AN ADVOCATES' TOOL FOR MONITORING RIGHTS-BASED PROVISION OF CONTRACEPTIVE INFORMATION AND SERVICES IN INDIA

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This Advocates' Guide for a rights-based programme on contraceptive services and information comes at the unfortunate juncture of the deaths of 16 women following laparoscopic sterilisations in the state of Chhattisgarh in central India. We dedicate this Guide and our work to these women and their families as we aspire to prevent such unnecessary deaths.

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Introduction and Context

Chapter 1

1.1 Introduction to the Advocates' Guide

This Advocates' Guide has been developed based on the recommendations made in the World Health Organization's "Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations," (herein referred to as the "WHO technical guidance"), which has been distributed to governments for their use[1]. This Guide is intended as a tool to enable Sexual and Reproductive Health and Rights (SRHR) advocates in India to hold the government accountable for upholding human rights in the provision of contraceptive information and services. It will enable advocates to ask the right questions in determining whether or not rights-based contraceptive services are being provided in their communities. This tool, then, seeks to give advocates an understanding of what constitutes a rights-based contraceptive programme, as per WHO technical guidance, and also provides a platform for discussion among government and civil society.

The series of recommendations made in the WHO technical guidance document is aimed at policy makers and programme managers to ensure that *"the different human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services" [1].* Voluntary choice in marriage and family formation; determination of the number, timing and spacing of one's children; and access to the information and means needed to exercise voluntary choice are not only goals to aspire for. These "reproductive rights" are core to the protection of human rights, self-determination and equality embodied in the Universal Declaration of Human Rights.

We examine the global and national contexts that have a bearing on the implementation of the contraceptive programme in India.

1.2 The Global Context

In 1994, the International Conference on Population and Development (ICPD) in Cairo rejected demographically driven population policies and upheld respect for reproductive rights. Through the ICPD Programme of Action, the 179 countries who signed on to it acknowledged that reproductive rights are human rights recognised by international and national laws. In subsequent decades, many UN institutions and mechanisms including the Human Rights Council and Human Rights Treaty Monitoring Bodies have contributed to the recognition of sexual and reproductive health and rights as an integral part of the entitlements guaranteed to all persons by human rights.

And yet, during this second decade of the twenty-first century, and 20 years after the ICPD, an estimated 222 million women globally, constituting 26 per cent of women who wish to avoid a pregnancy, are not using a modern method of contraception. This group of women with an 'unmet need' for contraceptive services account for 79 per cent of all unintended pregnancies [2]. Given the legal restrictions on abortion services in many countries globally, they are forced to continue with an unwanted pregnancy or to resort to illegal and often unsafe abortions putting their health and lives at jeopardy.

1. World Health Organization. *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations.* Geneva, WHO, 2014.

The London Summit on Contraceptives organised in 2012 by the Bill and Melinda Gates Foundation and the UK government brought together private foundations, governments, and international NGOs to reaffirm their commitment to achieving a significant reduction in the numbers and proportions of women with an unmet need for contraception. Countries pledged US$ 4.6 billion over the next eight years towards realising this goal.

Even while SRHR advocates and activists have reason to laud the increased investment in contraceptive services, they also have reason to be watchful about the ways in which this will impact realities on the ground. Memories of coercive population control policies and their traumatic consequences are still fresh in the minds of SRHR advocates and people in many countries of the global South. In India the continuing focus of targets and incentives, the old mindsets of 'population explosion' and the failure to acknowledge the demographic changes, and the need for a different programme on the ground, are a reality.

1.3 The Context in India

1.3.1 Recent Indicators

While many of the indicators related to the population programme in India have shown an improvement, there are others that are a cause for concern:

- **The Total Fertility Rate (TFR)** in the country has recorded a steady decline – from 2.9 in 2005 to the current levels of 2.4 (SRS 2011)
- **Mean Age at Marriage for Women** has increased from 20.2 years in 2005 to 21.0 years in 2011 (Census 2011)
- **The Contraceptive Prevalence Rate (CPR)**, the proportion of eligible couples protected by some method of contraception, is only around 54 per cent compared to the global average of 62.7 per cent in 2009 (World Contraceptive Use, 2011)
- **The Unmet Need,** which is the percentage of women who do not want to have another child but are not using any contraception, is 21.3 per cent (DLHS III); 154 out of 284 (54%) districts in the country have an unmet need of 25 per cent or more (AHS 2010)
- **Spacing between Births** is low, as around 47 per cent of births have less than a 30-month spacing
- **Adolescent Fertility:** 47 per cent of total fertility is within the 15-25 age group and this age group forms 45 per cent of total maternal mortality
- **Low Age at First Child Birth:** 5.6 per cent of girls aged 15-19 years are either pregnant or already a mother (DLHS 3); out of 284 districts, 133 have more than 35 per cent of girls aged 15-19 years who are already mothers or pregnant (AHS 2010)

1.3.2 Policy and Programme Context

The Historical Context. India was the first country to launch a national family planning programme, which it did in 1952. The objective of this programme was "reducing the birth rate to the extent necessary to stabilise the population at a level consistent with the requirement of the national economy". The programme has had a chequered past since its inception. In the 1960s, the widespread introduction of the intrauterine contraceptive device (IUCD), with inadequate attention to developing supportive and quality service-delivery systems, resulted in undermining the popularity of this safe, effective, and economical method [3]. During the Emergency years (1975–77) the government sponsored sterilisation camps and followed other potentially coercive strategies to meet aggressive family planning targets. In the 1980s, government programmes began to emphasise permanent and long-acting methods through various means, including setting targets for the numbers of sterilisations and IUCD insertions performed by health and non-health departments, workers and officials. The Programme also went through a series of name changes from Family Planning to Family Welfare and changes in strategies – the target-free approach, community needs assessment approach and so on. After the ICPD in 1994, where India also ratified the Programme of Action, in keeping with its commitments India adopted the target-free approach in family planning in 1996. This meant that family planning uptake would be guided by the needs of the population and decided by clients through informed choice. In 2012, in response to the global summit for Family Planning, India too decided to 'reposition' family planning.

India's current Family Planning Programme is guided by the National Population Policy, 2000. Programmatically, it is an integral component of the Reproductive Maternal Newborn and Child Health plus Adolescent Health (RMNCH+A) Strategy that was launched under the National Rural Health Mission (NRHM) in 2013 (see excerpts from the Strategy document below). This Strategy is based on ICPD principles, and follows the continuum of care approach across all life stages, from adolescence, through pregnancy and childbirth, and on to the infant and child. It details the interventions required at each stage to ensure optimal health (especially sexual and reproductive health) of the individual.

The RMNCH + A Strategy Document States:

A new strategic direction has been developed for the family planning programme, wherein it has been repositioned to not only achieve population stabilisation but also to reduce maternal mortality as also infant and child mortality. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health.

These services will be delivered at home, through community outreach and at all levels of health facilities and include adolescents and adults in the reproductive age group.

(A Strategic Approach to RMNCH+A in India, GOI, January 2013)

Strategies under Family Planning Programme in India	
Policy Level	**Service Level**
Target-free approach	More emphasis on spacing methods
Voluntary adoption of family planning methods	Assuring quality of services
Based on felt need of the community	Expanding contraceptive choices
Children by choice and not chance	

The RMNCH+A programme's emphasis is to address the unmet need for contraception through the introduction of newer contraceptives and community-based distribution of contraceptives through ASHAs. The programme also seeks to strengthen family planning service delivery, especially post-partum services in high case-load facilities and enlisting private/NGO facilities to improve the provider base for family planning services. Taking advantage of the institutional deliveries promoted by the Janani Suraksha Yojana (JSY) conditional cash transfers, the new programme thrust is also on post-partum IUCDs.

1.3.3 Issues in India's Family Planning Programme [3]

Despite all the policy and programmatic changes mentioned above, on the ground and in reality several issues remain. These are:

1. **Continuing Fear of a 'Population Explosion'** There is limited understanding that the population growth rate is declining and that whatever growth we see is due to the population momentum and unmet needs for contraceptives, and not due to wanted fertility.

2. **Continuing Emphasis on Targets** Although we are officially supposed to be in the 'target-free' era, the expected levels of achievement (ELAs) set by the state and district health authorities on the basis of past performance, is what the peripheral workers are expected to achieve. The lower-level health workers reportedly receive punitive action if these ELAs are not met.

3. **Continued Reliance on Camp-based Sterilisation Services** Sterilisation still continues to be the main contraceptive method in India with female sterilization at 34 per cent. Sterilisations mostly take place through camps, the quality of services in which has been the subject of much criticism.

4. **Incentives for Sterilisations** States offer inducements for sterilizations, ranging from gun licenses to Nano cars, television sets and two-wheelers.

5. **The Two-child Norm** which is implemented in many states, penalises usually lower-level government functionaries, panchayat members and women.

6. **Lack of Information, Health Literacy among Women and Girls as well as Men and Boys** lack of contraceptives counseling, lack of choice in relation to contraceptives.

7. **Anxiety and Inconsistency in Policy Arenas about Sexuality Education** even in a context where almost one-third of the girls are married before the age of 18 years. This results in a lack of contraceptive information and services. In addition, there are taboos associated with abortions and young girls cannot access these services from the public health facilities.

8. **Exclusion of many Groups from Services** such as, young people not in a relationship of marriage, sex workers, and people living with disabilities.

It is within this policy and programme context and with due cognizance of the issues in the programme, that this Advocates' Guide for rights-based contraceptive services has been developed.

1.4 How was this Guide Developed?

The contents of this document are adapted from an Advocates' Guide prepared by the second author for ARROW. The FP2020 tool is a generic tool for monitoring rights-based contraceptive services globally. The contents of the generic document were adapted for use in India. A draft of the India Advocates' Guide was discussed by a small group of experts in a consultation in September 2014. This version of the Guide is based on feedback received at the consultation and from external reviewers, as well as field-level enquiries with various stakeholders - young people, women users, frontline providers, district-level health officers, and so on. The field-level enquiries were conducted by participants of the September 2014 consultation.

Experts at the consultation reinforced the need for such an Advocates' Guide in India at the current moment, given the disjunction between stated policies and ground-level realities in programme implementation. Given the changing scenario at the global level regarding 'repositioning family planning' and its implications for national policies, it was felt that this Guide would help assess if contraceptive services in India are being provided in a rights-based manner or not.

1.5 How can this Guide be Used? And by Whom?

As mentioned above this Guide is meant for SRHR advocates in India to monitor contraceptive services at the state, district and sub-district levels. The possible target audience under the rubric 'SRHR advocates' can include:

- women's organisations (both NGOs and local CBOs/sangathans like mahila mandals, self help groups for example);
- health organisations, including those involved in community monitoring under the NRHM or those training Village Health and Sanitation Committees; and
- any organisation, group or individual working with a rights-based approach.

Health-care providers and health administrators can also use the Guide as a resource for equipping themselves to provide rights-based contraceptive services, to identify rights violations, and to monitor the provision of services from within the system. Medical educators can use the Guide as

teaching material. This Guide can be used during the annual Common Review Missions to assess contraceptives programmes in the states.

Since the WHO Guidelines have been sent to countries, who have then signed on its recommendations, the Advocates' Guide can be used as a tool for holding the Indian government accountable for providing rights-based contraceptive services. Existing platforms for health rights' advocacy can be used for protecting rights regarding contraceptive service provision. Some of these platforms and alliances are:

- National Coalition for Two-Child Norm and Coercive Population Policies
- Jan Swasthya Abhiyan
- CommonHealth
- NAMHHR- National Alliance for Maternal Health and Human Rights
- Community-Based Monitoring/Community Action for Health platforms such as Jan sunwai, CBM committee meetings and so on.

1.6 Contents and Design of the Guide

This Guide is designed as a resource on rights-based contraceptive programmes. Readers may therefore use specific sections according to their own areas of work and contexts, and not exhaustively. We explain the spirit and meaning of each WHO Recommendation and try and provide a broad range of standards against which progress on the Recommendation can be assessed. These standards can include government guidelines, protocols, programme contents and strategies, related international conventions and treaties. A checklist of possible questions to assess each Recommendation is also provided in each section. These checklists are then compiled in separate concise tools in an annexure for easy reference. There are two tools - one to assess policies related to contraceptive services and the other to assess the practice in local areas in the provision of these services. Depending on the context and need, readers/users may do a mix-and-match exercise and evolve their own checklist, drawing from their understanding of each WHO principle.

Contents of the Guide

The Guide is organised in four chapters. Chapter 1 provides an overall context of the contraceptive programme in India and globally. This chapter also introduces readers to the Advocates' Guide. Chapter 2 presents concepts and definitions related to rights-based contraceptive information and services. Chapter 3 contains the Recommendations from the WHO Guidance Document. Each WHO recommendation is followed by definitions of important terms and the rationale for the recommendation based on research evidence; wherever possible some standards from policy and programme guidelines have been used. Illustrative examples are provided where necessary in text-boxes. Following each recommendation, or a set of recommendations as mentioned above, is a box with a checklist of questions which probe the extent to which a government has implemented or complied with a specific (set of) WHO recommendation(s). Responding to the questions in each of

these would result in a human rights situation-analysis with respect to contraceptive information and services in a given setting.

Chapter 4 contains directions on how to use the information collected through the checklists – how to approach the structures and mechanisms for redress, how to prioritise the issues for advocacy in terms of rights' violations, how to generate evidence for advocacy to specific stakeholders, and so on.

Annexure 1 is a compilation of some standards from official guidelines and protocols. Annexure 2 contains compiled monitoring checklists. Annexure 3 contains a brief report of the Chhattisgarh sterilisations tragedy as a case study to highlight the WHO principles and recommendations.

1.7 Some Caveats

Participants in the September 2014 meeting emphasised that it is important to situate contraceptive services within a framework of comprehensive sexual and reproductive health and rights and primary health-care. Contraceptive services cannot be a stand-alone vertical programme - the backward and forward linkages have to be recognised. Body literacy, information and counselling are as important as safe abortion services in the event of the failure of contraceptives, and should be addressed in a seamless fashion. Similarly, the quality of care in a contraceptive programme cannot be isolated from a generic quality of health-care culture. And accessibility of contraceptive services is a function of accessibility of general health-care.

Thus while we develop – and use – this Advocates' Guide specifically for contraceptive services, the larger context and linkages to SRHR have to be kept in mind: how do we ensure and promote rights-based contraceptive services when there is gross indifference to health rights in general, when the sexual and reproductive health rights of many vulnerable groups are routinely being violated?

This chapter presents concepts and definitions related to contraceptive services and human rights that are used throughout the Guide.

2.1 Comprehensive Contraceptive Information and Services (Not Family Planning Services)

Throughout this document 'contraceptive services' has been used rather than the term 'family planning' services, although latter term has been in use for many decades, and may be better understood in many contexts. This is because the term 'family planning' is inherently biased in that it suggests that the services are only for those within the context of a family or a married couple. The indirect implication is that unmarried adolescents and young people, sex-workers and others who have a need to prevent pregnancy but may not be part of a "family" are not legitimate clients of the programme.

In using the term 'contraceptive services' this guide explicitly considers sexually active adolescents and young people, women and men of all ages and diverse sexualities as legitimate clients of contraceptive services.

Comprehensive' contraceptive information and services refers to the provision of information and services for all methods of contraception without imposing programme-based or provider-based restrictions of specific contraceptive methods.

2.2 Human Rights-Based Approach

Human rights derive from various sources like the Constitution of India, international treaties and agreements to which the Government of India is a signatory, and Supreme Court or High Court judgements that can be applied or interpreted in the context of contraceptive service provision.

A human-rights-based approach has two major features. One, it takes the position that ensuring access to education, health-care and other basic needs and amenities for all its citizens is not contingent on the good will of governments, but obligations they are required to fulfil as a result of their ratification of international and/or regional human rights treaties [6]. And two, a rights-based approach integrates international, regional and national human rights standards, principles and processes into plans, policies and programmes.

The human-rights-based approach considers all persons as rights-holders, while the government and its agents are duty-bearers with specific obligations to fulfil. This will mean, for example, that providing contraceptive services is an obligation of the state, not an act of charity, or left to the discretion of governments to provide or not (Box 1). High levels of unmet need for contraceptive services or poor quality of care are not inevitable, but the consequence of deliberate decisions and policies, and governments are obliged to explain why they did not increase progressively their investments in contraceptive and allied health services [7].

Box 1 Governments' Human Rights Obligations as Duty Bearer

Governments have three levels of obligation: to respect, protect and fulfil every right. Respecting rights means that the state cannot violate rights or interfere in the enjoyment of rights. For example, the state cannot have laws or procedures that discriminate against access to sexual and reproductive health services for single women.

Protecting rights means the state has to prevent violations of rights by non-state actors, and offer redress if a violation does occur. For example, the state would be responsible for making it illegal for a private health facility to deny health-care to a person on the basis of a health condition. Likewise, it would be the responsibility of the state to ensure that women are not subjected to violence within their homes or in their workplace.

Fulfilling rights means that the state has to take all appropriate action (e.g., legislative, administrative, budgetary and judicial measures) to create conditions that enable people to enjoy rights. For example, even a low-income state is expected to show an increase every year in the resources it mobilises to meet the public health needs of its entire population.

Source: *Adapted from WHO-EURO. (2010) Checklist for assessing the gender responsiveness of sexual and reproductive health policies. Pilot document for adaptation to national contexts. Copenhagen, World Health Organization Regional Office for Europe.pp 2 [5].*

2.3 Human Rights Principles and Standards

Within the context of contraceptive policies and programmes, a human-rights-based approach is one that will include the following nine key human rights principles and standards:

1. Non-discrimination in the provision of contraceptive information and services
2. Availability of contraceptive information and services
3. Accessibility of contraceptive information and services
4. Acceptability of contraceptive information and services
5. Quality in the provision of information and services
6. Informed decision-making on contraception
7. Privacy and confidentiality in provision of services
8. Participation in decision-making related to the contraceptive programme and policy, and
9. Accountability

These principles and standards are further elaborated overleaf.

A contraceptive programme adopting a human rights-based approach would not be a vertical, stand-alone programme, but integrated within a comprehensive sexual and reproductive health programme.

2.3.1 Non-discrimination in the Provision of Contraceptive Information and Services

Contraceptive information and services must be provided without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status. The design of programmes should take account of the fact that vulnerable groups may face special barriers.

2.3.2 Availability of Contraceptive Information and Services

This means that the following must be available in sufficient quantity and distributed equitably across geographical areas and communities: adequate health-care infrastructure and trained health-care professionals; supplies and equipment; basic amenities such as potable drinking water and sanitation; and information and services on sexual and reproductive health including contraception.

2.3.3 Accessibility of Contraceptive Information and Services

Accessibility has three overlapping dimensions: physical accessibility; economic accessibility or affordability; and access to information [7]. This principle requires that all health-care is accessible to everyone without discrimination. No one can be denied the preventive, promotive or curative health-care including contraceptive services and allied sexual and reproductive health services that s/he needs.

Box 2 Three Overlapping Dimensions of Accessibility

Physical accessibility: Sexual and reproductive health facilities, goods and services must be within safe physical reach throughout the year for all sections of the population, especially marginalised groups. Accessibility also implies that the underlying determinants of health, such as safe water and adequate sanitation facilities, are within safe physical reach, even in the rural areas. Accessibility further includes adequate access to buildings for persons with disabilities [7].

Economic accessibility (affordability): Sexual and reproductive health facilities, goods and services must be affordable for all, and no one should have to forgo or postpone seeking appropriate and timely health-care because s/he cannot afford to pay for it at the time of need. Publicly financed sexual and reproductive health services, free at the point of service delivery, would remove financial barriers to access.

Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas on sexual and reproductive health issues and on the entire range of contraceptive methods, both modern and traditional. Information should be made available to everyone through appropriate communication channels and methods so that it meets the needs of different language-speaking groups; persons with limited literacy skills; those with disabilities, and so on [7]. The content of the information provided should uphold rights and be sensitive to differences in needs by gender, age, ethnicity and other axes of vulnerability.

Source: *UNFPA and Harvard School of Public Health (2010). A human rights-based approach to programming, practical implementation manual and training materials. New York, United Nations Population Fund. p. 18 [7].*

2.3.4 Acceptability of Contraceptive Information and Services

Health-care facilities and providers must be respectful of medical ethics in the provision of contraceptive information and services. They should respect the dignity of all clients, provide culturally appropriate care, be responsive to their needs, based on gender, age, culture (including religion, belief, values, norms and language), and physical abilities [6].

2.3.5 Quality in the Provision of Information and Services

All health-care, including contraceptive information and services, must be medically appropriate and guided by technical quality standards and control mechanisms. More importantly, it should be characterised by a positive attitude on the part of providers and informed decision-making on the part of the client, and provided in a timely and safe manner to the client's satisfaction [6].

2.3.6 Informed Decision-making on Contraception

Informed decision-making is already a component of services that are acceptable and respect medical ethics. It is also a characteristic of good quality of care. However, this element is considered separately because client autonomy and informed decision-making are key characteristics of a rights-respecting contraceptive programme. Free, full and informed decision-making is an expression of autonomy, upheld by medical ethics and international human rights law [9].

2.3.7 Privacy and Confidentiality in the Provision of Services

Respect for a client's privacy, confidentiality and dignity is a fundamental tenet of medical ethics. Upholding the client's privacy and maintaining confidentiality is important in all areas of health-care. It is especially critical when providing contraceptive information and services, as failing to ensure privacy and confidentiality could have several negative consequences, such as losing the client's trust, so the client does not return for service or follow-up.

2.3.8 Participation in Decision-making related to the Contraceptive Programme and Policy

Individuals and communities must play an active, free and meaningful part in the design and implementation of contraceptive service policies and programmes. Policies and programmes, therefore, create structures and mechanisms that will allow and enable participation by all stake-holders, especially traditionally excluded and marginalised groups.

2.3.9 Accountability

Governments and public agencies must be held accountable and answerable for their actions or omissions related to their duties on protecting the right to health-care, including the right to contraceptive information and services, through enforceable standards, regulations and independent compliance-monitoring bodies [5]. Governments are also accountable for regulating the actions of private entities, such as private health-care providers, insurance companies and pharmaceuticals, so that their actions do not violate citizens' right to health.

2.4 Why a Human Rights-based Approach to Contraceptive Information and Services?

What is the "value-added" by adopting a human rights-based approach in the context of contraceptive services?

- A human rights-based approach provides an overall framework and set of universal values – for example, equality, non-discrimination, participation and accountability – on which to base contraceptive services.
- The principle of equality, which is fundamental to the human-rights-based approach, calls for a focus on the most vulnerable and marginalised sections of society, and makes it obligatory to reach the 'difficult-to reach' sections of the population.
- Attention to gender equality follows from the principle of non-discrimination that a human rights- based approach stands for.
- The principle of participation requires that people participate meaningfully in decisions about contraceptive policies and programmes.
- The accountability principle guarantees the availability to client/ users of programme of redress mechanisms for grievances and rights violations [8].

The cost of not adopting a human-rights-based approach in the provision of contraceptive information and services could be high. For example, it may result in the lack of attention to less powerful or poorly resourced groups, such as low-income people, young people, single women, and persons with different sexualities. This would influence the programme's ability to reduce the unmet need for contraceptive services. Worse still would be the consequences for the under-served groups, which could be unwanted pregnancies ending in poor pregnancy outcomes or unsafe abortions.

When human rights is not the guiding principle for programme planning, programmes may focus exclusively on achieving fertility reduction, contributing inadvertently to inadequate importance given to quality of care in service delivery settings. The consequences may be avoidable reproductive morbidity, including the threat of HIV infection and a poor image and low acceptability for contraceptive services. Providers who are not aware of the need for maintaining client confidentiality may inadvertently disclose to a husband contraceptive use by his wife. In the case of women experiencing gender-based violence this could seriously threaten their safety and security.

Lack of access to contraceptives is ultimately a violation of the right to equality of women because it hampers their equal participation in society. For these and many other such reasons, ensuring human rights in the provision of contraceptive information and services is not only an added value to an efficient programme, but a moral imperative.

2.5 Commitments and Standards

Monitoring the delivery of rights-based contraceptive services and information requires an examination against certain standards. These standards can be derived from a number of sources: sources of rights (like the Constitution of India, legal frameworks, judgements and rulings - see Box 3 for an example of legal standards); frameworks promised in policy and programme documents (e.g., the National Population Policy, Youth Policy, National Health Mission Framework for Implementation, RMNCH+A Strategy, etc.); and standard operating procedures, methods, processes and mechanisms that a programme lays down in various manuals (e.g., the IUCD Reference Manual for Medical Officers [July 2007], Guidelines for Administration of Emergency Contraceptive Pills by Health-care Providers [November 2008], IUCD Reference Manual for Medical Officers [July 2007], Comprehensive Abortion Care: Training and Service Delivery Guidelines [2010], and so on).

Box 3 Recent Legal Standards for Sterilisations

1. Ramakant Rai v. Union of India, Supreme Court W.P. (C) 209/2003

In this case, the Supreme Court ordered state governments to take immediate steps to regulate health-care providers who perform sterilisation procedures, and to compensate women and families of women who suffer complications or death as a result of unsafe sterilisations.

Outcome: The Supreme Court directed the Union of India to lay down uniform standards to be followed by state governments on the health and age of proposed patients, norms for compensation, the format of statistics, the checklist, consent proforma, and insurance. Until the Union of India proscribes guidelines governing compensation, the Supreme Court has directed states to pay Rs. 1 lakh in case the patient being sterilised dies, Rs. 30,000 if the patient is incapacitated or faces post-operative complications.

2. Devika Biswas v. Union of India & Ors., Supreme Court W.P. (C) 95/2012

In spite of the Supreme Court's orders in the Ramakant Rai case, forced and unsanitary sterilisations continue throughout India. Often held at public locations like government schools, these camps typically target poor, tribal, and dalit women. Women are sterilised without their consent because the nature of the procedure is not explained to them, and as a result of negligent treatment, many women eventually succumb to infection and death.

Outcome: The case was filed in mid-2012 and is still pending. The Supreme Court ordered states to file reports outlining the steps they have taken to comply with the Ramakant Rai orders. Some states took over two years to submit their replies, but the Petitioner now has a complete record of every state's actions to ensure informed consent and quality of care in sterilisation camps. Unfortunately, the state affidavits convey a message of resounding apathy. Not a single state provided proof of Quality Assurance Committee meetings. Only one state had ever taken punitive action following a guideline breach. Most states have updated their list of empanelled sterilisation doctors since 2006. The Supreme Court will hear full arguments in this matter in December 2014.

Annexure 1 provides some of the standards that can be used to assess rights-based implementation of contraceptive programmes. These standards are also included as illustrations in the body of the chapter on the WHO recommendations (Chapter 3). Readers are, however, encouraged not to restrict themselves to the standards listed here, but to search for other documents that can serve as or provide other standards.

WHO Recommendations for Monitoring

This chapter looks at applying the WHO Recommendations on the rights-based provision of contraceptive services in the Indian context. It allows practitioners to monitor the extent to which a government has implemented or complied with a specific recommendation (or set of related recommendations) while providing these services, and where the gaps remain. Service delivery and programmes can also be monitored against standards set by official Indian government sources.

We first give an overview of all the WHO Recommendations under each of the nine principles – non-discrimination, availability, accessibility, acceptability, quality, informed decision-making, privacy, confidentiality, and accountability. In the next section, under each principle, one recommendation is (or a cluster of related recommendations are) listed and explained. The issues related to this recommendation are then briefly stated, and some illustrations are provided in boxes alongside. A checklist of questions to help practitioners (and others) monitor the recommendation is then presented. These questions are listed in two columns – those that can help monitor at the policy and/or programme level, and others to monitor service delivery. We also provide material from selected Government of India documents that can serve as standards for the monitoring process.

3.1 Recommendations by the WHO to Member States

Box 4 below gives the WHO recommendations on the provision of rights-based contraceptive services based on the nine key human rights principles and standards (see section 2.3 in Chapter 2).

Box 4 Who Recommendations based on Key Human Rights Principles

1.	**Non-discrimination in the Provision of Contraceptive Information and Services**
1.1	Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice).
1.2	Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginaliszed populations in their access to these services.
2.	**Availability of Contraceptive Information and Services**
2.1	Recommend integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability.
3	**Accessibility of Contraceptive Information and Services**
3.1	Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition.

3.2	Recommend eliminating financial barriers to contraceptive use by marginaliszed populations including adolescents and the poor, and make contraceptives affordable to all.
3.3	Recommend interventions to improve access to comprehensive contraceptive information and services for users and potential users with difficulties in accessing services (e.g., rural residents, urban poor, and adolescents). Safe abortion information and services should be provided according to existing WHO guidelines (*Safe abortion: technical and policy guidance for health systems, 2nd edition*).
3.4	Recommend special efforts be made to provide comprehensive contraceptive information and services to displaced populations, those in crisis settings, and survivors of sexual violence, who particularly need access to emergency contraception.
3.5	Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health-care setting.
3.6	Recommend that comprehensive contraceptive information and services be provided during antenatal and postpartum care.
3.7	Recommend that comprehensive contraceptive information and services be routinely integrated with abortion and post-abortion care.
3.8	Recommend that mobile outreach services be used to improve access to contraceptive information and services for populations who face geographical barriers to access.
3.9	Recommend elimination of third-party authorization requirements, including spousal authorization for individuals/women accessing contraceptive and related information and services.
3.10	Recommend provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents.
4	**Acceptability of Contraceptive Information and Services**
4.1	Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that include skills building (i.e. communications and negotiations), and that are tailored to meet communities' and individuals' specific needs.
4.2	Recommend that follow-up services for management of contraceptive side-effects be prioritiszed as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and available.

5	**Quality of Contraceptive Information and Services**
5.1	Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes.
5.2	Recommend that provision of long-acting reversible contraception (LARC) methods should include insertion and removal services, and counselling on side-effects, in the same locality.
5.3	Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.
6	**Informed Decision-making on Contraception**
6.1	Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.
6.2	Recommend every individual is ensured the opportunity to make an informed choice for their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination.
7	**Privacy and Confidentiality in the Provision of Services**
7.1	Recommend that privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information.
8	**Participation in Decision-making related to the Contraceptive Programme and Policy**
8.1	Recommend that communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring.
9	**Accountability**
9.1	Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.
9.2	Recommended that evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur. Recommend that, in settings where performance-based financing (PBF) occurs; a system of checks and balances should be in place, including assurance of non-coercion and protection of human rights. If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability.

3.2 Principles and Recommendations

Based on this grouping of WHO Recommendations for the provision of contraceptive services based on human rights principles, we now explain the issues in India. For each recommendation in the WHO technical guidance, a checklist of probing questions is presented to assess whether rights are being upheld. Answering these questions will give us a subjective view of the following:

1. Have rights-based principles been applied to contraceptive programmes in the community/state/country?

2. To what extent has the community/state/country adopted the WHO recommendations to rights-based contraceptive services?

3. What are the remaining gaps that need to be addressed in order to ensure that the contraceptive programmes in the community/state/country meet the WHO recommendations to rights-based contraceptive services?

Answers to these questions will provide an view of the extent to which rights-based principles are incorporated into contraceptive information and services within a specific context; they will also give clear and specific direction to future advocacy by highlighting gaps and identifying inefficiencies or inconsistencies.

The checklists may appear to be long – readers can adapt the checklists, using what is relevant for them in their contexts. The checklist can be supplemented by the comprehensive and compiled monitoring tools given in Annexure 2.

1 Non-discrimination in the Provision of Contraceptive Information and Services

WHO RECOMMENDATION 1.1.

Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice)[2] .

This recommendation highlights the principle of autonomy, of voluntary acceptance of contraceptive services and information. There should be no coercion, either direct or indirect, either by conditionalities or through incentives.

Forced or coerced sterilisations and IUD insertions have been reported from many parts of the world. 'Forced' refers to sterilisation or IUD insertion without a person's knowledge, while 'coerced' includes situations when misinformation or intimidation is used to make a person accept a method of contraception, or when other benefits/services are made conditional on the 'acceptance' of

2. *Both this recommendation and the next address non-discrimination. To avoid repetition, the discussion on non - discrimination, and the corresponding checklist, has been taken up in the next sub-section, while this sub-section focuses on involuntary and coerced contraception.*

contraception [10]. For example, studies from India have reported that medical termination of pregnancy in government health facilities is often conditional on acceptance of sterilisation or an IUD [11]. Making limited contraceptives available is also a form of coercion – users are forced to accept contraceptives out of limited choices.

Incentives and disincentives are a more indirect means of taking choice away from the client. India has a history of building in incentives and disincentives to ensure "acceptance" of contraception. This takes the form of cash or other benefits to clients for adopting a contraceptive method, or denying them a benefit if they chose not to accept any method [12]. There are also rewards offered to health-care providers for achieving specific contraceptive "targets" or penalties imposed for non-achievement of specific targets. Not only are these clear violations of clients' right to choose, in practice, the system of incentives and disincentives has been seen to deteriorate into coercive or unethical practices on the part of health-care providers; clients have accepted contraception not because they did not want to have a child just yet or wanted to stop childbearing, but because they were in financial distress [13]. Box 5 describes how targets and incentives play out in Rajasthan.

Box 5 Examples of Targets and Incentives in Rajasthan

1. The ration unit and fair price shops in Bundi district of Rajasthan have been given instructions by the State Health Department to meet the target of at least two sterilisations before March 30, 2013. There is also an incentive attached. The dealers with the maximum cases will be certified and rewarded. Targets have been distributed to the fair price dealers because the Health Department workers have not been able to meet their family planning targets, which focus heavily on sterilisation.

2. In a family planning camp held (March 22, 2013) in a Community Health Centre (CHC) in Raipur Block of Pali district of Rajasthan, the District Collector announced various prizes including motorcycles, colour TVs and home appliances to be distributed to 'lottery winners' among couples who opted for permanent sterilisation, as well as to village health providers who met their targets to motivate women for sterilisation.

Source: *Rajasthan Patrika (local newspaper), 22.03.2013*

The two-child policy is another discriminatory practice in several states of India. This policy bars individuals with more than two children from contesting panchayat and municipal elections, and disqualifies government employees from promotions and other incentives. Rajasthan was the first state in the country to implement the two-child policy in 1992 barring people with more than two children after 1994 from contesting panchayat and municipal elections, and extended the policy to cover promotions and incentives for government employees with a cut-off date of June 2002. Many other states like Punjab, Haryana, Orissa, Himachal Pradesh, Bihar and Andhra Pradesh had also adopted this policy but most have now withdrawn it.

Independent audits of the two-child policy have clearly shown that women are at the receiving end because they have little say in deciding on the number of children they have and often faced

disqualification if they have a third child. [14] There have been instances where women have been abandoned by their husbands to avoid disqualification after the birth of a third child. Unfortunately, a Supreme Court judgment of 2003 upheld the discriminatory policy citing the reason as 'national interests'. A three-judge Bench on July 30, 2003 observed that "disqualification on the right to contest an election for having more than two living children does not contravene any fundamental right, nor does it cross limits of reasonability." [14]

Box 6 includes a stipulation from a government guideline that there should be no discrimination in prescribing the Emergency Contraceptive Pill to adolescent unmarried girls as commonly happens. Moralistic, judgemental health care providers consider it their duty to 'advice' girls and often this results in an indirect denial of services. This stipulation can be used as a standard for monitoring the delivery of services.

Box 6 — A Possible Standard for Non-discrimination

Emergency Contraceptive Pills (ECPs) should be not be denied to clients within the reproductive years irrespective of their age and marital status

Source: *Guidelines for Administration of Emergency Contraceptive Pills (ECPs), 2008, GOI*[3]

Monitoring Checklist 1: Non-discrimination

Examine the contraceptive programme guidelines, government orders and other official documents related to the programme. Also draw on observations from the field.

Policy/Programmatic Level	Service Delivery Level
Do any programme guidelines and/or Government Orders (GOs)/government documents state that no person shall be forced against his/her will to accept any method of contraception that s/he does not wish to?	In practice, do service providers/health facilities experience any disincentives or penalties for not achieving a specified number or proportion of "acceptors" of contraception?
Does the contraceptive programme have mechanisms in place (spot-checks, feed-back mechanisms) to ensure protection from forced or coerced contraceptive for persons from marginalised groups (e.g., low-income, minority communities, PLHIV, women living in institutions)? Is there a two-child policy in the state?	Is there a practice of offering any incentives (money or gifts) to a client for adoption of contraception in general or a specific method of contraception at any time or under any circumstances (e.g., those with three children in order to prevent higher order births)?

3. *Guidelines for Administration of Emergency Contraceptive Pills by Health-care Providers Family Planning Division,* Ministry of Health and Family Welfare, Government of India, November 2008

Monitoring Checklist 1: Continued

Do any programme guidelines and/or G.Os/government documents specify that informed consent should be obtained from any client receiving contraceptive services?	In practice, is any service (e.g., medical termination of pregnancy) or benefit (subsidised food, employment, maternity benefits) made conditional on acceptance of/being a user of contraception?

WHO RECOMMENDATION 1.2

Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalised populations in their access to these services.

This recommendation points to inclusive services, to ensure that no one is excluded either actively or inadvertently.

For contraceptive information and services to be 'inclusive' and provided to all segments of the population, the very terminology of 'family planning' may need to be dropped, so that those who require contraceptive services outside the context of 'family', e.g., single persons, adolescents and young people, and sex workers, do not feel intimidated and excluded.

Contraceptive information and service programmes have focused exclusively on women. Unfortunately, this has had the effect of burdening women with the entire responsibility for contraception, while at the same time restricting access to services even for those men who want to use contraception. Combining contraceptive services with maternal health-care – the classic MCH/FP programming model – is another example of discriminatory programming that sends signals to the community that men, single women, 'non-mothers' – women who have not yet begun childbearing or women who do not intend having children – are not considered potential clients.

An inclusive contraceptive information and services programme will not be a vertical stand-alone programme but an integral component of a comprehensive Sexual and Reproductive Health (SRH) Programme (see Box 7 for the components of such a programme).

As mentioned earlier, adolescents and young people frequently face discrimination in receiving contraceptive services. Health providers often believed that distributing contraceptives to adolescents and young people will encourage promiscuity [15]. The fear of being chided and humiliated by the provider is often reported by adolescents in many developing countries as a reason for not using SRH services. And young women are even more affected by providers' gender double-standards regarding appropriate sexual behaviour [16-17].

Box 7 Components of a Comprehensive Package of SRH Services

- Contraceptive (FP)/birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Safe abortion services and provision of post-abortion care
- Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) including HIV/AIDS
- Early diagnosis and treatment for breast cancer and reproductive tract cancers in women and men
- Promotion, education and support for exclusive breastfeeding
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting (FGC)
- Adolescent sexual and reproductive health services
- Prevention and management of gender-based violence (GBV)

Source: *Adapted from Reerink IH and Campbell BB (2004). Improving reproductive health-care within the context of district health services: A Hands-on manual for planners and managers. New York: UNFPA*

The delivery of contraceptive services is also hampered by discrimination by religion, ethnicity and socio-economic status in many settings. An example of such discrimination in India is the violation of the reproductive rights of some tribal groups. The Baigas, Pahari Korwas, Abujhmarias, Birhors and Kamars have been designated as Particularly Vulnerable Tribal Groups (PVTGs) in Chhattisgarh. These communities face high levels of poverty and malnutrition, and limited access to health and nutrition services, manifested in high mortality rates. As a strategy for curtailing the decrease in the population of PVTGs after 1979, the Madhya Pradesh/Chhattisgarh state government restricted sterilisation among these tribal groups, attempting an increase in the birth rate rather than a decrease in the mortality rate. Today, PVTGs, unable to cope with their poverty and large families, are demanding the right to choose their family size and access to family planning services [18]. See Box 8 for a case study of pro-natalist violation of reproductive rights.

Box 8 Pro-Natalist Policies - Violation of Reproductive Rights?

Sabutri Bai recounts that she opted for sterilisation after giving birth to her sixth child three years ago but was surprised at what followed. “When the staff at the Lakhanpur clinic found out I am a Pahari Korva, they were going to dismiss the nurse who allowed me to get operated,” she says. “It makes no sense. We have 1.5 acres land. How do they expect us to provide for more and more children?” asks her husband, Phool Chand Ram, who used to work under the rural employment guarantee act, MNREGA, two years ago but gave it up when he received his wages only a year later. Their eight-member family survives by selling firewood, earning Rs 100 (US$1=Rs 55) for every two-day trip they make into the depleting forest.

Source: *Sterile Ban October 2, 2012. http://thiscorrespondence.wordpress.com/2012/10/02/sterile-ban/*

Other segments of the population which are often by-passed in the provision of contraceptive services include people with disabilities. Studies from Uganda and Zambia reported that requests for contraceptive services by women with disabilities were met with shock and surprise, and the women are subject to interrogation by health-care providers who tended to assume that persons with disabilities are asexual [19-20].

People living with HIV are often told by health providers that they should refrain from sex and childbearing, and for this reason they may fear seeking contraceptive services. The risk of being coerced into sterilisation would also be a barrier to PLHIV accessing contraceptive services [10].

Monitoring Checklist 2

Policy/Programmatic Level	Service Delivery Level
Is the contraceptive information and services programme labelled a “family planning” programme?	Do the services exclude marginalised groups? Are barriers encountered by them in accessing contraceptive information and services? Which groups have been left out?
Is the programme part of the maternal and child health programme?	
Do programme objectives explicitly mention attention to the needs of adolescents, young people and men?	In practice, are contraceptive information and services available to all sexually active persons irrespective of age, marital status or sexual orientation (e.g., single women; all men; adolescents and young people; sex workers, PLHIV)?
Do programme objectives include attention to marginalised groups such as people living in remote geographic areas; members of marginalised community groups; single women; disabled persons; sex workers; PLHIV; people of diverse sexual orientations and gender identities?	

2 Availability of Contraceptive Information and Services

WHO RECOMMENDATION 2.1

Recommend integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to ensure availability.

Although ensuring availability of contraceptive information and services requires action on many fronts (Box 9), the recommendation by WHO focuses on reproductive commodity security at the programme level. This would mean for example, that the full range of contraceptive commodities and supplies including emergency contraception, and the equipment necessary to provide these, should be included in the National List of Essential Medicines. Advocacy may be needed for adequate public funding for procuring contraceptive and reproductive commodities [21].

When contraceptive supplies are stocked-out, or equipment and supplies necessary to provide a specific method are unavailable at the service delivery point, this represents a major opportunity lost to serve clients – predominantly women – who may have reached the services after negotiating many hurdles. They may never be able to return, and unintended pregnancy may be the consequence. Increasing product-availability at the service delivery point calls for good supply-chain management of all contraceptive commodities, supplies and equipment at all levels.

The recommendation also talks about an effective contraceptive supply chain. The aim of an effective contraceptive supply chain would be to get the "right quantities of the right contraceptives to the right places at the right time in the right condition at the right cost" [22]. Procurement of contraceptives must be based not only on estimates developed by tracking past use. A needs assessment should be undertaken among under-served groups or hitherto un-served groups in the community so that supplies are adequate to cater to all those who need them. Such estimates must be periodically reassessed to account for changes in patterns of demand. They should also account for all methods including emergency contraceptive pills and condoms, and for all distribution points, e.g., at the facility level, community level and self-dispensing points like for condoms.

Another aspect of an effective supply chain is planning for the storage of contraceptive devices. Storage areas should be clean, well-ventilated, dry, well-lit, out of direct sunlight and pest-free. Planning for quality control and storage of contraceptive commodities, supplies and equipment is an essential component of good supply-chain management [22].

Box 9 Standards for Availability of Contraceptive Information and Services

1. The following contents of the RMNCH+A Strategy can be used as standards to monitor availability of information and services:

- Community-based doorstep distribution of contraceptives through ASHAs

Box 9 : Continued

- The ASHA's medicine kit includes condoms, OCPs and emergency contraceptive pills.
- Family planning in the village health and nutrition days mandated by the RMNCH+A Programme.
- Provision of contraceptives up to the village level, an improved logistic management system and the development of appropriate IEC and BCC tools. RMNCH+A Strategy document

2. Table 18.3 of India's National List of Essential Medicines 2011 includes contraceptives to be provided; this can be used as a standard for availability. [http://pharmaceuticals.gov.in/NLEM.pdf].

Monitoring Checklist 3

Policy/Programmatic Level	Service Delivery Level
Does the National Essential Drugs list include an expanded range of contraceptives including emergency contraceptive pills?	In practice, is the full range of contraceptives available to clients visiting service-delivery points?
Is assessing the availability of contraceptives part of community monitoring by the VHSNCs and Rogi Kaliyan Samities?	Have there been instances of stock-out of any contraceptive supplies (w.r.t. a fixed reference period and in a specific reference location, for example, with the ASHA, ANM, AWW)?

Box 10 Various Dimensions of Availability of Contraceptive Information and Services

The availability of contraceptive information and services requires that an adequate number of health facilities and health-care providers are available within a state to cater to the needs of all of its population. According to the WHO, the minimum threshold is 2 health-care facilities (out-patient) and 23 physicians, nurses and midwives per 10,000 population.

Even when these minimum threshold levels are satisfied, there may still be a scarcity of contraceptive service providers in some settings where contraceptive service provision is restricted to physicians. WHO has recommended 'task-shifting' as a strategy to address the shortage and uneven distribution of health-care workers. Task-shifting is a process of delegation of tasks, where appropriate, to less-specialised health-care workers.

Another situation of non-availability is when health-care providers are not present at the service delivery point or facility for the full duration of service timings, or are frequently not present for legitimate reasons or otherwise.

Box 10 : Continued

Another form of non-availability is from the 'conscientious objection' by providers to not provide SRH services, such as abortions and contraception, which interfere with their faith and beliefs. Many countries do not have a policy or law related to the denial of health services on the grounds of conscientious objection. The use of conscientious objection should be regulated by law and policy and, as decreed in a recent case before the European Court of Human Rights, providers may not "give priority to their personal beliefs over their professional obligations"[23].

Some examples of indicators that may be used to monitor these additional dimensions of availability include:

- Are there enough service delivery (including community-outreach) points in the government sector to ensure population coverage (as specified above - two service delivery points per 10,000 population)? Are these distributed rationally across rural/urban locations and sub-regions?
- Are human resources adequate to ensure population coverage (as specified by WHO - 23 physicians, nurses and midwives per 10,000 population)? Are these distributed rationally across rural/urban locations and sub-regions?
- Does every primary health facility have a health service provider trained to provide information and services for a wide range of contraceptives?
- How often are staff members absent at contraceptive service delivery points (including community-outreach points)?
- Is there a point-person or an office to which clients may report about staff absenteeism at contraceptive service-delivery points?
- Are there policy guidelines regulating conscientious objection by service providers to not provide contraceptive and abortion services? Do they affirm reproductive rights?

3 Accessibility of Contraceptive Information and Services

WHO lists ten recommendations under the principle of accessibility. This section explains the spirit of each recommendation and the issues in India that are related to the accessibility of contraceptive service delivery.

WHO RECOMMENDATION 3.1

Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside of schools that include information on contraceptive use and acquisition.

Sexuality education is defined as "an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. 'Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality' [24]. The term 'comprehensive' in relation to sexuality education indicates that this approach will encompass the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. The approach, for example, will not be narrowly focused on abstinence-only or on HIV/AIDS prevention.

According to the International Planned Parenthood Federation (IPPF), comprehensive sexuality education should be rights-based and gender-sensitive. It should also be citizenship-oriented, fostering responsible behaviour and action skills that promote enabling social conditions for sexual and reproductive health and well-being. Most importantly, comprehensive sexuality education should be sex-positive. This means that the curriculum should demonstrate a positive attitude towards sexuality and sexual pleasure as important for personal well-being and happiness [25].

In terms of major themes to be covered by the curriculum, UNESCO guidelines on comprehensive sexuality education emphasise educating children and young people on six key concepts:

- Relationships;
- Values, attitudes and skills;
- Culture, society and law;
- Human development;
- Sexual behaviour; and
- Sexual and reproductive health [25].

The right of adolescents and young people to have access to comprehensive sexuality education is upheld by a number of international conventions and documents. For example, the UN Convention on the Rights of the Child (1989) states that children and young people have the right to have access to information which will allow them to make decisions about their health (Article 17) including contraception (Article 24). The United Nations Committee on the Rights of the Child (2003) requires state parties to provide adolescents with access to accurate sexual and reproductive health information, "including on contraceptive and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)", regardless of marital status and parental consent. [26].

A rights-based approach to the issue of adolescent sexuality would mean that adolescents have a right to information that has a direct bearing on their health and well-being. It would also affirm that sexuality is a rich and positive area of life and adolescents have a right to grow up understanding their bodies and being able to make informed and consensual choices about sex including the choice of sexual preference.' [27]

India's Adolescent Education Programme (AEP) 2005

The AEP was designed by India's Ministry of Human Resources Development and the National AIDS Control Organisation in 2005, as a merger of three existing programmes: the National Population Education Programme, the School AIDS Programme (NACO) and the Project on Adolescent Reproductive and Sexual Health in Schools supported by UNFPA [28]. The AEP was to be operationalised in all secondary and senior secondary schools in India, by providing age-appropriate information to students aged between 10 and 18 years. It was designed as an early HIV preventive intervention by providing adolescents information on the process of growing up during adolescence, HIV AIDS and substance abuse, along with life skills to stem the spread of infection and substance abuse.

The curriculum was rejected by several state governments including those of Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Kerala and Karnataka, with the chief ministers writing to the Ministry of Human Resources Development accusing it of corrupting the morals of the young [29]. The module was revised but, in turn, was rejected by 33 NGOs from across the country, including youth groups, sexual rights groups, women's groups and groups working with child sexual abuse.

Concurrent Evaluation (2010-11)

This evaluation, commissioned by the UNFPA [30] and conducted by an independent agency, covered 210 schools in five states. It elicited feedback from students (22,000 approximately), teachers and principals. Some key findings were:

- Most students who were exposed to the AEP appreciated its benefits and thought it would be useful for children at lower ages as well.
- Several students felt the AEP helped them open up. They learnt about themselves and about 'issues they hadn't even thought about, and began discussing such issues with friends'. They learnt life skills.
- Some quotes from the evaluation report:

  One girl noted, `We learnt life skills on how to deal with friends. We learnt about the refusal skill; the need to be open-minded; how to lift oneself and not feel dumb.'

  Another girl noted, `Teenagers don't understand what problem they are exactly facing. With this programme they get to know about their problems and themselves in a better way'.

  "There is one negative in the programme, it mainly focuses on adolescence. It doesn't focuses on our parents. This programme was introduced in schools recently, like 5 to 10 years back. Our parents are not exposed to it. So they don't know what we have learnt. We are children, we can't teach them. If we try to teach them they will say you are children so keep quiet."

Chapter 3

There is considerable research evidence which shows that well-planned and executed sexuality education programmes for adolescents and young people, implemented in schools and communities, have resulted in increased knowledge of human sexuality. Many of the interventions have helped delay the onset of sexual activity among adolescents and young people, reduce the frequency of unprotected sex and the number of sexual partners, and increase condom and contraceptive use [31-33].

Monitoring Checklist 4

Policy/Programmatic Level	Service Delivery Level
Is comprehensive sexuality education a component of one or more national and state policies?	What proportion of out-of-school young people is covered by any sexuality education programme?
Is there a policy or government order to implement comprehensive sexuality education: in schools; and for out-of-school youth?	Examine the curricula of any sexuality education programme implemented by the government. How 'comprehensive' is it, based on UNESCO's guidelines on the six essential components?
What proportion of schools has any sexuality education as part of its curriculum?	Does the sexuality education curriculum: Promote gender-equal values and norms? Address rights, stigma and/or discrimination? Is it sex-positive? And does it include diverse sexual and gender identities?

WHO RECOMMENDATION 3.2

Recommend eliminating financial barriers to contraceptive use by marginalised populations including adolescents and the poor, and make contraceptives affordable to all.

It is now well established that charging user fees for services or requiring the client to purchase medicines and supplies – leading to out-of-pocket expenditure for the client - reduces access especially for preventive and promotive services. Thus, in order to ensure maximum access especially for low-income women and young people without a source of income, contraceptive services have to be made free at the point of delivery at the least, for such population sub-groups.

Contraceptive services are often not covered by insurance schemes. Since almost all women need contraceptive services, contraception is not a non-random and/or high-probability event, and therefore considered "uninsurable". As a result, contraceptive services may be unaffordable not only for the poor, but also for non-poor groups without a regular income or access to cash. It is important to ensure that contraceptive services are a part of the benefits packages of insurance schemes.

Even where affordability has been addressed at the programme level through suitable measures, there may be financial barriers to overcome at the service-delivery level. One example, is the demand by various levels of personnel and health providers, for payments for services or supplies that are supposed to be free. 'Informal payments' are fairly widespread and constitute a significant proportion of out-of-pocket expenses incurred [34-35]. Informal payments may be hiked up in the case of particularly vulnerable individuals such as undocumented individuals and single women, who may fear being stigmatised for seeking contraceptive services.

Box 11 Standard for Financial Accessibility

The RMNCH+A Strategy Document states: that as a matter of service guarantee, the states are required to ensure that family planning information, commodities and services are provided absolutely free to every client.

Source : *A strategic approach to RMNCH+A in India, GOI, 2013)*

Monitoring Checklist 5

Policy/Programmatic Level	Service Delivery Level
Are contraceptive services available free at the point of delivery to all sexually active individuals and not only married persons of reproductive age?	Are contraceptive services a part of the benefits package of all insurance schemes: community-based health insurance and other prepayment schemes, other compulsory or voluntary insurance schemes (e.g., government-sponsored, employer-sponsored or paid for by individual insurers)? Do they cover the entire range of contraceptive options?
Are there mechanisms in place to ensure that those who cannot pay for contraceptive services are not denied access?	Are there measures to check and contain the practice of informal payments?

WHO RECOMMENDATION 3.3

Recommend interventions to improve access to comprehensive contraceptive information and services, for users and potential users with difficulties in accessing services (e.g., rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines *(Safe abortion: Technical and policy guidance for health systems, Second edition)*

WHO Recommendation 3.8

Recommend that mobile outreach services be used to improve access to contraceptive services for populations who face geographical barriers to access

These two recommendations relate to both geographic access as well as to social access, and are therefore discussed in one section.

In India the Total Unmet Need for Contraceptives is 21.3 per cent (DLHS 3). The unmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour. A study recorded that contraceptive use had helped prevent 44 per cent of maternal deaths globally including 86,000 deaths in India in 2008 [36]. If all the unmet need for family planning is met, an additional 29 per cent of maternal deaths, a large number of them in India, could be averted every year.

The unmet need for contraception is on average 2-4 times higher among low-income women than among women from higher income groups. Women living in rural areas and with lower levels of education are similarly disadvantaged [39]. DLHS 3 shows that the Total Unmet Need for family planning was 22.8 per cent for rural women and 18.2 per cent for urban women. The low coverage by contraceptive services of rural and less-developed areas including urban slums, and the cost of services are major factors contributing to this disparity in indicators.

While the recommendation above focuses on especially marginalised and disadvantaged groups, it may be important to acknowledge that being a woman in a patriarchal society in and of itself imposes many barriers to women's access to contraceptive information and services (See Box 12)

Adolescents and Young People [37]

According to the National Family Health Survey (NFHS-3) findings, only 14.1 per cent of unmarried sexually active adolescent females used a contraceptive. Even though condom awareness among youth is as high as 83.8 per cent on an all-India level, actual condom usage is reported to be less. Unmarried female adolescents are highly vulnerable to unwanted pregnancies, mainly as result of lack of contraceptive use and high-risk sexual behaviour. Also, a large number of abortion-seekers have become pregnant as a result of rape or sexual coercion. According to the NFHS-3 results, only 13 per cent (16% urban versus 12.4% rural) of currently married adolescents reported contraceptive use, with an Unmet Need of 27.1 per cent (25.1% spacing versus 2% limiting). The lack of sexuality education, absence of youth-friendly sexual and reproductive health services, legal and social barriers to access and lack of affordability are all factors that contribute to the high levels of Unmet Need for contraception among adolescents and young people. The situation is further complicated by the fact that through the Criminal Law (Amendment) Act, 2013, the Parliament has set 18 years as the age-limit for consensual sexual activity. This means that consensual sex even within marriage below 18 years of age is, in legal terms, rape, and therefore a crime and liable for prosecution. In this situation, how can a young person below the age of 18 access contraceptives?

Because young people are not a homogenous group, contraceptive information and services for them would have to be available in multiple sites to cater to their varying needs. For example, school-based services will not cater to out-of-school youth, whose numbers may be significant in some settings. Youth also require youth friendly services. 'Youth-friendly' staff may be described as staff members who have a sex-positive attitude and consider sexuality an integral part of human existence; understand that young people are not a homogenous group; understand diversity in sexual orientation and gender identity; and are able to strike a balance between protecting the young person and respecting and enabling their autonomy [38].

As noted earlier, contraceptive services provided free-of-cost or at subsidised cost to the client would help removing financial barriers. Community-based distribution of contraceptives is another strategy to increase access to contraceptive services, and addresses both cultural/gender-based barriers and time/cost related barriers to reaching functional contraceptive services. ASHAs in India are a key source of contraceptive services and counselling in the villages.

However, they can provide only oral contraceptive pills, and condoms.

Box 12 Addressing Gender-based Barriers to Contraceptive Access

A number of gender-based disadvantages may contribute to women's unmet need for contraception. These include:

- Lack of information
- Restrictions in physical mobility
- Lack of decision-making power on matters related to contraception;
- Lack of time due to heavy workloads both within and outside the home and their care-giving responsibilities
- Long-waiting times in health-care settings
- Reluctance to seek health-care from male health providers
- Hesitation to seek contraceptive services in health facility settings open to public gaze because of cultural sensitivities
- For women with low literacy or from minority populations, challenges related to the unfamiliar and alien nature of health-care settings – especially secondary and tertiary facilities.

Many of these barriers, even if not all, may be addressed by suitable changes in service delivery. The following are some examples:

- Plan clinic timings to suit the convenience of the majority of women
- Ensure availability of women health providers
- Take steps to minimise waiting time

Box 12 : Continued

- Have clear signs in the clinic indicating days and times at which contraceptive services are available
- Ensure that rooms have sign-boards so that clients can easily identify where to go
- Have a help-desk at the reception with a facilitator who helps clients in negotiating the systems and procedures within facilities; the facilitator should be able to communicate with marginalised and minority communities
- Provide home-based contraceptive information and services through women community - health workers who would accompany the women for referral services such as long-acting or permanent methods of contraception

Rural Residents and Urban Poor

Mobile outreach services have been identified as a strategy to fill the gap in the provision of contraceptive services to rural residents and the urban poor. Mobile outreach service delivery is defined as "family planning services provided by a mobile team of trained providers, from a higher-level health facility to a lower-level facility, in an area with limited or no family planning or health services" [39]. In some cases, services are actually provided inside the mobile unit, while in other instances, services are provided in a fixed location within communities.

Access to Safe Abortion Information and Services

With increasing access to contraceptive information and services during the past decades, the rates of induced abortion have tended to decline. For example, globally the rates of induced abortions declined from 35 per 1,000 women aged 15-44 years in 1995, to 29 in 2003 [40]. However, women will always need access to safe abortion services even if they are contraceptive users. According to the WHO, in 2008 globally 33 million women were estimated to become accidentally pregnant while using a method of contraception [41].

Restrictions in the availability of safe abortion services push women to seek unsafe abortions at considerable cost to their health. India alone reports over 6 million abortions annually. While there is no data on the number of unsafe abortions, it is the third largest cause of maternal mortality.

Support for women's right to access safe abortion services may be found in a number of international human rights treaties. Drawing on these, the 2012 WHO Technical and Policy Guidance Document on Safe Abortion calls on governments to remove regulatory, policy and programme barriers to safe abortion services, and to abide by the principle that the laws of the land should protect women's health and human rights. The Guidance Document recommends that safe abortion services be made available starting from the primary health-care level, with referrals to higher-level facilities as appropriate; and that services be made affordable to all sections of women including young women and adolescents [41].

Monitoring Checklist 6

Policy/Programmatic Level	Service Delivery Level
Have the location and timing of services, the physical infrastructure and human resources been planned taking into account the special needs of disadvantaged groups (e.g., those with low levels of literacy or with physical disabilities; linguistic and ethnic minorities)?	In practice, do young people and adolescents get contraceptive information and services? Are these available to different groups of young people and adolescents (e.g., in-school and out-of-school young people; girls and boys; married and single persons). Are safe abortion services available to all sections of women at affordable costs? Are some groups excluded?
Are there mobile contraceptive outreach services available to reach underserved populations with the full range of contraceptive services? What proportion of low-income and hard-to-reach population is covered by mobile out-reach services? How often do they provide the full range of contraceptives?	
Are there policy, programmatic and budgetary provisions for making safe abortion services (that are within the ambit of the country's laws) available at the primary health-care level?	

WHO RECOMMENDATION 3.4

Special efforts should be made to provide contraceptive information and services to displaced populations and those in crisis settings, and to survivors of sexual violence who particularly need access to emergency contraception.

In recent years India has been affected by several natural disasters and conflicts which have caused the large- scale displacement of people. A significant proportion of those displaced is sexually active, who are likely to be in need of sexual and reproductive health services including contraceptive services. Many would desire to prevent a pregnancy and childbirth during a time of displacement and emergency, and especially to prevent exposing a newborn to the risks posed by such a situation. Many of them may have been unable to carry with them the contraceptive methods they used or may have run out of supplies. And yet, contraceptive services are not often prioritised in the Minimum Initial Services package (MISP) provided in humanitarian settings.

The Inter-Agency Working Group on Reproductive Health in Crisis has, in a 2010 statement, recommended that contraceptives should be available to meet the demand from the onset of an emergency; and that comprehensive contraceptive services should be available as soon as the situation stabilises [42]. Implementation of contraceptive services in humanitarian settings involves staff training, community education, logistics and supply chain management and developing a system of client follow-up. The Inter-Agency field manual on reproductive health in humanitarian settings (2010) provides detailed guidelines on implementing contraceptive services in humanitarian settings [43].

A number of recent studies have reported that women and girls in humanitarian situations are at a higher risk of experiencing sexual violence (because of the use of rape as a weapon of war), or of being exposed to coercive sex [44]. Emergency contraception is therefore a critical need for women and girls displaced by disasters and conflict.

Sexual violence is not unique to humanitarian situations but prevalent also in everyday life across diverse cultures and social and economic settings. An estimated 7.2 per cent of adult women experience sexual violence from a non-partner at some time in their lives, and 30 per cent experience physical and/or sexual violence from an intimate partner [45]. The Government of India recently brought out guidelines and protocols for medico-legal care for survivors/victims of sexual violence which recommend the inclusion of emergency contraception as a part of the protocol.

Monitoring Checklist 7

Policy/Programmatic Level	Service Delivery Level
Do government agencies engaged in emergency (disaster) management have a policy related to reproductive health needs assessment in emergency situations, including assessing the demand for contraceptives?	If there is a positive policy in place, to what extent were its provisions implemented in practice during the most recent emergency?
Are providers in humanitarian settings trained to provide contraceptive services, including emergency contraception?	Is emergency contraception made available to survivors of sexual violence as a part of the medico-legal services?

WHO RECOMMENDATION 3.5

Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health-care setting.

About 80 per cent of all women and men living with HIV are in their reproductive years. As ART becomes more widely available with a concomitant increase in life expectancy among Persons Living with HIV (PLHIV) – numbering 2.1 million in India in 2014 [46] - many of them will want to have the

option of choosing whether and when to have children. They may wish to avoid pregnancy for a number of reasons, including fear that the child will be infected with HIV, or because they want to preserve their resources on maintaining their own health and the health of their families [47].

Unfortunately, contraceptive information and services are often inaccessible or unavailable to persons living with HIV. One of the reasons is that providers do not often have the knowledge and skills to counsel persons living with HIV on their contraceptive options. Also, stigma and biases on the part of the provider result in many providers pressuring women to undergo sterilisation, rather than presenting them with all their reproductive options [10].

Universal access to contraceptive services implies addressing the specific needs of PLHIV in the planning and implementation of services. Most contraceptive methods are safe and effective for persons living with HIV. Dual protection from infections as well as pregnancy should be an important part of the contraceptive options offered to HIV-positive persons. The 2013 Updated Guidelines by NACO provides details of what is in the PPTCT Programme [48].

Integrating contraceptive services with Voluntary Counselling and Testing (VCT), treatment and care services makes it possible to reach persons living with HIV as well as sections of the population which are unlikely clients of contraceptive services. For example, whether HIV-positive or not, contraceptive information and services may be offered to groups often underserved by contraceptive programmes, such as adolescents and young people, men who have sex with men (but also have female partners), transgender persons and sex workers. Programmes to prevent parent-to-child transmission of HIV should logically include contraception as a key element.

Monitoring Checklist 8

Policy/Programmatic Level	Service Delivery Level
Does the national HIV policy prioritise the integration of contraceptive services within HIV testing, treatment and care services? Is there a strategy in place on the integration of contraceptive services within HIV testing, treatment and care services?	Have HIV service providers been trained in providing contraceptive information and services to women and men?
Are there mechanisms for coordination between the departments/authorities responsible for HIV/AIDS and those responsible for sexual and reproductive health including contraceptive services in matters related to service integration? Are such mechanisms present at the state and district levels?	In practice, are contraceptive services routinely offered to users of HIV services? Are information and communication resources available to provide information on contraceptive options for PLHIV?

Monitoring Checklist 8: Continued

Have clinical protocols and standards for HIV testing, treatment and care been reviewed and revised to integrate contraceptive information, counselling and services?	

WHO RECOMMENDATION 3.6
Recommend that comprehensive contraceptive information, counselling and services be provided during antenatal and postpartum care

WHO RECOMMENDATION 3.7
Recommend that comprehensive contraceptive information, counselling and services be routinely integrated with abortion and post-abortion care

Since these two recommendations are related, we discuss them together in this section.

Integration of Contraceptive Information and Services with Prenatal and Postpartum Care

According to WHO, after a live birth the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes [49]. Given the unmet need, it goes without saying that integrating contraceptive services with prenatal and postpartum care should be an essential component of a human rights-based and gender-responsive contraceptive programme.

Integration of Contraceptive Services with Post-abortion Care

The WHO guidelines on birth spacing specify that after an abortion or miscarriage there should be at least a six-month interval before attempting the next pregnancy in order to avoid adverse maternal, perinatal and infant incomes [49]. Women who have had an abortion are at high risk of pregnancy soon after the abortion (as soon as one week after), and are in need of contraceptive information, counselling and services almost immediately. Studies of women receiving post-abortion care indicate that they have a high unmet need for contraception. A review of ten studies of women receiving post-abortion care reported that more than half of all women expressed an interest in using contraception after post-abortion care. A subset of six studies with relevant data showed that only about a quarter (27%) of the women left the facility with a contraceptive method [50]. As in the case of integrating contraceptive services with prenatal and postpartum services, there are several effective models of integrating contraceptive services with abortion and post-abortion services. The essential points to bear in mind are: providing the contraceptive services at the same time and location where the woman receives the abortion or post-abortion services; and offering a wide range of contraceptive methods [51].

Monitoring Checklist 9

The RMNCH+A provides guidelines on pregnancy, delivery and postpartum care; and on abortion and post-abortion care that integrates comprehensive contraceptive services

Policy/Programmatic Level	Service Delivery Level
If contraceptive services are integrated with postpartum and abortion/post-abortion services, as in the PPIUCD strategy, are there indications of any elements of restricting voluntary choice of contraception per se or specific methods of contraception? (Some examples of restricting choice may be post-partum sterilisation programmes or post-partum IUCD programmes in instances where they offer only a single method; or requiring women seeking abortion services to accept a method of contraception.) What informed consent procedures are followed?	Have service providers been trained in providing comprehensive contraceptive information and services to women and men, i.e., do they know about the full range of methods, and do they have the knowledge and skills to counsel and provide services?
Have clinical protocols and standards for maternal health-care and abortion/post-abortion care been reviewed and revised to integrate the provision of comprehensive contraceptive information, counselling and services?	In practice, are comprehensive contraceptive services routinely offered to users of antenatal and postpartum services? And to users of abortion and post-abortion services? Are information and communication resources available that provide information on contraceptive options to women and men postpartum and post-abortion?

WHO RECOMMENDATION 3.9

Recommend elimination of third-party authorisation requirements, including spousal authorisation for individuals/women accessing contraceptive and related information and services

In many countries, service providers ask for authorisation from the spouse, usually the husband, for providing family planning services. The practice of requiring women to obtain their husbands' authorisation in order to obtain contraceptive methods is especially damaging to women experiencing forms of intimate partner violence that include "birth control sabotage" and/or "pregnancy coercion," which include not allowing a woman to use contraception or actively sabotaging her use of contraception [52].

Spousal authorisation requirements are usually applied exclusively to women and, as such, represent a violation of women's right to equality and non-discrimination. International human rights

treaty bodies such as the CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) have expressed concern over laws that mandate authorisation by a husband for the wife to obtain contraceptive methods such as sterilisation, and recommended the removal of such restrictions [53].

Monitoring Checklist 10

Policy/Programmatic level	Service Delivery Level
In practice, do contraceptive service providers insist on authorisation by the husband/male partner for a woman to obtain any contraceptive services?	

WHO RECOMMENDATION 3.10

Recommend provision of sexual and reproductive health services, including contraceptive services, for adolescents without mandatory parental and guardian authorisation/ notification, in order to meet the educational and service needs of adolescents

The recently launched Rashtriya Kishor Swaasthya Karyakram [54] by the Government of India covers sexual and reproductive health in addition to nutrition, mental health, substance abuse, Non Communicable Diseases (NCDs), prevention of Gender Based Violence and injuries. While it does not explicitly mention the provision of contraceptive services, the prevention of teenage pregnancies is emphasised. Parents are included as an important stakeholder group to be addressed.

Research studies show that making parental consent mandatory for providing contraceptive services to adolescents discourages contraceptive use, without necessarily altering adolescents' sexual behaviour. The consequence is an increase in the number of unwanted pregnancies [55]. Contraceptive services, while encouraging adolescents to inform their parents, should not make parental involvement a precondition.

India has various policies and programmes, such as the Youth Policy 2011, SABLA, SAKSHAM, which provide directions and guidelines; these need to be analysed to assess the extent to which information and services provided to meet adolescent needs for contraceptives can be fulfilled.

The Convention on the Rights of the Child (CRC) explicitly recommends that state parties make appropriate sexual and reproductive health services available and accessible, keeping in mind adolescents' best interests and taking into account the 'evolving capacities'[4] of adolescents to exercise autonomy and participate in decisions[5] [56-58].

4. *The concept of 'evolving capacities' in the Child Rights Convention seeks to strike a balance based on capacity - between parental responsibility for protecting the child and the rights of the child to autonomy and decision-making.*
5. *For further information on international human rights treaties that oblige the state to reform laws that restrict adolescent access to contraceptive information and services, see "Chapter X. Adolescents' reproductive rights ', in Centre for Reproductive Rights (2006). Gaining ground: A tool for advancing reproductive rights law reform. New York, Centre for Reproductive Rights.*

   Available at: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_GG_adolescents.pdf

Monitoring Checklist 11

Policy/Programmatic Level	Service Delivery Level
Is there a law or regulation, which requires parental authorisation for an adolescent to obtain any sexual and reproductive health services?	Are there guidelines from the Ministry of Health on how health-care providers are to assess the competence of an adolescent to take independent decisions on SRH?
Is there a policy or strategy document on sexual and reproductive health services for adolescents and young people, which specifies that services will be available irrespective of marital status and does not mandate guardian or parental consent for accessing services for adolescents?	

4 Acceptability of Contraceptive Information and Services

WHO RECOMMENDATION 4.1

Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that includes skill-building (i.e., communications and negotiations) and that are tailored to meet communities' and individuals' specific needs.

There are two dimensions of acceptability at the service-delivery level: medical and socio/cultural. Services should respect medical ethics, be organised and delivered in a gender-sensitive manner and be tailored to the specific needs of the communities being served. The recommendations on informed decision-making and privacy and confidentiality address aspects of medical ethics, and the focus in this section is on gender-sensitivity and meeting community-specific needs.

Acceptability implies that sexual and reproductive health facilities, goods and services are respectful of the needs of different population subgroups. Some examples include: having a staff member who is from the same language-speaking or ethnic group as minority communities; using suitable media for disseminating information to a low-literacy population; providing sexual and reproductive health services to indigenous populations in a place and manner in which they would feel comfortable; and tailoring services to meet the specific needs of men.

The recommendation talks of "gender-sensitive" counselling, educational interventions and 'skill-building' for communication and negotiation. Gender-sensitivity implies acknowledging differences in the needs of women and men, based on biology as well as socially constructed gender-

norms; and being aware of the ways in which gender-based inequalities between women and men constrain women's autonomy and choices. In particular, gender-based norms about appropriate sexual and reproductive behaviour restrict women's knowledge about their bodies and their sense of entitlement to make reproductive decisions. Patriarchal societies restrict women's sexuality and control their reproduction, making reproductive autonomy beyond the reach of the majority of the world's women.

Women facing intimate partner violence may have several concerns that affect contraceptive use: partner support for certain methods like condoms may not be available; and they may not have adequate financial resources to pay for a particular service. Such women may fear further violence for using or talking about contraception. And intimate partner violence may cause disruptions in everyday life, which make it difficult to use methods such as oral contraceptive pills.

Gender-sensitive counselling will try to understand the underlying, often gendered, reasons why women are hesitant to make contraceptive decisions and encourage them to express their constraints and fears. During counselling sessions, the specific needs of clients experiencing intimate partner violence, e.g., visibility of the method used, side-effects or need for partner support, must be considered and providers must be able to offer contraceptive choices accordingly. Beyond gender-sensitive counselling, specific gender-responsive interventions may be needed such as workshops to help women develop skills for negotiating contraceptive use with their husbands, or interventions with men to encourage them to be better informed and to take responsibility for contraception.

Another aspect to be emphasised in counselling is about positive sexuality, the move from control of sexuality, and the use of contraceptives to prevent pregnancy, to the enhancement of pleasure.

Box 14 Standards for Counselling

States need to strengthen the counselling system at facilities with high case-loads and in order to do so, the placement of RMNCH counsellors would be a key strategy.

Source: *A strategic approach to RMNCH+A in India, GOI, January 2013*

1.4.1. Counselling

Counselling is the processes of helping clients make informed and voluntary decisions about fertility. General counselling should be done whenever a client has a doubt or is unable to take a decision regarding the type of contraceptive method to be used. However, in all cases, method-specific counselling must be done.

Counselling Women before Sterilisation

The following steps must be taken before women sign the form consenting to sterilisation:

- Clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes this operation is a permanent one.

Box 14 : Continued

- Clients must make an informed and voluntary decision regarding sterilisation.
- Clients must be counselled whenever required in the language they understand.
- Care should be taken to explain to clients what will happen before, during and after the surgery, its side-effects, and potential complications.

  The following features of the sterilisation procedure must be explained to the client:
  - It is a permanent procedure for preventing future pregnancies.
  - It is a surgical procedure that has the possibility of complications, including failure, requiring further management.
  - It does not affect sexual pleasure, ability or performance.
  - It will not affect the client's strength or her ability to perform normal day-to-day functions.
  - Sterilisation does not protect against RTIs, STIs or HIV/AIDS.
- Clients must be told that a reversal of this surgery is possible, but that reversal involves major surgery and that its success cannot be guaranteed.
- Clients must be encouraged to ask questions to clarify their doubts, if any.
- Clients must be told they have the option of deciding against the procedure at any time without being denied their rights to other reproductive health services.

Source: *Quality Assurance Manual for Sterilization Services, Research Studies & Standards Division, Ministry of Health and Family Welfare Government of India, October 2006*

Monitoring Checklist 12

Policy/Programmatic Level	Service Delivery Level
Do the contraceptive/SRH programme guidelines uphold the need for gender-sensitive service delivery? If yes, do they set out norms for the same?	Are health facilities equipped with the personnel and physical space for counselling and educational materials appropriate for different levels of literacy and cultural diversity?
Do the contraceptive/SRH programme guidelines highlight the specific needs of clients experiencing intimate partner violence? If yes, do they set out norms for counselling and service delivery for such clients?	Do health facilities provide an enabling environment for disclosure and discussion by clients experiencing intimate partner violence and/or reproductive coercion? For example, - Posters in public spaces such as waiting rooms, examination rooms, hallways

Monitoring Checklist 12: Continued

	- Referrals to domestic violence services - Screening for reproductive coercion or intimate partner violence is standard procedure prior to discussion of reproductive intentions and contraceptive options
Are providers trained for gender-sensitive service provision? - Does this include training for gender-sensitive counselling for contraception? - Does gender-training for reproductive health service providers include training to address the specific needs of women experiencing reproductive coercion or other forms of intimate partner violence?	

WHO RECOMMENDATION 4.2

Recommend that follow-up services for management of contraceptive side-effects be prioritised as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and available.

Concern about side-effects is an important reason why women do not use a contraceptive method despite intending to postpone or stop childbearing. There is a critical importance of follow-up services in contraceptive service delivery, for reviewing the client's health, for counselling to address any concerns and for managing any side effects.

A rights- based contraceptive service should be able to provide a range of contraceptive methods that meet the varying needs of different clients. At the Programmatic level, a full range of appropriate methods for a particular facility is decided based on the level of facility, the skills of providers and legal requirements. The Programme has to plan for providing clients with easy access to methods that cannot be made available at lower levels of care. For example, specialist providers may be brought in on specific fixed days. If this is not feasible, the facility should make provisions for referral, and also transportation to reach the referral facility at no extra cost to the client and with minimum delay.

Box 15 — Standards for Followup Care of Contraceptives

Standards for post IUCD Removal counselling, Combined Oral Contraceptives, Progestogen Only Pills (breastfeeding and not breastfeeding), Intra-uterine devices, Implants

Source: *Selected Practice Recommendations for Contraceptive Use, WHO 2004*

Monitoring Checklist 13

Policy/Programmatic Level	Service Delivery Level
Are there protocols for different levels of facilities and providers for follow-up visits, management of side-effects and referrals for contraceptive services?	In practice, are clients given appropriate and adequate information about follow-up visits, timings and procedures?
Are providers trained in follow-up and referral procedures related to contraceptive services?	In practice, do service providers facilitate access to contraceptive methods of the client's choice which are not available at a give site? Do clients receive appropriate follow-up care for contraceptive side-effects at the same facility without incurring additional expenditure?

5 Quality of Contraceptive Information and Services

There are three recommendations under the Quality principle.

WHO RECOMMENDATION 5.1

Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes

WHO RECOMMENDATION 5.2

Recommend that the provision of long-acting reversible contraception (LARC) methods include insertion and removal services and counselling on side-effects in the same locality

WHO RECOMMENDATION 5.3

Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.

Quality of care is a major determinant of contraceptive use. Recently, Germain (2013) outlined elements of six actions that are necessary to ensure that quality standards meet human rights norms (some of these are addressed in the WHO recommendations related to quality):

- "Widest possible range of choices among contraceptive methods
- Decent facilities, equipment and commodities

- Training and supervision of service providers
- Essential package of integrated sexual and reproductive health services as agreed originally in the Programme of Action of the International Conference on Population and Development paragraph 7.6
- Outreach and communications
- Quality assurance mechanisms, monitoring, redress for individuals and mechanisms to remedy policy failures, as well as to prevent and correct discrimination in access and other abuses" [59].

Quality assurance is a component of quality management, which involves putting in places processes and mechanisms that guarantee that products and services meet defined quality standards. India has in various places specified quality standards for the provision of sterilisation services; Boxes 16 and 18 contain some examples of these quality standards in select central government documents.

Box 16 **Standards for Quality Assurance**

Quality Assurance Committees

Quality Assurance Committees will be formed at the state and districts level to ensure that the standards for female and male sterilisation as laid down by the GOI are followed in respect of pre-operative measures (for example, by way of pathological tests, health and patient, etc.), operational facilities (for example, sufficient necessary equipment and aseptic condition and post-operative follow-ups). It shall be duty of the Quality Assurance Committee to collect and publish six monthly reports on the number of persons sterilised as well as the number of deaths or complications arising out of the sterilisations. The Committee should meet at least once in three months.

Source: *Manual for Family Planning Insurance Scheme, Government of India, Ministry of Health & Family Welfare, January 2008*

Quality Assurance Manual for Sterilisation Services (2006)

This contains a checklist for infrastructure and equipment at the facility where sterilisations will be conducted. A detailed informed consent form and pre-surgery assessment format are also given in the manual.

Source: *Quality Assurance Manual for Sterilization Services, Research Studies & Standards Division, Ministry of Health and Family Welfare Government of India, October 2006*

A rights-based approach to the quality of contraceptive services has at least two major components: assurance of the quality of medical standards of care and responsiveness to a client's expectations from contraceptive services. Assurance of the quality of medical care is usually done through supervision, clinical reviews and audits and accreditation by quality assurance bodies such as the Indian Standards Organisation. Some ways in which client feedback may be sought are suggestion boxes, formal review committees in which clients participate, and periodic client-exit interviews and studies on client perspectives. Box 17 provides clients' expectations from contraceptive services ascertained through a study [60].

Box 17 — Women Users' Perceptions on what constitutes Good Quality Family Planning Services

- Clinic timings suitable to clients' work schedules
- Short waiting times
- Feeling respected by providers
- Feeling that providers were empathetic
- Attentive listening by providers
- Attention to client comfort by providers
- Privacy during counselling, physical examinations and procedures
- Assurance that providers will keep their personal information confidential
- Client's health needs met/health problem resolved

Source: *Creel L.C., Sass, J.V., Yinger, N.V. Client-centred quality: Clients' perspectives and barriers to receiving care. (2002) New Perspectives on QOC. No. 2. New York, Population Council and Population Reference Bureau. At: <http://www.prb.org/pdf/NewPerspQoC-Clients.pdf>. Accessed on 19 November 2013*

A key component of good quality contraceptive services is the assurance to clients that if they decide to discontinue the method for any reason, their decision will be respected; and that removal services for intra uterine devices and such other, will be provided, either in the same facility or in a facility within a reasonable distance, at affordable costs without undue delay. For example, if clients want to discontinue using a medication or a contraceptive method, staff would be required to discuss with them their reasons for wanting to discontinue, and offer appropriate alternatives or support and information if they wish to become pregnant.

The technical competence of the provider is an important aspect of quality of care. Further, the development and use of standard protocols for the provision of contraceptive services constitutes an important component of high technical quality. To ensure this, investments have to be made to train providers of contraceptive services on the WHO's latest clinical guidelines published at regular intervals.

Chapter 3

Box 18 — Standards for IUCD Insertion

This manual seeks to ensure that all providers have the latest information on IUCDs and can provide high quality services that are safe and client-centered. It is an attempt to revitalise the training aspect of IUCD services with a long-term plan of repositioning the IUCD in its rightful place in India's family welfare programme as a spacing method.

The manual specifies standards for pre examination preparations, for insertion and removal, for timing of the insertion, post insertion assessment, quality of IUCD services, and many others.

Source: *IUCD Reference Manual for Medical Officers Family Planning Division, Ministry of Health and Family Welfare, Government of India, July 2007*

Monitoring Checklist 14

Policy/Programmatic Level	Service Delivery Level
Is a comprehensive strategy for quality assurance, including for contraceptive information and services, a component of the sexual and reproductive programme guidelines?	Are there processes and mechanisms in place at the programme and facility levels to obtain client feedback on the quality of contraceptive services? Are there examples of incorporating results of the feedback for modifying/improving service provision?
Have standards of quality care been elaborated for the provision of contraceptive services at different levels of care?	Do protocols for service provision explicitly mention a client's right to request removal of long-acting contraceptives such as the IUCD and implants?
Is the budgetary allocation sufficient to assure adherence to quality standards?	Is there a system of regularly updating providers' knowledge and clinical skills about contraceptive methods?
Are there processes in place for regular audits and monitoring of quality of contraceptive services?	

6 Informed Decision-making on Contraception

WHO RECOMMENDATION 6.1

Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.

WHO RECOMMENDATION 6.2

Recommend every individual is ensured an opportunity to make an informed choice for their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination.

Client autonomy and informed decision-making are key components of a rights-respecting contraceptive service. 'Informed decision-making' in contraception means that the client makes a decision considering all the circumstances of his/her life, after hearing all the information related to a wide range of contraceptive options. It also means that if the client receives all the relevant information and decides not to use any contraceptive method, this is still a successful outcome [61].

For "informed" decision-making, clients should receive at least the following information on each available method of contraception:

- The benefits and risks, including the protection offered for the prevention of STIs/HIV/AIDS, taking into account the specific circumstances of the individual;
- The conditions that would make the contraceptive inadvisable to use; and
- The common side-effects [62].

The following are some ways in which informed decision-making may be facilitated within contraceptive information and service programmes.

- Providing contraceptive information as a one-off activity. One example of an empowering information strategy is the 'Smart Patient' initiative in Indonesia, which provided contraceptive information to women and men in community-based outreach programmes so they could think through the pros and cons of different methods, discuss it with others and then make an informed choice [63].
- Multiple modes and sites of information delivery are important to ensure coverage of diverse audiences.
- Clients often request the health provider to take a decision on their behalf because they have not been traditionally encouraged to take decisions. Rather than trying to 'fix' the problem for them, providers would help clients most when they help them assess their choices and make an informed decision.
- "Understood consent" should be operationalised for contraceptive services. The client could be asked to answer a short questionnaire of not more than ten questions after she receives the information; if more than half the answers are incorrect, the information and counselling should be repeated.
- In settings where couples are jointly counselled for family planning, providers need to be conscious of the unequal power relations between the man and woman, and ensure that men do not control the decision-making process. The following scenarios are some examples of men's control of decision-making in a joint-counselling session: the husband responds to many questions asked of the woman; he frequently interrupts her or contradicts her when she is speaking; or the woman remains silent and lets her husband do all the talking on her behalf. If this happens, then joint counselling may not be a good approach.
- Providers should not allow their own assumptions, beliefs or moral values come in the way of giving information to clients on all methods of contraception. For example, providers may refuse to provide emergency contraceptives because they believe that they lead to abortions. Patriarchal values related to appropriate sexual behaviour may prompt providers to deny information on contraception to adolescents, young people and single people. Clients may not be given information on non-reversible methods of contraception such as surgical sterilisation because the provider thinks that s/he has not yet completed family size.
- An important component of informed decision making is the client's right to refuse any method of contraception. This component assumes that safe abortion services are available – this should also be a part of informed decision-making.

Monitoring Checklist 15

Policy/Programmatic level	Service Delivery Level
Do guidelines and protocols for counselling and service provision elaborate on elements of and processes for informed decision-making on contraception?	In practice, do all clients receive essential information (as defined above) on all contraceptive methods available?
Are providers aware of and trained to facilitate informed decision-making?	What about informed decision-making and consent of groups like HIV-positive women and women (and minors) living in institutions like shelter homes – can they make informed decisions?
Do providers have the resources necessary to ensure informed contraceptive decision-making by clients? Are posters and Information Education and Communication material in local languages available and displayed in health facilities?	

7 Privacy and Confidentiality in the Provision of Services

WHO RECOMMENDATION 7.1

Recommend that privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information

Privacy is "the right and power to control the information (about oneself) that others possess" [64]. Privacy also commonly refers to respecting the rights of individuals not to be physically exposed against their will. Confidentiality is "the duty of those who receive private information not to disclose it without the patient's consent" [64]. Confidentiality is the mechanism through which the provider protects the client's right to privacy [65].

Upholding the client's privacy and maintaining confidentiality are important in all areas of health-care. They are especially critical when providing sexual and reproductive health services, as failure to do so may result in the loss of client trust regarding the services. While in many settings, the extended family and spouses may be considered to have the 'right' to know about a client's contraceptive decisions, providers must always make an effort to uphold an individual client's privacy, unless the client specifically indicates a desire to include others in the decision- making (in which case this desire must be respected and provided for). Likewise, irrespective of the cultural context, young people have a right to privacy and confidentiality when seeking sexual and reproductive health services.

Privacy

Both visual and auditory privacy are important. Some simple ways in which visual privacy may be ensured are, for example:

- Partitioning space with curtains or blinds;
- Closing doors and drawing curtains when the provider is interacting with a client or when the client is dressing or undressing;
- Ensuring that examination couches face away from windows and doors;
- Putting up a DO NOT DISTRUB sign on the door of a counselling or examination area; and
- Ensuring that colleagues do not walk in and out of counselling and examination areas.

In order to ensure auditory privacy, i.e., so others cannot hear what is spoken between the client and counsellor/provider, the following should become an integral part of the culture of contraceptive service delivery:

- Speaking softly;
- Keeping doors closed;
- Not speaking to a client in a public area where one can be overheard; and

- Ensuring that colleagues do not walk in and out of the counselling and examination area, and that other clients are not seated where they can hear the interactions [65].

Confidentiality

In order to uphold the client's right to privacy, the provider must keep confidential all information related to the client. Some ways in which this may be ensured are [65]:

- Medical records must be made anonymous, kept in a secure place, and preferably locked up;
- Staff providing sexual and reproductive health services should not discuss details of a client's health problem in a public space even with the concerned client, or share client information with persons from the community, for example, for reasons such as follow-up of a defaulting client.
- No member of the service delivery team, including support staff, should be allowed to be present during client-provider interactions or discussions between providers about a client.
- Information regarding a client should not be discussed or shared with his or her partner or a family member without his or her express consent. A partner or family members can be invited to participate in the counselling/examination sessions only with the client's permission [65].

Monitoring Checklist 16

Policy/Programmatic Level	Service Delivery Level
Do guidelines and protocols for contraceptive information and services elaborate on how to ensure the privacy and confidentiality of the client seeking contraceptive services, including young clients?	Are providers aware of the importance of ensuring privacy and confidentiality? Do they act accordingly?
Are norms related to the space requirements of health facilities developed keeping in mind the need for visual and auditory privacy, and for separate waiting, counselling and examination spaces for young people?	Are clients comfortable with the privacy and confidentiality aspects of contraceptive information and service provision?
Are adequate infrastructural facilities available in health facilities to ensure privacy and confidentiality of all clients?	

8 Participation in Decision-Making related to the Contraceptive Programme and Policy.

WHO RECOMMENDATION 8.1

Recommend that communities, particularly people directly affected, have an opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring

Participation by different stakeholders, especially those who are less powerful and have scarce resources, is an important tenet of a human rights-based programme. One of the most common mechanisms for community or users' participation in health programmes is committees: health centre or clinic committees, facility health committees, and village health committees. A systematic review of studies evaluating the role of such committees reports some measure of success in their enhancing service accountability. Key factors that influenced the success of health committees were: how committee and group members were selected and their motivation for involvement; whether they received adequate support in terms of financial and technical resources for effective participation; and the extent to which they received co-operation from health workers and health managers [66]. In India the Village Health, Nutrition, Sanitation Committees (VHSNCs), facility-level Rogi Kalyan Samitis are an appropriate forum for eliciting users' perspectives on Sexual and Reproductive Health and Rights (SRHR) services including contraceptive services.

The extent to which community-participation mechanisms address contraception-related concerns and articulate gender-specific needs and the needs of marginalised groups is not clear from the literature. Because of power hierarchies and social stratification within communities, community-based structures may exclude women and those from less powerful groups, and as representatives of patriarchal values, oppose contraception and sexual and reproductive health services [67]. Another challenge would be that duty-bearers such as policy makers, health managers and health-care providers may not always see the need for or value of consulting with users of services.

Measures that may be useful in ensuring that participation actually happens in practice include: fixing specific quotas for the inclusion of women and people from marginalised groups; building their skills for meaningful participation through capacity-building initiatives; and enhancing duty-bearers' knowledge and skills to encourage and engage with community-participation mechanisms.

Monitoring Checklist 17

Policy/Programmatic Level	Service Delivery Level
Do the sexual and reproductive health policy/programme guideline specify the creation of mechanisms for regular participation and consultation of community members and service-users?	In practice, what proportions of participatory mechanisms are functional? For example, what issues are raised by marginalised groups? How are these addressed? What follow up is done?

Monitoring Checklist 17: Continued

Do the sexual and reproductive health policy/programme guideline specify the creation of mechanisms for regular participation and consultation of community members and service-users?	In practice, what proportion of members attending meetings of the participatory mechanisms are women or members of marginalised groups? Which population sub-groups are absent?
Are there mechanisms/ processes present to facilitate participation of groups like the LGBT (Lesbian, Gay, Bisexual and Transgender) community to express their needs?	

9 Accountability

WHO RECOMMENDATION 9.1

Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.

WHO RECOMMENDATION 9.2

Recommend that evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur.

Recommend that, in settings where performance-based financing (PBF occurs), a system of checks and balances should be in place, including the assurance of non-coercion and protection of human rights. If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability.

Accountability may be defined as the "obligation of power-holders to take responsibility for their actions... towards citizens who have the right to demand" [68]. The concept of accountability in a programme framework combines three elements: keeping track of what is happening where and to whom, and what is not happening; reviewing progress against objectives, targets and bench-marks, noting differentials in progress across population groups and reflecting on barriers and facilitators for progress; and action to improve performance and provide redress to those who have been ill-served by a programme.

Accountability mechanisms exist at various levels, from the international to local. Reproductive rights including the right to information and services related to contraception are grounded in international human rights treaties. These include, for example, the International Covenant on Economic, Social and Cultural Rights; the Convention of Elimination of All forms of Racial

Discrimination; Convention on the Rights of the Child; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and Convention on the Rights of Persons with Disabilities. Governments, which have ratified these treaties, are obligated to submit regular, periodic reports to committees which monitor the compliance of states with the treaty's obligations. The committees use these reports to engage in a constructive dialogue with representatives of the state party and then issue concluding observations, which commend the positive aspects but also raise concerns and make recommendations for further action. This is an example of an accountability mechanism applied globally. At the same time, NGOs may hold their governments accountable by preparing and submitting a "shadow report" to the same treaty monitoring body which addresses omissions, deficiencies, or inaccuracies in the official government reports. Accountability mechanisms at the national and sub-national levels include human rights commissions, professional disciplinary proceedings, annual health or health-condition-specific reviews like the Common Review Missions, and so on.

Civil society actors have participated in holding governments accountable through 'social accountability' mechanisms. Budget tracking is one such activity. The amount that a government has allocated in its budget for a particular programme may be seen as an indicator of its real priorities, no matter what its policy documents proclaim. Use of the Right to Information Act is another tool for demanding transparency and accountability.

No matter what the manner of tracking progress is, one important consideration is that the indicators used are "human rights-based". This would mean, for example, that we track not only end-results such as contraceptive prevalence rates, but also processes that ascertain that human rights were upheld, or at least not violated, in the course of achieving these results.

In a human-rights framework, accountability combines elements of responsiveness, answerability and redress. Formal redress procedures in the health sector are intended to rectify something that has gone wrong, and consist of "official venues in which individuals can present their understanding of their entitlements, receive an attentive hearing, and be given an explanation or compensation [69]." The National (and state) Human Rights Commissions are examples of remedial and redress mechanisms. Where the 'Right to Health,' as elaborated in international human rights treaties, has been incorporated into domestic laws, courts of law within a country would be an effective mechanism of remedy and redress. At the international level, the CEDAW Committee oversees complaints procedures including for the violation of a woman's reproductive rights. Any woman who is not satisfied with the redress provided within her own country may approach the CEDAW Committee with her complaint. The CEDAW Committee has a good track record of redress for the violation of reproductive rights [70]. The UN Rapporteur for Health is another office at the international level that can mediate with national governments.

The emergence of performance-based financing (PBF) raises some concern from a human rights perspective. PBF is a national tool for improving utilisation and provision of health-care services "based on financial or in-kind rewards made to providers, payers or consumers after measurable actions have been taken" [71]. Examples include conditional-cash transfers (CCTs) to clients; and

incentives paid to providers for meeting targets. Evidence on the effects of PBF suggests there are many down-sides to the approach, including a focus on quantity rather than quality of services; and an increase in inequity by rewarding users, providers and facilities that are better able to meet conditionality or targets set by the programme [72]. Both these are in conflict with a human rights-based approach.

Monitoring Checklist 18

Policy/Programmatic Level	Service Delivery Level
Are there any national or state-level committees to ensure accountability for SRHR issues?	Has performance-based financing been adopted in sexual and reproductive health services? Are there studies on the equity impact of these? Is any marginalised group disadvantaged as a result of the PBF?
Does the National Human Rights Commission have legal backing? In the past year, has it received any complaints related to the provision of contraceptive information and services? What proportion of these complaints has been addressed? What proportion has been resolved?	Does the government submit regular reports to human rights treaty bodies on how it has acted to fulfil reproductive rights supported by the treaties it has ratified? What proportion of the drafting committee consists of civil society actors or sexual and reproductive health advocates?
What proportion of complaints received/addressed/resolved by human rights commissions, ombudsman offices or other grievance redress mechanisms are from members of marginalised groups?	Are sexual and reproductive rights supported by international human rights treaties incorporated into domestic laws? Identify examples of domestic laws that may violate Sexual and Reproductive Rights supported by treaties that the government has ratified?
Are any of the indicators used by the government for tracking progress in sexual and reproductive health, including in contraception, 'rights-based'?	

3.3 Beyond WHO recommendations: Protecting and Upholding the Rights of Service Providers

Rights-based contraceptive information and services depend on the extent to which providers and the service delivery team as a whole are equipped and supported by the health system. We therefore outline some essential dimensions of upholding the rights of contraceptive service providers, although recommendations contained in the WHO Guidance document do not address this issue explicitly.

Non-discrimination and Affirmative Action

If health-care providers are to imbibe rights-based and gender-sensitive responsive values, then these same values must be reflected in various domains of health providers' work-environment including in recruitment, working conditions, work-place safety and security. For example, the recruitment of health providers must be such that the work force represents the diversity of the community it serves in terms of gender, race, religion, caste, etc. This may require specific affirmative action policies, long-term investment in education and training of persons from marginalised groups.

Health workers must be protected from discrimination based on caste, race, religion, gender or sexual orientation. There should be a clear policy on zero-tolerance for discriminatory behaviour, and redress mechanisms for the violation of such a policy. The management should signal its commitment to equality and non-discrimination in word as well as in deed.

Workplace Safety and Security

Health-care workers are exposed to a number of health and safety hazards in their workplace every day. It is essential to have a health and safety policy for workers in the health sector, which addresses all the various hazards faced by all levels of health workers, especially those working in outreach and community services. Violence in the workplace is an important concern. It is estimated that about 25 per cent of all workplace violence takes place in the health sector. Since the large majority of the health workforce consists of women, a large number of the victims of violence are women [73]. Studies show that this violence may be gender based, too [74]. Hate crimes based on communalism, homophobia, racism and other prejudices, also pose risks.

Capacity-building for Human-rights Based and Gender-responsive Approaches to Service Delivery

Pre-service training of health professionals does not equip health-care providers adequately in human rights, culturally sensitive or gender-responsive approaches. Early innovations offer potential models for in-service training on human rights for reproductive health-care/family planning service providers. For example, experiences from pilot interventions in Nicaragua and El Salvador to build the capacity of doctors and nurses on human rights issues in sexual and reproductive health-care suggest that human rights training should focus on developing problem-solving skills which build provider-capacity to identify and act on human rights and ethical dilemmas in real-world settings, for e.g., through services audits or critiquing video-taped service delivery scenarios [75].

Enabling Community Health Workers (CHW)

A large cadre of women community workers are recruited to provide community-based sexual and reproductive health services, especially contraceptive information and distribution. Enabling them to adopt a human rights-based approach poses some specific challenges.

For example, ASHAs must be recruited from the communities they will be serving [76]. In hierarchical societies, ‘community-selection’ may not be a good option and caste/ethnic/race-based biases in the community may play out in the selection of community health workers, and a member of a dominant social group may be recruited. Once ASHAs are recruited, their training is an essential element. In addition to knowledge inputs, training should include a focus on human rights and the value of social justice and gender equity [77-78]. This is because many would have internalised the dominant cultural values and norms in the community that are not supportive of equity (e.g., caste or ethnicity-based discrimination, elitism) and will need to unlearn these.

ASHAs encounter high safety and security risks. Such as when they take up human rights issues, they may face a backlash both from vested interests and from within the community [79-80]. Often, cultural norms are at cross-purposes with human rights and equity values. ASHAs from the local community thus face the additional burden of maintaining their place within the community when they go against culture and traditions to uphold human rights values.

Community-based health workers, like all other workers in the health system, need support in the form of supportive personnel policies, training, supportive supervision, and access to supplies and equipment. They do not always receive these, because there is no clarity on whether they are representatives of the community or workers in the health system. The lack of clarity on the ASHA’s role also results in poor and unfair compensation of her time and effort. She is recruited as a ‘volunteer’ and, if paid at all, only given ad hoc payments for specific tasks done. This situation needs to be reviewed and reconsidered as a matter of workers’ rights.

These checklists provide a grading system by which to measure the extent of compliance to rights-based principles in the provision of contraceptive information and services. Rights violations identified through the checklists are based on constitutional rights, the right to the highest attainable standards of health and the Availability, Accessibility, Acceptability, and Quality (the AAAQ) framework. Once information about rights violations is collected, it must be fed into appropriate levels for redress to be sought.

Possible Accountability Structures and Forums for Redress

- The community monitoring structures, the Rogi Kalyan Samities – these have to be made to work;
- The elected representatives and panchayati raj structures including the gram sabhas, and
- Legal recourse through public interest litigations.

It is desirable that the spaces for redress should be closest to the community – this will enhance affected people and groups' ownership of the issue as well as their participation. Therefore it is important that these checklists are preferably used along with other community organising initiatives. The checklists can help highlight gaps, which can be translated into strategic advocacy plans. While different contexts will require a tailored set of next steps, these are some suggestions on how to proceed, should you find that the contraceptive programme under review does not meet the standards of rights-based principles, as outlined by the WHO technical guidance.[6]

Identify Key Priority Areas The checklists can be used to identify key priority areas that need immediate advocacy and attention. You may choose to prioritise some gaps over others, based on various criteria, dependent on the context of the problem, urgency of the situation, resources available, and current/future advocacy opportunities. You may also choose your demands according to the context and urgency of the situation – do you want an improvement in the quality of services, do you want redress and compensation, or do you want the barriers to accessibility removed?

Evidence Generation Evidence generation can occur through several mechanisms. Indicators can be used to analyse both the extent of the gap or the resulting consequences of the gap; both are powerful components for advocacy to close the gap. This can occur through data collection at the local level, through observational research, or through secondary analysis of pre-existing data, such as those from the Demographic and Health Surveys, WHO databanks, and others. Fact-finding exercises including case stories or on-the-ground records also serve as powerful, emotionally stimulating tools for advocacy.

Identifying Stakeholders It is also important to identify stakeholders who can bring about changes in the contraceptive programme under review. While much effort will be targeted at government bodies and officers, such as the Ministry of Health, there are other important stakeholders who could influence governments and the contraceptive programmes. These include: service providers, other national or local organisations and coalitions and networks mentioned earlier (e.g., the National Coalition against the Two-Child Norm and Coercive Population Policies, Jan Swasthya Abhiyan, and so on), the legal fraternity, international organisations, such as the WHO, and regional advocacy organisations, such as ARROW. An analysis of the role these various stakeholders can play and how they will react to the issue is critical in determining how to initiate and sustain the conversation with them.

Identifying Important Platforms for Advocacy Being at key events is imperative, not only to bring awareness for your advocacy, but also to connect with the right people to move your advocacy forward. Identifying in advance the main advocacy platforms and the attendees for the event will equip advocates with the information they need to plan their intervention at such events. Interventions could range from organising one-on-one conversations with key stakeholders, distributing briefing sheets or publications, and holding side-events to communicate the advocacy to a larger audience. There is no single method of advocacy, each situation requires a different course of action.

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Monitoring the delivery of rights-based contraceptive services and information requires examining these against certain standards. These standards can be derived from a number of sources - the programme's stated actions, its standard operating procedures, methods, processes and mechanisms, legal frameworks and so on. In this annexure we outline some of these standards and provide references which can provide further details if necessary. This annexure also lists some documents which are useful for deriving standards for the assessment of contraceptive care. Subsequently, it delineates some general standards for the assessment of contraceptive services and specific standards for each contraceptive methods.

Some Published Resources for Deriving Standards for Assessment of Contraceptive Services

1. Selected Practice Recommendations for Contraceptive Use[1]

This document addresses ongoing controversies and inconsistencies on maximising the effectiveness of contraceptive methods and managing their side-effects and other problems during use. Its recommendations provide a basis for rationalising the provision and use of various contraceptives based on the most up-to-date information available. It also delineates general standards which are essential for the successful implementation of contraceptive programmes.

2. Medical Eligibility Criteria for Contraceptive Use[2]

The document provides recommendations for appropriate medical eligibility criteria based on the latest clinical and epidemiological data, and is intended for use by policy-makers, family planning programme managers and the scientific community. It aims to provide guidance for national family planning/reproductive health programmes in the preparation of guidelines for the service delivery of contraceptives. It should not be seen or used as the actual guidelines, but rather as a reference. The document covers the following family planning methods: low-dose combined oral contraceptives (COCs), combined patch (P), combined vaginal ring (R), combined injectable contraceptives (CICs), progestogen-only pills (POPs), depot medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), levonorgestrel (LNG) and etonogestrel (ETG) implants, emergency contraceptive pills (ECPs), copper-bearing intrauterine devices (Cu-IUDs), levonorgestrel- releasing IUDs (LNG-IUDs), copper-IUD for emergency contraception (E-IUD), barrier methods (BARR), fertility awareness-based methods (FAB), lactational amenorrhoea method (LAM), coitus interruptus (CI), and female and male sterilisation (STER).

3. Contraceptive Updates - Reference Manual [3]

This document gives information about various contraceptive services such as OC pills, condoms, emergency contraceptive pills, injectable contraceptives, intrauterine devices, sterilisation methods, centchroman, fertility awareness-based methods and the lactational amenorrhoea method. It also provides a checklist to rule out pregnancies as well as a list of useful websites on contraceptives.

4. IUCD Reference Manual for Medical Officers[4]

This manual has been prepared with the objective of bridging gaps in knowledge on IUCDs. It provides basic information about IUCDs, how they work, the counselling necessary prior to IUCD insertion, the medical eligibility criteria, insertion, removal, follow-up care and management of potential problems.

5. Guidelines for Administration of Emergency Contraceptive Pills by Health Care Providers[5]

Emergency contraception (EC) is considered an important intervention to prevent unwanted pregnancies following contraceptive failure or unprotected sexual exposure. The Drug Controller General of India approved levonorgestrel, a progestin-only pill, as a dedicated product for emergency contraception in 2001 and the pill has been introduced in the Family Welfare Programme since 2003. Guidelines for its administration have been developed with inputs from UNFPA, USAID, NGOs and various professional bodies like FOGSI, and other experts in the field of obstetrics, gynaecology and public health. This document provides general information on EC pills, counselling and medical eligibility criteria for clients of these pills.

6. Manual for Family Planning Insurance Scheme[6]

This document gives details of the Indian government's Family Planning Insurance Scheme, which was introduced on November 29, 2005 to take care of cases of failed sterilisation, medical complications or death resulting from sterilisation, and to also provide indemnity cover to the doctor/health facility performing sterilisation procedures.

7. Quality Assurance Manual for Sterilisation Services[7]

This manual is a guide for assessing service quality and for enabling programme managers and service providers in the public sector and accredited private/NGO facilities to provide quality sterilisation services. It is envisaged that programme managers and service providers will be encouraged to take remedial measures and corrective steps outlined in this manual to ensure adherence to standards in service delivery.

8. Standards for Female and Male Sterilisation Services[8]

This document delineates standards for female and male sterilisations including standards for physical requirements, clinical processes, counselling and post-operative care.

1. WHO (2004) *Selected practice recommendations for contraceptive use, Second edition, Department of Reproductive Health and Research, Family and Community Health,* Geneva.
2. WHO (2010) *Medical eligibility criteria for contraceptive use, Fourth edition*
3. Ministry of Health and Family Welfare Government of India and UNFPA (2005) *Contraceptive updates - Reference manual.*
4. Ministry of Health and Family Welfare, Government of India (2007) *IUCD Reference manual for medical officers,* Family Planning Division.
5. Ministry of Health and Family Welfare, Government of India (2008) *Guidelines for administration of emergency contraceptive pills by health care providers,* Family Planning Division.
6. Ministry of Health & Family Welfare, Government of India (2008) *Manual for family planning insurance scheme.*
7. Ministry of Health and Family Welfare, Government of India (2006) *Quality assurance manual for sterilization services,* Research Studies & Standards Division.
8. Ministry of Health and Family Welfare, Government of India (2006), *Standards for female and male sterilization services,* Research Studies & Standards Division

General Standards Essential for Successful Implementation of Contraceptive Programmes[9]

- Clients should be given adequate information so they can make an informed, voluntary choice of a contraceptive method. Information on any contraceptive method given to clients should at least include:
  - An understanding of the relative effectiveness of the method
  - The correct use of the method
  - How the method works
  - Common side-effects of the method
  - Health risks and benefits of the method
  - Signs and symptoms that would necessitate a return to the clinic
  - Information on return to fertility after discontinuing use of the method
  - Information on STI protection
- For methods that require surgical approaches, insertion, fitting and/or removal by a trained health provider (such as sterilisation, implants, IUDs, diaphragms, and cervical caps), appropriately trained personnel in adequately equipped facilities must be available for those methods to be offered, and appropriate infection prevention procedures must be followed.
- Adequate and appropriate equipment and supplies need to be maintained and held in stock (for example, contraceptive commodities, equipment and supplies for infection-prevention procedures).
- Service providers should be given guidelines (or client cards or other screening tools) so they can appropriately screen clients for conditions in which the use of certain contraceptive methods could carry unacceptable health risks.
- Service providers must be trained in providing family planning counselling to help clients make informed and voluntary decisions about their fertility.

Standards for Specific Contraceptive Methods

1 Emergency Contraceptive Pills (ECPs)[10]

Standards for availability: These pills can be provided safely and effectively by any well-informed health care provider (clinical, nursing and paraclinical) such as a doctor, nurse, midwife, pharmacist, paramedic, family welfare assistant, health assistant and community-based health worker.

9. WHO (2004) *Selected practice recommendations for contraceptive use, Second edition,* Department of Reproductive Health and Research, Family and Community Health, Geneva.
10. Ministry of Health and Family Welfare, Government of India (2008) *Guidelines for administration of emergency contraceptive pills by health care providers,* Family Planning Division,

ECPs should be not be denied to clients within the reproductive years irrespective of their age and marital status

1.1 Standards for the Provision of ECPs

- All women in their reproductive age group and their partners should be informed about the availability of ECPs during regular family planning consultations.
- Women should be provided with a supply of ECPs in advance as a back-up method for contraceptive mishaps.

1.2 Standards for Providing ECPs

- If intercourse has taken place within the previous 72 hours (3 days), ECPs can be prescribed and provided.
- Even if the client is breast-feeding, ECPs can still be given, as the progestin pills do not affect the quantity or quality of breast milk.
- If the recommended time-limit of 72 hours for using ECPs has been crossed, the insertion of an IUCD at this stage, depending on the client's situation, would be a better choice, for which she may be referred to an appropriate health centre.
- If the woman has crossed the 120-hour time limit (5 days) or if there is a possibility that she may be pregnant, she should be asked to wait until the next menses starts. A pregnancy test can be conducted to confirm her pregnancy status.

2 Contraceptives Pills[11]

- It should be emphasised that these pills do not protect against STI/HIV.
- If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method.

2.1 Standards for Follow-up Care for Combined Oral Contraceptives

- An annual follow-up visit is recommended.
- A three-month follow-up contact after initiation is recommended.
- The client should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.

2.2 Standards for Follow-up Care for Progestogen-Only Pills (while not breastfeeding)

- Three months after initiation, follow-up is recommended.
- The client should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.

11. WHO (2004) *Selected Practice Recommendations for Contraceptive Use,* Second edition, Department of Reproductive Health and Research, Family and Community Health.

2.3 Standards for Follow-up care for Progestogen-Only Pills (while breastfeeding)

- The client should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.
- The client should be advised that when she either ceases or significantly reduces the frequency of breastfeeding, she should return for further contraceptive advice and counselling.

3 Intrauterine Contraceptive Devices [12]

3.1 Standards for Physical Examination

- A general and systemic examination including an abdominal examination
- A pelvic examination which includes examination of the external genitalia, a bimanual examination, and a speculum examination of the vagina and cervix
- If the findings from the bimanual examination are unclear, a rectovaginal examination should be perfomed.

3.2 Standards for Pre-examination Preparations

- Ensure that high-level disinfectant (HLD)/sterile supplies, and a light source are available and ready for use
- Use the HLD/sterile cheatles forceps, and arrange the instruments and supplies in the stainless steel tray, being very careful not to touch any parts that will go into the vagina or uterus
- Ensure the IUCD is available in a pre-sterilised pack
- Ensure the client's privacy
- Ask the woman to empty her bladder and wash the perineum with clean water
- Provide additional information and reassurance, as needed
- Before doing a vaginal examination, wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry or perform an alcohol rub
- Put on clean HLD gloves on both hands.
- Make the client lie down on the table in the dorsal position, with knees flexed and abducted to expose her perineal area.

3.3 Standards for Insertion and Removal

IUCD insertion and removal should be performed only by providers (physicians, nurses, and midwives) who have been trained to perform these procedures.

3.4 Standards for Timing of the Insertion

- Within seven days of the beginning of last menstrual period or any time during the menstrual cycle, provided the service provider is reasonably sure the client is not pregnant

12. *IUCD Reference manual for medical officers,* Family Planning Division, Ministry of Health and Family Welfare, Government of India, July 2007

- Immediately or within 48 hours after delivery (by a provider who is trained in inserting IUCDs) or more than 6 weeks post-partum
- Concurrently with the first trimester medical termination of pregnancy
- After the first menstrual period following a spontaneous/medical/second trimester abortion
- In a woman with lactational amenorrhea, provided pregnancy can be ruled out
- Within five days of unprotected sex as an emergency contraception

3.5 Standards for Post-insertion Assessment

The client should be asked how she is feeling, and whether she is experiencing any of the following symptoms:

- Nausea, mild-to-moderate lower abdominal pain/cramping, dizziness or fainting (rare)
- If she is experiencing any of these symptoms, provide reassurance and allow her to remain on the examination table to rest until she feels better.
- Although most women will not experience problems after IUCD removal, all women should remain at the clinic for 15 to 30 minutes as a precaution.

3.6 Standards for the Quality of IUCD Services

There are eight key areas to monitor the performance of IUCD services. These areas include:

3.6.1 Standards for Human and Physical Resources

- The provider is trained to provide IUCD and other family planning services
- The clinic has adequate clean space for providing the services.
- The clinic has an area where counselling can be conducted in privacy.
- The clinic has instruments and equipment to provide IUCD services.
- The clinic has sufficient supplies of IUCDs.
- The clinic has infection prevention supplies and record-keeping and reporting materials to provide family planning services.
- Good storage principles are applied to contraceptives, essential drugs and medical supplies.

3.6.2 Standards for Client-focused IEC Materials for Family Planning

- The clinic has informational posters or panels on the family planning services it offers and on clinic timings.
- It has information on clients' rights regarding family planning.
- It has flip charts and IEC material and samples of family planning methods for counselling.

3.6.3 Standards for Management Systems

- There are written routine protocols and instructions for the delivery of family planning services.

- The clinic has a simple family planning client record system.
- The records are reviewed and analysed regularly.

3.6.4 Standards for Infection Prevention

- The clinic has clean running water.
- It has a facility for hand hygiene.
- Antiseptics for skin and mucous membranes are available and used as per standards.
- The decontamination of instruments and other articles (immediately after use and before cleaning) is performed according to standards.
- The waste disposal system is according to standards.

3.6.5 Standards for Family Planning for New Clients: General Counselling

- The provider uses appropriate interpersonal communication skills during the entire visit.
- The provider gives information on the contraceptive methods available in the clinic and confirms the client's choice.
- The provider rules out pregnancy in the client.

3.6.6 Standards for Providing IUCD to a New Client

- The provider assesses the client's eligibility to use an IUCD.
- The provider explains warning signs associated with IUCD use.
- The provider performs the pre-insertion tasks and inserts the IUCD as per guidelines.
- The provider gives instructions about the client's return visits and/or follow-up visits.

3.6.7 Standards for Follow-up Visits and Management of IUCD Side Effects and Problems

- The provider verifies the client's satisfaction (or non-satisfaction) with the IUCD.
- The provider identifies the side-effects or problems with the IUCD.
- The provider manages the side-effects and problems with the IUCD.
- The provider gives instructions about return visits and follow-up visits for the IUCD.

3.6.8 Standards for IUCD Removal

- The provider prepares for the removal procedure.
- The provider removes the IUCD following standard procedure guidelines.
- The provider performs post-removal tasks and provides counselling on other family planning methods.

3.6.9 Standards for Post-IUCD Removal Counselling

- The provider asks the client how she is feeling, and whether she is experiencing any of the following symptoms: nausea, mild-to-moderate lower-abdominal pain or cramping, dizziness or fainting (rare). If she is experiencing any of these symptoms, the provider reassures her and allow her to rest on the examination table until she feels better.

3.6.10 Standards for Follow-up Care for IUCDs

The basic components of routine follow-up care are essentially the same for new and continuing users of these devices. Some components, however, may be more important for new users, such as:

- Assessing for menstrual changes (the most common side-effect of IUCD use), which often subside within a few months of IUCD insertion;
- Assessing for infection, which is uncommon but most likely to occur in the first 20 days after IUCD insertion; and
- Checking for IUCD expulsion, which is very uncommon but most likely to occur within the first few months after IUCD insertion.

For a continuing user, on the other hand, it may be more critical to assess for significant changes since her last visit, such as changes in her overall health, reproductive goals or individual risk for HIV and other STIs.

- The recommended follow-up schedule is a first visit after the first menstrual period or after one month, whichever is earlier; subsequent visits after three months and thereafter once a year; and unscheduled visits as and when required.
- The client should be advised to return at any time to discuss side-effects or other problems, or if she wants to change the method.
- For devices that have a high rate of expulsion, more frequent follow-up than above may be indicated.
- The client should be advised to return when it is time to have the IUCD removed.

4 Standards for Female Sterilisation Services[13]

4.1 Standards for Availability of Number of Facilities Providing Fixed Day Services in a District of 20 and 10 lakh Population (Approximate)

Facility	District with 20 lakh Population	District with 10 lakh Population
District Hospital	1	1
Sub-district Hospital	1	1
Community Health Centre/Block Primary Health Centre	10	5
24X7 Primary Health Centre	10	5
Total	22	12

13. *Standards for female and male sterilization services,* Ministry of Health & Family Welfare, 2006

4.2 Standards for Qualification Norms of Providers

Procedure	Qualification
NSV/c onventional vasectomy	Medical officer with MBBS qualification trained in NSV/ conventional vasectomy
Minilap	Medical officer with MBBS qualification trained in Minilap
Laparoscopic sterilisation	DGO/ MD (gynaec) trained in laparoscopic sterilisation

4.3 Approximate Number of Providers Required for the Procedures

in a district with 20 lakh population is around 30

Procedure	District Hospital	Sub-district Hospital	Community Health Centre/ Block Primary Health Centre	24/7 Primary Health Centre	Total
NSV/ conventional vasectomy	1	1	4	4	10
Minilap	2	1	10	5	18
Laparoscopic sterilisation	1	1	0	0	2
Total	4	3	14	9	30

4.4 Standards for Physical Requirements

i Provision of Male and Female Sterilisation Services

The following health facilities in a district should provide female and male sterilisations as regular, routine services throughout the year:

- District hospitals.
- Sub-district Hospitals.
- Community Health Centres and block Primary Health Centres with a functioning operation theatre
- 24 x 7 Primary Health Centres with a functioning operation theatre
- Other government facilities with a functioning operation theatre

ii Range of Services to be Provided

- NSV/conventional vasectomy
- Minilap sterilisation
- Laproscopic sterilisations wherever gynecologists/surgeons are available

iii Periodicity of Services to be Provided

- District Hospital - weekly
- Sub-district Hospital - weekly
- Community Health Centre/ Block Primary Health Centre - fortnightly
- 24×7 Primary Health Centre/ Primary Health Centre - monthly

4.5 Standards for a Safe Tubectomy Procedure

Essential elements of quality sterilisation include counselling, client assessment and screening, informed consent, infection prevention, selection of appropriate procedures, safe anaesthesia regimens and post-operative care and instructions.

4.5.1 Counselling: Since female sterilisation is intended to be a permanent method of contraception, it should be provided only to women who have decided on their own that they do not want children any more. Clients should be counselled about all available methods of contraception before deciding on sterilisation.

4.5.2 Client Assessment: Pre-operative and client screening should be performed to ensure the client's physical and emotional fitness for the sterilisation procedure, to determine the client's characteristics such as age, and number and ages of living children, and to rule out known and identifiable physical and medical risk factors. Client assessment consists of taking a history (medical and obstetrics and gynaecological history) and performing a physical examination (vital signs, heart, lungs, abdomen, and pelvic and speculum examination).

4.5.3 Laboratory Tests: The recommended laboratory tests include tests to screen for anaemia and to rule out current pregnancy. To minimise the chances of pregnancy at the time of the procedure, sites should have criteria for being reasonably sure that a woman is not pregnant. For example, performing the procedure within seven days of the menstrual period (in the follicular phase), within seven days of abortion, within seven days of term delivery or in women using reliable method of contraception.

4.5.4 Informed Consent: The surgeon should verify that the client has signed the informed consent form before beginning the procedure. Although the purpose of signing the form is to document informed consent, the principle focus should be on confirming that the client has made an informed choice of tubal occlusion as a contraceptive method.

4.5.5 Infection Prevention: The surgeon should strictly follow infection-prevention practices at all time to ensure the safety of the procedure. Proper aseptic techniques are essential to prevent immediate and long-term infectious morbidity and mortality. Inadequate infection prevention practices can lead to surgical site infections, tetanus and infections such as HIV, hepatitis B and hepatitis C. Shaving or clipping the hair at the operation site is no longer recommended. Studies have clearly shown that shaving at surgical sites significantly increases the chances of infection.

4.5.6 **Anaesthesia:** Client safety and satisfaction should be the primary considerations in the choice of the anaesthesia regimen used during female sterilisations. The purpose of anaesthesia is to ensure that the client is free from pain and discomfort during the operation. There are choices of anaesthesia regimens - local, general, or regional - for female sterilisation procedures. It is important to have a provider skilled in administering regional and general anaesthesia if these regimens are being followed.

4.5.7 **Instructions to Accompanying Persons:** All clients and their accompanying family members should be provided with clear written and oral post-operative instructions on post-operative wound care, the venue for follow-up, warning signs, and appropriate advice on the restriction on activities following the surgery.

5 Standards for Male Sterilisation Services

5.1 Standards for Clinical Processes

- Preparation for the surgery includes counselling, preoperative instructions, case selection, preoperative assessment, review of the surgical procedure, and post-operative care.
- It is essential to ensure that the client had voluntarily consented to the surgery, has been well-informed about the process, and is physically fit for the surgery.
- Preoperative assessment can also provide an opportunity for overall health screening and treatment of RTIs/STIs.

5.2 Standards for Clinical Assessment and Screening of Clients

- The medical history of a client should include a history of illnesses to screen out diseases mentioned under the medical eligibility criteria and also to screen out other conditions, such as: severe anaemia, acute febrile illness, jaundice, chronic systemic disease, bronchial asthma, heart disease, uncontrolled diabetes, hypertension, thyrotoxicosis, severe nutritional deficiencies, sexual impairments or sexual problems. It will also check for the immunisation status for tetanus, current medications, if any, current use of contraception by the couple, and the partner's last menstrual period (LMP).

5.3 Standards for Follow-up Instructions

- All clients who undergo vasectomy (both conventional and non scalpel vasectomy (NSV) should report to the clinic within 48 hours.
- In the case of a conventional vasectomy, the client should come after a week for the removal of stitches.
- In both conventional vasectomy and NSV, the client should be encouraged to come in for a semen analysis after three months.

5.4 Certificate of Sterilisation

- A certificate of sterilisation should be issued only after the semen analysis shows no sperm.

5.5 Standards for a Safe Vasectomy Procedure[14]

Essential elements of quality sterilisation include counselling, client assessment and screening, informed consent, infection prevention, selection of appropriate procedures, safe anaesthesia regimens and post-operative care and instructions.

5.5.1 **Counselling:** Since vasectomy is intended to be a permanent method of contraception, it should be provided only to men who have decided on their own that they do not want children any more. Clients should be counselled about other available methods of contraception before deciding on sterilisation.

5.5.2 **Client Assessment:** Prior to vasectomy, a medical history should be taken and a limited physical examination should be done including a genital examination; the penis, scrotum and the inguinal region should be inspected visually; and the scrotum should be palpated.

5.5.3 **Laboratory Tests** should not be routine but should be reserved for specific cases in which the provider suspects a condition that requires extra preparation.

5.5.4 **Informed Consent:** The surgeon should verify that the client has signed the informed consent form before beginning the procedure. Although the purpose of signing the form is to document informed consent, the principal focus should be on confirming that the client has made an informed choice of vasectomy as a contraceptive method.

5.5.5. **Infection Prevention:** Strict adherence to infection prevention practices at all times (before, during and after) is also crucial to the safety of the procedure. Proper aseptic technique is essential to preventing both immediate and long-term infectious morbidity and mortality. Inadequate infection prevention practices can lead to surgical site infections, tetanus and infections such as HIV, hepatitis B and hepatitis C. Shaving or clipping the hair at the operation site is no longer recommended. Shaving of the scrotum is no longer recommended, as this significantly increases the chance of surgical-site infection.

5.5.6. **Anaesthesia:** Both, conventional and no scalpel vasectomy are done under local anaesthesia.

5.5.7. **Instructions to the Client:** Men undergoing vasectomy should receive clear instructions about post- operative care, the anticipated side-effects, action to be take if complications occur, sites where they can access emergency care, the need for post-operative semen analysis and the time and place for a follow-up visit.

6 Standards for Quality Assurance[15] for Sterilisation Services[16]

The Reproductive Health Quality Framework (according to the UNFPA technical report, 1999) specifies nine elements of quality that can be categorised into generic and specific elements:

The generic elements (common to all RCH services) are service environment, client provider

14. Government of India Ministry of Health and Family Welfare and UNFPA (2005): *Contraceptive updates - Reference manual*

interaction, informed decision-making, integration of services, and women's participation in management: and

The service-specific elements (specific to each RCH service) are access to services, equipment and supplies, professional standards and technical competence, and continuity of care.

6.1 Standards for Assessment of a Facility

6.1.1 Infrastructural Facilities

- Is the building in good condition (walls, doors, windows, roof, and floor)?
- Is the facility clean?
- Is running water available at the service points?
- Is there a clean and functional toilet facility for staff and clients?
- Is electricity available?
- If there is no running water or electricity, are alternatives available that permit providers to deliver the available services hygienically?
- Is there a functional generator available?
- Are petrol, oil and lubricants (POL) available for the generator?
- Has space been earmarked for examination and counselling to assure privacy?
- Is there a waiting area with adequate seating?

6.1.2 Standards for Clinical Processes

- Preparation for surgery includes counselling, preoperative assessment, preoperative instructions, review of the surgical procedure, and post-operative care.
- It is essential to ensure that the consent for surgery is voluntary and well informed, and that the client is physically fit for the surgery.
- Preoperative assessments also provide an opportunity for overall health screening and treatment of RTIs/STIs.

15. *Quality assurance (QA) is defined as a cyclical process involving assessment leading to improvement, followed by further assessment and improvement. It is designed to objectively and systematically monitor and evaluate services offered to clients in accordance with pre-established standards, to resolve identified problems and pursue opportunities for improving services, leading to client satisfaction. It is critical to ensure that QA is recognised as an essential element of the reproductive health approach within the domain of reproductive rights. QA is viewed as a systematic process aimed at providing services that the client views as good, desirable, and of high quality. This means offering services that are safe and effective and that satisfy the clients' needs and wants. QA is a comprehensive and multifaceted concept that measures how well clients' expectations and providers' technical standards are being met. Quality is the way in which individuals and clients are treated by the system providing services (Bruce 1990; Jain 1989). Quality of care is defined as 'attributes of a service programme that reflect adherence to professional standards, a congenial service environment and satisfaction on the part of the user'.*

16. Ministry of Health and Family Welfare Government of India (2006) *Quality assurance manual for sterilization services,* Research Studies & Standards Division.

6.1.3 Standards for Counselling[17]

General counselling should be done whenever a client has a doubt or is unable to take a decision regarding the type of contraceptive method to be used. However, in all cases, method-specific counselling must be done.

The following steps must be taken before clients sign the consent form:

- Clients must be informed of all the available methods of family planning and should be made aware that, for all practical purposes, this operation is a permanent one.
- Clients must make an informed decision for sterilisation voluntarily.
- Clients must be counselled whenever required in the language they understand.
- Clients should be made to understand what will happen before, during and after the surgery, its side-effects, and potential complications.

The following features of the sterilisation procedure must be explained to the client:

- It is a permanent procedure for preventing future pregnancies.
- It is a surgical procedure that has a possibility of complications, including failure, requiring further management.
- It does not affect sexual pleasure, ability or performance.
- It will not affect the client's strength or ability to perform normal day-to-day functions.
- It does not protect against RTIs, STIs or HIV/AIDS.
- A reversal of this surgery is possible, but that the reversal involves major surgery and its success cannot be guaranteed.
- Clients must be encouraged to ask questions to clarify their doubts, if any.
- Clients must be told that they have the option of deciding against the procedure at any time without being denied their rights to other reproductive health services.

6.1.4 Standards for Clinical Assessment and Screening of Clients

- Prior to the surgery, the client's medical history needs to be compiled and a physical examination, and laboratory investigations, as specified below, should be done to ensure the eligibility of the client for surgery.
- Medical history should include a history of illnesses to screen for the diseases mentioned under the medical eligibility criteria, immunisation status of women for tetanus, current medications, and last contraceptive used and when.
- The menstrual history should include the date of the last menstrual period and current pregnancy status

17. *Counselling is the process of helping clients make informed and voluntary decisions about fertility.*

- Obstetrics history
- The physical examination should include measuring the pulse rate, blood pressure, respiratory rate, temperature, body weight, general condition, pallor, auscultation of the heart and lungs, examination of the abdomen and pelvis, and other examinations as indicated by the client's medical history or general physical examination.
- Laboratory examinations should include a blood test for haemoglobin, urine analysis for sugar and albumin, and other laboratory examinations as indicated.

6.1.5 Standards for Post-operative Care

- Pulse, respiration, and blood pressure should be monitored and recorded every 15 minutes for an hour following surgery or longer if the patient is unstable or not awake.

  The client may be discharged when the following conditions are met:
- After at least four hours of the procedure, when the vital signs are stable and the client is fully awake, has passed urine, and can walk, drink or talk.
- The client has been seen and evaluated by the doctor. Whenever necessary, the client should be kept overnight at the facility.
- The client must be accompanied by a responsible adult while going home.
- Analgesics, antibiotics and other medicines may be provided and/or prescribed as required.

6.1.6 Standards for Post-operative and Follow-up Instructions

- Both written and verbal post-operative instructions must be provided in the local language.
- A certificate of sterilisation should be issued by the Medical Officer of the facility a month after the surgery or after the client's first menstrual period.

7 Family Planning Insurance Scheme[18]

- Under the scheme, the central government releases funds to states/UTs in the following manner: Rs. 300 for each tubectomy, Rs. 200 per vasectomy and Rs. 20 per IUD insertion.
- States and UTs have the flexibility to decide the apportionment of the funds among the various components, provided a minimum amount of Rs. 150 is paid to each client undergoing a tubectomy or vasectomy; and the amount used by the medical facility towards drugs and dressing is Rs. 60 per tubectomy, Rs. 25 per vasectomy and Rs. 20 per IUD insertion.
- In the case of EAG states, viz., Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttaranchal, the compensation package for sterilisation had been raised from Rs.300 to Rs. 400 per tubectomy; from Rs. 200 to Rs. 400 per vasectomy if conducted in a public health facility or an approved private sector health facility; and from

18. *Manual for family planning insurance scheme*, Government of India, Ministry of Health & Family Welfare, January 2008

Rs. 20 to Rs. 75 per IUD insertion if conducted in an approved private sector health facility. This scheme was renewed and improved from January 1, 2008 with modifications in the limits and payment procedures. The revised package and guidelines are as follows:

Revised Package for Family Planing Insurance Scheme

Section		Coverage	Caps
I	IA	Death following sterili sation in hospital or within seven days from the date of discharge from the hospital.	Rs. 2 lakh
	IB	Death following sterili sation within 8 - 30 days from the date of discharge from the hospital.	Rs. 50,000
	IC	Failure of sterilisation	Rs 25,000
	ID	Cost of treatment up to 60 days from the date of discharge arising out of complications.	Actual not exceeding Rs 25,000
II		Indemnity insurance per doctor or facility but not more than four cases in a year.	Up to Rs. 2 lakh per claim
The total liability of the insurance company shall not exceed Rs. 9 crore in a year under each section.			

7.1 Standards for a Quality Assurance Committee

- A Quality Assurance Committee will be formed at the state and districts level to ensure that the central governments' standards for female and male sterilisation are followed in respect of pre-operative measures (for example, by way of pathological tests), operational facilities (for example, sufficient necessary equipment) and aseptic condition and post-operative follow ups).
- It is the duty of the Quality Assurance Committee to collect and publish six monthly reports on the number of people sterilised as well as the number of deaths or complications arising out of the sterilisation.
- The Committee should meet at least once in three months.
- The composition of the Committee would be as follows:

At the State Level: Secretary, Medical and Health, Director Family Welfare (Convener), Director (Med. Education), one empanelled gynaecologist, one empanelled vasectomy surgeon, one anaesthetist, a state nursing advisor, the Joint Director (FW)/Deputy Director (FW) or any other person as determined by the Department of Family Welfare, one member from an accredited private sector organisation, and one representative from the legal cell.

At the District Level: the District Collector, Chairperson, Chief Medical Officer/District Health Officer (convener), one empanelled gynaecologist, one empanelled vasectomy surgeon, one anaesthetist, the District Family Welfare Officer/RCHO, one representative from the nursing cadre, any other person as determined by the Department of Family Welfare, and one representative from the legal cell.

Annexure 1

The checklist for infrastructure and equipment at the facility where sterilisation will be conducted is given in the manual. Similarly, the detailed informed consent form and pre-surgery assessment format are also given in the manual.

Useful Websites on Contraceptives Guidelines

1. http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/family-planning-guidelines.html
2. http://nrhm.gov.in/mediamenu/fp-mass-media-campaign/birth-spacing-campaign/contraceptive-choices-for-birth-spacing.html
3. http://nrhm.gov.in/mediamenu/fp-mass-media-campaign/birth-spacing-campaign/oral-contraceptive-pills.html
4. http://www.who.int/reproductivehealth/publications/family_planning/en/
5. http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf
6. http://www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/
7. http://mohfw.nic.in/WriteReadData/l892s/Chapter9ContraceptionFINAL-76217594.pdf
8. http://www.gfmer.ch/Guidelines/Family_planning/Family_planning_mt.htm
9. http://dhs.kerala.gov.in/docs/pdf/fwiec5.pdf
10. http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/adolescent-reproductive-and-sexual-health-arsh.html
11. http://countryoffice.unfpa.org/india/drive/Referencemanualfordoctors.pdf

Annexure 2 Monitoring Checklists

In this chapter, we have brought all the recommendations from Chapter 3 under two headings - Checklist to monitor rights-based contraceptives **policies and programmes** and Checklist to monitor contraceptives **service delivery** from a rights perspective. The checklists can be used independently by persons and organizations engaged at different levels. Policy analysts can use Checklist 1 and those engaged at the community level can use Checklist 2 to monitor rights based service delivery of contraceptives' programmes.

Checklist 1 Monitoring Contraceptives Policies and Programmes

NON DISCRIMINATION

Recommend that access to compre hensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice)

1 Is there a two-child norm in the state that results in discrimination of those with more than two children?

2 Do any programme guidelines, or government offices or government documents state upfront that no person shall be forced against his/her will to accept any method of contraception that s/he does not wish to?

3 Do any programme guidelines, or government offices or government documents specify that informed consent has to be obtained from any client receiving contraceptive services?

4 Is there a practice of offering any incentives (money or gifts) to a client for the adoption of contraception in general, or a specific method of contraception, at any time or under any circumstances (such as people with three children in order to prevent higher-order births)?

Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalised populations in their access to these services.

5 Do programme objectives include attention to marginalised groups, such as people living in remote geographic areas, members of marginalised community groups, single women, disabled persons, sex workers, PLHIV, or people of diverse sexual orientations and gender identities?

6 Is the contraceptive information and services programme labelled as a "family planning" programme, thereby excluding those who are not in 'families'?

7 Is the programme part of the maternal and child health programme thereby excluding men.

8 Do programme objectives explicitly mention attention to the needs of adolescents and young people?

9 Does the programme place an undue burden of contraception on women? Does it cater to men? Do programme objectives explicitly mention paying attention to the needs of men?

AVAILABILITY

Recommend the integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to ensure availability.

10 Does the National Essential Drugs list include an expanded range of contraceptives including emergency contraceptive pills?

ACCESSIBILITY

Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside schools that include information on contraceptive use and acquisition.

11. Is comprehensive sexuality education a component of one or more national and state policies?
12. Is there a policy or government order to implement comprehensive sexuality education: a) in schools; and b) for out-of-school youth?
13. What proportion of schools has any sexuality education as part of its curriculum?

Recommend eliminating financial barriers to contraceptive use by marginalised populations including adolescents and the poor, and make contraceptives affordable to all.

14 Are contraceptive services available free at the point-of-delivery to all sexually active individuals and not only to married persons of reproductive age?

15 Are there mechanisms in place to ensure that the non-poor who cannot pay for contraceptive services are not denied access?

Recommend interventions to improve access to comprehensive contraceptive information and services, for users and potential users with difficulties in accessing services (e.g., rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines *(Safe abortion: Technical and policy guidance for health systems,* second edition*).*

Recommend that mobile outreach services be used to improve access to contraceptive services for populations who face geographical barriers to access

16 Has the planning of the location and timing of services, the physical infrastructure and human resources taken into account the special needs of disadvantaged groups (e.g., those with low literacy, or with physical disabilities; linguistic and ethnic minorities)?

17 Are there mobile contraceptive outreach services available to reach out to underserved populations with the full range of contraceptive services? What proportion of low-income and hard-to-reach population is covered by mobile out-reach services? Do they routinely provide the full range of contraceptive methods and services?

Special efforts should be made to provide contraceptive information and services to displaced populations and those in crisis settings, and to survivors of sexual violence who particularly need access to emergency contraception.

18 Do government agencies engaged in emergency (disaster) management have a policy related to reproductive health needs assessment in emergency situations, including assessing the demand for contraceptives?

Recommend that contraceptive information and services, as part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health care setting.

19 Does the National HIV Policy prioritise the integration of contraceptive services within HIV testing, treatment and care services? Is there a strategy in place on the integration of contraceptive services within HIV testing, treatment and care services?

20 Are there mechanisms for coordination between departments/authorities responsible for HIV/AIDS and those responsible for sexual and reproductive health including contraceptive services in matters related to service integration? Are such mechanisms present at the state and district levels?

21 Have clinical protocols and standards for HIV testing, treatment and care been reviewed and revised to integrate contraceptive information, counselling and services?

Recommend that comprehensive contraceptive information, counselling and services be provided during antenatal and postpartum care

Recommend that comprehensive contraceptive information, counselling and services be routinely integrated with abortion and post-abortion care

22 If contraceptive services are integrated with postpartum and abortion/post-abortion services, as in the Post Partum IUCD strategy, are there indications of any elements of restricting voluntary choice of contraception per se or of specific methods of contraception? (Some examples of restricting choice may be post-partum sterilisation programmes or post-partum IUCD programmes in instances where they offer only a single method; or requiring women seeking abortion services to accept a method of contraception.) What are the informed consent procedures followed?

23 Have clinical protocols and standards for maternal health-care and abortion/post-abortion care been reviewed and revised to integrate the provision of comprehensive contraceptive information, counselling and services?

Recommend elimination of third-party authorisation requirements, including spousal authorisation for individuals/women accessing contraceptive and related information and services

24 Do any laws or policy and programme documents specify spousal authorisation for individuals/women accessing contraceptive and related information and services?

Recommend provision of sexual and reproductive health services, including contraceptive services, for adolescents without mandatory parental and guardian authorisation/ notification, in order to meet the educational and service needs of adolescents

25 Is there a law or regulation, which requires parental authorisation for an adolescent to obtain any sexual and reproductive health services?

26 Is there a policy or strategy document on sexual and reproductive health services for adolescents and young people which specifies that services will be available irrespective of marital status and does not mandate guardian or parental consent for accessing services for adolescents?

ACCEPTABILITY

Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that includes skill building (i.e., communications and negotiations) and that are tailored to meet communities' and individuals' specific needs.

27 Do the contraceptive/sexual and reproductive health (SRH) programme guidelines uphold the need for gender-sensitive service delivery? If yes, do they set out norms for this?

28 Do the contraceptive/SRH programme guidelines highlight the specific needs of clients experiencing intimate partner violence? If yes, do they set out norms for counselling and service delivery for such clients?

29 Are providers trained for gender-sensitive service provision?

- Does this include training for gender-sensitive counselling for contraception?
- Does gender training for reproductive health service providers include training to address the specific needs of women experiencing reproductive coercion or other forms of intimate partner violence?

Recommend that follow-up services for the management of contraceptive side-effects be prioritised as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and made available.

30 Are there protocols for different levels of facilities and providers for follow-up visits, the management of side-effects and referrals for contraceptive services?

31 Are providers trained in follow-up and referral procedures related to contraceptive services?

QUALITY

Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes

Recommend that the provision of long-acting reversible contraception (LARC) methods include insertion and removal services and counselling on side-effects, in the same locality.

Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.

32. Is a comprehensive strategy for Quality Assurance, including for contraceptive information and services, a component of the sexual and reproductive programme guidelines?

33 Is there a comprehensive strategy for quality assurance, including for contraceptive information and services, a component of the secual and reproductive programme guidelines?

34. Have standards of quality care been elaborated for the provision of contraceptive services at different levels of care?

35. Is the budgetary allocation sufficient to assure adherence to the quality standards?

36. Are there processes in place for regular audits and monitoring of quality of contraceptive services?

INFORMED DECISION MAKING

Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.

Recommend every individual is ensured an opportunity to make an informed choice about their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination

37 Do guidelines and protocols for counselling and service provision elaborate on elements of and processes for informed decision-making on contraception?

38 Are providers aware of and trained to facilitate informed decision-making?

39 Do providers have the resources necessary to ensure informed contraceptive decision-making by clients? Are posters and IEC material in local languages available and displayed in health facilities?

PRIVACY AND CONFIDENTIALITY

Recommend that privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information

40 Do guidelines and protocols for contraceptive information and services elaborate on how to ensure privacy and confidentiality of the client seeking contraceptive services, including young clients?

41 Are norms related to space requirements of health facilities developed keeping in mind the need for visual and auditory privacy, and for separate waiting, counselling and examination spaces for young clients?

42 Are adequate infrastructural facilities available in health facilities to ensure privacy and confidentiality of all clients?

PARTICIPATION

Recommend that communities, particularly people directly affected, have an opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring

43 Do the SRH policy/programme guidelines specify the creation of mechanisms for regular participation and consultation of community members and service-users?

44 If mechanisms for participation exist, what proportion of the members of these groups are women? Or members of marginalised groups? Are there specific sub-groups that are systematically absent from the membership of such mechanisms?

45 Are there mechanisms/processes present to facilitate the participation of groups like the Lesbian, Gay, Bisexual, Transgender (LGBT) community to express their needs?

46 How do the Village Health and Sanitation Committees (VHNSCs) and the Rogi Kalyan Samities (RKS) function in the area?

ACCOUNTABILITY

Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.

Recommend that evaluation and monitoring of all programmes ensure the highest quality of services and respect for human rights.

47 Are there any national-level committees or state-level committees to ensure accountability for SRHR issues?

48 Does the National Human Rights Commission have legal backing? In the past year, has it received any complaints related to the provision of contraceptive information and services? What proportion of these complaints has been addressed? What proportion has been resolved?

49 What proportion of complaints received/addressed/resolved by human rights commissions, ombudsman offices or other grievance redress mechanisms are from members of marginalised groups?

50 Are any of the indicators used by the government for tracking progress in sexual and reproductive health, including in contraception, 'rights-based'?

51 Is assessing the availability of contraceptives part of the community monitoring by VHSNCs or the Rogi Kaliyan Samities?

Checklist 2 Monitoring Contraceptives Service Delivery and Information Provision

NON-DISCRIMINATION

Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice).

1 Is there a practice of offering any rewards to service providers/their institutions/panchayats for achieving a specified "target" in terms of numbers/proportions of contraceptive users?

2 In practice, do service providers/health facilities experience any disincentives or penalties for not achieving a specified number or proportion of "acceptors" of contraception (Expected Levels of Achievement)?

3 In practice, is any service (e.g., medical termination of pregnancy) or benefit (subsidised food, employment, maternity benefits) made conditional on acceptance of/being a user of contraception?

4 Does the contraceptive programme have mechanisms in place (spot-checks, feed-back mechanisms) to ensure protection from forced or coerced contraceptive for persons from marginalised groups (e.g., low-income, minority communities, PLHIV, women living in institutions)?

Recommend that laws and policies support programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalised populations in their access to these services.

5 Are data available on who the excluded and marginalised groups are; their sexual and reproductive health needs; and barriers encountered by them in accessing contraceptive information and services? Are service providers aware of the size of gaps in information? Or of which groups have been left out?

6 In practice, are contraceptive information and services available to all sexually active persons irrespective of age, marital status or sexual orientation (e.g., single women, all men, adolescents and young people, sex workers, PHHIV)?

AVAILABILITY

Recommend integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to ensure availability.

7 In practice, is an expanded range of contraceptives available to clients visiting service-delivery points?

8 Have there been instances of stock-out of any contraceptive supplies (w.r.t. a fixed reference period and in a specific reference location, for example, with the ASHA, ANM, AWW)?

ACCESSIBILITY

Recommend the provision of scientifically accurate and comprehensive sexuality education programmes within and outside schools that include information on contraceptive use and acquisition.

9 What proportion of out-of-school young people is covered by any sexuality education programme?

10 Examine the curricula of any sexuality education programme implemented by the government. How 'comprehensive' are these, based on UNESCO's guidelines on the six essential components?

11 Does the sexuality education curriculum promote gender-equal values and norms and address rights, stigma and/or discrimination? Is it sex-positive and does it include diverse sexual and gender identities?

12 In practice, do young people and adolescents receive contraceptive information and services? Are these available to different groups of young people and adolescents (e.g., in-school and out-of-school young people, girls and boys, married and single persons)?

Recommend eliminating financial barriers to contraceptive use by marginalised populations including adolescents and the poor, and make contraceptives affordable to all.

13 Are contraceptive services part of the benefits package of all insurance schemes: community-based health insurance and other prepayment schemes, other compulsory or voluntary insurance schemes (e.g., government-sponsored, employer-sponsored or paid for by individual insurers)? Do they cover the entire range of contraceptive options?

14 Are there measures to check and contain the practice of informal payments?

Recommend interventions to improve access to comprehensive contraceptive information and services, for users and potential users with difficulties in accessing services (e.g., rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines *(Safe abortion: Technical and policy guidance for health systems, second edition)*

Recommend that mobile outreach services be used to improve access to contraceptive services for populations who face geographical barriers to access

15 Are safe abortion services available to all sections of women at affordable costs? Are some groups routinely excluded?

16 Are safe abortion services available at the primary health care level?

Special efforts should be made to provide contraceptive information and services to displaced populations and those in crisis settings, and to survivors of sexual violence who particularly need access to emergency contraception.

17 If there is a positive policy in place, and to what extent was its provisions implemented in practice during the most recent emergency?

Are providers in the humanitarian setting trained to provide contraceptive services, including emergency contraception?

18 Is emergency contraception made available to survivors of sexual violence as a part of medico-legal services?

Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment and care provided in the health care setting.

19 Have HIV service providers been trained in providing contraceptive information and services to women and men?

20 In practice, are contraceptive services routinely offered to users of HIV services? Are information and communication resources available that provide information on contraceptive options for PLHIV?

Recommend that comprehensive contraceptive information, counselling and services be provided during antenatal and postpartum care.

Recommend that comprehensive contraceptive information, counselling and services be routinely integrated with abortion and post-abortion care.

21 Do service providers know about the full range of methods, and have the knowledge and skills to counsel and provide services?

22 In practice, are comprehensive contraceptive services routinely offered to users of antenatal and postpartum services? To users of abortion and post-abortion services? Are information and communication resources available that provide information on contraceptive options to women and men postpartum and post-abortion?

Recommend elimination of third-party authorisation requirements, including spousal authorisation for individuals/women accessing contraceptive and related information and services.

23 In practice, do contraceptive service providers insist on husband's/male partner's authorisation for a woman to obtain any contraceptive services?

Recommend provision of sexual and reproductive health services, including contraceptive services, for adolescents without mandatory parental and guardian authorisation/ notification, in order to meet the educational and service needs of adolescents.

24 Do health care providers know how to assess the competence of an adolescent to take independent decisions on SRH?

ACCEPTABILITY

Recommend gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information, that includes skill-building (i.e., communications and negotiations) and that are tailored to meet communities' and individuals' specific needs.

25 Are health facilities equipped with the personnel, physical space for counselling and ducational materials appropriate for different levels of literacy and cultural diversity?

26 Do health facilities provide an enabling environment for disclosure and discussion by clients experiencing intimate partner violence and/or reproductive coercion, such as posters in public spaces such as waiting rooms, examination rooms, hallways)? Referrals to domestic violence services and screening for reproductive coercion or intimate partner violence are standard procedures prior to the discussion of reproductive intentions and contraceptive options.

Recommend that follow-up services for management of contraceptive side-effects be prioritised as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and made available.

27 In practice, are clients given appropriate and adequate information about follow-up visits, timings and procedures?

28 In practice, do service providers facilitate access to contraceptive methods of the client's choice but which are not available at a given site? Do clients receive appropriate follow-up care for contraceptive side-effects at the same facility without incurring additional expenditure?

QUALITY

Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes.

Recommend that provision of long-acting reversible contraception (LARC) methods include insertion and removal services and counselling on side-effects, in the same locality.

Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services. Competency-based training should be provided according to existing WHO guidelines.

29 Are there processes and mechanisms in place at the programme and facility levels to obtain client feedback on the quality of contraceptive services? Are there examples of incorporating results of the feedback for modifying/improving service provision?

30 Are clients informed that they have the right to request the removal of long-acting contraceptives such as the IUCD?

31 Is there a system of regularly updating providers' knowledge and clinical skills on contraceptive methods?

INFORMED DECISION MAKING

Recommend the offer of evidence-based, comprehensive contraceptive information, education and counselling to ensure informed choice.

Recommend every individual is ensured an opportunity to make an informed choice for their own use of modern contraception (including a range of emergency, short-acting, long-acting and permanent methods) without discrimination.

32. In practice, do all clients receive essential information on all contraceptive methods available?

33 What about informed decision-making and consent of groups like HIV-positive women and women including minors living in institutions like shelter homes – are they allowed to make informed decisions?

PRIVACY AND CONFIDENTIALITY

Recommend that the privacy of individuals is respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information

34 Are providers aware of the importance of ensuring privacy and confidentiality? Do they act accordingly?

35 Are clients comfortable with the privacy and confidentiality aspects of contraceptive information and service provision?

PARTICIPATION

Recommend that communities, particularly people directly affected, have an opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring

36 In practice, what proportion of participatory mechanisms is functional? For example, what issues are raised by marginalised groups? How are they addressed? What follow-up is done?

37 In practice, what proportion of members attending meetings of the participatory mechanisms is women? Or members of marginalised groups? Which population sub-groups are absent?

ACCOUNTABILITY

Recommend that effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels.

Recommend that evaluation and monitoring of all programmes must take place to ensure the highest quality of services and respect for human rights.

38 Has performance-based financing (PBF) been adopted in sexual and reproductive health services?
Are there studies on the equity impact of these? Is any marginalised group disadvantaged as a result of the PBF?

39 Does the government submit regular reports to human rights treaty bodies on how it has acted to fulfil reproductive rights supported by the treaties that it has ratified? What proportion of the drafting committee consists of civil society actors? Or SRH advocates?

40 Are sexual and reproductive rights supported by international human rights treaties incorporated into domestic laws? Identify examples of domestic laws that may violate Sexual and Reproductive Rights supported by treaties that the government has ratified.

The write-up below is on the recent deaths of the women in the Chhattisgarh sterilisations tragedy (November 2014). We use this tragic story to highlight the possible outcomes of human rights violations in the process of sterilisation. (The bold matter within parentheses contains the WHO violations and recommendations violated).

Robbed of Choice and Dignity: Indian Women Dead After Mass Sterilisation

Situational Assessment of Sterilisation Camps in Bilaspur District, Chhattisgarh: Report by a Multi-organisational Team, December 1, 2014[1]

Introduction

The tragic deaths of 16 young women and the critical condition of several others following tubal sterilisations at a camp in Bilaspur District, Chhattisgarh, has once again brought to the fore the disregard for the dignity of women and the dismal quality of care of India's family planning programme. In recognition of the fact that violations of standard operating procedures and guidelines prescribed by the Ministry of Health and Family Welfare (MOHFW) are not limited to Bilaspur or Chhattisgarh, but are a grave concern across the country, a multi-organisational fact-finding team travelled to Bilaspur on 19-20 November 2014 to assess the situation and recommend corrective actions at the national and state levels.

The fact-finding team surveyed the camp sites, interviewed doctors and support staff involved in the service delivery, as well as women who had been sterilised, and family members of those who had died.

Findings

The fact-finding team from four organisations working on public health has called for the setting up of an independent commission to inquire and ascertain the facts in the Bilaspur sterilisation camp disaster which led to the deaths of 16 women. The argument being made is that spurious medicines were responsible for the deaths of the women during the process of sterilisation. However, the team found that some of the critically ill women, admitted at Apollo Hospital after the sterilisation, showed raised levels of procalcitonin that suggests septicaemia. Post-mortem examinations of the first seven deaths at the Chhattisgarh Institute of Medical Sciences and the District Hospital had evidence of peritonitis and septic foci in the lungs and kidneys, also suggesting septicaemia. These indicate deaths by infection during or after the operation **[Quality of contraceptive information and services]** and not merely from spurious medicines. Further, according to forensic medicine and toxicology experts, the amount of zinc phosphide considered lethal for women is 4.5 gm, which is much higher than what could possibly have been consumed by the women in 500 mg of Ciprofloxacin. This also strengthens the argument that it was not the medicines alone that caused these deaths.

The team has come up with a list of recommendations for Chhattisgarh and the country as a whole, in a 37-page report, excerpted here, that was released in New Delhi on 1 December 2014.

1. *Full report: http://populationfoundation.in/news/robbed-choice-and-dignity-indian-women-dead-after-mass-sterilisation.*

It has also urged the state government of Chhattisgarh to immediately make public the post-mortem reports, laboratory reports on drug analysis and the state committee set up to probe the tragedy. The team found that the families of the deceased had not been given the hospital records, nor told about the possible cause(s) of death **[Participation - people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme].**

Analysing the expenditure on family planning, the team points out that for the year 2013-14, India spent Rs 396.97 crore on female sterilisation, which constitutes 85 per cent of the total expenditure on the Family Planning Programme . A major segment of this amount, Rs 324.49 crore was spent on incentives and compensation, and Rs 14.42 crore was spent on the camps. The amount spent as compensation for female sterilisation was 2.5 times the untied grants given to primary health centres for infrastructure strengthening **[access to comprehensive contraceptive information and services should be provided equally to everyone voluntarily, free of discrimination, coercion or violence (based on individual choice)].** The huge spends on compensation/incentives, only to bring women to non-functional facilities with poor quality services that are a health risk, is inappropriate and unacceptable.

Less than1.5 per cent of the annual expenditure on family planning for the country as a whole, went towards promoting spacing methods. The remaining 1.3 per cent was spent on equipment, transport, IEC activities and staff expenses. Similarly, the figures for Chhattisgarh show that 85 per cent of the Rs 15.59 crore spent on family planning went towards sterilising women; Rs 12.76 crore was paid as compensation and incentives; and only 1 per cent went towards funding spacing methods **[availability of contraceptive information and services].**

Recommendations

Based on the fact-finding mission, the team recommended the following:

1. Discontinue incentives for all service providers – doctors, nurses and support staff. Incentives lead doctors to take on more cases than the infrastructure can handle and in complete violation of protocols and quality norms. The team has proposed that only acceptors be compensated for wage- loss and transportation. The incentive amount should be diverted to strengthen facilities and procure equipment.

2. Promote spacing methods like oral pills, condoms and IUCDs, and add new methods. Ensure the uninterrupted supply of these methods, and train health workers to counsel women and men so they can make an informed choice. It also strongly recommended the expansion of contraceptive choices available in the public sector and extensive promotion of non-scalpel vasectomy as an easier, safer, permanent method.

3. Put an end to sterilisation targets as well as sterilisation in camps across the country. The surgeon in Bilaspur, working in an abandoned dirty hospital, spent about a minute to a minute-and-half in each of the 83 surgeries he conducted, with inadequate basic facilities and manpower **[Quality of contraceptive information and services - adherence to standards].**

Annexure 3

The team noted the complete disregard for the dignity of the women at the camp, with the surgeries being carried out assembly - line fashion, with male ward boys positioning the women for surgery and then physically carrying them out of the operating theatre. The women had neither been counselled about the spacing methods they could use, nor informed about the consequences of the surgery and possible side- effects to enable them to make an informed choice **[gender-sensitive counselling and educational interventions on family planning and contraceptives that are based on accurate information.]**

4. Conduct family planning services on fixed days at government facilities by suitably trained doctors and support staff, with strict adherence to standards protocols and quality assurance guidelines. Meanwhile, public health centres should be strengthened and equipped to provide regular services based on demand **[access to comprehensive contraceptive information and services for users and potential users with difficulties in accessing services (e.g., rural residents, urban poor, and adolescents.)]**

5. Plan and orient all officials at the block, district and state levels on sterilisation procedures and quality assurance. District Quality Assurance Committees, as directed by the Supreme Court, should be set up, with a special role in assuring quality in family planning services. **[Quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programmes].** The Rogi Kalyan Samitis (Patient Welfare Committees) and the Village Health Sanitation and Nutrition Committees should be strengthened for community participation and monitoring. **[Evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur].** In the Bilaspur sterilisations, the quality of care guidelines of the Ministry of Health and Family Welfare (MoHFW) were violated at every stage, the team points out. In fact, the staff were found to be ignorant of the safety and quality procedures and guidelines. **[Ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information and services].**

6. Fill all vacant posts for doctors in the state and train more doctors in sterilisation procedures in the state. The district of Bilaspur was found to have only three laparoscopic surgeons, of whom one had retired from government service. **[Availability of trained contraceptive service providers].** It has called for gynaecologists and surgeons at District Hospitals and the Community Health Centres to be trained in laparoscopic surgery, while doctors in these facilities could be trained in mini- laparotomy sterilisation and non-scalpel vasectomy, both of which are simple and less risky procedures.

7. Strengthen the drug procurement policy and ensure that the quality of drugs is regularly monitored for efficacy, toxicity, lethality and composition. **[Availability: Recommend the integration of contraceptive commodities, supplies and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to ensure availability].**

Annexure 3

The women who died were young mothers and they leave behind toddlers and babies. The youngest is a baby barely a month old. While the state government has provided monetary support for the children left motherless, there is an immediate need to provide support to the affected families in terms of appropriate infant feeding practices **[effective accountability mechanisms are in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and systems levels].** Many of the babies are now under the care of their grandparents who need to be guided on proper sterilisation and hygiene practices of bottle feeding. The team has, therefore, proposed that anganwadi workers be suitably trained to follow up on the affected children on a regular basis.

The organisations have called for quick corrective action, as the tragedy in Bilaspur has the potential of completely derailing the country's family planning programme. To quote one ASHA, known as Mitanin in the state: "Ab kis mooh se logon ko nasbandi ke liye bolenge? Ab to voh samne chal kar aayein toh bhi hum khud hichkichayenge. (With what face can we now tell people to go for sterilisation? Now, even if they come to us for it, we will hesitate)".

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SAHAJ, Society for Health Alternatives

SAHAJ was founded with an idea of providing supportive and facilitative atmosphere to persons interested in the area of health and development.

SAHAJ's vision is a just, equitable and sustainable society where every child has an opportunity for quality education and every person is healthy. SAHAJ's philosophy is to strive for health of poor communities - health defined broadly to encompass the social, spiritual, economic and political.

CommonHealth

A Coalition for Maternal - Neonatal Health and Safe Abortion
We are a coalition of concerned individuals and organizations from across India, who have come together to work towards changing the unacceptable situation around issues of maternal-neonatal health and safe abortion.

Vision

A society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities in India.

Mission

To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged. To mobilise advocates from different constituencies to:

a. ensure effective implementation of relevant policies and programmes.

b. contribute to the development of new policies and changing of existing ones when needed.

c. build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

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