

# Ensuring human rights in the provision of contraceptive information and services

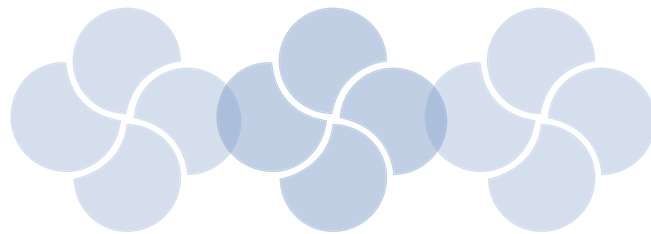
## Guidance and recommendations



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Organization



Ensuring Human Rights  
in the provision of contraceptive  
information and services  
Guidance and recommendations



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The following annexes are included as part of this guidance and are available online at [www.who.int/reproductivehealth/publications/family\\_planning/human-rights-contraception/en/](http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/)

Annex A Guideline Steering Group

Annex B Guideline Development Group

Annex C Grade Summaries and Evidence Tables

Annex D Health and human rights standards pertaining to contraception



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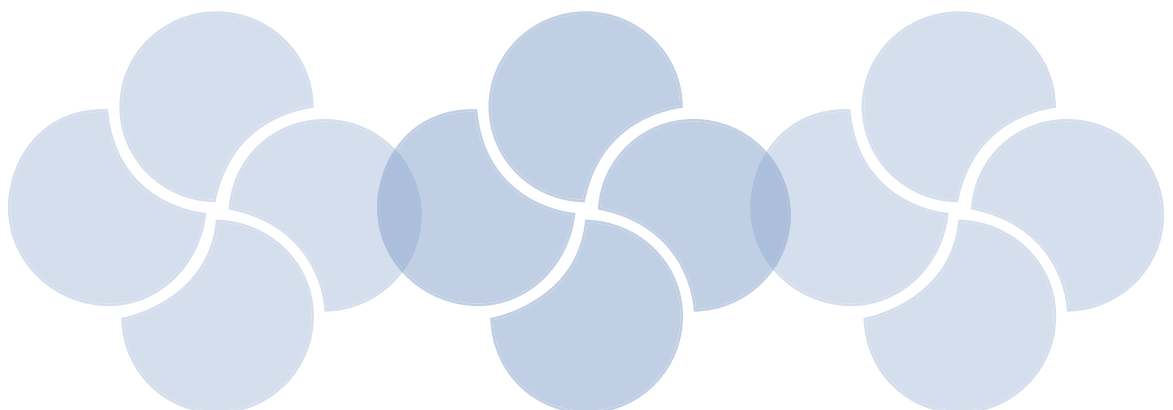
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## Acronyms and abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	United Nations Committee on Economic, Social and Cultural Rights
DFID	United Kingdom's Department for International Development
GDG	Guideline Development Group
GRADE	Grading of Recommendations Assessment, Development and Evaluation
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IUD	intrauterine device
LARC	long-acting reversible contraception
MSI	Marie Stopes International
PBF	performance-based financing
PSI	Population Services International
SRH	sexual and reproductive health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization







## Executive summary

Unmet need for contraception remains high in many settings, and is highest among the most vulnerable in society: adolescents, the poor, those living in rural areas and urban slums, people living with HIV, and internally displaced people. The latest estimates are that 222 million women have an unmet need for modern contraception, and the need is greatest where the risks of maternal mortality are highest.

The World Health Organization's primary mandate is to provide assistance to its Member States in achieving the goal of the highest attainable standard of health for all, including sexual and reproductive health. Among other interventions, the provision of high-quality contraceptive information and services is essential for achieving this goal. It has been recognized that this cannot be done without respecting, protecting and fulfilling the human rights of all individuals.

International and regional human rights treaties, national constitutions and laws provide guarantees specifically relating to access to contraceptive information and services. In addition, over the past few decades, international, regional and national legislative and human rights bodies have increasingly applied human rights to contraceptive information and services. They recommend, among other actions, that states should ensure timely and affordable access to good quality sexual and reproductive health information and services, including contraception, which should be delivered in a way that ensures fully informed decision-making, respects dignity, autonomy, privacy and confidentiality, and is sensitive to individuals' needs and perspectives.

In order to accelerate progress towards attainment of international development goals and targets in sexual and reproductive health, and in particular to contribute to meeting unmet need for contraceptive information and services, the World Health Organization (WHO) has developed this guideline. WHO standards for guideline development were followed including: identification of priority questions and outcomes; retrieval, assessment and synthesis of evidence; formulation of recommendations; and planning for dissemination, implementation, impact evaluation and updating. A Guideline Development Group, comprising members of an international panel of public health and human rights experts, reviewed and revised the draft recommendations based on the evidence profiles, through a participatory, consensus-driven process. Human rights standards and principles that are directly or indirectly applicable to contraceptive information and services were systematically incorporated.

This guidance is complementary to existing WHO recommendations for sexual and reproductive health programmes, including guidance on maternal and newborn health, sexuality education, safe abortion, and core competencies for primary health care.

The objective of this document is to provide guidance for policy-makers, managers, providers and other stakeholders in the health sector on some of the priority actions needed to ensure that different human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services.



## Summary recommendations

Non-discrimination in 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 marginalized populations in their access to these services.
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.
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 marginalized 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, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines ( <i>Safe abortion: technical and policy guidance for health systems, 2nd edition</i> ).
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.
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 prioritized as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and available.
<b>Quality of contraceptive information and services</b>	
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.
<b>Informed decision-making</b>	
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.
<b>Privacy and confidentiality</b>	
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.
<b>Participation</b>	
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.
<b>Accountability</b>	
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	<p>Recommended that evaluation and monitoring of all programmes to ensure the highest quality of services and respect for human rights must occur.</p> <p>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.</p>



## I. Introduction

### Unmet need for contraception

Unintended pregnancy, resulting from unmet need for contraception, threatens the lives and well-being of women and their families globally. The latest estimates are that 222 million women have an unmet need for modern contraception and the need is greatest where the risks of maternal mortality are highest (1). In the least developed countries, 6 out of 10 women who do not want to get pregnant, or who want to delay the next pregnancy, are not using any method of contraception (1). Unmet need for contraception is highest among the most vulnerable in society: adolescents, the poor, those living in rural areas and urban slums, people living with HIV, and internally displaced people.

### The World Health Organization's mandate

The World Health Organization (WHO) has a core mandate to provide assistance to its Member States in achieving the goal of the highest attainable standard of health for all (2). With respect to sexual and reproductive health, the details of what this might entail became clearer at the 1994 International Conference on Population and Development (ICPD). The ICPD Programme of Action, adopted by 179 countries, articulated a vision for the relationships among population, development and individual well-being, bringing in a new rights-based perspective to help meet the challenges. The ICPD Programme of Action recognized that reproductive health and rights, as well as women's empowerment and gender equality, are cornerstones of individual health and well-being, sexual and reproductive health, and population and development programmes. It also noted that the increasing availability of safer methods of modern contraception permitted greater opportunities for individual choice and responsible decision-making in matters of reproduction (3, Paragraph 7.13).

The years since the ICPD have seen an extensive elaboration of human rights standards in relation to sexual and reproductive health (SRH), as well

as conceptual and programmatic work defining a rights-based approach to health including SRH. Among the numerous pledges and strategies developed to increase access to contraceptive information and services with a view to achieving SRH, in 2004 the World Health Assembly adopted a reproductive health strategy to accelerate progress towards the attainment of international development goals and targets, which set a clear mandate for both WHO and its Member States. This included ensuring access to contraceptive information and services while promoting and protecting human rights. The reproductive health strategy specifically states that "In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, give priority to poor and underserved populations and population groups, especially adolescents, and provide special support to those countries that bear the largest burden of reproductive and sexual ill-health".<sup>1</sup>

Most recently, the United Nations Secretary-General's global initiative for maternal and child health, Every Woman Every Child, which was launched in 2010 in support of the Global Strategy for Women's and Children's Health, and the creation in 2011 of the Commission on Information and Accountability for Women's and Children's Health, provide an important context for strengthening the use of human rights to improve all aspects of SRH, including the provision of contraceptive information and services.

### Contraception, health and human rights

Contraception has clear health benefits, since the prevention of unintended pregnancies results in a subsequent decrease in maternal and infant mortality and morbidity. Providing access to all women in developing countries who currently have an unmet need for modern methods of contraception would prevent 54 million unintended pregnancies, 26 million abortions (of which 16 million would be unsafe) and 7 million

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1 Available at: [http://whqlibdoc.who.int/hq/2004/WHO\\_RHR\\_04.8.pdf](http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf) (p. 21).

miscarriages; this would also prevent 79 000 maternal deaths and 1.1 million infant deaths (1). This situation would particularly benefit adolescent girls, who are at increased risk for medical complications associated with pregnancy and who are often forced to make compromises in education and employment that may lead to poverty and lower educational attainment (4–7).

In addition to a reduction in maternal and infant morbidity and mortality, access to and use of contraception also contributes to individuals being able to take control over their sexuality, health and reproduction, thus helping them to achieve a satisfying sexual life (8).

Human rights are guaranteed in international and regional treaties, as well as in national constitutions and laws. They include the right to non-discrimination, the right to life, survival and development, the right to the highest attainable standard of health, and the rights to education and to information (9). These rights have been applied by international, regional and national authoritative human rights bodies – such as UN treaty-monitoring bodies, international and regional courts, constitutional and supreme courts – to a wide range of sexual and reproductive health issues, including the accessibility of contraceptive information and services. All rights are interdependent and indivisible (10, Article 5). The right to the highest attainable standard of health, for example, which includes access to health services and health-related information, cannot be fulfilled without promotion and protection of the rights to education and information, because people must know about health commodities and services to be able to use them (11).

All states in the world have ratified at least one human rights treaty, and 80% have ratified at least four (9). When governments ratify international human rights treaties, they are legally bound to ensure that their national laws, policies and practices do not conflict, and are consistent, with their obligations under international law (10, Article 7).

The main way governments do this is through respect, protection and fulfilment of rights. Respect of rights requires refraining from interfering with the enjoyment of rights, such as not criminalizing methods of preventing unwanted pregnancy. Protection of rights requires enacting laws that prevent violations of rights by state authorities or by non-state actors and ensuring that some form of redress mechanism is available; ensuring guarantees against forced sterilization would be an example of this. Fulfilment of rights requires taking active steps to put in place institutions and procedures that enable people to enjoy their guaranteed rights through, for example, appropriate training for health-care providers, fostering the participation of people in the design, implementation and monitoring of services, or ensuring equitable geographic outreach to the population (12, 13).

Among the Millennium Development Goals (MDGs) agreed by states in 2001, target 5b calls for universal access to reproductive health by 2015, with one of the indicators being the extent to which the need for contraception has been met (14). Evidence shows, however, that in many countries, laws, policies and practices are not always consistent with human rights obligations and this can present barriers to achieving the MDGs and the highest attainable standard of sexual and reproductive health (15). Through their laws, policies and practices, some state actors limit the availability of particular contraceptive methods, such as emergency contraception, or they may not assure regular stocks and distribution of contraceptives at an affordable price throughout the country. States and the international donor community may not have invested adequate resources to put in place good quality family planning and contraceptive services, which should include appropriately trained staff offering a full range of methods within easy reach of the entire population (15).

States have an obligation to review and revise any related laws, policies and practices to ensure that they support all human rights obligations and development goals related to sexual and reproductive health. Systematic integration of



human rights into law, policy and programme development to facilitate timely provision of good quality services requires addressing the underlying determinants of health, such as gender inequality, and the establishment of participatory, transparent and responsive processes (12, 16).

### Ensuring human rights within contraceptive programmes

Evidence shows that the respect, protection and fulfilment of human rights contributes to positive sexual health outcomes. For example, introducing sexuality education contributes to healthy development of adolescents and responsible sexual and reproductive health behaviour, which in turn results in positive health outcomes such as delayed sexual debut, a reduced number of unintended pregnancies, and a reduced level of sexual risk-taking (17). The provision of contraceptive information and services that respect individual privacy, confidentiality and informed choice, along with a wide range of safe contraceptive methods, increase people's satisfaction and continued use of contraception (18–21). Evidence also shows that health policies and programmes have a more positive effect on health outcomes when affected populations take part in their development (16). The legal environment has an important role to play and contributes to sexual health when it is in line with human rights standards. For example, elimination of third-party authorization requirements for women respects women's rights to autonomy and privacy, and is likely to lead to increased access to sexual and reproductive health services (13). Similarly, liberalization of abortion laws helps to eliminate unsafe abortion and thus results in reduced maternal mortality and morbidity. Thus, explicitly grounding contraceptive policies and programmes in a human rights framework improves people's access to information and services. It also guarantees the active participation of people in the processes that affect them, and calls for the elimination of any existing policy or programmatic barriers and for the establishment of clear accountability mechanisms.

In order to meet the urgent need for contraception, address inequities in access to information and services, and ensure that human rights are not infringed, this guidance focuses on recommendations related to promoting and protecting human rights in the provision of contraceptive information and services. It recognizes, however, that contraceptive information and services are only one part of the broader spectrum of sexual and reproductive health information and services to which all individuals are entitled. In particular, this guidance recognizes that no contraceptive method is 100% effective in preventing pregnancy, and that other factors – such as coercive sexual relations, and socioeconomic or political circumstances – may make it impossible for women to use contraception; thus contraception alone cannot entirely eliminate women's need for access to safe abortion services (22).

### Objectives

Ensuring that human rights are actively protected and promoted in the context of contraceptive information and services requires specific steps to be taken. This document is intended to provide guidance on some of the actions that should be taken to ensure that the different human rights dimensions that have been discussed above are systematically and clearly integrated into the provision of contraceptive information and services.

The guidance is intended for use by policy-makers, managers and other stakeholders in the health sector at the programme, national and international levels. This document provides broad guidance on the provision of contraceptive information and services, which will require more specific elaboration and adaptation to particular country contexts. It should be noted that this guidance is not exhaustive: it is issued as a first step to address human rights obligations related to the provision of contraceptive information and services. It will be regularly expanded and updated.

## II. Methods

This document was prepared according to the standards and requirements specified in the *WHO handbook for guideline development*.<sup>2</sup> In summary, with due attention to human rights standards and principles, this process included: determining critical questions and outcomes; retrieving evidence; assessing, synthesizing and grading evidence; presenting the evidence using a structured approach; and formulating the recommendations.

### Determination of critical questions and outcomes

A Guideline Steering Group of international stakeholders, including health-care providers, health-care programme managers, researchers, methodologists, human rights lawyers, and women's health and human rights advocates, was established to review and prioritize the draft questions and outcomes, which covered clinical, technical and programmatic issues (Guideline Steering Group members are listed in Annex A).<sup>3</sup> Identification of priority topics was conducted at two separate technical consultations on expanding access to contraceptive information and services in 2012 (June and November). Subsequent follow-up was conducted electronically, and all responses were reviewed by members of the WHO Secretariat. Questions and outcomes rated as "critical" by the Steering Group were included in the scope of this document, as a basis for grading the evidence using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach,<sup>4</sup> and developing the recommendations. The final list of questions considered for the GRADE tables and outcomes is available online.<sup>3</sup>

### Retrieval of evidence

Systematic and comprehensive retrieval of evidence was conducted to identify published studies pertaining to interventions in family planning programmes that are necessary for the realization of human rights. For each priority question that could not be answered using an existing recent systematic review of currently available (less than two years old) publications, a search and systematic review was conducted by the WHO Secretariat, including both the published literature and the grey literature. A combination of MeSH (medical subject headings) and keywords was used. The four main aspects of health services described in the General Comment on the right to the highest attainable standard of health by the United Nations Committee on Economic, Social and Cultural Rights (CESCR) were: availability, accessibility, acceptability and quality (12). Specific rights-related outcomes were determined by the Steering Group (Table 1).

To obtain evidence on equitable access to contraception, data specific to underserved groups were sought (for example, adolescents, rural residents and displaced/refugee populations). The PubMed and Cochrane databases and the grey literature were searched. Limited data specific to rights-based outcomes were identified in the published literature. Thus, reference lists were hand searched for additional citations, and experts in key areas were asked to provide additional information. The searches were not restricted by language or date. The grey literature was searched using the same keywords in Google Scholar. Web pages of partner organizations (USAID, DFID, UNFPA, MSI, PSI and Ipas) were also searched. Studies were excluded if they lacked a defined intervention or did not report on any of the specified rights-based outcomes (i.e. measures of availability, accessibility, acceptability or quality).

2 Available at: [http://apps.who.int/iris/bitstream/10665/75146/1/9789241548441\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75146/1/9789241548441_eng.pdf)

3 Available at: [www.who.int/reproductivehealth/publications/family\\_planning/human-rights-contraception/en/](http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/)

4 See: <http://www.gradeworkinggroup.org/index.htm>



**Table 1. Outcomes and measures used for retrieval of evidence**

Rights-related outcomes	Measures
<b>Availability</b>	
Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.	method mix; modern contraceptive prevalence; facilities available; commodity stock-outs; provider capacity; funds budgeted to family planning
<b>Accessibility</b>	
Health-care facilities, commodities and services have to be accessible to all, without discrimination.	contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use
<b>Acceptability</b>	
Clients have to be comfortable with the more immutable characteristics of the provider, and vice versa, to an adequate extent.	client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in programme; demand for services
<b>Quality</b>	
Health-care facilities have to have an adequate standard of medical care, choice of methods, amount of information given to clients, level of technical competence, quality of interpersonal relations, follow-up and continuity mechanisms, and the appropriate array of services.	meeting the established standard of care; method mix; range of services available; client satisfaction; provider satisfaction; access to follow-up

### Assessment, synthesis and grading of evidence

Evidence summaries were prepared according to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, to assess the overall quality of the evidence for each outcome. GRADE is a systematic approach to reviewing the body of evidence for each topic, assessing the strength of the evidence, and developing recommendations (23, 24). Evidence quality is assessed based on study design, risk of bias, precision, and size of effect (25). The GRADE approach is particularly useful for compiling clinical practice guidelines based on randomized controlled trials, and indeed was originally developed for this purpose (26). Once the information on study quality and the results are entered, a GRADE table can be produced. The GRADE table clearly presents the

type of evidence used, any quality issues with the evidence, a summary of the findings, a ranking of the quality of the evidence, and the pre-defined importance of the outcome considered.

### Limitations of GRADE for assessing evidence relevant to human rights in contraceptive information and services

Given that the realization of human rights within contraceptive information and services is not a research area that lends itself to randomized controlled trials or comparative observational studies, much of the evidence available for the priority topics could not be readily synthesized using the GRADE approach. This is largely because many of the available studies are either non-comparative, or include comparisons that are not provided in a manner suitable for assessment using GRADE (26).



For example, the findings from a programme may report that contraceptive use doubled during the study period, without including a clear description of the intervention (specific enough that it could be replicated), a comparative level of contraceptive use prior to the study, or any indication of statistical significance. Furthermore, a large amount of the evidence identified came from the grey literature, in the form of reports of programme experience. Limitations in the way these reports presented their findings, such as non-standardized reporting of programme context, interventions and outcomes, prevented the systematic assessment of their internal validity or the generalizability of their findings, and also made it impossible to enter the majority of these data into the GRADE system.

Narrative evidence summaries were therefore prepared for all evidence as an alternative to GRADE tables. These narrative summaries included the following information:

1. study design
2. objective(s) of the study
3. population and number of subjects
4. intervention(s) used
5. brief summary of key results
6. statement on relevance of the study to the identified priority topic and questions.

The narrative evidence summaries were shared with the Steering Group and additional participants in advance of a technical consultation in April 2013 to review the evidence. All evidence with sufficient detail was included in GRADE “summary of findings” tables, which were shared with participants at the technical consultation.<sup>5</sup>

## Declaration of interests

Members of the Guideline Steering Group and the Guideline Development Group (GDG) completed a Declaration of Interest form prior to the technical consultations in April and September 2013, and these were reviewed by the WHO Secretariat. None

of the meeting participants were current or past recipients of support from any commercial entity that had relevance to this work (members of the GDG are listed in Annex B).<sup>5</sup>

## Formulation of recommendations

Narrative evidence summaries, and GRADE “summary of findings” tables where possible, were shared with participants in advance of the first meeting of the GDG (i.e. the technical consultation in April 2013). At the consultation, participants were presented with the draft recommendations, prepared by the WHO Secretariat. Participants were asked to consider the quality of the evidence, the balance between risks and benefits, resource use of the interventions, and systematic integration of human rights. Participants were also asked to consider whether the recommendations promoted non-discrimination, informed choice, individual agency, equity and/or gender transformation.

Participants met in small groups to reflect on all these considerations and to revise the draft recommendations. All participants then reconvened in plenary to review all the draft recommendations and finalize the new input. Consensus was sought for all recommendations.

Participants could decide to recommend, recommend against, recommend only in the context of research, or not make a recommendation. The first two categories (“recommend” and “recommend against”) correspond broadly with the GRADE category of “strong recommendation”. The last category (“recommend only in the context of research”) corresponds broadly with the GRADE category of “conditional recommendation”. Recommendations were made by consensus, defined as the majority of participants (>75%) agreeing with no strong objections. Any strong disagreement was recorded in the justification. If participants were unable to reach consensus, a vote was held. The recommendation would stand if the majority supported it (>75%), with the minority view recorded.

<sup>5</sup> These tables are available online at: [www.who.int/reproductivehealth/publications/family\\_planning/human-rights-contraception/en/](http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/)



The GDG's use of the different categories of recommendation (recommend, recommend against, recommend in the context of research) is explained as follows. Only low- to moderate-quality data were identified. Given the low general quality of evidence, a checklist was developed to facilitate systematic discussion of all key considerations underpinning the recommendations (see Box 1) (26). Interventions were "recommended" if they were supported by public health or medical practice, were judged to carry no risk of harm to health, and were supported by internationally recognized human rights standards and principles. The category "recommend only in the context of research" indicates the existence of uncertainty about the effectiveness of the intervention or the potential for harm to the health and rights of marginalized groups. "Recommend against" was used to indicate that the intervention had unacceptable levels of risk and no proven benefit. The justification for each decision was recorded, along with key issues that need to be considered for implementation.

#### Box 1. Checklist for formulating recommendations with weak evidence

- Does this intervention promote access to contraception?
- Do the health benefits of this intervention outweigh any potential risk?
- Is this intervention supported by internationally recognized human rights principles and standards?
- Does this intervention carry any risk, particularly for marginalized groups?
- Is this strategy an effective use of limited resources?
- Does this action promote non-discrimination, informed choice, individual agency, equity, and/or gender transformation?

Following the first consultation in April 2013, the WHO Secretariat worked to consolidate evidence and participant comments into the draft guidance. This was then shared with all members of the GDG for review, comment and endorsement. Written feedback was received from 26 of the 54 participants. Themes included endorsement of the document, copy-editing suggestions, incorporation of additional human rights concerns and reiteration of dissatisfaction with the GRADE methodology for this purpose. Most notably, there was a strong recommendation to have the document reflect a more comprehensive human rights approach to contraceptive information and service delivery, both in its overall organization and in relation to specific recommendations. For this reason, the WHO Secretariat requested the assistance of a team of health and human rights experts to propose revisions to reflect these concerns, and a second consultation with the GDG was held in September 2013.

#### Systematic incorporation of human rights standards and principles

Consideration was given to human rights standards as they are directly or indirectly applicable to contraceptive information and services. Direct applicability was determined to refer to a standard specifically related to the provision of contraceptive information and services, and indirect applicability to standards related to barriers, such as third-party authorization for sexual and reproductive health services, or the lack of sexuality education – aspects that have an impact on individuals' access to, and use of, contraceptive information and services.

The sources for the human rights standards applied include international and regional human rights treaties, the general comments and recommendations issued by the United Nations human rights treaty-monitoring bodies, international and regional court decisions, and international and regional consensus documents. All of these additional sources were considered in conjunction with already-established health-system-based standards and health-related evidence.

This exercise resulted in proposed revisions to the organization of the recommendations, and reformulation of some of them. These were then discussed at the second technical consultation, in September 2013, attended by a sub-group of the original meeting participants. As a result of this process of revision and review, the recommendations are now grouped under 10 headings reflecting human rights principles and standards relating to contraceptive information and services. These are:

1. non-discrimination in 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 of contraceptive information and services
6. informed decision-making in provision of contraceptive information and services
7. privacy and confidentiality in provision of contraceptive information and services
8. participation in provision of contraceptive information and services
9. accountability in provision of contraceptive information and services.

The health and human rights content of these principles and standards, and what they imply for the different stakeholders responsible for the provision of services, is described in the explanatory text at the beginning of each section in Chapter III.



## III. Guidance and recommendations

### 1. Non-discrimination

#### Health and human rights rationale

The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation (27).

Discrimination poses a serious threat to sexual and reproductive health (SRH) for many people (28). The legal or social restrictions on women's and girls' access to contraceptive information and services affect their ability to take decisions regarding their sexual and reproductive health and lives, are a manifestation of discrimination on the basis of sex, and often contribute to poor physical and mental health. People who live in rural areas may not have access to the same SRH services as people in urban areas, thus being discriminated against on the grounds of place of residence. Discrimination on the grounds of age or other status is manifested through, for instance, the fact that adolescents may be denied services at family planning clinics because of their age, and others may be denied health services because they are HIV-positive. Some individuals suffer discrimination on multiple grounds, e.g. gender, race, socioeconomic status and health status (27).

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

As part of their human rights commitments, states must strive to eliminate all forms of discrimination and to promote equality by ensuring that vulnerable groups have access to information and services (13). All individuals have the right to decide the number and spacing of children and the right to found a family on an equal basis (29, Article 16[e]; 30). State family planning policies should not be discriminatory or compulsory (30). Laws, regulations and policies, including those related to contraceptive information and services, should not be discriminatory and should aim at eliminating stereotypes and discriminatory attitudes that lead to forced and coercive practices (13, 27, 29, 31–35).

- 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 marginalized populations in their access to these services.**

## 2. Availability of contraceptive information and services

### Health and human rights rationale

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

As part of this core obligation, states should ensure that the commodities listed in national formularies are based on the *WHO model list of essential medicines*, which guides the procurement and supply of medicines in the public sector (12, 36). A wide range of contraceptive methods, including emergency contraception, is included in the core list of essential medicines (36).

In many low- and middle-income countries, however, contraceptives such as condoms (male and female), oral contraceptives, intrauterine devices (IUDs), hormonal injectable contraceptives, implants and emergency contraception, are lacking or not available, owing to inadequate laws and policies, inefficient systems of supply and logistics management, or low or absent funding. Lack of availability may also result from ideology-based policies regarding the range of medicines or services (11). For example, in some countries emergency contraception is not available on the false grounds that it causes abortion (37).

**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

#### Health and human rights rationale

International human rights law requires health-care facilities, commodities and services to be accessible to everyone without discrimination. This includes physical and economic accessibility, as well as access to information (12, Paragraph 12[b]). Human rights bodies have called on states to eliminate the barriers people face in accessing health services, such as high fees for services, the requirement for preliminary authorization by spouse, parent/guardian or hospital authorities, distance from health-care facilities, and the absence of convenient and affordable public transport (13, Paragraph 21).

In order to make informed decisions about sexuality and reproduction, all individuals –without discrimination – need access to good quality, evidence-based and comprehensive information on sexuality and sexual and reproductive health, including effective contraceptive methods (12, Paragraph 11). This requires counselling on SRH by trained personnel (13) and the provision of comprehensive sexuality education, which should be provided both within and outside of schools and must be evidence-based, scientifically accurate, gender sensitive, free of prejudice and discrimination, and adapted to young people’s level of maturity, to enable them to deal with their sexuality in a positive and a responsible way (12, 39–40). In schools, such education should be mandatory and provided routinely at various ages and levels of education (41–44). Inadequate counselling tools and services, limited or no sexuality education within or outside of schools, and no or incorrect information about the safety and effectiveness of contraceptives (39) all hinder individuals’ ability to make informed decisions.

The fulfilment of human rights obligations requires that health commodities, including contraceptives, be physically accessible and affordable for all (12). The goal of universal health coverage is to ensure that all people can obtain the health services they need without suffering financial hardship caused by paying for them (45). Services must be within safe physical reach for everyone, including for marginalized populations (12). They should be affordable, whether they are privately or publicly provided, and poorer households should not be burdened disproportionately with health expenses, including with the cost of contraceptives, in comparison to richer households. This applies to both low- as well as high-income countries where some sectors of the population do not have access to these services and information (1). Programmes therefore need to be established to address these financial barriers, including health insurance schemes, and other budgetary and economic measures to make contraceptives and other health services affordable (12, 13). Free or affordable sexual and reproductive health care – including contraceptive information and services – must be provided to persons with disabilities (31).

Adolescents in many countries lack adequate access to contraceptive information and services that are necessary to protect their sexual and reproductive health (13, 46). Human rights bodies have called on states to strictly respect adolescents’ rights to privacy and confidentiality, including with respect to advice and counselling on health matters (33, 47, 48) and to ensure youth-friendly, confidential reproductive health care, including contraceptive services, for adolescents from different socioeconomic backgrounds (12, 13, 49). Adolescents’ best interests<sup>6</sup> and

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6 Best interests of the child: According to the Committee on the Rights of the Child, “in all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration” (51, Article 3).

their evolving capacities<sup>7</sup> need to be systematically considered, and appropriate SRH services should be available and accessible to them without necessarily requiring parental or guardian authorization by law, policy or practice (13, 47, 48, 50, 51).

In crisis settings there is often a lack of access to SRH services, meanwhile affected populations have a particular need for these services because of increased exposure to sexual violence. Access to contraceptive methods, particularly emergency contraception, and also to safe abortion, is of paramount importance to safeguard women's health (52).

Experience in a variety of different settings has shown that integrating contraceptive information and services into other SRH services has the potential for increasing accessibility of such services. For example, integrating HIV services and maternal health services is cost-effective and contributes to improving overall family health (53). Within the context of abortion and post-abortion care services, all women should be offered comprehensive contraceptive information, counselling and services, to help increase effective use of contraceptive methods and reduce the rate of repeat abortions (22, p. 52; 54).

Requirements for third-party authorization to receive contraceptive information and services are a significant barrier faced by women in many countries. Not only are such requirements a breach of confidentiality, but they also deny women autonomy in their decision-making; for these and other reasons, these requirements deter women from seeking the health services they need. International, regional and national human rights bodies have frequently emphasized that states should not restrict women's access to health services or to clinics that provide those services on the grounds that women do not have third-party authorization or because they are unmarried, or simply because they are women (13, Paragraph 14).

Women's access to contraceptive information and services may be jeopardized by health-care providers' refusal to provide services due to conscientious objection. In the context of contraceptive services, this is usually manifested in a provider's refusal to issue a prescription for contraceptives, or a pharmacist's refusal to dispense or sell contraceptives, especially emergency contraceptives. While international human rights law protects the right to freedom of thought, conscience and religion, it also stipulates that the freedom to manifest one's beliefs in the professional sphere is not absolute and might be subject to limitations that are necessary to protect the rights of others, including the right to access reproductive health care (55, Article 18; 56). Human rights bodies have consistently called on states to regulate the practice of conscientious objection in the context of health care, to ensure that patients' health and rights are not in jeopardy (13, 57). Some human rights bodies have explicitly addressed conscientious objection in the context of contraceptive service provision, stating that where women can only obtain contraceptives from a pharmacy, pharmacists cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products (56).

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<sup>7</sup> Evolving capacities of the child: "In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. ... States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion" (48, Paragraph 31).



- 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 marginalized 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, 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

### Health and human rights rationale

All health-care facilities, commodities and services must be respectful of medical ethics and of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, and must be designed to respect confidentiality and improve the health status of those concerned (12, Paragraph 12[c]). States should place a gender perspective at the centre of all policies, programmes and services affecting women's health and should involve women in the planning, implementation and monitoring of such policies, programmes and services.

Contraceptive information should include the likely benefits and potential adverse effects of proposed methods and available alternatives (13, Paragraph 20). Concerns about the side-effects of contraceptive methods – particularly hormonal methods – remain a major reason why users discontinue or switch to other, often less effective, methods (58). Counselling about how to manage side-effects and information about options for switching to other methods is therefore crucial to helping women who wish to control their fertility.

- 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 prioritized 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

### Health and human rights rationale

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

In the provision of contraceptive information and services, studies show that where people feel they are receiving good quality care, contraceptive use is higher (18–21), and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them (59, 60). Elements of quality of care include: choice among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent trained health workers; provider–user relationships based on respect for informed choice, privacy and confidentiality; and the appropriate constellation of services (including follow-up) that are available in the same locality (61).

Anyone seeking contraceptive information and services has the right to be fully informed, by appropriately trained personnel, of their options in relation to agreeing to treatment or participation in research, including the likely benefits and potential adverse effects of proposed procedures and available alternatives (3, Paragraph 20). States have been called upon to expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communication and counselling skills (3, Paragraph 7.23[d]), and training on issues of human rights and gender-based violence (13, Paragraph 31[f]). This is in line with WHO guidance on core competencies for the provision of sexual and reproductive health care (62).

- 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

### Health and human rights rationale

Showing respect for individual dignity and for the physical and mental integrity of a person includes giving each person the opportunity to make autonomous reproductive choices (13, Paragraph 22; 29, Article 16; 31, Articles 12 and 23). The principle of autonomy, expressed through free, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law (63). People should be able to choose contraception but also to refuse it. In order to make an informed decision about safe and reliable contraceptive measures, comprehensive information, counselling and support should be accessible for all people, including people with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people (62).

Respecting autonomy in decision-making requires that any counselling, advice or information that is provided by health workers or other support staff should be non-directive, enabling individuals to make decisions that are best for themselves. People should be able to choose their preferred method of contraception, taking into consideration their own health and social needs (64–66).

Individuals have the right to be fully informed by appropriately trained personnel. Health-care providers have the responsibility to convey accurate, clear information, using language and methods that can be readily understood by the client, together with proper, non-coercive counselling, in order to facilitate full, free and informed decision-making (13, Paragraph 11.3; 34, Paragraph 22; 67). The information provided to people so that they can make an informed choice about contraception should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and should enable comparison of various contraceptive methods. Censoring, withholding or intentionally misrepresenting information about contraception can put health and basic human rights in jeopardy (12). Clear guidelines should be available concerning the requirement of “informed consent” (68).

- 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 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.**



## 7. Privacy and confidentiality

### Health and human rights rationale

The right to privacy means that individuals should not be subject to interference with their privacy, and they should enjoy legal protection in this respect (55, Article 17). Sexual and reproductive health involves many sensitive issues that are not widely discussed within families or communities, and health workers are often entrusted with very personal information by their patients. Confidentiality, which implies the duty of providers to keep secret or private the medical information they receive from patients and to protect an individual's privacy, has an important role to play in sexual and reproductive health. If people feel that confidentiality and privacy are not guaranteed in the health-care environment, they may decide not to seek services (13, Paragraph 12[d]), thus jeopardizing their own health and potentially that of others. This is often the case for vulnerable groups such as adolescents (33, Paragraph 20). Privacy is also key to protecting the sexual and reproductive rights of groups who are stigmatized on the basis of their sexuality, sexual identity or sexual practices, such as gay, lesbian, bisexual, transgender and intersex people, as well as sex workers.

In line with human rights commitments, and in order to promote the health and development of all, states are urged to strictly respect the right to privacy and confidentiality, including with respect to advice and counselling on sexual and reproductive health matters (47, Paragraph 11). Health-care providers have an obligation to keep medical information confidential, both written records and verbal communications. Such information may only be disclosed with the consent of the client.

The right to access information regarding one's health includes access to medical records. All persons are entitled to know what information has been collected about their own health (68, Article 10). Where individuals cannot access their medical records, this may make it hard for them to get information about their health status or to receive a second opinion or follow-up care, and can block their access to justice (69).

#### **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

### Health and human rights rationale

It has been recognized that participation of affected populations in all stages of decision-making and implementation of policies, programmes and services is a precondition for sustainable development and the highest attainable standard of health (70, 71). Evidence shows that laws, policies and programmes better reflect the needs and perspectives of affected populations when members of these populations take part in their development, thus helping to secure improvements in health outcomes and the quality of health care (72, 73). For example, there is evidence of an association between women's participation and improved health and health-related outcomes (72). Where women's participation in policy-making is guaranteed, a gender perspective tends to be more fully integrated into public policy, and the health system is more responsive to women's needs (73).

Under international human rights law, states have an obligation to ensure active, informed participation of individuals in decision-making that affects them, including on matters related to their health (12, Paragraph 17). The ICPD Programme of Action reaffirms this core principle in relation to SRH and states that "the full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community" (3, Principle 4). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically requires states to ensure that women have the right to participate fully and be represented in the formulation of public policy in all sectors and at all levels (74).

Participation can range from communities coming together to plan strategies to address local priorities, to the delivery of community-based responses for SRH, or social movements advocating for national policy change. Participation also includes the active involvement of individuals, communities or community-based organizations in the design, implementation, management or evaluation of their community health services or systems, including in matters relating to their sexual and reproductive health (72, 75).

People should be seen as active agents who are entitled to participate in decisions that affect their sexual and reproductive health. The criteria and evidence for prioritizing actions must be transparent and subject to public scrutiny. Power differentials based on literacy, language, social status or other factors – which may exclude those who are most affected by the decisions taken, such as women and girls – should be redressed to promote meaningful participation (75).

#### **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

### Health and human rights rationale

Accountability guides states in putting their legal, policy and programmatic frameworks and practices in line with international human rights standards (76). Establishing effective accountability mechanisms is intrinsic to ensuring that the agency and choices of individuals are respected, protected and fulfilled. Effective accountability requires individuals, families and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to SRH and empowers them to claim these entitlements (75).

International human rights law requires states to ensure effective accountability mechanisms, including monitoring and evaluation, and availability of effective processes for remedy and redress, and to ensure participation of a wide range of stakeholders in the development and implementation of laws, policies and programmes (13, 71).

Effective monitoring of health care requires a functioning health management information system, civil registration system and availability of disaggregated data. A strong capacity to collect data on women's health is essential in each country, in order to determine where investments should be focused and whether progress is being made (77). Within a human rights framework, monitoring requires the use of a range of indicators, not all of which are quantitative or directly related to the health sector (78). Wherever possible, the disaggregation of information on the basis of sex, age, urban/rural residence, ethnicity, level of education, wealth quintile and geographic region is essential for ensuring non-discrimination and equity, and as a basis for affording due protection to vulnerable and marginalized groups (77). All victims of human rights violations have a right to an effective remedy and to reparation.

Remedies take a variety of forms including: restitution (i.e. re-establishing a situation as it was before a violation took place); rehabilitation (i.e. medical or psychological care or social or legal services); compensation (i.e. payment for any financially assessable damage); satisfaction (i.e. acknowledgement of a breach, an apology, etc.); and guarantees of non-repetition (i.e. legislation, organizational improvements, etc.) (27). Some of these measures primarily assist individual victims of violations, while others are more directed at the general population, to facilitate proactive protection of their rights. Depending on the situation, full reparation for a violation may require a combination of these measures (12, 79–81). In all cases, remedies should be accessible, affordable, timely and effective, which will require adequate funding, capacity and mandates (75).

Accountability is achieved through a variety of processes and institutions, which vary from country to country and may involve both national and international mechanisms and multiple forms of review and oversight, including, administrative, social, political and legal forms. Examples of these processes and institutions include courts, national human rights institutions, professional disciplinary proceedings, international and regional human rights bodies' state reporting processes, and individual complaint mechanisms. Civil society participation in the development and monitoring of laws and policies, including budgets and use of public funds, is an important element of accountability (75).

While it is primarily the state's obligation to respect, protect and fulfil human rights with regard to the provision of contraceptive information and services, it is important to note that, in addition to their obligations to guarantee the right to contraceptive information and services in their own country, donor countries also have a responsibility to protect and promote human rights through international assistance and cooperation. The same is true of other development partners (75, 82).

- 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. 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 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.



## References

1. Singh S, Darroch JE. Adding it up: costs and benefits of contraceptive services – estimates for 2012. New York (NY): Guttmacher Institute and United Nations Population Fund; 2012, p. 4 (<http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>, accessed 3 October 2013).
2. Constitution of the World Health Organization, 1946. In: World Health Assembly Basic Documents, 45th edition, Supplement 2006.
3. Programme of Action of the International Conference on Population and Development (Cairo, 5–13 September 1994). In: Report of the International Conference on Population and Development. New York (NY), United Nations, 1994 (A/CONF.171/13, <http://www.un.org/popin/icpd/conference/offeng/poa.html>, accessed 3 October 2013).
4. WHO Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.
5. Boden JM, Fergusson DM, John Horwood L. Early motherhood and subsequent life outcomes. *J Child Psychol Psychiatry*, 2008, 49(2):151–60.
6. Chen XK, Wen SW, Fleming N, Demissie K, Rhoads GG, Walker M. Teenage pregnancy and adverse birth outcomes: a large population based retrospective cohort study. *Int J Epidemiol*. 2007;36(2):368–73.
7. Klepinger DH, Lundberg S, Plotnick RD. Adolescent fertility and the educational attainment of young women. *Fam Plann Perspect*. 1995;27(1):23–8.
8. Developing sexual health programmes: a framework for action. Geneva: World Health Organization; 2010.
9. What are human rights? In: Office of the High Commissioner for Human Rights [website]. United Nations; 2013 (<http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx>, accessed 3 October 2013).
10. Vienna Declaration and Programme of Action. Adopted by the World Conference on Human Rights in Vienna on 25 June 1993, (<http://www.ohchr.org/en/professionalinterest/pages/vienna.aspx>, accessed 3 October 2013).
11. Cottingham J, Germain A, Hunt P. Use of human rights to meet the unmet need for family planning. *Lancet*. 2012;380(9837):172–80.
12. General comment No. 14 (Committee on Economic, Social and Cultural Rights, 22nd session): The right to the highest attainable standard of health – Article 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR). Geneva: United Nations Economic and Social Council; 2000 (E/C.12/2000/4, <http://www.unhcr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>, accessed 3 October 2013).
13. General recommendation No. 24 (20th session): Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) – women and health. In: Report of the Committee on the Elimination of Discrimination against Women, Fifty-fourth session of the General Assembly, Supplement No. 38 (Chapter I). New York (NY): United Nations; 1999 (A/54/38/Rev.1, <http://www.un.org/womenwatch/daw/cedaw/reports/21report.pdf>, accessed 3 October 2013).
14. Goal 5: Improve maternal health. In: Millennium Development Goals and Beyond 2015 [website]. United Nations; 2013 (<http://www.un.org/millenniumgoals/maternal.shtml>, accessed 3 October 2013).
15. Cottingham J, Kismodi E, Martin-Hilber A, Lincetto O, Stahlhofer M, Gruskin S. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. *Bull World Health Organ*. 2010;88:551–5.
16. Potts E. Accountability and the right to the highest standard of health. Colchester: University of Essex Human Rights Centre; 2008.
17. International technical guidelines on sexuality education. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO); 2009.
18. Koenig MA. The impact of quality of care on contraceptive use: evidence from longitudinal data from rural Bangladesh. Baltimore (MD): Johns Hopkins University; 2003.
19. Arends-Kuenning M, Kessy FL. The impact of demand factors, quality of care and access to facilities on contraceptive use in Tanzania. *J Biosoc Sci*. 2007;39:1–26.
20. RamaRao S, Lacuest M, Costello M, Pangolibay B, Jones H. The link between quality of care and contraceptive use. *Int Fam Plan Perspect*. 2003;29(2):76–83.
21. Sanogo D, RamaRao S, Johnes H, N'diaye P, M'bow B, Diop CB. Improving quality of care and use of contraceptives in Senegal. *Afr J Reprod Health*. 2003;7:57–73.
22. Safe abortion: technical and policy guidance for health systems, 2nd edition. Geneva: World Health Organization; 2012.
23. Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*. 2008;336(7650):924–6.
24. Schunemann HJ, Oxman AD, Brozek J, Glasziou P, Bossuyt P, Chang S et al. GRADE: assessing the quality of evidence for diagnostic recommendations. *Evid Based Med*. 2008;13(6):162–3.
25. Jaeschke R, Guyatt GH, Dellinger P, Schunemann H, Levy MM, Kunz R et al. Use of GRADE grid to reach decisions on clinical practice guidelines when consensus is elusive. *BMJ*. 2008;337:a744.
26. Barbui C, Dua T, van Ommeren M, Yasamy MT, Fleischmann A, Clark N et al. Challenges in developing evidence-based recommendations using the GRADE approach: the case of mental, neurological, and substance use disorders. *PLoS Med*. 2010;7(8):pii:e1000322. doi:10.1371/journal.pmed.1000322 (<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000322>, accessed 4 October 2013).
27. General comment No. 20 (Committee on Economic, Social and Cultural Rights, 42nd session): Non-discrimination in economic, social and cultural rights – Article 2, paragraph 2, of the International Covenant on Economic, Social and Cultural Rights (CESCR). Geneva: United Nations Economic and Social Council; 2009 (<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G09/434/05/PDF/G0943405.pdf>, accessed 3 October 2013).
28. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt. Commission on Human Rights, 60th session. New York (NY): United Nations Economic and Social Council; 2004, Paragraph 33 (E/CN.4/2004/49, <http://www.unhcr.ch/Huridocda/Huridoca.nsf/%28Symbol%29/E.CN.4.2004.49.En>, accessed 3 October 2013).



29. United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). New York (NY): United Nations General Assembly; 1979 (A/47/38, 1249 UNTS 14).
30. General comment No. 19: Protection of the family, the right to marriage and equality of the spouses. Geneva: United Nations Human Rights Committee; 1990 (HRI/GEN/1/Rev.6 at 149).
31. Convention on the Rights of Persons with Disabilities. New York (NY): United Nations General Assembly; 2006 (A/RES/61/106, 2515 UNTS 3).
32. International Covenant on Economic, Social and Cultural Rights (CESCR). New York (NY): United Nations General Assembly; 1966 (A/6316, 993 UNTS 3).
33. General comment No. 3 (32nd session): HIV/AIDS and the rights of the child. New York (NY): United Nations Committee on the Rights of the Child; 2003 (CRC/GC/2003/3).
34. General recommendation No. 21 (13th session): Equality in marriage and family relations. New York (NY): United Nations Committee on the Elimination of Discrimination against Women (CEDAW); 1994 (A/47/38).
35. General recommendation No. 19 (11th session): Violence against women. New York (NY): United Nations Committee on the Elimination of Discrimination against Women (CEDAW); 1992, Article 16, Paragraph 22.
36. WHO model list of essential medicines. 17th list. Geneva: World Health Organization; 2011 ([http://whqlibdoc.who.int/hq/2011/a95053\\_eng.pdf](http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf), accessed 3 October 2013).
37. Emergency contraception. Fact sheet No. 244. Geneva: World Health Organization; 2012 (<http://www.who.int/mediacentre/factsheets/fs244/en/>, accessed 3 October 2013).
38. Resolution 2012/1: Adolescents and youth. In: Commission on Population and Development, report on the 45th session. New York (NY): United Nations Department of Economic and Social Affairs; 2012, Paragraph 26 (E/2012/25, E/CN.9/2012/8, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N12/337/17/PDF/N1233717.pdf>, accessed 3 October 2013).
39. Report of the United Nations Special Rapporteur on the right to education. New York (NY): United Nations General Assembly; 2010 (A/65/162, <http://www.right-to-education.org/sites/r2e.gn.apc.org/files/SR%20Education%20Report-Human%20Right%20to%20Sexual%20Education.pdf>, accessed 3 October 2013).
40. International technical guidelines on sexuality education. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO); 2009, pp. 19–22.
41. Interights v. Croatia. European Committee on Social Rights. Council of Europe; 2009, Paragraphs 45, 47.
42. Concluding comments (Committee on the Elimination of Discrimination against Women, 36th session): Republic of Moldova. Geneva: Office of the United Nations High Commissioner for Human Rights; 2006, Paragraph 31 (CEDAW/C/MDA/CO/3, <http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/CEDAW.C.MDA.CO.3.En>, accessed 3 October 2013).
43. Concluding observations (Committee on the Rights of the Child, 41st session): Trinidad and Tobago. Geneva: Office of the United Nations High Commissioner for Human Rights; 2006, Paragraph 54 (CRC/C/TTO/CO/2, <http://www.crin.org/docs/T&T%20concluding%20observations.pdf>, accessed 3 October 2013).
44. Concluding observations (Committee on the Rights of the Child, 37th session): Antigua and Barbuda. Geneva: Office of the United Nations High Commissioner for Human Rights; 2004, Paragraph 54 (CRC/C/15/Add.247).
45. Universal health coverage: World Health Organization [website]. Geneva: World Health Organization; 2013 ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/), accessed 3 October 2013).
46. Investing in our future: a framework for acceleration action for the sexual and reproductive health of young people. Geneva: World Health Organization with United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF); 2006.
47. General comment No. 4 (33rd session): Adolescent health and development in the context of the Convention on the Rights of the Child. New York (NY): United Nations Committee on the Rights of the Child; 2003 (CRC/GC/2003/4, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/427/24/PDF/G0342724.pdf>, accessed 8 October 2013).
48. General comment No. 15 (62nd session): The right of the child to the enjoyment of the highest attainable standard of health (Article 24). New York (NY): United Nations Committee on the Rights of the Child; 2013 (CRC/C/GC/15, [www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-15\\_en.doc](http://www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-15_en.doc), accessed 8 October 2013).
49. Making health services adolescent friendly. Developing national quality standards for adolescent-friendly health services. Geneva: World Health Organization; 2012 ([http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf), accessed 3 October 2013).
50. Hodgkin R, Newell P. Implementation handbook for the Convention on the Rights of the Child, 3rd edition. Geneva: United Nations Children's Fund (UNICEF); 2007 ([http://www.unicef.org/publications/files/Implementation\\_Handbook\\_for\\_the\\_Convention\\_on\\_the\\_Rights\\_of\\_the\\_Child\\_Part\\_1\\_of\\_3.pdf](http://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child_Part_1_of_3.pdf), accessed 3 October 2013).
51. United Nations Convention on the Rights of the Child (CRC). New York (NY): United Nations General Assembly; 1989 (Resolution 44/25).
52. Integrating sexual and reproductive health into health emergency and disaster risk management. Policy brief. Geneva: World Health Organization; 2012 ([http://www.who.int/hac/techguidance/preparedness/SRH\\_HERM\\_Policy\\_brief\\_A4.pdf](http://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf), accessed 3 October 2013).
53. Implementing Best Practices Initiative. Family planning for health and development: actions for change. Geneva: World Health Organization, United Nations Population Fund, United States Agency for International Development; 2010 ([http://www.ibpinitiative.org/\\_include/PDF/FamilyPlanningKampalaReportIBP.pdf](http://www.ibpinitiative.org/_include/PDF/FamilyPlanningKampalaReportIBP.pdf), accessed 3 October 2013).
54. Senlet P, Cagatay L, Ergin J, Mathis J. Bridging the gap: integrating family planning with abortion services in Turkey. Int Fam Plan Perspect. 2001;27(2) (<http://www.guttmacher.org/pubs/journals/2709001.html>, accessed 3 October 2013).
55. International Covenant on Civil and Political Rights (CCPR). Geneva: Office of the United Nations High Commissioner for Human Rights; 1966 (entry into force 1976).
56. Pichon and Sajous v. France, Application No. 49853/99. Strasbourg: European Court of Human Rights; 2001.



57. RR v. Poland, Application No. 217617/04. Strasbourg: European Court of Human Rights; 2011, Paragraph 206.
58. Bradley SEK, Schwandt HM, Khan S. Levels, trends, and reasons for contraceptive discontinuation. DHS Analytical Studies No. 20. Calverton (MD): ICF Macro; 2009 ([http://pdf.usaid.gov/pdf\\_docs/PNADQ639.pdf](http://pdf.usaid.gov/pdf_docs/PNADQ639.pdf), accessed 3 October 2013).
59. Jain AK, Ramarao S, Kim J, Costello M. Evaluation of an intervention to improve quality of care in family planning programme in the Philippines. *J Biosoc Sci*, Cambridge University Press. 2012;44(01):27–41.
60. Darroch JE, Singh S. Trends in contraceptive need and use in developing countries in 2003, 2008 and 2012: an analysis of national surveys. *Lancet*. 2013;381(9879):1756–1762.
61. Bruce J. Fundamental elements of the quality of care: a simple framework. *Stud Fam Plann*. 1990;21:61–91.
62. Sexual and reproductive health: core competencies in primary care. Geneva: World Health Organization; 2011 ([http://whqlibdoc.who.int/publications/2011/9789241501002\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501002_eng.pdf), accessed 3 October 2013).
63. Faden RR, Beauchamp TL. A history and theory of informed consent. New York (NY): Oxford University Press; 1986.
64. Family planning: a global handbook for providers (2011 update). Geneva and Baltimore: World Health Organization Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, Knowledge for Health Project; 2011 ([http://whqlibdoc.who.int/publications/2011/9780978856373\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9780978856373_eng.pdf), accessed 3 October 2013).
65. Desjardins M. The sexualized body of the child, parents and the politics of ‘voluntary’ sterilization of people labelled intellectually disabled. In: McRuer R, Mollow A, editors. *Sex and disability*. Durham (NC): Duke University Press; 2012.
66. Guidelines on ethical issues in the management of severely disabled women with gynecological problems. London: International Federation of Gynecology and Obstetrics; 2011.
67. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Anand Grover. New York (NY): United Nations General Assembly; 2009 (A/64/272, <http://www.refworld.org/pdfid/4aa762e30.pdf>, accessed 3 October 2013).
68. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. Oviedo: Council of Europe; 1997.
69. KH and others v. Slovakia, Application No.32881/04. Strasbourg: European Court of Human Rights; 2009, Paragraph 65.
70. Investing in development. A practical plan to achieve the Millennium Development Goals. New York (NY): United Nations Development Programme (UNDP); 2005.
71. United Nations Secretary-General. Global strategy for women’s and children’s health. New York (NY): The Partnership for Maternal, Newborn and Child Health; 2010 ([http://www.who.int/pmnch/topics/maternal/201009\\_globalstrategy\\_wch/en/](http://www.who.int/pmnch/topics/maternal/201009_globalstrategy_wch/en/), accessed 3 October 2013).
72. Ferguson L, Halliday E. Participation and human rights: impact on women’s and children’s health. What does the literature tell us? In: *Women’s and children’s health: evidence of impact of human rights*. Geneva: World Health Organization; 2013.
73. Potts H. Participation and the right to the highest attainable standard of health. Colchester: University of Essex Human Rights Centre; 2008.
74. General recommendation No. 23 (16th session): Article 7 – political and public life. New York (NY): United Nations Committee on the Elimination of Discrimination against Women (CEDAW); 1997.
75. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. Report of the Office of the United Nations High Commissioner for Human Rights. Human Rights Council (20th session). Geneva: United Nations General Assembly; 2012 (A/HRC/21/22, [http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session21/A-HRC-21-22\\_en.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session21/A-HRC-21-22_en.pdf), accessed 3 October 2013).
76. Commission on Information and Accountability for Women’s and Children’s Health. Translating recommendations into action. First progress report on implementation of recommendations: November 2011–June 2012. Geneva: World Health Organization; 2012 ([http://www.who.int/woman\\_child\\_accountability/about/first\\_partner\\_progress\\_report\\_COIA\\_recommendations/en/index1.html](http://www.who.int/woman_child_accountability/about/first_partner_progress_report_COIA_recommendations/en/index1.html), accessed 3 October 2013).
77. Commission on Information and Accountability for Women’s and Children’s Health. Keeping promises, measuring results. Geneva: World Health Organization; 2011.
78. International Human Rights Instruments. Report on indicators for promoting and monitoring the implementation of human rights. Geneva: United Nations; 2008 (HRI/MC/2008/3, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/423/62/PDF/G0842362.pdf>, accessed 3 October 2013).
79. Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law. General Assembly resolution 60/147, 16 December 2005.
80. General comment No. 31 (Human Rights Committee, 80th session): The nature of the general legal obligation imposed on States Parties to the Covenant [International Covenant on Civil and Political Rights]. Geneva: Office of the United Nations High Commissioner for Human Rights; 2004, Paragraph 15 (CCPR/C/21/Re v.1/Add.13, <http://www.unhcr.ch/tbs/doc.nsf/0/58f5d4646e861359c1256ff600533f5f>, accessed 8 October 2013).
81. Commentary of the International Law Commission to Article 34 of the Draft Articles on Responsibility of States for Internationally Wrongful Acts, Paragraph 2. Official Records of the Fifty-sixth session of the General Assembly, 2001, Supplement No. 10 (A/56/10).
82. Bueno de Mesquita J, Hunt P. International assistance and cooperation in sexual and reproductive health: a human rights responsibility for donors. Colchester: University of Essex Human Rights Centre; 2008.





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