause analysis. **These actions will form the basis for your action plan.**

Worksheet #2: Prioritizing challenges and identifying actions

Directions: From Worksheet #1, review the major weaknesses and/or gaps in programmes and practices. (This could also include strengthening what works.) List them here, and then rank them 1, 2 or 3 from highest (1) to lowest priority (3). Identify root causes and set forth recommended actions and specific tasks to address these challenges. Add rows as needed.

COMMUNITY LEVEL Supportive values and social and gender norms			
Programme weaknesses and gaps	Priority ranking (1–3)	Root causes of top priorities	Recommended actions and specific tasks

LAWS & POLICY LEVEL Enabling legal and policy environment			
Programme weaknesses and gaps	Priority ranking (1–3)	Root causes of top priorities	Recommended actions and specific tasks

Worksheet #2: Prioritizing challenges and identifying actions

Directions: From Worksheet #1, review the major weaknesses and/or gaps in programmes and practices. (This could also include strengthening what works.) List them here, and then rank them 1, 2 or 3 from highest (1) to lowest priority (3). Identify root causes and set forth recommended actions and specific tasks to address these challenges. Add rows as needed.

SERVICE DELIVERY LEVEL Quality information and services			
Programme weaknesses and gaps	Priority ranking (1–3)	Root causes of top priorities	Recommended actions and specific tasks

INDIVIDUAL LEVEL Empowered and satisfied client			
Programme weaknesses and gaps	Priority ranking (1–3)	Root causes of top priorities	Recommended actions and specific tasks

WORKSHEET #3

Developing an action plan

Purpose: Workshop discussions and small group work around this worksheet will be pulled together to develop an action plan for the next one to two years.

Set up: Determine in advance which of the priority areas will be the focus of this exercise.

Timeframe: Please note that this planning process will be completed over two (2) sessions.

1. Priorities

From Worksheet #2, identify one or two priority areas and one or two recommended activities/ tasks under each area. Do this under each level of the health system: community, laws & policy, service delivery and individual.

2. Tasks and targets

Break down each recommended action into one or two concrete tasks. Then, for each task, specify who will be responsible for taking action and by what target date. Consider whether the action can be completed within existing resources or if additional resources will have to be mobilized. If advocacy is required to enlist additional support, add this as a recommended action.

3. Partners

Next, brainstorm what potential partnerships could complement or supplement this plan, and consider what they could contribute (e.g. resources, complementary mandate, specific expertise). Record the ones that would be most feasible and helpful.

4. Indicators

Finally, list indicators that could be used to monitor progress towards completion of each planned action.

COMMUNITY LEVEL Supportive values and social and gender norms				
From Worksheet #2, identify 1 or 2 priority areas and 1 or 2 recommended activities/tasks under each area.	Responsible party(ies)	Target date for completion	Desired partnerships and their contributions	Monitoring indicators
1.				
2.				

LAWS & POLICY LEVEL Enabling legal and policy environment				
From Worksheet #2, identify 1 or 2 priority areas and 1 or 2 recommended activities/tasks under each area.	Responsible party(ies)	Target date for completion	Desired partnerships and their contributions	Monitoring indicators
1.				
2.				

SERVICE DELIVERY LEVEL

Quality information and services

From Worksheet #2, identify 1 or 2 priority areas and 1 or 2 recommended activities/ tasks under each area.	Responsible party(ies)	Target date for completion	Desired partnerships and their contributions	Monitoring indicators
1.				
2.				

INDIVIDUAL LEVEL

Empowered and satisfied client

From Worksheet #2, identify 1 or 2 priority areas and 1 or 2 recommended activities/ tasks under each area.	Responsible party(ies)	Target date for completion	Desired partnerships and their contributions	Monitoring indicators
1.				
2.				

Resources List

UNFPA resources

UNFPA. 2023. **Human Rights-Based Approach to Family Planning: UNFPA Support Tool**. New York: UNFPA. Available at: www.unfpa.org/sites/default/files/pub-pdf/UNFPA-HRBAtoFP-SupportTool-v231207.pdf

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UNFPA. 2023. **Advancing SRH in UHC through a human rights-based approach: A Toolkit**. New York: UNFPA Technical Division. (forthcoming)

UNFPA. 2020. **Strengthening the Human Rights-based Approach to Family Planning at UNFPA. An Assessment**. New York: UNFPA. Available at: www.unfpa.org/sites/default/files/news-pdf/Strengthening_UNFPA_Human_righs-based_approach_to_FP_Assessment.pdf

UNFPA. 2020. **Elevating Rights and Choices for All. Guidance Note for Applying a Human Rights Based Approach to Programming in UNFPA**. Available at: www.unfpa.org/sites/default/files/pub-pdf/2020_HRBA_guidance.pdf

UNFPA and WHO. 2015. **Ensuring Human Rights Within Contraceptive Service Delivery: Implementation Guide**. New York: UNFPA; and Geneva: WHO. Available at: www.unfpa.org/sites/default/files/pub-pdf/Ensuring_human_rights.pdf

UNFPA and Harvard School of Public Health. 2010. **A Human Rights-Based Approach to Programming: Practical Implementation Manual and Training Materials**. New York: UNFPA. Available at: www.unfpa.org/sites/default/files/jahia-publications/documents/publications/2010/hrba/hrba_manual_in%20full.pdf

Additional resources

Center for Reproductive Rights. 2019. **Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights**. New York: Center for Reproductive Rights. Available at: https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf

FP2020. 2016. **Momentum at the Midpoint: 2015–2016 Progress Report**. "FP2020's Rights and Empowerment Principles for Family Planning", p. 41. Washington, DC: FP2020. Available at: http://2015-2016progress.familyplanning2020.org/uploads/08/01/FP2020_DIGITAL_Single_LoRes.pdf

FP2020. 2018. **Rights-sizing Family Planning. A Toolkit for Designing Programs to Respect, Protect, and Fulfill the Rights of Girls and Women**. Washington, DC: FP2020. Available at: http://familyplanning2020.org/sites/default/files/Rights-sizing_Family_Planning_Toolkit_EN.pdf

Hardee, K, J Kumar, K Newman, L Bakamjian, S Harris, M Rodriguez, and W Brown. 2014. **"Voluntary, Human Rights-based Family Planning: A Conceptual Framework."** Studies in Family Planning. 45(1): 1-18. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1728-4465.2014.00373.x

United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). 2016. **General comment No. 22** (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights). Available at: https://digitallibrary.un.org/record/832961?ln=en

United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). 2000. **General Comment No. 14**: The Right to the Highest Attainable Standard of Health (Art. 12). E/C.12/2000/4. Available at: https://digitallibrary.un.org/record/425041

UNDG Human Rights Working Group. 2003. **The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among UN Agencies**. Available at: https://unsdg.un.org/resources/human-rights-based-approach-development-cooperation-towards-common-understanding-among-un

World Health Organization (WHO). 2014. **Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations**. Available at: https://iris.who.int/bitstream/handle/10665/102539/9789241506748_eng.pdf?sequence=1

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