

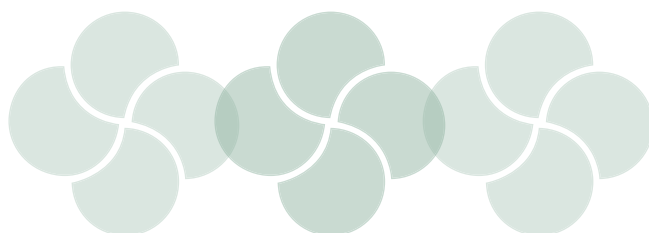
# Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers



World Health  
Organization



Quality of care in contraceptive  
information and services,  
based on human rights standards:  
A checklist for health care providers



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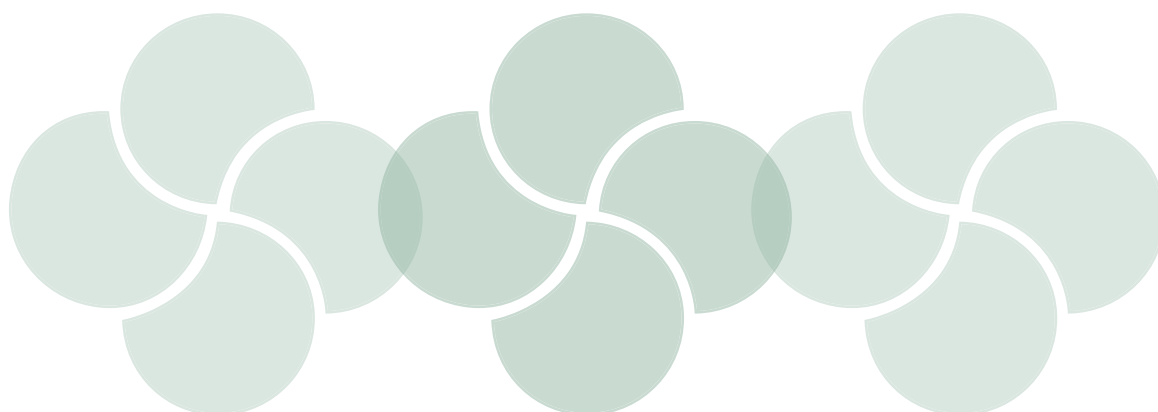
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## Acronyms and abbreviations

<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>CESCR</b>	United Nations Committee on Economic, Social and Cultural Rights
<b>HIV</b>	human immunodeficiency virus
<b>ICPD</b>	International Conference on Population and Development
<b>IUD</b>	intrauterine device
<b>LARC</b>	long-acting reversible contraception
<b>MSI</b>	Marie Stopes International
<b>PBF</b>	performance-based financing
<b>PSI</b>	Population Services International
<b>QoC</b>	Quality of Care
<b>SRH</b>	sexual and reproductive health
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	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 225 million women have an unmet need for modern contraception, and the need is greatest where the risks of maternal mortality are highest.

There is increasing recognition that promotion and protection of human rights in contraceptive services and programs is critical to addressing this challenge. However, despite these efforts, human rights are often not explicitly integrated into the design, implementation and monitoring of services. A key challenge is how to best support health care providers and facility managers at the point of service delivery, often in low-resource real-world settings, to ensure their use of human rights aspects in provision of contraceptive services. The point of service delivery is the most direct point of contact where potential violations/omissions of rights come into play and requires special attention. This checklist covers five areas of competence needed by health care providers to provide quality of care in contraceptive information and services including: respecting users' privacy and guaranteeing confidentiality, choice, accessible and acceptable services, involvement of users in improving services and fostering continuity of care and follow-up.

International and regional human rights treaties, national constitutions and laws provide guarantees specifically relating to access to contraceptive information, commodities 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.

This document presents a user friendly checklist specifically addressed to health care providers, at the primary health care level, who are involved in the direct provision of contraceptive information and services. It is complimentary to WHO guidelines on *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations*, and the Implementation Guide published jointly with UNFPA in 2015. This checklist also builds on WHO vision document on Standards for Improving Quality of Care for Maternal and Newborn Care and its ongoing work under the Quality, Equity and Dignity initiative. The checklist should be read along with other guidance from WHO and also from partners.

## I. Introduction

There is increasing momentum to ensure promotion and protection of human rights in contraceptive services and programs. Despite these efforts, human rights are often not explicitly integrated into the design, implementation and monitoring of services. As a result, the unmet need for contraception remains staggeringly high, especially among vulnerable groups such as adolescent girls.<sup>1</sup> A key challenge is how to best support health care providers and facility managers at the point of service delivery, often in low-resource real-world settings to ensure their users' human rights. The point of service delivery is the most direct point of contact where potential violations/omissions of rights come in to play and requires special attention.

In 2014, to help guide its Member States, WHO published guidelines on *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations*.<sup>(1)</sup> Developed in accordance with WHO standards for guideline development, these guidelines provide 24 recommendations grouped to reflect nine human rights principles and standards. Addressed to policy-makers, managers, providers and other stakeholders, the guidelines, do not provide details on the implementation of the recommendations.

A companion document, *Ensuring human rights within contraceptive service delivery: implementation guide*,<sup>(2)</sup> was published by WHO and UNFPA in 2015. This guide sets out core minimum actions that can be taken at different levels of the health system, and provides examples of implementation of the recommendations in the WHO 2014 guidelines. It is addressed to mid-level policy makers and programme managers involved with family planning service provision in all settings.

Following from this, WHO have developed a checklist to support health care providers to ensure human rights by ensuring quality of care at the point of service delivery. This checklist provides a

set of questions and considerations to guide health providers in assessing the quality of care in context of contraceptive services and take measures to enhance quality using human rights. The focus is on those areas that primary health care providers have within their authority to ensure or improve for service users, facilities and themselves. These include and builds on the critical dimensions of quality assurance in the immediate environment of the health centre or clinic, and all the dimensions related to their skills and knowledge, competencies, attitudes and behaviour.

This document presents the checklist specifically addressed to health care providers, at the primary health care level, who are involved in the direct provision of contraceptive information and services. These might be in stand-alone family planning clinics, in primary health care centres more generally, or in the context of HIV/STI services or those for maternal and child health. The context will vary from country to country. But the essentials for ensuring quality of care in the provision of contraceptive information and services grounded in human rights standards remain the same. This checklist should be read along with other guidance from WHO and also from partners.

### Quality of care based on human rights

Quality of care forms a critical and accepted part of any contraceptive services. The framework for understanding the elements of FP provision developed by Judith Bruce and Anrudh Jain in their seminal papers of 1990 and 1992 highlights key elements of a quality of care for high quality family planning. Studies show that where people feel they are receiving good-quality care, contraceptive use is higher, and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them.<sup>2</sup> While the understanding and perceptions of quality of care can vary by settings, ensuring quality of care is likely to have benefits

<sup>1</sup> Guttmacher. Facts on the Sexual and Reproductive Health of Adolescents in the Developing World. 2015.

<sup>2</sup> Leisher SH, Sprockett A, Longfield K, and Montagu D (eds.) (2016). Quality Measurement in Family Planning: Past, Present, Future: Papers from the Bellagio Meeting on Family Planning Quality, October 2015. Oakland, CA: Metrics for Management.

both in terms of personal well-being of individuals and for the communities they live in.<sup>3</sup> Furthermore, the perceptions of quality of care will also differ by client, for instance the needs and perception of quality for a sexually active 17-year-old client in a rural area differs from a woman who is a mother of two children. These nuances requires providers to ensure that the delivery of services is responsive to the specific needs of the diverse range of people seeking contraceptives.

Quality of care in health services is a central component of the right to health (CESCR General Comment 14), and an essential element in ensuring that human rights are respected, protected and fulfilled in the delivery of contraceptive information and services. 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 health workers; respectful provider-user relationships, safeguarding privacy and confidentiality; and the appropriate constellation of services (including follow-up) that are available in the same locality.

The principle of autonomy, expressed through free, prior, full and informed decision-making, is a central to medical ethics, and is embodied in human rights law. For an individual to make an informed decision about safe and reliable contraceptive measures, comprehensive information, counselling and support should be accessible for all people, including adolescents, persons with disabilities, indigenous peoples, ethnic minorities, migrants, people living with HIV, and others. The fulfilment of human rights requires that all healthcare facilities, commodities and services adhere to 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.

For quality of care based on human rights standards to be assured in contraceptive information and services, three groups of requirements must be fulfilled:

1. *A functioning health system* must be in place, with a budget, supportive and clear policies and protocols, adequate physical infrastructures – actual clinics or health centres that are organized to adhere to standards of care – training curricula, supervision, equipment and supplies, accessible information, and a referral mechanism between services.
2. *Technically competent health care providers* who are paid and protected. Technical competence includes not only the carrying out of procedures and giving information related to providing contraceptives, but also the cultivation and use of effective and respectful interpersonal communication and counselling skills. Providers must be well trained and comfortable in providing different methods to the range of clients as necessary.
3. *User satisfaction* with the information and services they received.
4. *Accountability mechanism* that allows and enables participation, redress and remedies

Given the focus on implementation, the checklist is structured around the categories often used in the provision of primary health care and contraceptive information and service delivery. Building on accepted programming categories, benefits from its wider acceptance and familiar and enhances the rights principles informing quality of care standards.

<sup>3</sup> J Bruce. Fundamental Elements of Quality of Care: A Simple Framework. Studies in Family Planning (1990)

Table 1. Human rights standards in relation to programme implementation

Category for programme implementation	Human rights standard as set out in the WHO Guidance	Rights-related outcomes (examples)	Measures
1. Ensuring access for all	1. <i>Non-discrimination</i>	Equal access to contraceptive services and information	Contraceptive cost ; contraceptive uptake by new users adolescent contraceptive use.
2. Commodities, logistics and procurement	2. <i>Availability of contraceptive information and services</i>	Method mix; modern contraceptive prevalence; facilities available; commodity stock-outs; provider capacity; funds budgeted to family planning	Method mix ; modern contraceptive prevalence ; facilities available ; commodity stock-outs ; provider capacity; funds budgeted to family planning.
3. Organization of health facilities: outreach; integration	3. <i>Accessibility of contraceptive information and services</i>	Contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use.	Contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use.
4. Quality of care	4. <i>Acceptability of contraceptive information and services</i> 5. <i>Quality in contraceptive information and services</i> 6. <i>Informed decision-making</i> 7. <i>Privacy and confidentiality</i>	Client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in programme; demand for services.	Client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in programme; demand for services.  Meeting the established standard of care; method mix; range of services available; client satisfaction; provider satisfaction; access to follow-up.
5. Comprehensive sexuality education	<i>Comprehensive sexuality education (under "Accessibility")</i>	Good quality evidence based comprehensive information on sexuality and sexual and reproductive health	
6. Humanitarian context	<i>Crisis settings (under "Accessibility")</i>	Contraceptive methods, including emergency contraception and abortion	
7. Participation by potential and actual users of services	8. <i>Participation</i>	Mechanisms for women's participation	
8. Accountability to those using services.	9. <i>Accountability</i>	Redress and remedies	

The checklist is intended as a self-assessment administered by health care providers themselves to assess gaps in the high-quality provision of contraceptive services and to take steps to improve quality of care.

### Relationship between a human rights based approach and quality of care frameworks

International and regional human rights treaties, national constitutions and laws provide guarantees specifically related 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 guidelines on ensuring human rights in the provision of contraceptive services and information (2014).

The fulfilment of human rights requires that health-care facilities, commodities and services be scientifically and medically appropriate and of good quality. Quality of care and human rights are therefore two intrinsically connected approaches. Realisation of a rights based approach without ensuring quality of care is not possible. Similarly programmes cannot achieve quality of care without guaranteeing human rights of clients.

As the schematic below highlights the high degree of overlap between the approaches, both are mutually dependent and reinforce each other. While the human rights based approach reinforces a quality of care approach by adding elements such as non-discrimination, accountability; the quality of care approach emphasises the importance of putting the user and experience of care at the centre. Human rights and quality of care are mutually reinforcing concepts and should be implemented in an integrated manner. Policies, programmes and interventions which do espouse to build quality of care based on human rights considerations are likely to have more sustainable outcomes. This checklist is an initial attempt to achieve this integration in the provision of contraceptive services and information at the facility level.

*Diagram: The relationship between quality of care and human right*



## Linking with other resources and initiatives on QoC

The checklist is developed with the knowledge that interactions at the point of service delivery are shaped by the wider policy and programs of the surrounding health system that affect an individual's ability to obtain desired contraceptive information and services. As set out in *Ensuring human rights within contraceptive service delivery: implementation guide*, the wider systems barriers beyond the point of service delivery also need to be assessed to ensure full, free, and informed decisions about contraception, leading to more effective solutions.

Other organizations have been developing complementary tools to examine the wider system. Population Council which led the work in 1990's towards development of a formal framework outlining the essential elements of quality care in FP service delivery continues to play a leadership role in this regard and is undertaking pioneering work in determining how to implement and assess the quality of services in the field. Furthermore, FP2020 through its work is also examining quality issues related to quality of care and family planning from a policy and programming and measurement perspective.

At the facility level the Evidence Project, the Palladium Group, and a group of expert advisors have developed measurement tools for rights-based family planning (RBFP), and are testing instruments to develop a Rights Based Family Planning Service Delivery (RBFP SD) Index to measure individual facilities' readiness to implement a rights-based approach to family planning and outcomes of interventions. RBFP SD Index builds on existing quality assurance approaches and combines and triangulates measurements taken from facility audits, provider-interviews, provider-client observations and client exit interviews. Index can be used with a range of interventions, by any organization and provides a facility-specific assessment for continuous quality improvement.

There are complementary tools being built to support health care providers and programmers to operationalize a rights-based approach. This includes development of common measurements of family planning quality by Metrics for Management. There are also training for health care providers in rights based approaches and a checklist for supervisors to support trained health care providers being developed by the Palladium Group, are currently being piloted in Nigeria and Uganda.

Alongside tools to support health care providers and programmers, a new generation of client satisfaction instruments are emerging. These instruments build on and advance client satisfaction surveys of quality assurance to assess issues such as autonomy, non-discrimination etc. The Department of Global Health and Population, Harvard T.H. Chan School of Public Health has developed in the Client-Based Contraceptive Counselling scale a new composite measure of voluntary, informed contraceptive choice in the context of client-provider interactions.

## How to use this check-list

This guide covers five areas of competence needed by health care providers to provide quality of care in contraceptive information and services. Based on both human rights standards and available public health evidence, these are:

1. Respecting users' privacy and guaranteeing confidentiality
  - 1.1 Autonomous decision-making and confidentiality
  - 1.2 Physical integrity and private spaces for counselling and examination
2. Choice of contraceptives
  - 2.1 Ensuring accurate and unbiased information
  - 2.2 Ensuring non-judgmental and respectful counselling and interactions with users
  - 2.3 Ensuring a range of contraceptive methods
3. Fostering an accessible and acceptable service
4. Involvement of users in improving services
5. Fostering continuity of care and follow-up and ensuring your own efficacy.

**Answers to questions.**

The guide is set out as a check-list of questions addressed to individual service providers. Providers should try to answer each of the questions to the best of their ability. During the pilot phase, the checklist was tested both as self-administered tool and also as administered through an interviewer. Given language issues and other considerations in some settings self-administration might not be feasible, requiring the tool to be administered through an interviewer.

Each question provides a scale from 1–5 for the response, providers should try and identify the score based on their knowledge and present provision in relation to contraceptive services at the facility. A score of one is strong disagree and score 5 is strongly agree. Scores under 3 suggest need for urgent action (based on steps suggested below) whereas scores higher than 3 suggest a good level of facility preparedness to ensure quality with some follow up actions required.

**Analysis:**

For analysis purposes, Strongly disagree is assigned 1 score, Disagree: 2, Undecided/uncertain: 3, Agree: 4 and Strongly agree: 5 respectively. After the questionnaire is completed, each item may be analysed separately or in some cases item responses may be summed to create a score for a group of items. The checklist can be conducted at different time points and the score analysed and reviewed to compare and assess change in the facility preparedness to ensure quality of care in contraceptive services.

**Application of findings:**

- *Individual service providers:* After each section, there is a series of action points geared

to steering the provider towards making improvements in both her/his *approach* to providing contraception information and services in a quality fashion, as well as in the service setting as a whole.

- *Workshops with service providers.* Results from the check-list exercise can be used as a basis for discussion among service providers from the same health centre or clinic, or even – if practical in terms of geographical location – across services. An informal workshop in which a team of service providers jointly examine the scores and then discusses the ways in which improvements could be made across the service as a whole, in a way that is continually supportive of individual providers. Such workshops can also be conducted on a regular basis, every 6 or 12 months.
- *Workshops with service users.* Information arising from the checklist could also be used in an informal workshop with service users. This would require some careful planning to ensure that an atmosphere of genuine exchange of ideas among equals is fostered.
- *Possible evaluation tool.* The check-list and scores could be used as an evaluation tool, but only in a process in which the provider and her/his supervisor discuss the scores of the check-list in advance and come to an understanding about what is intended and how improvements can be introduced. But please bear in mind that the main purpose of the check-list is to help improve services. It is not intended, in the first instance, to be used as an evaluation, and *never as the basis of a punitive approach.*

# 1. Respecting users' privacy and guaranteeing confidentiality

## 1.1 Autonomous decision-making and confidentiality

Health care providers have an obligation to keep personal health information confidential and to ensure that patients make autonomous, independent decisions, without the unwanted intervention of others, including family members. It is also the duty of providers and others who have access to medical and other personal information to ensure that personal information is not shared with third parties, including users' partners, family or friends, without the user's full and informed consent.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
1.1.a. I feel comfortable to provide all necessary information in order for the user to make a voluntary, informed decision						
1.1.b. I explain that the user has the right to be provided counselling and services confidentially, without family members present						
1.1.c. I clearly state to the user that all information she provides and medical diagnosis, prognosis, etc., will be held strictly confidential, including towards family members, unless she expressly authorizes release of such information						
1.1.d. I make clear to the user what the counselling (including the asking of personal questions) and examination will include, and do you ask for consent before continuing?						
1.1.e. If a family member is present, I consider not asking the personal questions or (especially in the case of providing a diagnosis) not doing so until the user is alone						
1.1.f. After having provided the user with complete information, I am certain to the best of my knowledge, that she/he is making the decision voluntarily, without the influence of others						
1.1.g. I keep case notes in a safe place in the facility so that non-health care professionals cannot read them						
1.1.h. There information sharing, including sharing of medical records between providers						
1.1.i. This transfer of information respects confidentiality						



### Action points on autonomous decision-making and confidentiality:

- 1.1.i Ask your supervisor or another colleague for further training and/or guidance.
- 1.1.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on SRH and human rights)
- 1.1.iii Suggest to your supervisor and/or other colleagues that the results of the check-list could be used as a basis for a workshop to discuss quality of care and human rights, particularly the aspects of privacy and confidentiality covered here.
- 1.1.iv Start a discussion with colleagues about how confidentiality and privacy are maintained in the service, and whether there are ways of improving the safeguards, especially in cases where case notes are shared or available to all providers.
- 1.1.v If it is not already carried out from time to time, suggest to your supervisor and others that a

user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

### 1.2 Physical integrity and private spaces for counselling and examination

Having private spaces for both examination and counselling, is important to guaranteeing privacy and confidentiality. Physical privacy or integrity also allows users to accept or deny examination or treatment. But even if permission is given, it still requires careful protection from unnecessary or embarrassing bodily contact or exposure. Facilities and services must be designed to provide privacy and confidentiality. This means, at a minimum, separate, screened space and seating for consultations, with special provisions for adolescents.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
1.2.a. My facility has separate waiting rooms, especially for young people						
1.2.b. I ensure that counselling rooms are protected from others being able to listen and see						
1.2.c. I ensure that examination rooms are protected from others being able to listen and see						
1.2.d. I use a separate room for consultation and counselling, including for disclosure and discussions by users that I suspect are experiencing intimate partner violence						
1.2.e. When examining a user, I make sure the area of examination is in a separate room or curtained-off so as to prevent what might be considered by the client embarrassing exposure						
1.2.f. The examinations are conducted with explicit consent of the user and with consideration of preventing embarrassment						
1.2.g. Both male and female service providers are available						
1.2.h. Users are able to request a same sex provider						

### Action points on physical integrity and private spaces:

1.2.i Ask your supervisor or another colleague for further training and/or guidance.

1.2.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on SRH and human rights)

1.2.iii Ask your supervisor or other relevant person to supply chairs and separation curtains if these are not already in place.

1.2.iv Start a discussion with colleagues about the facility can be adapted to improve the space for waiting and for consultations so that privacy and confidentiality can be safeguarded as much as possible.

1.2.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be used as a basis for a workshop to discuss quality of care and human rights, with particular attention to physical space and privacy considerations, using the questions in this checklist.

1.2.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

## 2. Choice of contraceptives

### 2.1 Ensuring accurate and unbiased information

To make informed decision about contraceptive use, individuals have the right to receive accurate, evidence-based information, using terminology, language and methods that are relevant and readily understood. Health care providers must make the client feel conformable and ensure that the information provided by them is in language and format understood by the client, is well -understood and that clients have the option of follow up as

needed. Thus, for example, the information you give users should provide details on the safety and effectiveness, including side effects and benefits, of the different contraceptive methods available either at your centre or through referral to another centre. contraceptives, including on side effects and warning signs of side effects. You should also ensure that client understands that s/he has recourse available in case of follow up and other related aspects. You should also ensure clients that the information provided will be treated confidentiality and details about choice of methods will be kept secret.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
2.1.a. I have provided/I provide users with enough information for them to understand what to expect in the service, and to help them know their rights, including on privacy and confidentiality						
2.1.b. I have provided/I provide comprehensive, unbiased and accurate information (verbally) to users						
2.1.c. I have provided/I provide comprehensive, unbiased and accurate information (in writing) to users						
2.1.d. This include information about:						
i. Recourse available Risks (side effects) and benefits of all the different forms of contraception that are available in the service, including emergency contraception, and those for which referral can be made						
ii. Protection from HIV and STIs						
iii. Where contraceptives can be obtained, when and with what requirements						
iv. Safety of switching from one method to another						

*continued*

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
2.1.e. Once the user has chosen a method, I give her (him) information about:						
i. how to manage side effects?						
ii. What to do if pills are missed						
iii. What to do if condom breaks?						
iv. What to do in the case of a missed period?						
v. Where/how to get removal of a long acting method (IUD or implants)?						
vi. When to come for a follow-up visit?						
vii. Recourse available						
2.1.f. There are written information and materials available on the various contraceptive methods, so that users can take materials home to read  (The information is written in the major languages of user)						
2.1.f. The users are provided with a list of the various services provided in the health service delivery, with prices						

### Action points for ensuring accurate and unbiased information:

- 2.1.i Ask your supervisor or another colleague for further training and/or guidance.
- 2.1.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on human rights)
- 2.1.iii Ask your supervisor or other relevant person for regular updates on contraceptive methods, their benefits and side-effects and any other information needed to ensure that you are able to provide users with the most up-to-date information.
- 2.1.iv Start a discussion with colleagues about how the different methods of contraception are used and provided in the service, and suggest ways of

keeping up-to-date with new information about contraceptives.

- 2.1.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be discussed in a workshop for all providers can keep up-to-date with information about contraceptives.
- 2.1.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

## 2.2 Ensuring non-judgmental and respectful counselling and interactions with users

Every person coming to the health service has the right to be seen and treated equally. This means that people of different race or colour, language, ethnicity religion, national or social origin, sexual orientation or gender identity must be treated in the same way. Those who are adolescents or unmarried, or those with a physical or mental disability, or those who are poor have the same rights to services as everyone else.<sup>4</sup> Often these are the people who

need services most. Care should not vary in quality because of any of the personal characteristics of users (including residence, health status, insurance status, drug use, or employment in sex work). Your interactions and counselling with these different users should be respectful and maintain eye contact to make client feel comfortable and include information that is specifically tailored to their circumstances, needs and desires. And you should provide this information and counselling in a non-judgmental, non-coercive manner to facilitate full, free, informed, voluntary and empowered decision-making. You should also explain to the client the recourse available to her (him) in case of follow up or other aspects.

<sup>4</sup> 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>)

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
<b>Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility</b>						
<b>2.2.a. I feel comfortable providing contraceptive information and services to:</b>						
i. Adolescents (married and unmarried)						
ii. People with HIV						
iii. Sex workers						
iv. Disabled people						
v. People with little or no income						
vi. People from another country, community or ethnic group						
vii. Migrants and refugees						
2.2.b. I respect her choices, even if I may disagree with them						

## Action points on ensuring non-judgmental and respectful counselling:

2.2.i Ask your supervisor or another colleague for further training and/or guidance.

2.2.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on SRH and human rights)

2.2.iii Suggest to your supervisor or other relevant person to elaborate a charter of non-discrimination, which can be posted on the clinic wall, to ensure that all users – whoever they are – have access to contraceptive information and services, and that both users and providers are aware of this.

2.2.iv Start a discussion with colleagues about the different kinds of people who come to the services and how to ensure that all are treated with respect and dignity.

2.2.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be used in a workshop to discuss how all providers can ensure that they do not – knowingly or unknowingly – discriminate against any user coming to the service.

2.2.vi If it is not already carried out from time to time, suggest to your supervisor and others that a

user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

## 2.3 Ensuring a range of contraceptive methods

Everyone has a right to access the broadest range of contraceptives, so that their needs and changing preferences are taken into account, as well as their need to switch to contraceptives at across their reproductive lives. Being able to make a choice also involves being able to afford the method, and requires you, the health care provider, to support and respect each user's choice.

The broadest range of methods include those that act in different ways: male and female condoms, emergency contraception, short-acting hormonal methods (the pill, injectables, the vaginal ring), long-acting reversible methods (implants and IUDs), and permanent methods (male and female sterilization).

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
<b>2.3.a. The following methods are available in my facility's service:</b>						
i. male condoms)						
ii. Female condoms						
iii. emergency contraception						
iv. short-acting hormonal methods (the pill, injectables, the vaginal ring)						
v. long- acting reversible methods (implants and IUDs)						
vi. permanent methods (male and female sterilization)						
2.3.b. The contraceptives are: (in a way that allows me to keep a continuous supply of different methods to offer to users)?						
i. procured						
ii. stored						
iii. tracked						
2.3.c. If not, I am able to refer users to services where the methods are available						
2.3.d. The concerns are related to affordability addressed in relation to the choice of contraceptive method by the user						
2.3.e. I take into consideration affordability for key population, including						
i. adolescents						
ii. women in violent relationships						
2.3.f. I am able to ascertain the user's need for financial assistance for contraception (and other SRH services)						

### Action points on ensuring a range of contraceptive methods:

2.3.i Suggest to your supervisor or other relevant colleague that adding contraceptive methods to the mix offered in the service would improve access for users.

2.3.ii Explore with your supervisor and other staff how procurement, storage and tracking of contraceptives could be improved.

2.3.iii Ask your supervisor or other relevant person for information about referral to other centres or services where users can access methods not available at your centre.

2.3.iv Start a discussion with colleagues about means you could use to (a) ascertain the user's need for financial assistance for contraception and (b) ensure

that those who are unable to pay – in particular adolescents – can have access to contraceptives.

2.3.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be the basis for a workshop to discuss how the service can improve its acquisition of contraceptives to ensure a regular and continuous supply, and about how to cover costs for those unable to afford them.

2.3.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.



### 3. Fostering an accessible and acceptable service

The right to accessible health facilities, goods and services is a central to realizing the right to quality of care.<sup>5</sup> It includes the points above about information being accessible and understandable to all individuals and ensuring that services are affordable. In addition, once a user of services is at the health service, it is important that she/he feels comfortable in the facility and that it is simple and convenient to navigate for different people. While some of these may be within the authority of facility management, as the health care provider, you can consider some the actions you can take to ensure their realization.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
3.a. There are signs near the location of the service delivery point to guide users along the way						
3.b. The opening hours are convenient for clients, especially women and girls from key populations, including adolescents						
3.c. There are clear signs in the clinic on days and times in which services are available						
3.d. The rooms have sign-boards so that clients can easily identify where to go						
3.e. There are simple seating and waiting areas for users sheltered from sun, wind and rain						
3.f. There is a reception desk at the facility to help inform and guide clients						
3.g. There is a private place for staff to rest or have discussions						

<sup>5</sup> CESCR GC 14. Under international human rights law, countries are required to ensure that health-care facilities, commodities and services are accessible to everyone. This includes physical and economic accessibility, as well as access to information.

### Action points on fostering an accessible and acceptable service:

3.i Ask your supervisor or another colleague for further training and/or guidance.

3.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on human rights)

3.iii Suggest to your supervisor or other relevant person that signs be put up near the service indicating where/how to find it; and that clinic opening hours be changed to cater for key populations.

3.iv Start a discussion with colleagues about how the clinic hours might be adjusted to ensure that those with difficulty reaching services can do so.

3.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be used as a basis for a workshop to discuss how the

service could become more physically accessible to users and potential users, based on the questions above.

3.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

## 4. Involvement of users in improving services

Quality of services can often be improved based on users' experience and feedback. As a health care provider, you should encourage users to express their views and to give feedback either directly or through client surveys. Users should also be

informed of the complaints mechanisms, in case of alleged mistreatment. Appropriate responses to feedback and complaints should be provided to users in a timely and respectful manner.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision of contraceptives services at the facility						
4.a. The services are provided in a participatory way, where the user can provide input and express an opinion						
4.b. The users are told about formal suggestion mechanisms						
4.c. They are provided with client surveys and told how the surveys are used to improve services						
4.d. The users are told of local follow up possibilities						

### Action points on involvement of users:

4.i Ask your supervisor or another colleague for further training and/or guidance.

4.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on SRH and human rights)

4.iii Suggest to your supervisor or other relevant person that providers in the service pay particular attention to ensuring users can express their opinion and give feedback.

4.iv Start a discussion with colleagues about how the service could be made more user-friendly, using the questions above.

4.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be used as a basis for a workshop with users to discuss how the service can be made more user-friendly and provider-friendly.

4.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

## 5. Fostering continuity of care and follow-up and ensuring your own efficacy

Continuity of care is the constant quality of care over time.<sup>6</sup> Continuity of care may be viewed from the perspective of both patient and provider. It includes prioritizing follow-up on the management of potential adverse side effects of contraceptive methods (particularly hormonal methods), which constitute a major reason why users may discontinue or switch to less effective methods. Continuity also ensures a continuous and respectful relationship with an identified health care professional, integrated and coordinated services, and the sharing of information between providers.

Clients' medical and health records should be completed properly, with information essential for the continuity of care. Appropriate referrals for methods not available on-site should be offered and available (see earlier sections). Clients should be told if and when to return for routine follow-up care, including when using emergency contraception, and told they can return at any time if they have questions or concerns. Follow up visits should be scheduled at a convenient time for the client. If they are travelling long distances to the service delivery point for surgical procedures, such as female sterilization or vasectomy, they should be informed of where to obtain follow up care, closer to where they live, if available.

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision in relation to contraceptives services at the facility						
5.a. There is a possibility to see the same provider on future visits, if the client so chooses						
5.b. I maintain accurate, confidential records on each user's: (in order to provide continuing care and follow-up)						
i. contact information						
ii. relevant medical history						
iii. contraceptive method selection and use						
iv. use of other SRH service						
5.c. I am able to get regular supervision and evaluation of my work						

<sup>6</sup> WHO has defined continuity of care both in the short term and in long term. It is the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional or horizontal continuity), or an uninterrupted series of contacts over the long term (longitudinal continuity), WHO Sexual and Reproductive Health-Core Competencies in Primary Health Care (last visited 22 September 2015).

Key questions:	(1)	(2)	(3)	(4)	(5)	Comments and action points (if need be, for explanations)
Mark a cross "X" based on your knowledge and present provision in relation to contraceptives services at the facility						
5.d. I receive an on-going training to update my skills and knowledge						
5.e. I receive support from other colleagues and supervisors						
5.f. I feel I have the appropriate technical skills to provide safe contraceptive services, including skills required (if relevant to the service) to remove contraceptive implants and IUDs on demand, provide male and female sterilization						
5.g. I feel I am able to provide information about other SRH services including:						
i. maternity care						
ii. skilled attendance at birth						
iii. safe abortion						
iv. prevention, diagnosis and treatment of STIs						
v. prevention of violence against women and girls as well as services and referrals for survivors of violence						
5.h. I understand and abide by regulations on conscientious objection i.e. if providing certain contraceptive methods is a problem for me, I always refer users to another provider together with the information about how to reach that provider						

### Action points on continuity of care

5.i Ask your supervisor or another colleague for further training and/or guidance on any of the above aspects.

5.ii Explore other training possibilities. (e.g. NGOs in some countries organise training on human rights)

5.iii Ask your supervisor or other relevant person for the clinic's policy regarding conscientious objection.

5.iv Start a discussion with colleagues about how monitoring and evaluation might be done in a participative, non-punitive way.

5.v Suggest to your supervisor and/or other colleagues that the results of the check-list could be used as a basis for a workshop to discuss how

all providers can have access to on-going training, including training in removal of implants and IUDs, on different aspects of other sexual and reproductive issues such as STIs, maternal health services, abortion services and prevention of violence against women, and on maintaining accurate, confidential records.

5.vi If it is not already carried out from time to time, suggest to your supervisor and others that a user-satisfaction questionnaire be administered to gather their experience and feedback. Ensure that this is done anonymously.

**Bravo!**

*You've come to the end of the check-list. You're on your way to improving quality of care based on human rights principles!*

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