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Use of human rights to meet the unmet need for family planning

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In this report, we describe how human rights can help to shape laws, policies, programmes, and projects in relation to contraceptive information and services. Applying a human rights perspective and recognising the International Conference on Population and Development and Millennium Development Goal commitments to universal access to reproductive health including family planning, we support measurement of unmet need for family planning that encompasses more groups than has been the case until recently. We outline how human rights can be used to identify, reduce, and eliminate barriers to accessing contraception; the ways in which human rights can enhance laws and policies; and governments’ legal obligations in relation to contraceptive information and services. We underline the crucial importance of accountability of states and identify some of the priorities for making family planning available that are mandated by human rights.

Introduction

Other articles in this series outline the many benefits of investment in family planning, including acceleration of progress towards achieving the Millennium Development Goals. We explain how measures to respect, protect, and fulfil human rights enable people to use contraceptive information and services and help achieve the full benefits of such investments.

Many people think of human rights in terms of violations. This aspect is important, and the history of family planning policies and programmes—particularly some undertaken for population control—includes instances of people being coerced to accept contraceptive implants or intrauterine devices and being subjected to forced abortion or sterilisation.1–9 Human rights mechanisms, such as treaty monitoring bodies, regional human rights tribunals, and national courts, enable individuals and communities to seek redress for such violations.2,9 Human rights law can also be used to prevent violations occurring in the first place. For example, consideration of human rights standards can ensure that health services do not discriminate against particular groups such as people younger than 18 years, ethnic minorities, or people with HIV infection, and can also require improvements in the quality of services. When human rights are integrated into policy-making processes, they can help to ensure that health facilities and services are non-discriminatory and of good quality from the outset. The application of human rights law and standards to programme design and monitoring, and use of human rights mechanisms to hold governments accountable, are essential devices to ensure health for all.

Internationally agreed human rights that are particularly relevant to contraceptive information and services include the rights to: non-discrimination, information and education, the highest attainable standard of health, privacy, and life.10–12 These rights are inextricably linked. For example, the right to the highest attainable standard of health, which includes access to health services and health-related information, cannot be fulfilled without promotion and protection of the rights to education and information because people must know about services to use them. In this report we give special attention to the right to contraceptive information and services, which is grounded in these internationally recognised human rights,13,14 and we suggest that the promotion and protection of these rights should be part of a multidimensional strategy to satisfy the unmet need for family planning.

Over the past four decades, international human rights law has established and expanded standards for sexual and reproductive health, including family planning. For example, states have affirmed the right to the highest attainable standard of health,15 authoritatively interpreted to encompass “sexual and reproductive health services, including access to family planning”.15 They have also agreed to “eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care...”

Search strategy and selection criteria

We reviewed all major human rights sources, such as international and regional covenants and conventions, international, regional, and national human rights law relevant to family planning, together with work (including published and unpublished material) done by UN agencies, human rights experts, and non-governmental organisations in which human rights have been actively used in support of sexual and reproductive health. Because a PubMed search with the terms “human rights” and “family planning” or “contraception” revealed only a few published, peer-reviewed articles about this topic, we also relied on consultation with UN and other colleagues to identify examples of family planning programmes.

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services, including those related to family planning.11 These agreements are legally binding for all the countries that have ratified the relevant covenants and conventions, such as the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). All states in the world have ratified at least one of the core international human rights treaties and most have ratified many more.16 Many have translated these standards into their national laws and regulations, and many national constitutions guarantee rights such as the right to non-discrimination. These standards place legal obligations on governments to make high quality contraceptive information and services accessible for everyone, and to enable people to demand access to such services. Human rights treaties are supported and amplified by intergovernmental consensus documents such as the Programme of Action of the International Conference on Population and Development.19 Such agreements can be used by various groups to hold accountable the governments that are party to them, and they also guide the policies and programmes of UN agencies, donor governments, and non-governmental organisations.

Because this series focuses on family planning, defined as contraceptive information and services, we do not discuss access to other essential sexual and reproductive health services such as prevention, diagnosis, and treatment of sexually transmitted infections, and provision of safe abortion, although access to safe abortion is also central to women’s ability to regulate their fertility. International human rights law requires that governments provide a comprehensive legal and policy framework to ensure that abortion services allowable by law are safe and accessible in practice.19–20 This obligation requires that health providers be trained and equipped, and that other measures be taken to protect women’s health. Other issues crucial to the health and human rights of women are outside the scope of this report, such as early and forced marriage and female genital mutilation, both of which breach international human rights law.12,21–23

Whose unmet need?

The human rights principle of non-discrimination leads us to examine who is included in prevailing definitions of unmet need by policy makers, programme managers, service providers, and demographics. The sources used to estimate unmet need generally include only married or cohabiting women of reproductive age who do not want to become pregnant, but who are not currently using a method that is unsatisfactory to them and who, without the necessary programme support, are at risk of unwanted pregnancy or of stopping contraceptive use or both. Boys and men are not explicitly addressed in estimates of unmet need because the woman who reports contraceptive use is asked to include use by her husband or partner.

About half all sexually active adolescent women (aged 15–19 years) in sub-Saharan Africa and Latin America and the Caribbean who want to prevent pregnancy are not using a modern contraceptive method.25 Still left out of the estimate are women who are using a modern method that is unsatisfactory to them and who, without the necessary programme support, are at risk of unwanted pregnancy or of stopping contraceptive use or both. Of those, only 41% in sub-Saharan Africa and 50% in Latin America and the Caribbean are using a modern method of contraception. No equivalent data for sexually active adolescent men are available. Yet, there are 1·4 billion adolescents aged 10–19 years, many of whom are, or soon will be, sexually active. About 90% of them live in low-income and middle-income countries,
have limited access to schooling and health services, and are likely to engage in sexual activity before or outside, as well as within, marriage.

The decisions of these young people about beginning sexual activity, marriage, sexual expression, and use (or not) of contraception will have a great effect on their lives and determine a major portion of future population growth. Whether married or not, they have particular needs in family planning because they are more likely to have unprotected and non-consensual sex, and commonly lack the information and services needed to protect themselves. Nor are these young people drawn to services that are designed to meet adults' needs. Many young people can be interested in contraception to prevent unwanted pregnancy and to protect against sexually transmitted infections, but conventional messages about planning their families are irrelevant. Addressing their needs requires trained and supportive staff, privacy and confidentiality, emphasis on both contraception and disease prevention, and comprehensive sexuality education which is grounded in human rights, including gender equality and non-discrimination, sexual attitudes, and behaviour.27–30

The many women who are using a method that they do not like are not currently considered to have an unmet need. In some countries, more than four women in ten discontinue their contraceptive method within the first year of use.11 Yet these women, before they discontinue, are not included in the estimates of unmet need, which is indicative of the long-standing failure of many programmes to recognise the importance of provision of sufficient information about side-effects, and support for women to tolerate them or switch methods.

In all regions, entire categories of women have little or no access to contraceptive services; these groups include refugees and internally displaced women, those in stigmatised occupations such as sex work, those who are otherwise stigmatised, such as rape victims, women with disabilities, HIV infection, or AIDS, and those from religious or ethnic minorities.12–15 The human rights principle of non-discrimination requires that contraceptive information and services are available and accessible to all these groups. Special outreach, training, and other investments that are needed, will affect cost estimates of both global and national resources required to address the unmet need. In many countries, meeting these unmet needs will also require changes in laws, policies, strategies, and programmes, consistent with national and international human rights standards.

**Use of human rights to overcome barriers to access**

The right to the highest attainable standard of health requires that everyone can access health information and services without restrictions, including specific services related to family planning27 that are both affordable and delivered in a timely fashion.31 Nonetheless, many barriers impede women's access to contraception, including: conditions that do not allow them to make free and informed decisions (such as lack of intelligible information or counselling); lack of confidentiality; the requirement for authorisation by spouse, parent, or hospital authorities; high fees for services; distance from health facilities and the absence of affordable public transport; lack of choice of a wide range of contraceptive methods;32–44 and inadequate training, insufficient numbers, and poor supervision of health-care providers.35–43 Laws that restrict access to services for particular population groups, or that ban the display of materials about, or sale of contraceptives, have been identified as serious barriers to women's access to family planning services.34–44 Each of these barriers could be the focus of a report, but we describe below four examples where human rights standards have been used to remove barriers, thus contributing to reduction of unmet need.

**Inadequate supplies of safe and effective commodities**

Reports from the past 3 years show that, in some African countries, stock-outs of contraceptives are a chronic problem.45–47 In Kenya, for instance, 24% of women who do not want another child within the next 2 years are not using contraception because many methods, particularly implants and injectables, are not available.45 Such shortages are likely to contribute to maternal morbidity and mortality.46 In some instances, substandard contraceptives are available at low prices, but pose a serious threat to people's lives and health.47 The human rights and public health obligations of governments require them to establish strict quality controls for manufacture and import of contraceptives, and effective surveillance of other sources such as the internet.

Human rights standards require that a wide range of approved contraceptive supplies be continuously available.31,35,36–39 Approved contraceptives are those, at a minimum, that are on the WHO Model List of Essential Medicines40 and its companion Essential Medicines for Reproductive Health.41 These lists include emergency contraception, a method that is often not available even when other methods are, and a range of contraceptives including condoms and other barrier methods, hormonal contraceptives (oral, injectable, implants, rings), intrauterine devices, and contraceptive sterilisation. An example of how human rights standards have been used is a decision by the Colombian Council of state, which ruled that access to emergency contraception is in accordance with the right to life as established in the Colombian Constitution, thus rejecting efforts by some groups to ban such contraceptives.42 Another problem is that the ability of states to ensure continuous supplies has been, and in many cases remains, dependent on donor funding, which has been reduced over the past decade, and on free supplies from international agencies, which can be erratic.31–40
Poor quality services
In the early 1990s, poor quality of care in contraceptive services was identified as a major problem, and a user-centred quality of care framework was designed that is implicitly grounded in human rights. Its elements are: choice among contraceptive methods; accurate information about the effectiveness, risks, and benefits of different methods; technical competence of providers; provider–user relationships based on respect for informed choice, privacy, and confidentiality; follow-up; and the appropriate constellation of services. The framework has been variously adapted to include additional elements such as cost, proximity of services, and consideration of gender relations. Studies in Bangladesh, the Philippines, Senegal, and Tanzania have shown that improvement of care quality according to these standards increases women’s contraceptive use; where women felt they were receiving good care, rates of contraceptive use were higher than in regions with lower quality provision of health care. In addition to the public health imperative, the right to the highest attainable standard of health obligates governments to ensure that health facilities, goods, and services, including contraceptive services, are of good quality. The framework provides guidance for this requirement and experience shows that it helps address unmet need by improving women’s satisfaction with and effective use of contraceptives and can increase the numbers of women and young people accessing services.

Conscientious objection
An apparently increasing number of health-care providers refuse to provide various sexual and reproductive health services including contraception on grounds of conscience, because they disagree, for personal or religious reasons, with the use of contraception. Human rights law is clear: providers’ exercise of their rights to freedom of thought, conscience, and religion must not jeopardise their patients’ health. The European Court of Human Rights elaborated this standard in a case in which two pharmacists in France were found liable for refusing to provide doctor-prescribed contraceptives to several women on religious grounds. The court explained that as long as the sale of contraceptives is legal and occurs by medical prescription only in pharmacies, pharmacists “cannot impose their religious beliefs on others as a justification for their refusal to sell such products, ...[They] can manifest those beliefs in many ways outside the professional sphere”. The pharmacists were subsequently also found guilty of violating France’s Consumer Code, which prohibits refusal to sell a product or provide a service to a customer for no legitimate reason. These decisions are consistent with the Ethical Guidelines of the International Federation of Gynecology and Obstetrics. Individuals who object on grounds of conscience to providing contraceptives must refer patients to willing providers, and provide services where they have a monopoly and in emergency situations.

Lack of community engagement
Participation in the decision-making process by the people who are affected is a core human rights principle. In family planning, if communities are not engaged in processes of contraceptive introduction, the result is likely to be less effective. In recognition of this, WHO has outlined a participatory approach to contraceptive introduction explicitly grounded in human rights, which has been effectively used in nearly 20 countries. Engaging not only the Ministry of Health, but also representatives of women’s health advocacy and other community groups, health-care providers, and researchers, this strategic approach culminates in changes to improve people’s access to contraceptive services. In Romania, for example, the process drew attention to free family planning services in one part of the country, by contrast with fees charged to users in a much poorer region; consequently contraceptive methods became available free of charge throughout the country.

Laws and policies in line with human rights commitments
Making human rights explicit in a country’s laws, policies, and programmes can help to ensure positive health outcomes for all. For example, for more than a decade, Brazil has put in place various strategies aimed at improving women’s health, particularly sexual and reproductive health, explicitly shaped by human rights. In 1996, the National Congress approved a law on family planning according to which family planning is a right of every citizen. Thereafter, two successive national policies were implemented to broaden the provision of reversible birth-control methods by the public health system, and to provide free contraception to women and men of reproductive age. Use of contraception by sexually active women in Brazil increased from 55% in 1996 to 68% in 2006, and access to oral contraceptives through the public health system more than doubled during the same period, including among some disadvantaged populations. Problems remain, especially with regard to ensuring access to all disadvantaged and remote communities. Nonetheless, overall progress is impressive, and although many factors contributed to the development and implementation of these strategies, the explicit use of human rights in the design of the policy and strategies seems very likely to have contributed to their success.

Since 1994, many intergovernmental negotiations have affirmed the right of adolescents and young people to contraceptive information and services and comprehensive sexuality education, in line with the human rights standard that adolescents must be treated according to their evolving capacities for decision making, not according to any arbitrary age limitation.
Evidence available from a range of countries shows that comprehensive sexuality education improves sexual health outcomes, including reduction of unintended pregnancies, delay of sexual debut, and reduction of high-risk sexual behaviour. In 2006 and 2008 respectively, African Ministers of Health and Latin American Ministers of Health and Education each adopted declarations, framed by human rights, that commit their governments to concrete actions to provide sexuality education. Many countries are in various stages of taking such concrete actions, inspired by, and based on, these declarations. The provision of comprehensive sexuality education is a public health imperative backed by international human rights standards that place legally binding obligations on governments to take steps to ensure that adolescents have access to such education, including information about contraception.

Although many developed countries provide outstanding sexuality education to adolescents, the USA has struggled to do so. Between 1998 and 2009, the American federal government invested more than US$1·5 billion in promotion of abstinence-only-until-marriage programmes, which prohibited distribution of information about contraception. Under President George W Bush, such programmes became the leading federal government strategy for dealing with adolescent sexuality—both domestically and internationally. In 2009, during President Obama’s administration, most federal support for domestic abstinence-only programmes ended and funding shifted to science-based approaches, although some funding for abstinence-only programmes was revived by Congress in 2010.

Human rights and health arguments contributed to the Obama administration’s decisions. For example, the influential 2006 Society for Adolescent Medicine report concludes: “Current U.S. federal law and guidelines regarding abstinence-only funding are ethically flawed and interfere with fundamental human rights”. Opposition to American domestic abstinence-only programmes also came from constitutional litigation brought by the American Civil Liberties Union. In the opinion of Santelli and colleagues: “Documentation of the scientific and rights-based problems was instrumental in reducing...federal support for [abstinence-only-until-marriage] AOUM programs in the USA”.

**Legal obligations and mechanisms for accountability**

Because international and national human rights give rise to legally binding obligations on states, they demand accountability of states for their performance. Accountability can be achieved through many different mechanisms and procedures that vary from country to country, and also include the UN and other mechanisms with global responsibility. A few examples include national courts, national human rights institutions, international human rights treaty bodies, democratically elected local health councils, patients’ committees, professional disciplinary proceedings, and other civil society organisations.

Some countries enshrine human rights in their national constitutions and provide effective judicial remedies when these rights are violated. For example, the South African Constitutional Court, relying on the right to the highest attainable standard of health and other constitutional protections, ordered the government to provide the antiretroviral drug nevirapine in public hospitals and clinics when medically indicated. In Argentina, a court relied upon CEDAW and CRC to uphold the constitutionality of a law requiring the provision of sexual and reproductive health services to all fertile people, including adolescent girls. National courts are increasingly relying on international human rights law to uphold access to emergency contraception in the same way that national organisations and individuals are using international and regional human rights tribunals to uphold access to lawful abortion.

Established by national law, national human rights institutions, such as the Kenyan National Commission on Human Rights, are not judicial, but can receive and investigate complaints and undertake public enquiries. The Kenyan commission received a major report from civil society drawing attention to profound problems in the country’s health-care sector, including with family planning, in light of which the commission launched a public enquiry into reproductive health services for women. The enquiry took written and oral evidence from all interested groups across the country. Its report and recommendations will be submitted to the President and Parliament. Such processes are likely to lead to improvements in women’s access to reproductive health services including family planning.

International human rights accountability mechanisms, such as the CEDAW Committee, can be used to good effect. In the case of a Roma woman who was forcibly sterilised, the committee ruled that Hungary had failed to provide appropriate information and advice on family planning, and had not ensured that the woman had given her fully informed consent to be sterilised. It ordered the government to take specific measures to ensure the occurrence was not repeated. The CEDAW Committee can also undertake inquiries in situations that are deemed to be grave or systematic. In 2008, and 2009, a coalition of non-governmental organisations requested that the committee investigate Manila City’s ban on the sale of modern contraceptives in the public health system, to support the lawsuit they filed against the Office of the Mayor of Manila. At the time of writing, the case is still pending. International human rights tribunals are increasingly elaborating on their understanding of certain rights and principles, such as privacy and confidentiality, free and informed decision making, autonomy and self-determination, and the freedom to give and receive information, all of which
are essential to improve access to contraceptive information and services. Such elaboration enhances the possibility of judicial application of these human rights principles to family planning.

Some international human rights demand immediate action. For example, the prohibition against discrimination requires that, if a policy discriminates against women, the government must take immediate remedial action, whatever its resource capacity. Various elements of the right to health, including the right to contraceptive information and services, require immediate action, such as ensuring that services are not discriminatory, providing access to essential medicines, and putting in place a national health strategy based on epidemiological evidence. However, international human rights, including the right to contraceptive information and services, also have elements that are subject to progressive realisation and resource availability, such as the obligation to construct an effective health system. Progressive realisation means that countries have to improve their performance steadily, consistent with their available resources. If indicators and benchmarks suggest inadequate progress, a government has to provide a rational and objective explanation, otherwise an accountability mechanism could find that the government is in breach of its legally binding human rights obligations.

Millennium Development Goal target 5B—universal access to reproductive health by 2015—strongly corresponds to the right to contraceptive information and services. One of the indicators for this target is unmet need for family planning. Thus, if unmet need is not decreasing in a country, the government is neither on track to achieve Millennium Development Goal 5, nor in conformity with its binding obligations to fulfil the right to contraceptive information and services, unless the authorities can provide a compelling explanation for the country’s performance.

Of particular importance are commitments made by wealthy countries and international agencies to provide resource-poor countries with financial support and contraceptives and other reproductive health commodities. Mechanisms to hold donors accountable for these commitments are very weak. In a new development, all stakeholders, including donors and businesses will be held accountable by a global independent Expert Review Group, and national accountability mechanisms, for their commitments to the UN Secretary-General’s Global Strategy for Women’s and Children’s Health, which encompasses contraceptive information and services.

**Panel: Priority measures required by human rights standards and principles for governments to eliminate the unmet need for family planning**

**National and sub-national plans for sexual and reproductive health education, information, and services, including family planning**

Design plans, through a participatory process, to provide universal access (not only for married but also for unmarried people, adolescents, others marginalised by income, occupation, or other factors); to encompass all appropriate public, private, national, and international actors; and to include certain features, such as objectives and how they are to be achieved, timeframes, a detailed budget, financing, reporting, indicators, and benchmark measures

**Removal of legal and regulatory barriers**

Remove barriers that impede access to sexual and reproductive health education, information, and services, including family planning, particularly by disadvantaged groups

**Commodities**

Make available the widest feasible range of safe and effective modern contraceptives, including emergency contraception, as enumerated in a national List of Essential Medicines based on the WHO Model List and delivered through all appropriate public and private channels

**Community-based and clinic-based health workers**

Train adequate numbers of health workers who are skilled and supervised to provide good quality sexual and reproductive health services, including full and accurate contraceptive information and modern contraceptives, using the local language and exercising respect for privacy, confidentiality, diversity, and other basic ethical and human rights values

**Health facilities**

Provide health facilities that are clean, provide seating and privacy for user-provider interaction, are adequately stocked and equipped, adhere to published hours of services, and inform users of their rights

**Financial access**

Provide state subsidies and community insurance schemes to allow access for people who would not otherwise be able to afford services

**Monitoring and accountability**

Establish mechanisms that provide effective, accessible, transparent, and continuous review of the quality of services; assess progress toward equitable access and other objectives; and check that the commitments of all stakeholders are met

**Conclusions: legally required priorities**

We have shown that taking a human rights perspective of unmet need for family planning results in a broader definition than that conventionally used of who has a need and right to contraceptive information and services, of what kind, under what conditions. The right to contraceptive information and services, like other human rights, requires translation into many practical actions that will meet the needs of diverse groups living in diverse circumstances. Thus priorities and plans must be determined primarily at country level, buttressed by local, national, and international accountability mechanisms, and donor support for low-resource countries. Priority setting and planning must take into account three crucial considerations.

First, contraceptive information and services are necessary but not sufficient to reduce the unmet need for family planning. As agreed in the International Conference on Population and Development Programme of Action, they are most effectively delivered as a key element of a package of mutually reinforcing sexual and
reproductive health services,” which must be a priority in health systems strengthening, and must be provided with full respect for the human rights of the user.

Second, states have human rights obligations to protect people from discrimination. They must therefore ensure that policies, programmes, and accountability mechanisms for contraceptive information and services are designed to enable all, especially vulnerable and disadvantaged groups, to exercise their right to information and services free of discrimination, coercion, and violence. Who is vulnerable or disadvantaged varies between country and within countries and needs to be explicitly assessed in each case for policy and programme development and monitoring.

Third, progressive realisation and resource constraints cannot be used as a reason for failure to make required progress. These principles and other human rights considerations, including consideration of epidemiological evidence, must be used to establish priority among the many necessary measures needed to implement the right to contraceptive information and services, and to protect against abuses. Concrete ways to finance the priority measures are available even for low-income countries.

Taking into account these three considerations, and recognising that countries are at different stages of meeting their sexual and reproductive health and rights obligations, we emphasise in the panel seven priority measures that are required by human rights standards and principles for governments to eliminate unmet need for family planning and achieve universal access to contraceptive information and services.

Governments have a legal obligation to do all they reasonably can to put these measures in place as a matter of urgent priority. If they fail to do so without compelling justification, they are in breach of their legally binding international human rights commitments in relation to health, contraceptive information and services, and women’s equality. For this reason, human rights are a strong device that could be more widely used by governments to shape, and secure support for, effective and inclusive policies, but also by health-care providers and advocates to improve the quality of services and achieve universal access to reproductive health including family planning. Guidance and other assistance are available to help countries meet their human rights obligations. For example, WHO has developed an instrument that helps governments and other stakeholders to identify inconsistencies between national laws and human rights obligations (eg, denying unmarried women contraceptive services although CEDAW has been adopted into law) and agree on actions to remove such barriers to people’s access to, and the provision of, good quality sexual and reproductive health services including family planning. Such processes can contribute much to fulfilment of the unmet need for family planning.

Contributors
All authors contributed equally to the writing of this report.

Conflicts of interest
We declare that we have no conflicts of interest.

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