RIGHTS: THE UNFINISHED AGENDA

LONDON, UK CONSULTATION JULY 13-14, 2017 MEETING REPORT

FP FAMILY PLANNING 2020

Acknowledgements

This report would not be possible without the contributions and support of numerous individuals and organizations who came together in London to further the June 2016 discussion on rights in programming. We thank them for their on-going efforts to advance this important effort to advance individual agency, autonomy and the full spectrum of rights in all programs.

Special thanks to the International Planned Parenthood Federation for again providing the space and support for the meeting, and special thanks to the meeting facilitators, and authors of this report, Lynn Bakamjian, Jan Kumar, and Karen Newman as well as to Karen Hardee for her continued guidance and leadership on this issue.

INTRODUCTION AND OVERVIEW

This report documents the proceedings of a Family Planning 2020-sponsored meeting of donor and implementing agency representatives held in London in July 2017 to focus on developments and needs in rights-based family planning (FP). It was timed to build upon the outputs of the Second Family Planning Summit for Safer, Healthier, and Empowered Futures[1] that took place earlier that week. The goal was to take stock of gains made since the First Summit five years ago, and to advance and update the agenda articulated at the FP2020 Rights-based FP Donor's Consultation held in June 2016. The focus was on new learning, emerging issues, persistent challenges, and new ones posed by changes in the political and funding context.

Meeting Objectives:

1. Reflect on developments in FP/RH since the first London FP Summit in 2012;
2. Share updates and learning regarding incorporating human rights into FP programming;
3. Define success of FP programs from a human rights perspective and explore how this reframing would change "business as usual"; and
4. Identify concrete actions to advance a rights-based approach to FP (RBFP) in light of the outcomes of the 2017 London FP Summit, existing challenges, and opportunities.

It put a spotlight on the individual perspectives of women and girls and explored three tracks in depth:

Track 1: What are we learning about rights-based FP program design?
Track 2: What are we learning about operationalizing rights in FP service delivery?
Track 3: What are we learning about strengthening accountability in FP programs?

In addition, participants were engaged in discussing how to balance a focus on human rights with three critical tensions:

- Method-specific promotion of long-acting, reversible contraceptives (LARCs);
- Pursuing ambitious numerical goals; and
- A focus on quality of care- is it enough?

The meeting ended with a challenge to reframe how we define success when applying a rights lens to FP programs: How should we do things differently from "business as usual" and what actions can stakeholders take? The full meeting agenda is attached.

[1] A summary of the commitments made at the London Summit can be found here.

OPENING AND WELCOME

In the opening session, FP2020 Executive Director Beth Schlachter noted the many new commitments made by FP2020 partner countries, donors, civil society organizations, and private sector entities at the Family Planning Summit which had taken place earlier in the week in London. Both she and Sandra Jordan, FP2020 Senior Director for Global Advocacy, Rights and Youth, emphasized that human rights are central to FP2020's work. The convening of this meeting was evidence of their commitment to maintaining a focus on this still-new approach, and to advancing the generation and sharing of learning about how to implement and measure rights-based FP.

During the introductions, co-facilitator Karen Newman invited all participants to identify an issue that should be addressed during the meeting. These issues appear on Appendix A.

PANEL: WHERE ARE WE – THE BROAD CONTEXT

Karen Newman introduced the opening panel discussion, which featured six speakers, all of whom had attended the Summit earlier in the week: -

- Julia Bunting (Population Council)
- Lester Coutinho (Bill and Melinda Gates Foundation)
- Suzanne Ehlers (Population Action International)
- Jane Hobson (UK Department for International Development)
- Rajat Khosla (World Health Organization)
- Tamara Kreinin (Packard Foundation)

Each speaker was invited to reflect briefly on the current status of sexual and reproductive health and rights (SRHR), including family planning, within the context of the Summit and other geopolitical realities, and to highlight their priority concerns. There was consensus that progress has been made regarding human rights since the first Summit, that some challenges persist, and that significant new ones have emerged.

The interventions identified several key areas in which there has been significant improvement:

- The 2017 Summit signaled the international reproductive health community's increased commitment to quality and rights compared to the Summit in 2012. The latest Summit had an intentional focus on groups typically discriminated against, particularly adolescents and those suffering humanitarian crises. It also created space to speak about safe abortion and sexuality within the context of differing institutional boundaries (Coutinho, Kreinin, Hobson, Bunting).
- Forty-one of the 69 FP2020 focus countries have made FP commitments, and the locus of power is shifting to the national level. Even Costed Implementation Plans (CIPs) for family planning are embedding rights (Ehlers, Kreinin, Hobson).
- We have made significant progress in explaining that a rights-based approach goes beyond quality of care, and in measuring rights. A number of FP2020 indicators are about rights, and we have a lot more tools to measure rights and make them practical (Hobson, Khosla).

The speakers also listed the following needs, challenges and concerns:

- We need a greater focus on the structural and institutional mechanisms that are required to ensure rights, alongside the focus on the final transaction between women and service providers (Coutinho).
- We need to focus more on monitoring. This should include addressing the lack of quality assurance requirements for contraceptive products (Coutinho).
- We need nuanced conversation to advance reproductive rights when other human rights aren't respected, structuring the conversation around rights in a way that is meaningful for women and girls in the context within which they live (Coutinho).

- We need to educate women and girls about their SRHR and to recognize and demand quality, taking the context and realities of women's lives into consideration (Kreinin). We need to think about youth as whole people subject to factors and needs in different sectors (Bunting).
- We need to claim power with and on behalf of women. We are too satisfied with our baby steps; we have to demand giant steps (Kreinin).
- We need to make full, free and informed choice the norm (Hobson).
- Donor and provider focus on effective methods, notably long-acting reversible contraceptives (LARCs), can create bias that undercuts clients' full, free, and informed choice. We need to provide women and girls with a broad choice of methods and correct and balanced information to help them make informed and voluntary FP decisions (Kreinin).
- The dramatic change in the U.S. political climate since the latest presidential election poses a major threat to overseas development assistance and USAID's leadership role in international SRHR. President Trump has given people permission to hate, which undercuts human rights and creates opportunities for coercion (Ehlers, Kreinin).
- Other actors should collaborate with the U.S. government in areas in which they can help and fill gaps when the U.S. doesn't step up. The international community should react to the U.S. retreat from its leadership role in reproductive health and rights as it did to the U.S. pullout from the Paris Climate Change Agreement: Let the U.S. go its own way while the rest of the world moves on to fulfill its national and global commitments (Ehlers).
- In addition to the Mexico City Policy, or Global Gag Rule, we are challenged by policy incoherence and by lack of a common understanding of rights concepts (Khosla).
- We silo issues and censor ourselves, avoiding the sensitive topics of abortion and sexuality, fearing that to address them would risk losing the gains we've made in family planning (Khosla).
- In some cases, fundamental gaps in evidence and science are being replaced with knee-jerk reactions on the part of our opponents, as well as by our own supporters (Khosla).
- We need to bring Ministers of Finance on board by making the economic argument for FP. We cannot succeed without dedicated budget lines for women's health (Hobson).
- We need to make tough choices to reconcile quality and quantity of services. With limited resources, how can we fulfil every single woman's rights? Do we focus on the urban areas or on big countries (Bunting)?
- We need to do a better job of talking to those who don't agree with us about human rights. In this era of fake news and alternative facts, we must insist that both sides provide evidence and take it seriously (Bunting).

PRESENTATION: SUMMARY OF OUTCOMES FROM THE 2016 DONORS' CONSULTATION ON RIGHTS- BASED FP

To establish a common foundation on which to build discussions, Karen Newman summarized the outcomes of the FP2020-sponsored Consultation on Realizing Sustainable Programming for Rights-based Family Planning, which took place in London in June 2016. The objectives of the workshop were to:

- Reach a common understanding of what is meant by a rights-based approach to family planning;
- Establish where we are in defining, implementing, and measuring a rights-based approach;
- Plan for moving forward by formulating recommendations for
    - messaging and communication,
    - operationalizing a rights-based approach in FP programs, and
    - research, monitoring and measuring human rights in FP programs; and
- Explore how we can hold ourselves accountable.

Ms. Newman gave an overview of the meeting agenda, which covered updates on where we were programmatically at the time of the meeting, the status of monitoring and measuring human rights, donor perspectives, critical tensions and questions, and how to go forward. Participants explored the practical aspects of operationalizing a rights-based approach as well as four critical tensions and questions:

1. Quality is necessary, but is it sufficient?
2. How to identify and address problems without jeopardizing relationships with or between governments and donors?
3. Unintended consequences: Can efforts to increase uptake of a particular method or methods—i.e., long-acting reversible contraception (LARCs)—with the intention of increasing choice have the effect in practice of decreasing choice?
4. Can we focus on rights even as we are working toward a timebound deadline and the focus on an aspirational numerical goal?

Several insights, needs and concerns emerged from these discussions:

- There is a rights imperative of equity and a challenge to serve the most vulnerable.
- We need to focus more attention on rights related to abortion as part of the SRHR agenda.
- We need simple ways to convey the complex concepts related to human rights in healthcare programs. In some settings it may be more practical to use programmatic language, which is less sensitive and more easily understood.
- It is important to work both at the ground level and politically with policy-makers at district and national levels.
- Yes, we can measure rights!
- Embrace complexity. Human rights are multidisciplinary. Implementing a rights-based approach to FP is multifaceted and takes place across sectors and agencies at multiple levels. In short, it's complicated.
- Engage communities. Ultimately, individual empowerment is linked to changing communities' social norms.
- Rights violations do occur, and recognizing and addressing them is a sign of a healthy, accountable program. It is important that such cases are managed to improve programs, rather than to shut them down.

The report includes short-term and long-term recommendations to strengthen advocacy and messaging, operationalize the approach, for monitoring and measuring human rights and for research.

PRESENTATION: WHAT DO WE MEAN BY A RIGHTS-BASED APPROACH TO FP?

Co-facilitator Jan Kumar provided an overview of what we mean by a rights-based approach to FP (RBFP), how it differs from and adds value to "business as usual", the risks of *not* taking this approach, and how to apply it in practice.

She explained that a rights-based approach is people-centered, rather than method, system, or number-centered. In this approach, human rights are the frame of reference, or lens, that defines and drives all that programs do. The goal of a RBFP is to empower people to control their fertility by ensuring that their human rights are respected, protected, and fulfilled in their experience of the FP program. She summarized the derivation and meaning of key human rights and principles relevant to family planning (Figure 1).

Ms. Kumar walked through the evolution of FP programming and highlighted the added elements that a rights-based approach brings to what may be called "business as usual", which typically consists of striving for the availability, accessibility, acceptability, and quality of services. This also includes informed choice,

privacy, and confidentiality. To this, RBFP adds a focus on equity (who are you *not* serving?), non-discrimination, participation, and accountability (Figure 2).

She discussed the unique nature of FP as a healthcare issue which makes it especially vulnerable to rights violations, and listed some of the advantages of taking a rights-based approach to family planning as well as the risks of not doing so. She noted that a rights-based approach can serve as a unifying concept that subsumes all other program elements and fosters comprehensive programming by addressing factors at all levels of the healthcare system (policy, service delivery, community, and individual) that affect human rights (Figure 3).

Ms. Kumar noted that applying a human rights lens leads to identifying different challenges and coming up with different solutions. In conclusion, she called for reframing the way we think about, and go about, FP programming. Being intentional about human rights, she noted, involves a shift in focus from methods and numbers to individuals' needs and rights (Figure 4). We are still building the evidence base, but have reason to believe that applying this approach in the way we design, assess, manage, monitor, and evaluate programs will yield better outcomes both for individuals and for program performance. This will help us meet our FP2020 and Sustainable Development Goals.

Figure 1

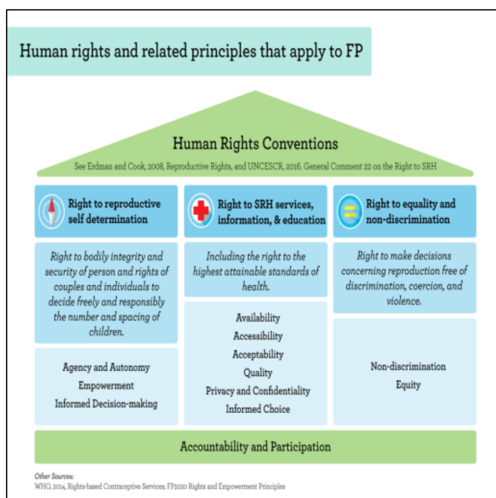


Figure 2

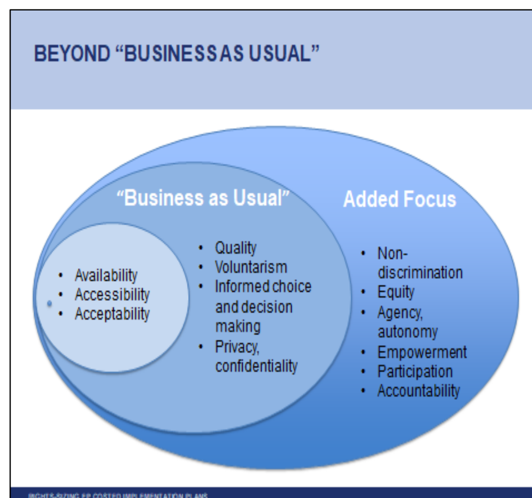


Figure 3

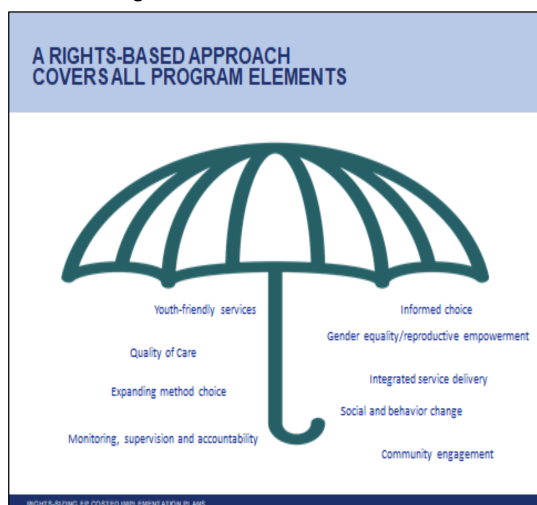
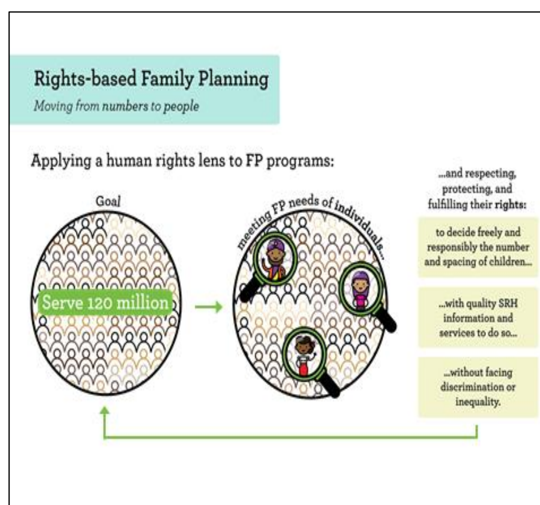


Figure 4



ARE WE LISTENING TO WOMEN AND GIRLS? INDIVIDUAL PERSPECTIVES ON WHAT MORE WE CAN DO

A rights-based approach for family planning puts individuals at the center of programming. This session was designed to put individuals' perspectives front and center on the program. We heard from two advocates regarding their experiences and the importance of incorporating input from clients and prospective clients in the design and implementation of programs that are intended to meet their needs. Dr. Junice Melgar founded the Likhaan Center for Women's Health in the Philippines and spoke of her days as an activist working underground to oppose the Marcos dictatorship. She didn't start out as a health activist, but worked to support women's economic empowerment in marginalized, rural communities. She found that women wanted and needed reproductive health services as central to enabling them to fully participate in and lead their lives. The Likhaan approach to health services is infused with a rights orientation, and emphasizes dignity, empowerment, and participation in its work.

Amanda Joan Banura, Uganda Youth Alliance for Family Planning and Reproductive Health, spoke of taboos regarding contraception for young people and the stigma that surrounds unmarried pregnant girls and young women. Family Planning as a term doesn't resonate with young people, but "Future Planning" aligns with their needs and aspirations. She related how staff at schools in Uganda, and elsewhere in Africa, check whether girls are pregnant by squeezing their breasts, a barbaric practice that persists in several countries. If found to be pregnant, girls are not allowed to remain in school or take their exams. This is changing in Uganda due to advocacy by Amanda and her group. She gave the example of advocating successfully to place girls on the school board of her primary school; the girls on the board were able to arrange for tutors for two pregnant girls to complete their studies and exams to graduate from primary school. Amanda spoke of the need for young people to have a voice in the planning and implementation of activities and services that affect their lives.

Discussion:

During the ensuing dialogue, the speakers called for women and youth to be meaningfully engaged in program planning. They know what they need and what must change in the way services are delivered, even if they don't use the exact terms or the language of rights. Clients are afraid of provider judgment and interrogation. Youth know where and how to reach other youth. With regard to participation, we need to look at who is being engaged. If we truly want to hear from the marginalized, we must address issues such as language barriers. We also need to find ways to avoid "tokenism," i.e., assuming that to invite one or two youth to a conference will result in meaningful participation across the board. We are asking civil society organizations and communities to address change, but without offering adequate or long-term support to do so. Some spoke of the need to break through silos between the Ministries of Health and Education while others noted that women's movements are often not recognized as partners in the struggle to advance SRHR and contraception. Strong women's groups are gaining ground in many countries and could be important partners to address rights in FP.

TRACK 1 PANEL: WHAT ARE WE LEARNING ABOUT RIGHTS-BASED FP PROGRAM DESIGN?

This panel was designed to share updates on ongoing efforts to explicitly incorporate human rights in the design and measurement of family planning programs operating at different levels, including the service delivery level, the organizational level, and at the national level through Costed Implementation Plans (CIPs).

Reproductive Health Uganda (RHU) Rights based Approach to FP:

RHU is implementing a rights-based approach to family planning (RBFP) [2]service delivery using the Voluntary Rights-based Family Planning Conceptual Framework [3]as the basis for both programming and measurement and with support from the USAID Sustainable Networks and Evidence Projects. Diana Kabahuma Muhwezi (RHU) shared experiences from program implementation.

The RHU intervention is focused on supporting rights literacy training in a sample of public and RHU sites, engaging men and local human rights organizations as champions, and developing an organizational policy on RBFP to guide RHU programming. Challenges in implementation include the lack of understanding among officials that implementing RBFP is not "just another program" or parallel project activity, but one that can unify and support broader implementation. The short time frame for project implementation between baseline and end-line studies using the RBFP Index - discussed below - is also a challenge, as shifting mindsets and behavior take time.

Kelsey Wright, from Population Council, discussed baseline findings from the RBFP Index, a tool developed to measure and track improvements in rights-based FP services. The RBFP Index was developed to measure and track adherence to the globally agreed Human Rights and Empowerment Principles for FP[4]. It is built upon a well-known service quality index [5]with added indicators for non-discrimination, equity, empowerment, participation, and accountability. The index includes several instruments – a facility audit, service provider interviews, and client exit interviews to triangulate data across indicators. Key findings from the baseline evaluation demonstrate that neither clients, providers, or facility managers have high

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[2] There are many acronyms used for a human rights-based approach to family planning, including RBA (rights-based approach); VRBFP (voluntary, rights based family planning); HRBA (human right based approach); and rights-based family planning (RBFP). For this report we have chosen to use RBFP.
[3] Hardee, K. et al (2014). Voluntary Rights-based Family Planning: A Conceptual Framework. Studies in Family Planning, Vol 45, No. 1 (March 2014), p 1-18.
[4] WHO Guidance and FP2020 Rights and Empowerment Principles http://apps.who.int/iris/bitstream/handle/10665/102539/9789241506748_eng.pdf;jsessionid=C7DC3FE787417EEACFB5A612983D4BB3?sequence=1.
[5] https://www.popcouncil.org/uploads/pdfs/2016RH_MeasuringQOC_wp2.pdf.

knowledge of clients' rights. There is also a difference between observations of RBFP adherence through objective criteria (in facility audit) and what is self-reported by facility managers and providers.

Implementing a Rights-based Approach to Family Planning in Kaduna State, Nigeria: Palladium is implementing a package of rights-based family planning interventions in 16 primary health care facilities and catchment areas (with 8 as controls) over a 12-month period, funded by the Bill & Melinda Gates Foundation. As with the RHU rights-based approach, this project draws on the Hardee et al Conceptual Framework, and is utilizing the RBFP Index (including an additional instrument for simulated client visits) to track and measure progress. The interventions are focused on service delivery, and provider and facility health committee training on rights-based FP, facility-level action planning (with some minor support), development of client materials that explain rights principles and what to expect and not expect during a FP visit, and on-going mentorship to support facility action and advocacy with LGA (local government authority) and State representatives.

Kaja Jurczynska shared selected findings from the baseline study: clients tend to be unwilling to report abuse; approximately 50% of providers believe that a woman needs her husband's permission to access a contraceptive method. While the majority of clients know that they are entitled to decide on their healthcare, many of them do not know they are entitled to privacy and confidentiality, should receive the same standard of health care as others, or can hold the provider accountable for his/her behavior. Only 20% of providers can identify a mechanism in place to address potential problems with human rights issues and few reported a systematic method for obtaining client feedback.

Bathsheba Halid, Palladium Nigeria, presented additional information on the package of interventions with a particular focus on an intensive program component in which experienced mentors visited intervention facilities on a monthly basis to check on action plans, provide guidance and support to facility staff and health committees in problem-solving and advocacy, and conduct observations of counseling and client-provider interactions. Through this process, they were able to monitor and provide quick fixes in key problematic areas such as stockouts, lack of privacy, overcharging for services, requiring husband permission, and denial of services to adolescents. Providers took action when these routine problems were elevated to rights issues and when they understood they had responsibility for protecting and respecting the rights of their clients.

Using a Rights-based Approach to Drive Program Design in Cote D'Ivoire: With support from the William and Flora Hewlett Foundation, EngenderHealth is supporting a 15-month technical assistance (TA) intervention to support 13 SRHR organizations to incorporate human rights into their program plans. The intervention included a technical orientation and action planning, followed by monthly TA visits, and additional workshops for knowledge sharing and strategy development. Mina Barling deferred presenting on the project, and rather shared remarks on what SRHR organizations should do to advance rights-based programming. She called for a broader response from the narrow programming focused on FP that was featured at this meeting: "We know that women are coming to us for other reasons than contraception." She raised several questions: How do we use the language of rights when women come for a safe abortion, when we are hamstrung by different donor requirements? Orienting towards post-abortion care is important but not enough. While we are making absolute progress on advancing method mix and choice, how can we extend rights beyond FP?

Rights-based Family Planning in Costed Implementation Plans (CIPs): Karen Hardee from Evidence Project-Population Council, presented highlights of the FP2020 Asia Focal Points meeting in May 2017. One of the objectives of the meeting was to orient FP2020 focal points to rights-based family planning to support future efforts to integrate activities that address rights challenges within future or revisions to CIPs. CIPs are a coordinated response to support national-level planning to achieve the FP2020 goal, and include six

thematic areas: demand creation, service delivery, contraceptive security, policy and enabling environment, and monitoring and accountability.

An analysis of early CIPs indicated that there was little or no mention of rights and empowerment principles in CIPs and those that did mention rights did not include specific action on how RBFP would be addressed. CIPs tend to address the rights related to availability, accessibility, and quality, but not those related to equity, participation, non-discrimination, and accountability. FP2020 introduced the Focal Points to its toolkit on implementing rights and empowerment principles in CIPs including a "crosswalk" that links CIP themes to related rights and empowerment principles, challenges that might be encountered, and potential actions in response. The tool advanced understanding of RBFP among the Focal Points, which included government representatives as well as major donors in the country, and several included rights-supportive elements in their plans.

Discussion: It was noted that many countries have CIPs that do not extend to 2020; therefore, there is the opportunity to address rights and empowerment principles in upcoming CIPs. An extended discussion followed regarding the tensions regarding men's engagement and empowering women. How do we mitigate against the risk of the unintended consequence that these efforts might abridge women's agency rather than advance women's rights? This tension is one that must be managed, as it is difficult to change social norms without educating and involving men. As we do so, we cannot brook harmful social norms and sacrifice women's autonomy to facilitate easy access to contraception.

Also discussed was how to track progress on rights at the country level. The RBFP Index is resource-intensive and requires a special study. More work needs to be done to identify indicators that can be integrated into PMA2020 and Track2020 and other mechanisms for tracking trends and progress over time. Measures are needed at the policy and community levels. Comments from participants also concerned the importance of cultural context, i.e., the relative value placed by communities on individual versus collective action, and how this might inform how one designs a rights-based approach in a particular setting. While RBFP interventions might look different in different places, the panelists recommended that at a minimum, there is a need to support rights literacy for different stakeholders. Finally, the intersectionality of women's needs is important to address. While we are addressing one area, there are others such as education, economic, food, and environment concerns as well. We need to bring in non-SRHR experts and access other movements if we are to be successful in advancing rights and empowerment principles.

Discussion: Exploring critical tensions in taking a rights-based approach to FP:
During this session, co-facilitators Lynn Bakamjian and Jan Kumar presented two fictional yet recognizable vignettes drawn from program, provider, and client experiences in FP service delivery to prompt dialogue about how to navigate and manage tensions that commonly challenge human rights in the implementation of FP programs. The point was not to resolve the tension, but to explore how these tensions relate to rights and empowerment principles and to identify ways to address them.

The first vignette concerned a situation in which a country set ambitious national contraceptive prevalence goals, while at the same time prioritizing training in LARC insertion. Providers in the vignette interpreted the priority by high-level officials and their supervisors at the program level as pressure to increase uptake of this method which resulted in biased client counseling and reduced choice at the service level.

A rich discussion followed, and several critical issues were identified. While goals are necessary and aspirational, they rarely are explicit about rights and there are challenges in how they are established. There are difficulties in monitoring and measuring qualitative outcomes in RBFP, especially in the context of program efforts to accelerate quantitative results. Several participants spoke of the tension between promoting a new method to expand choice and the backlash when those efforts are perceived as, or are indeed, directive. LARC programs have faced this while method-specific efforts to expand short acting,

Sayana Press, or natural, Cycle Beads, methods seem exempt from this backlash. More needs to be done to develop core indicators that track progress on the rights principle of informed choice (beyond method mix, discontinuation, and stockouts). Again, the issue of context was raised. As one participant said, “In patriarchal societies women make choices that we think are not their own when they are, or we think they are their own when they are not.”

The second vignette described an initiative to improve quality of care via infrastructure upgrades and refresher training in FP within a program context which is challenged by severe poverty, inequality, and low literacy; and where women have little autonomy over the fundamental decisions in their lives. Contraceptive prevalence is low and access to SRH information and services remain a challenge.

The discussion that followed reiterated the maxim that quality is necessary but not sufficient to address the needs of women in this context. Programs need to move beyond quality and address rights related to voice (participation), empowerment, and accountability. We must tackle underlying issues related to gender and social norms. It is difficult and unfair to put the burden on the facility and its service providers to address all these issues. This example pertained to FP; however, we know that women come to clinics for a variety of different services and we should ensure that a rights-based approach can be applied beyond just FP. Finally, if we are serious about rights and equity, we must address the fact that it will cost more to reach marginalized and vulnerable groups.

TRACK 2 PANEL: WHAT ARE WE LEARNING FROM OPERATIONALIZING RIGHTS IN FP SERVICE DELIVERY?

Crucial learning is emerging from interventions designed to incorporate human rights systematically into FP service delivery programs and to strengthen accountability for quality and the fulfillment of other human rights in FP programs. In the first panel in the morning of Day 2 (Track 2), speakers shared research evidence and practical programmatic experience related to incorporating human rights into the design and implementation of FP service delivery. The first two presentations built upon the abstract discussion held on Day 1 about the critical tensions between quality of care and a rights-based approach, and between the promotion of LARCS and assuring free method choice. The last two speakers introduced additional challenges to human rights that arise in the delivery of FP services.

Quality in the context of a rights-based approach- an on-going discussion:
Dr. Anrudh Jain of Population Council focused on the right to good quality services and the issue of contraceptive discontinuation, which is responsible for 35% of unintended pregnancies. He attributed this in large part to poor quality of care. He used the image of a leaky bucket holding current FP users, which has holes created by poor quality. Many women with an ongoing desire to use contraception stop using their method for reasons that optimum quality of care and counselling could effectively address, and fall through the holes into the pool of non-users with an unmet need for contraception. Focusing on the rights of quality and informed choice, he argued, would plug up those holes. This would reduce discontinuation, fulfill more unmet need for FP, and reduce the number of unintended births.

He also shared key outcomes of a Pre-Summit Meeting on Strategies to Improving Quality of Care in the Context of Rights-Based Family Planning, sponsored by the Population Council which included:

- A call for a rights-based, client-centered approach to care;
- A call for improvement in the quality of client-provider interactions and information provided, and offering more method options;
- Modifications to the Bruce Quality of Care Framework for FP to align it more fully with a rights-based approach to FP; and

- Recommendations for improving quality at the policy, program, and client levels.

He urged participants to "mind the gap" between discontinuation of the original method and initiation of a different method consistent with intentions. He urged our community to follow the client, not the method, meaning that we should support method switching to promote continuous contraceptive use.

Mixed messages: the effects of numerical goals and LARC promotion on provider behaviors:

Heidi Quinn, Sustainable Networks, SIFPO2 at IPPF, discussed the tensions inherent in protecting human rights while pursuing numerical goals and promoting specific methods. Ms. Quinn explored how donor policies and government goals influence nurse and midwife behaviors that have bearing on clients' human rights. Representing the perspective of service providers and program/project managers managing quality and quantity, she began by stating that instead of mixed messages, we need method mix. She noted that numerical goals put providers under pressure that can lead them to cut corners. They are generally blamed when those goals are not met. She said that we shouldn't be afraid of numerical goals, but need to help providers understand human rights and support their role in protecting and fulfilling them. She also called for adding method mix, continuation, and client satisfaction to contraceptive prevalence goals.

She raised several salient questions, including: How can we make providers part of the solution and not the enemy? She also identified what is needed to address common challenges that providers face and make services more rights-supportive, such as:

- Make human rights understandable and meaningful to providers;
- Provide training that includes underused methods without privileging one method over others (e.g., client-centered counseling, balanced counseling);
- Promote contraceptive continuation as well as new users;
- Take measures to support providers in high volume settings to enable them to maintain quality standards (e.g., supplement staff and share tasks to increase capacity to inform and pre-screen clients (e.g., engage community health workers, apps like JHUCCP's[6] Smart Client);
- Create simple client feedback mechanisms;
- Provide supportive supervision: create a "no blame" environment with more carrot, less stick;
- Revisit what gets measured and what staff get paid for to promote rights-supportive practices;
- Delink performance expectations from client method choice;
- Increase transparency in performance-based funding, create incentives for quality and choice,
- Make services and social and behavior change communication (SBCC) efforts more cohesive, link with the education sector to increase client knowledge of their human rights, and strengthen social accountability; and
- Guard against output-based aid that puts organizations under pressure to compete to offer the lowest possible prices which are likely to compromise on quality, rights, and choice.

Ensuring access to implant removal services:

Being able to exercise free choice and access quality removal services for implants and IUDs is as much of a human rights issue as is access to these methods themselves. Megan Christofield, Co-lead of the Implant Removal Task Force, Jhpiego, focused on access to implant removals. She shared PMA2020 data that revealed that 4% of current implant users in Kenya and over 7% in Ethiopia have made unsuccessful attempts to have their implants removed. Studies have shown that the main reasons were providers counseling against removal or lacking the necessary removal training. Where removals are performed, poor service quality is a problem in some places. The growing contraceptive prevalence worldwide is fueled in part by the growing use of implants. This raises concern about the availability, accessibility, and quality of removal services for increasing numbers of clients. Ms. Christofield explored the limiting factors, including

[6] John Hopkins University Center for Communication Program.

inadequate caseload for training, and insufficient supplies of consumables and equipment. The interagency Implant Removal Task Force is promoting client-centered standards for removal as part of insertion training. A Best Practices Project on Removal is currently working in Kenya and Uganda to increase the capacity for removals and to advocate for including plans and resources for implant removal into FP programs. Ms. Christofield shared key lessons that have emerged from implant removal work:

- Collaboration among institutions is key;
- Effort is required to gain in-country buy-in;
- Supplies and consumables planning is currently insufficient; and
- Accountability for guaranteeing the accessibility of implant removal is difficult to identify and leverage.

A rights-based approach to reducing reproductive coercion, intimate partner violence and unintended pregnancy:

Dr. Jay Silverman, Center on Gender Equity and Health, U.C. San Diego, introduced the concept of reproductive coercion, which relates to male partners violating women's rights by sabotaging their partners' wish to use contraception and coercing them into becoming pregnant. He shared evidence that intimate partner violence (IPV) and associated controlling behaviors interfere with women's ability to make their own reproductive decisions and compromise reproductive autonomy. He noted that healthcare professionals do a poor job of defining, measuring, and taking action related to this phenomenon. Violence is the most extreme problem and serves as a marker for more subtle and chronic everyday limiting behaviors. He explained ARCHES, Addressing Reproductive Coercion in Health Settings, which is a rights-based approach to reducing reproductive coercion and intimate partner violence in service delivery. It entails brief interventions that incorporate risk assessment, harm reduction counseling and referral into standard healthcare practice. It was found effective in two U.S.-based RCTs and is currently being implemented in Mexico, Kenya, and Bangladesh.

In the Q and A that followed the panel, participants noted the need to get the rights-based approach to FP into pre-service training and the need to include values clarification in training, as providers tend to reflect the norms of the cultures in which they work.

TRACK 3: WHAT ARE WE LEARNING ABOUT STRENGTHENING ACCOUNTABILITY IN FAMILY PLANNING PROGRAMS?

Social accountability in India:
Poonam Muttreja, Population Foundation of India, noted that community accountability is the core pillar of true accountability. She shared experience from India where, she said, the government resists accountability, which is a very political issue. Although frameworks exist, they are not applied at the community level and there is limited access to grievance redress mechanisms. In India, civil society organizations (CSOs) lead social accountability efforts. Her CSO, the Population Foundation of India (PFI), has an accountability framework and has the authority to investigate cases when things go wrong. She shared an example in which they helped to hold the central Government of India accountable for a crisis in 2014 in which sixteen women died as a result of complications of sterilization surgery performed in a government-run mobile health clinic. PFI investigated and reported on the incident and formulated recommendations. The Supreme Court used the report to order the government to act and report upon all of the recommendations. Ms. Muttreja called for more accountability mechanisms and a global accountability framework for FP.

Evaluating social accountability in Uganda:
The Evidence Project is seeking deeper knowledge of whether and how social accountability improves clients' access to and the quality of services. Victoria Boydell and Heather McMullen, IPPF/Evidence Project, noted

that although formal, legal accountability mechanisms exist, it is largely up to citizens and civil society to use less formal mechanisms, like performance appraisals, supervision, suggestion boxes, and other client feedback mechanisms to hold duty bearers to account for providing promised services and to remedy failures to do so. Social accountability has been shown to bring about improvements in a range of health-related outcomes.

The Evidence Project is looking at two models in Uganda: the woman champion model, in which individuals representing their community serve as a link to duty bearers; and the community scorecard model, in which community members generate indicators that they monitor. It employs a range of research methods to examine problems related to infrastructure, supplies and facilities, the health workforce, and FP services. The research is still in progress, but has already yielded learning, including:

- People experience multiple barriers to service simultaneously;
- Service providers are commonly blamed for the harmful impact of funding delays;
- People have overlapping roles and identities (e.g., duty bearer, citizen, woman champion) that affect who listens to them;
- Flexible outcome measures are needed; many findings are unforeseen or are actually outcomes for other sectors (i.e., education, infrastructure);
- It is difficult to isolate "cause," "effect," or "impact" for complex social processes, and therefore to determine what to measure and at what level (at the service site or in the community?); and
- Social accountability and empowerment changes relationships between FP program staff and those they serve.

Ensuring rights and results: Evaluating CARE's Community Scorecard in Malawi:
Christine Galavotti, CARE, featured CARE's community score (detailed at www.raisingthescore.org), a tool that fosters community participation and program accountability while also addressing providers' needs. One of the premises of this tool is that perceived quality drives service utilization more than cost and distance, provider attitudes and behavior. She explained that use of the tool involves a five-phase process that engages community members and service providers in identifying program areas needing improvement, and then bringing them together to jointly set priorities and develop an action plan, which is then implemented and monitored. The process is repeated every six months to track changes over time. While it may not work everywhere, Ms. Galavotti noted, initial experience in Malawi has been positive, where use of this tool led to a 12% increase in the uptake of FP, an increase in CHW visits and other significant improvements. The scorecard process is a low-cost mechanism to improve patient-centered dimensions of quality, and it fosters meaningful participation of women and youth. At the same time, it empowers health workers and provides a mechanism for them to communicate both with clients and with supervisors and management. It has been shown to help in building relationships and trust.

Ms. Galavotti noted knowledge gaps to address in the future, which include: How to ensure adolescents' meaningful participation; how to elevate issues/voices to get higher level responsiveness, what factors support sustainability, and how to adapt for sensitive populations (e.g. HIV-positive women). She also cited CARE's new publication, *The Path to 2020*, which explains how to deliver transformative, rights-based FP services.

Holding governments accountable for protecting and fulfilling human rights in reproductive healthcare:
Rebecca Brown, Center for Reproductive Rights (CRR), explained that CRR uses litigation and inquiry procedures in conjunction with advocacy and policy reform efforts to increase state accountability for the realization of the rights to abortion, contraception, and quality maternal care. Meaningful and effective accountability requires access to legal remedies and compensation, she said, and litigation is a critical tool in a human-rights based approach to SRHR. She also stressed the importance of social movements and civil society, and human rights mechanisms and treaty bodies, such as Universal Periodic Reviews, CEDAW, the U.N. Human Rights Committee, etc.

Ms. Brown shared case examples of how the CRR helped to hold the Government of Peru accountable for ensuring effective access to therapeutic abortion in the case of rape or risk to the woman's life or health, in accordance with Peruvian law; and how it collaborated with the Philippines Commission on Human Rights

to undertake a national inquiry on reproductive health and rights to hold the government accountable for its obligations under the international CEDAW agreement to ensure access to the full range of reproductive health services, including contraception and safe abortion. She noted that litigation is the formal mechanism used to implement treaties and international agreements. These agreements and mechanisms have teeth and are effective in getting governments to focus on their obligations, to abide by, or change, their own laws.

Discussion:
In the Q & A following the panel, people noted the sensitivities around accountability. Some governments may evade accountability, some donors may not be open to reports that they have been funding negative practices, and providers may not want to hear critical feedback from their clients. We need to use both carrots and sticks, and both formal and informal mechanisms at different levels to ensure that governments and program staff meet their responsibility and commitments to respect, protect and fulfil human rights. Legal accountability is monitored by the international community, which reviews government compliance (though not the U.S.) with human rights treaty commitments every 3-5 years, depending on the treaty. Governments are obligated to report regularly on how they are fulfilling their commitments under various treaties, and must respond to findings when their reports are reviewed. Participants were encouraged to write letters to treaty bodies (e.g., CEDAW) when their country reviews are due. The Center for Reproductive Rights has access to pro bono attorneys and can assist in some cases. Social accountability is complicated and context specific. It needs the support of advocacy and investigative journalism.

Discussion: Going forward
In the final session, Karen Newman shared some reflections:

- Complexity is not chaos, it is just complicated. This applies to rights-based FP programming.
- We need to reframe how we define success when applying a rights approach and recognize that rights-based programming is not business as usual; different metrics are necessary because we are measuring and prioritizing different approaches.
- Experience has shown that, if you tell clients they have rights, they are likely to complain. This is good; it means they think they deserve a higher quality of service. However, service providers will not welcome complaining clients unless they have rights literacy and training in how to manage client feedback.
- Proactive recognition of evidence of gender-based violence is a hallmark of rights-based services.
- There is a lot to do; we need to engage more partners from diverse sectors, including people working in humanitarian settings; climate change, etc. Be creative in strategic partnering.

A wide-ranging discussion ensued; key highlights included the following:

- As evidenced by CARE's work on social accountability, rights- based programming can be effective in increasing CPR.
- Raising awareness is a never-ending task; inviting young people to attend this meeting was valuable and seen as an important step in raising awareness about RBFP and capacity building to advance their participation.
- Language is important; tailor terms to your audience and context. Claiming rights can seem like an attack, but the core concepts remain relevant and important. We should get used to talking about things in different ways; rights-related terms don't always resonate at the tables we sit at. That doesn't mean the work has to stop.
- Human rights defenders need defenders, these people are threatened and targeted. What mechanisms we can use to provide that support?
- Engaging communities and community leaders helps women to know their rights and to claim them.
- Embrace complexity and respect contextualization; consider the context in which women live and how it affects their decision making
- A challenging policy environment doesn't mean support for rights-based work has disappeared. Solidarity is important.
- Media prominence is important; we can and should work more with journalists. When rights issues attract public attention, they also attract government attention.

Participants identified needs for the following:

- A global scorecard for monitoring RBFP.
- International monitoring of human rights violations in family planning field, including holding leaders accountable for broken promises.
- Engagement of civil society organizations (human rights groups, women's rights groups and women from marginalized groups) with human rights processes.
- Need to know and utilize existing accountability mechanisms (e.g., Universal Periodic Review (UPR) and CEDAW reviews of national human rights records; write to the World, the Commission on the Status of Women, etc.).
- Revised cost per service calculations. This is currently not rights sensitive; it is calculated based on the number of women served.
- Effective advocacy at the point where resources are being allocated-- in many countries it is at the subnational level or community level; tracking should take place at the same level.
- Documentation of successes, for example instances where people are already saying that they feel different about the services because they are rights-based.
- Incorporate rights-based approaches into CIPs.
- Develop value propositions for different constituents from a rights-based perspective.
- Network for change; continue to engage in conversation.

Final remarks and next steps

Beth Schlachter and Sandra Jordan offered closing reflections and next steps. Beth confirmed that the meeting was part of FP2020's commitment to advancing this work. She noted that rights elements are now explicit in CIPs. She invited participants to help build the FP2020 website by adding resources, and asked for input on what needs to happen in this field. To ensure adequate funding, she encouraged participants to work with governments to sharpen costing so we know what to advocate for to support CIPs. To improve accountability, she noted that FP2020 will review Summit pledges to make sure they are measurable. She also noted that we should learn from other sectors with experience in monitoring national plans of action, such as the climate change community. And she urged participants to engage in the conversation about global accountability, especially with the *Every Woman Every Child* initiative.

As next steps, she said that FP2020 would advance these discussions and government's commitments at the upcoming Reference Group meeting in Nigeria in October and the Anglophone Africa Focal Point meeting in November. In addition, they have decided to use a rights-based framework to drive FP2020's annual report for next year. Beth noted that at the International Conference on Family Planning, to be held in Rwanda in 2018, we must ensure that evidence related to rights-based programming is presented to the wider community.

Sandra closed the meeting by thanking all participants, funders, contributors, and facilitators, and noting that we have come quite far since the question "What's a right in a results-based world?" was put in 2012 to participants at the London Summit on Family Planning. She reaffirmed FP2020's resolve to support and promote this work in the coming months and years.