

# Voluntary, Human Rights–Based Family Planning: A Conceptual Framework

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*At the 2012 Family Planning Summit in London, world leaders committed to providing effective family planning information and services to 120 million additional women and girls by the year 2020. Amid positive response, some expressed concern that the numeric goal could signal a retreat from the human rights–centered approach that underpinned the 1994 International Conference on Population and Development. Achieving the FP2020 goal will take concerted and coordinated efforts among diverse stakeholders and a new programmatic approach supported by the public health and human rights communities. This article presents a new conceptual framework designed to serve as a path toward fulfilling the FP2020 goal. This new unifying framework, which incorporates human rights laws and principles within family-planning-program and quality-of-care frameworks, brings what have been parallel lines of thought together in one construct to make human rights issues related to family planning practical.* (STUDIES IN FAMILY PLANNING 2014; 45[1]: 1–18)

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The global community has the opportunity to transform family planning programs worldwide as a result of the 2012 London Summit on Family Planning, where more than 150 world leaders, international agencies, civil society organizations, foundations, and firms from the private sector in donor and developing countries committed resources to bring voluntary family planning services to an additional 120 million women and girls by 2020. This initiative, largely based on meeting unmet need, is now known as FP2020. The London Summit “underscored the importance of access to contraceptives as both a right and a transformational health and development priority” (Bill & Melinda Gates Foundation and DFID 2012: 1). In the final business plan leading up to the London Summit, one of the guiding principles noted was “protection of the human rights of women and girls” (London Summit on Family Planning 2012: 5).

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Yet amid the positive response to FP2020, some civil society organizations expressed concern that reaching the numeric goal of 120 million additional contraceptive users by 2020 could signal a retreat from the human rights–centered approach that underpinned the 1994 International Conference on Population and Development (ICPD) (Girard 2012; Khosla 2012; Krishnan 2012). Concern was also raised that the goal could lead to a focus on urban populations that already have access to services, at the expense of marginalized women, men, and young people, who may be more costly to reach but who may face greater financial, social, or other barriers that prevent them from accessing such services. These concerns highlighted the need to focus on human rights in general, and reproductive rights in particular, in implementing family planning, with strong accountability systems in place to ensure that programs offer voluntary family planning services based on human rights laws and principles. This reaction underscored the need to bring together diverse stakeholders and disciplines—including family planning, reproductive health, human rights, and public health perspectives—to harness relevant approaches to programming and to create the conditions for achieving the FP2020 goal of 120 million additional users of modern contraceptive methods by 2020 by means that guarantee freedom of contraceptive choice and that respect, protect, and fulfill human rights.

The principle of voluntarism has been a long-standing cornerstone of international support for family planning—in theory if not always in practice (Bongaarts and Sinding 2009). The commitment to respect, protect, and fulfill an expanded list of human rights that relate to reproductive health has been articulated and reaffirmed since the 1994 ICPD (Cook, Dickens, and Fatalla 2003). The expanded focus on sexual and reproductive health has, however, diffused the attention that has been given to family planning since ICPD. This article attempts to answer the following questions: How should family planning programs integrate human rights principles? Can programs move from the rhetoric of universal human rights to the practical implementation of ensuring that rights are respected and protected in policies and programs? It responds to the call to address family planning from a human rights perspective through a comprehensive operational framework, to guide the design, implementation, monitoring, and evaluation of policies and programs. Included are: (1) a discussion of human rights and their relationship to family planning; (2) a new framework designed to help ensure that family planning programs are voluntary and that they respect, protect, and fulfill rights; and (3) recommended actions for facilitating the operationalization of integrated public health and human rights approaches in family planning programs.

## SOURCES

This article is based on a broader literature review of the history of the family planning movement and on human rights literature as it relates to reproductive rights and family planning. We conducted reviews of the evidence base for voluntary, human rights–based family planning and the tools to undertake such programming. More than 400 studies, resource documents, and tools were reviewed and categorized into the four levels of our conceptual framework. The review also identified gaps in the evidence. (For additional details regarding the studies and resource documents reviewed and the findings, see Kumar et al. 2013 and Rodríguez et al. 2013.)

We also conducted group meetings and webinars with nearly 200 experts from more than 25 countries, including a consultation with the World Health Organization (WHO) in April 2013 (WHO 2014). The current version of the conceptual framework reflects feedback from experts and practitioners including implementers, civil society representatives, researchers, and bilateral and multilateral donors and organizations from Africa, Asia, Europe, and North and Latin America.

## **HUMAN RIGHTS IN RELATION TO FAMILY PLANNING AND REPRODUCTIVE HEALTH**

Human rights are rights to which individuals are entitled by virtue of being human beings. They include civil, political, economic, social, and cultural rights and are rooted in international treaties that have the status of international law (OHCHR 2006). The 1948 UN Universal Declaration of Human Rights was followed in 1966 by the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which take the Universal Declaration a step further by making provisions legally binding. International conferences and declarations provide additional content and specificity to human rights and can provide practical guidance to states in their implementation (UNHCR 2005).

### **The Link between Human Rights and Family Planning**

The foundation for voluntary and human rights–based family planning can be traced to the 1968 International Conference on Human Rights held in Tehran, which included in its proclamation that “parents have a basic human right to decide freely and responsibly the number and spacing of their children” (UN 1968: 4). This right was reaffirmed at three subsequent international population conferences: Bucharest, in 1974; Mexico, in 1984; and Cairo, in 1994 (Singh 2009). The landmark International Conference on Population and Development, which took place in Cairo in 1994, affirmed this right and built on other established human rights. It declared:

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so, and the right to attain the highest standards of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (UNFPA 1995: para. 7.3)

The UN Committee on Economic, Social, and Cultural Rights (CESCR) is the body of independent experts that monitors implementation by state parties of the International Covenant on Economic, Social, and Cultural Rights. In 2000 it published General Comment No. 14 to further define and provide guidance on states’ obligations related to the right to the highest attainable standard of health, which is defined in Article 12 of the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights. General Comment No. 14 provides details of four “interrelated and essential” elements of the right to the highest attainable standard of health: availability, accessibility, acceptability,

and quality, collectively referred to as AAAQ.<sup>1</sup> AAAQ was created to clarify the content and meaning of the right to the highest attainable standard of physical and mental health.

Whereas General Comment No. 14 offers four components relevant to the right to the highest attainable standard of health, Erdman and Cook (2008) list three broad categories of reproductive rights, which are derived from legally defined human rights, within which family planning falls:

1. Right to reproductive self-determination (right to bodily integrity and security of person and the rights of couples and individuals to decide freely and responsibly the number and spacing of their children).
2. Right to sexual and reproductive health services, information, and education (including right to the highest attainable standard of health).
3. Right to equality and nondiscrimination (right to make decisions concerning reproduction free of discrimination, coercion, and violence).

Taken together, Erdman and Cook's three categories and the four components of General Comment No. 14 form a valuable basis for identifying both government and service-provider obligations to respect, protect, and fulfill the right to the highest attainable standard of health, promote reproductive health, and reinforce an obligation to provide family planning information, services, and supplies. The array of human rights instruments can be used to hold governments accountable and to guide policies and programs—whether in the public, not-for-profit, or private sectors—to ensure available, accessible, acceptable, and high-quality family planning and reproductive health information and services (Cottingham et al. 2010; Cottingham, Germain, and Hunt 2012).

## The Range of Violations of Reproductive Rights and Contraceptive Choice

Because violations of reproductive-health rights have tended to focus on egregious cases—such as forced abortion in China (Kaufman 2003) and forced sterilization in India (Harkavy and Roy 2007), in Peru (Shepard 2002), and more recently among HIV-positive women (Open Society Foundation 2011)—more subtle forms of rights violations have been overlooked (Jacobson 2000; Barot 2012). Some programs or providers pressure or coerce clients into using family planning methods they do not want, whereas others create barriers that prevent individuals from obtaining and using methods they prefer. Some of these factors are covert and some overt. Although coercion receives the most attention (Hardee et al. 2014), arguably all conditions that constrain a woman's capacity to make a full, free, and informed choice violate rights (EngenderHealth/RESPOND Project 2013). Inadequate supplies of safe and effective

1 The components of AAAQ were defined by CESCR as follows: "Availability" refers to functioning public health and healthcare facilities, goods and services, and programs available in sufficient quantity within the country. "Accessibility" has four components: nondiscrimination, physical accessibility, economic accessibility, and information accessibility. "Acceptability" implies that all health facilities, goods, and services must be respectful of medical ethics and culturally appropriate (i.e., respectful of the culture of individuals, minorities, peoples, and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned). "Quality" emphasizes that health facilities, services, and commodities must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation (UNCESCR 2000).

contraceptives, the myriad barriers women face to access contraceptives, and poor-quality services also contribute to human rights violations (Cottingham, Germain, and Hunt 2012). Furthermore, whereas no “ideal” contraceptive method mix has been established, the range of methods available and their accessibility contribute to contraceptive use (Ross and Hardee 2012). When individuals cannot make reproductive health and family planning decisions because of barriers presented by the health system and by social networks, and their right to use family planning is not protected by the policy and legal context, choice is compromised (EngenderHealth/RESPOND Project 2013).

### **Voluntary and Rights-Based Family Planning Programs**

Recognition of the rights of individuals and couples to decide freely and responsibly the number and spacing of their children and to access the information and means to do so has been built into international support through donor requirements. The principle of voluntarism has been integrated into all US government assistance for family planning since the inception of this assistance in the 1960s (Ravenholt 1968; US Congress 1968; USAID 1982 and n.d.; Donaldson 1990; Bongaarts and Sinding 2009; Barot 2012). The focus on quality of care (Jain 1989; Bruce 1990; Lynam, Rabinovitz, and Shobowale 1993; RamaRao and Mohanam 2003; Jain et al. 2012) began in the 1980s, and gained widespread acceptance in the 1990s and beyond. As part of the quality of care movement, Huezco and Diaz (1993) published an article on clients’ rights and the corresponding need for providers to offer quality care. International Planned Parenthood Federation (IPPF) produced a “Rights of the Client” poster listing ten rights (information, choice, privacy, dignity, continuity, access, safety, confidentiality, comfort, and opinion), and family planning associations displayed this poster in their clinics.

A strong link exists between the quality of care movement and the human rights framework of AAAQ services. Addressing quality of care is crucial but is not fully sufficient to ensure that all relevant human rights are respected, protected, and fulfilled within programs. In addition to quality of care, which pertains to clients who come in for services, the right to health also includes addressing the needs of community members who are not currently using services by ensuring that services are available, accessible, and acceptable.

Following ICPD, reproductive rights were linked with a broader definition of reproductive health, within which family planning was considered a core component (UNFPA 1995; IPPF 1996; Jacobson 2000; DFID 2004; Eager 2004; Erdman and Cook 2008; UNFPA 2008; Cottingham et al. 2010). Several donors adopted a reproductive health and rights framework in their programming. For example, the IPPF published a Charter of Sexual and Reproductive Rights in 1996 and reissued it in 2003 (IPPF 1996). UNFPA’s programming framework is reflected in the document “Sexual and Reproductive Health Framework: A Reality for All” (UNFPA 2008). The vision of WHO’s Department of Reproductive Health and Research is, according to its website, “the attainment by all peoples of the highest possible level of sexual and reproductive health....” In 2010, the UK’s Department for International Development (DFID) published its “Framework for Results” for improving reproductive, maternal, and newborn health in the developing world (DFID 2010). This document notes that DFID’s vision “is a developing world where all women are able to exercise choice over the size and timing of their families, where no woman dies giving birth, and where all newborns survive and

thrive” (DFID 2010: 2). UNFPA’s 2012 State of the World Population Report was titled “By Choice, Not by Chance: Family Planning, Human Rights and Development” (UNFPA 2012).

### **Applying Human Rights to Voluntary Family Planning in Practice**

Since 2003, UN agencies have adopted a common agenda regarding human rights–based approaches (HRBA) to development programming that is the basis of all UN programming, including that regarding reproductive health and family planning (see the UN’s HRBA Portal at <http://hrbaportal.org>). Whereas a definitive human rights–based approach has not been established, taking such an approach toward family planning would include the following (OHCHR 2006; Gruskin et al. 2007; UNFPA 2010):

- Analyzing the inequalities regarding family planning and reproductive health and the laws and policies under which programs operate.
- Ensuring that the plans, policies, and programs are anchored in a system of rights and corresponding obligations established by international law and that they integrate core human rights principles such as accountability, empowerment, nondiscrimination, and participation.
- Working toward equitable service delivery.
- Focusing on key elements of the right to health—availability, accessibility, acceptability, and quality—when defining standards for provision of services.
- Empowering individuals, especially the most marginalized, to participate in policy formulation and hold accountable those who have a duty to act.

The incorporation of human rights in family planning also calls attention to the need for mechanisms that support accountability, including better routine monitoring and means of redress for rights violations.

## **THE PROPOSED FRAMEWORK**

We propose what we call a “Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights.” The framework is intended to offer a practical approach to operationalizing human rights in the development, implementation, monitoring, and evaluation of voluntary family planning programs (see Figure 1). By applying human rights laws and principles to family planning programs and quality of care frameworks, this new conceptual framework brings what have traditionally been parallel lines of thought together in one construct to make the issue of rights in family planning explicit and practical. In essence, the framework takes government obligations to respect, protect, and fulfill human rights and applies these to the relevant service context, the duties of programs to ensure equitable access, and service-provider responsibility to ensure that clients of family planning services are able to make full, free, and informed choices. The framework includes voluntarism, rights, and programmatic language to show the compatibility of the approaches.

The framework is intended to assist policymakers, program managers, donors, and civil society in bridging what Louise Arbour, the former UN High Commissioner for Human



Rights, described as the “chasm between theory and practice...in translating human rights norms into concrete programming guidance applicable in diverse policy contexts and national circumstances” (OHCHR 2006: III). Although providing a broad view of a potential rights-based family planning program, the framework defines the desired health and rights outcomes and identifies the policy, programmatic, and other elements that need to be in place to achieve them.

The framework identifies the inputs required at the policy, service, community, and individual levels to achieve the desired results, and situates these levels within the country context that affects both the supply of and demand for family planning (EngenderHealth 2011). The framework shows how the four levels support the three broad categories of reproductive rights identified by Erdman and Cook (2008): the right to reproductive self-determination; the right to sexual and reproductive health services, information, and education; and the right to equality and nondiscrimination. The outputs in the conceptual framework link the current focus on quality of care in family planning programming to the elements of AAAQ. The framework also reflects the core principles of public health: autonomy, beneficence, and equity (Shelton 2001). The framework can also guide program design supported by the twin pillars of social justice and equity.

The framework can apply to all phases of the program life cycle, including needs assessment, planning, implementation, monitoring and evaluation, scale-up, and sustainability. Clearly, program planners need to think beyond what occurs during client–provider interactions to the effects of the policy and resource environment (which elements support or hinder method choice and access support of clients’ rights) as well as to community factors (whether sociocultural and gender norms support clients’ rights and ability to make and act upon autonomous family planning decisions).

The framework approaches family planning through a holistic, client-centered, and health-systems view, addressing factors that affect human rights and the choice and use of family planning. Also considered are the country and global contexts in which family planning programs operate. Further, the framework addresses the current context of health programming, focusing on promoting universal healthcare through the strengthening of health systems rather than through vertical programming. The framework reflects recent discourse on the social determinants of health,<sup>2</sup> which were clearly articulated at ICPD. Sen (2010: 143) has noted that ICPD “recognized that people can make free and responsible choices about how, when, and how many children they will have only if they can determine how, when, and under what conditions they can have sex, cohabit, or marry, and if these decisions are free from coercion and violence and are made with full adult autonomy and agency. ICPD acknowledged the centrality of power relations based on age and gender.” Furthermore, the conference described and made operational the requirements that Cottingham, Germain, and Hunt (2012) concluded, from a human rights perspective, are necessary to achieve universal access to contraceptive information and services. These requirements are:

- Establishment of concrete national and subnational plans that enable universal access.
- Removal of legal and regulatory barriers.
- Continuous supply of high-quality reproductive health commodities, including the widest possible range of safe and effective contraceptives.

2 See the “Social determinants of health” section of the WHO website at [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/).

**FIGURE 1 Framework for voluntary family planning programs that respect, protect, and fulfill human rights**

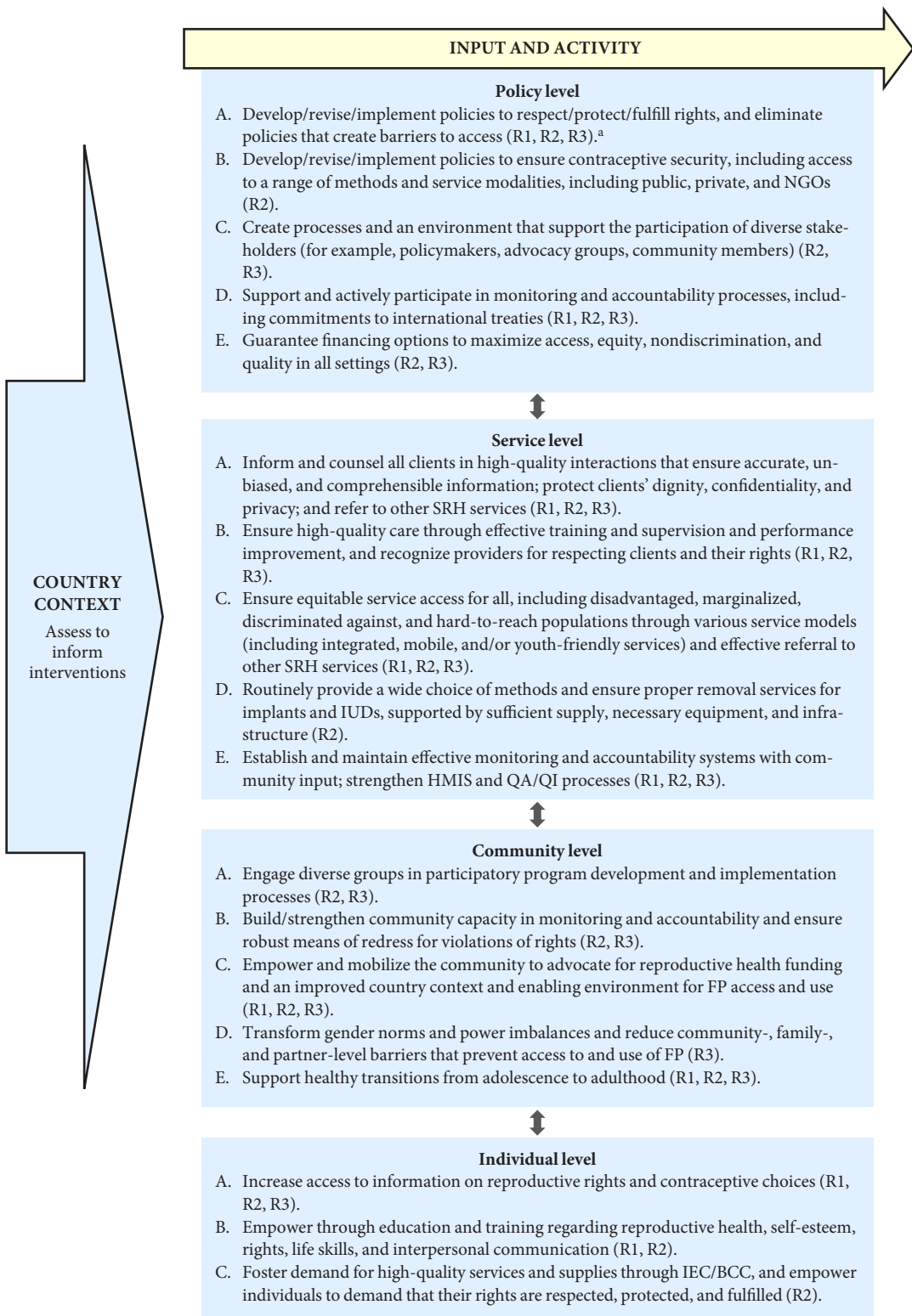
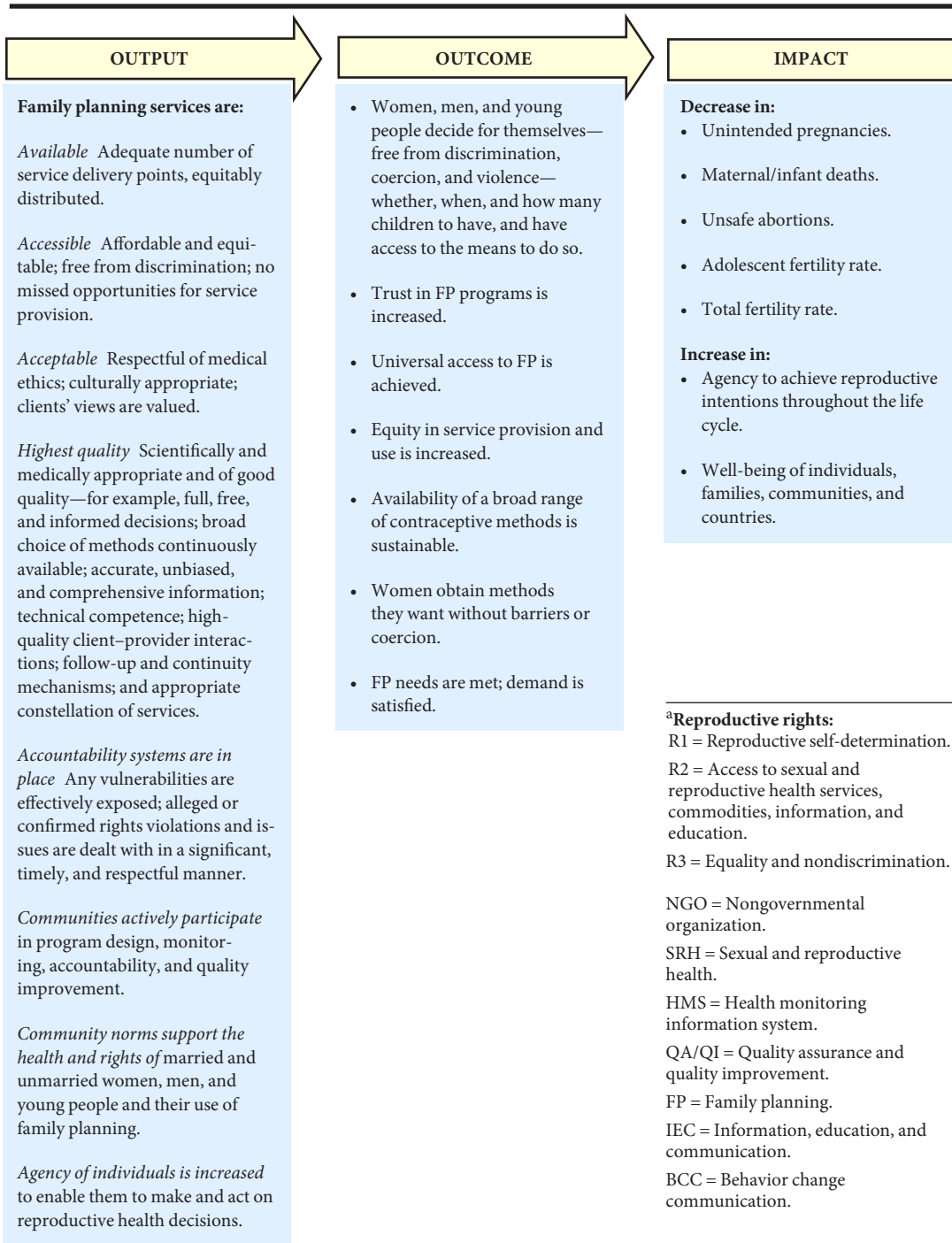




FIGURE 1 (continued)



- Employment of appropriately skilled and supervised health workers who respect privacy and confidentiality, provide full and accurate information, and ensure free and informed consent.
- Maintenance of high-quality facilities.
- Removal of financial barriers to access.
- Establishment of effective monitoring and accountability mechanisms to check that human rights and other commitments are upheld.

Adopting a human rights–based approach to family planning can help ensure that values and concepts associated with human rights are explicitly infused into all aspects of programming and can act as a valuable safeguard against policies and practices that are likely to result in coercion. In such programming, attention is given to health outcomes and also to program implementation.

The framework for family planning programs focuses on family planning but does not preclude links with other components of reproductive health, such as services related to sexually transmitted infections, HIV, and maternal health. This framework does not address abortion-related activities. The definition of family planning used in this framework is consistent with paragraph 8.25 of the ICPD Programme of Action (UNFPA 1995), which addresses the need to “deal with the health impact of unsafe abortion as a major public health concern,” and which states that “in no case should abortion be promoted as a method of family planning.” Abortion is legal in some countries but not others, and advocacy and service delivery programming is supported by some donors and not others. All programs and donors recognize the need for strong postabortion care. With increased attention to the quality of care that women experience at facilities during childbirth, mistreatment during childbirth is another human rights issue that could be addressed within the framework, as could infertility.

## **Components of the Framework**

### ***Country Context***

Family planning programs are affected by a country’s cultural, economic, political, and social environments. An assessment of this overall context is important, as is working within it and seeking to change aspects of it to promote and implement voluntary family planning programs that respect and protect rights. The value of such an analysis is that the process itself, and the analysis and recommendations that it yields, can be helpful in securing an increased understanding of the need for collaboration across disciplines and sectors to identify and reduce barriers to universal access to sexual and reproductive health and rights, particularly among vulnerable groups. Aspects of the country context that are important to voluntary, human rights–based family planning include the following: country governance overall, including responsiveness of the government to wide stakeholder participation; health governance at the national and decentralized levels; finance/resources available for health and participation in decisions regarding resource allocation; the health policy environment; the sociocultural context and gender norms; government adherence to human rights agreements, including the

presence and operation of national accountability mechanisms; and global accountability of donors and other global actors to country-level work.

### ***Policy Level***

Supportive policy has been identified as one of ten elements of successful family planning programming (Richey and Salem 2008). Policymaking is a complex process that involves a range of actors having differing demands and priorities (Walt et al. 2008; Buse et al. 2010). In addition to enacting policies that support voluntary, human rights–based family planning, eliminating existing policy barriers and ensuring correct implementation of supportive policies is essential. Equally important is the implementation of policies that support family planning (Hardee, Irani, and Rodriguez forthcoming). National policies, laws, operational guidelines, strategic plans, and other policy-related instruments—within the health sector and other sectors—establish the method by which countries address family planning issues and whether they do so in ways that respect, protect, and fulfill rights. For example, in Africa and Latin America, ministers of health and education have “adopted declarations, framed by human rights, that commit their governments to concrete actions to provide sexuality education” (Cottingham, Germain, and Hunt 2012: 176).

The policy level includes those actions or factors that influence policies—and thus the enabling environment—that affect equitable access and treatment; adequate resources; good governance; and management and accountability to ensure the availability, accessibility, acceptability, and quality of family planning information and services. Policies also address contraceptive development and method mix and human resources issues, which affect method choice and access.

### ***Service Level***

Programs that meet individuals’ reproductive health needs and that respect, protect, and fulfill rights will appropriately focus significant attention on service delivery. As noted above, the conceptual framework draws from and links key existing frameworks, most notably, the fundamental elements of quality of care (Bruce 1990), the framework presented by IPPF staff in the article titled “Quality of Care in Family Planning: Clients’ Rights and Providers’ Needs” (Huezo and Diaz 1993), the IPPF Charter on Sexual and Reproductive Rights (IPPF 1996), and General Comment No. 14 of the UN International Covenant on Economic, Social and Cultural Rights (UNCESCR 2000). The concept of quality of care (Bruce 1990; Huezo and Diaz 1993) reinforces the rights to self-determination, information, and education by underscoring the importance of informed choice, the quality of the interpersonal interaction between clients and providers, and the technical competence of the provider.

The service level spans across issues associated with (a) quality of care; (b) contraceptive choice; (c) provider training; and (d) all modalities of service delivery, including public, private, and NGO; clinic- and community-based; and integrated with HIV/AIDS, postpartum and postabortion services, and social marketing. At this level, the framework considers those actions or factors that influence the capacity of the health system to make voluntary family planning services available, accessible, acceptable, and of high quality (meeting clients’ rights and providers’ needs) within both facilities and communities. The framework highlights the

dual importance of trained, efficient, and respectful providers and fully informed and empowered clients.

### ***Community Level***

Emphasis on community participation in health programs dates back to the 1978 Alma Ata declaration and is a central tenet of human rights–based approaches to development programs, as articulated in the UN Common Understanding, adopted in 2003 (HRBA Portal n.d.). Community participation can empower individuals to take a more active role in health and development projects, increasing their degree of self-determination and making them more capable of managing their own lives (Wallerstein 1993). Zakus and Lysack (1998: 2) note that community participation is “a strategy that provides people with a sense that they can solve their problems through careful reflection and collective action.”

Whereas a focus on the service–delivery level is essential, potential clients may still not be reached in communities in which sociocultural barriers (including gender) to family planning use or to autonomous decisionmaking prevent women from exercising their right to contraceptive information and services. Community participation—whether directed toward program development, monitoring, accountability, or advocacy—may contribute most substantially to the acceptability of family planning programs and the ability of programs to gain traction in traditionally hard-to-reach populations (Rifkin 2003).

At the community level, the framework considers those actions and factors that empower communities to (1) participate in the development and implementation of the policies and programs designed to serve them; (2) hold policymakers and service providers accountable; (3) transform norms and customs; and (4) enhance community knowledge of human rights and family planning to facilitate the respect, protection, and fulfillment of community members’ rights to high-quality voluntary family planning information and services. Community-level involvement can also help ensure that services respect the right to nondiscrimination, by examining who is not using services and by working toward reducing barriers to access among minority or marginalized population groups, including young people. Activities at the community level also address gender and power imbalances to overcome barriers to access and use through gender-sensitive and transformative approaches.

### ***Individual Level***

Given the right of individuals and couples to decide freely and responsibly the number and spacing of their children, the individual is at the heart of a voluntary, human rights–based approach to family planning. With the realization that individuals can face significant challenges to the exercise of their reproductive rights, the individual level of the framework considers those actions and factors—including those pertaining to education, family, gender, partner, religion, and social status—that influence individual agency and the ability of individuals in a particular community to exercise their reproductive rights. While acknowledging that an individual’s role and relationship within a dyadic couple and within a family structure can directly influence the realization of reproductive rights, the family level is not included in the framework because, ultimately, rights holders are individuals who should exercise agency when making decisions regarding their reproductive health. Whereas reproductive rights tend

to focus on women, the framework also acknowledges the rights and needs of men in regard to family planning services.

### **Outputs**

The framework, designed as a logic model, links proposed inputs/activities to corresponding rights-based outputs and outcomes. These outcomes are related to the availability, accessibility, and acceptability of family planning that have been achieved, and emphasize accountability in programming for quality and equity.

Availability, accessibility, acceptability, and quality (AAAQ) in family planning should be activity outputs at the policy and service levels. Whereas these obligations fall on governments, the framework indicates their relevance to service managers and providers, who bear the responsibility of ensuring that their services respect, protect, and fulfill rights. The activity outputs associated with increasing AAAQ in the context of family planning can be made more specific when the framework used is applied to a specific program. Only a few outputs are provided in the framework as examples.

In the context of family planning, the historical and ongoing emphasis on quality of care constitutes the “Q” element of AAAQ. Therefore, the elements of quality of care for family planning, articulated by Bruce (1990), are included in the outputs section of the framework to indicate their unique contribution to framing outputs and related indicators. By including AAAQ, the outputs of the framework are described in such a way that both the equality (non-discrimination) and quality are adequately reflected.

Additional outputs are expected from the community- and individual-level activities. Priority outputs that are adapted to the needs, concerns, and context of the community need to be determined at the local level. Outputs that describe community participation in developing and accessing programs, promoting accountability mechanisms, engaging in advocacy, meeting the needs of adolescents, and disseminating information can be specified at the local level. Additionally, individuals themselves must feel empowered to demand access to high-quality services and to exercise agency in making fully informed reproductive health decisions. Ultimately the desired outcome is that rights to reproductive self-determination; rights to sexual and reproductive health services, information, and education; and rights to equality and non-discrimination are respected, protected, and fulfilled.

### **Outcome and Impact**

Family planning programs contribute to a range of positive outcomes for individuals and for societies. Over time, these outcomes have provided three rationales for investment in family planning: individual empowerment, improved health and well-being of mothers and children, and a country's ability to plan and manage development. These three rationales have also been classified as human rights, health, and demographic rationales (Seltzer 2002). The conceptual framework presented here outlines a vision of success for voluntary, human rights-based family planning programs that embraces both human rights and health outcomes. Leading up to the 2012 London Summit, the health rationale was emphasized first, and the human rights rationale was included subsequently. Yet when women choose and use family planning services that respect and protect rights, additional benefits to over-

all improved health become evident, as does the ability to achieve wider national sustainable development goals. The outcomes are likely to contribute to countries' ability to plan and manage sustainable development. Illustrative outcomes in the framework include, for example, increased trust in family planning programs, achievement of universal access to family planning, increased equity in service provision and use, sustainable availability of a broad range of contraceptive methods, and increased satisfaction of the demand for family planning. One can reasonably hypothesize that use of the rights-based approach to guide family planning programs will result in increased numbers of new contraceptive users and in the needs of existing users being better met.

Illustrative impacts include reductions in unintended pregnancies, maternal and infant deaths, unsafe abortion, adolescent fertility, and total fertility. Moreover, effects include an increase in women's agency to achieve their reproductive intentions throughout their reproductive years and an increase in the well-being of individuals, families, communities, and societies.

## RECOMMENDED ACTIONS

Countries throughout the world are signatories to human rights treaties and conventions that have the status of international law and that uphold reproductive rights. Family planning programming with human rights values and norms at their core must be central to efforts to meet FP2020 goals. This conceptual framework, although developed with FP2020 implementation most immediately in mind, can also serve as the blueprint for (1) reaching the broader goal of universal access to reproductive health, and (2) designing programs to achieve the goals to be set under the "ICPD Beyond 2014" review and the "Beyond 2015" campaign related to the Millennium Development Goals.

Human rights and public health outcomes are complementary, not contradictory, and combining approaches leads to a strong enabling context for family planning and for respecting, protecting, and fulfilling the rights of individuals. The framework provides common ground for public health professionals and human rights activists to work together and expand access to family planning through services that respect, protect, and fulfill human rights in the way that they are designed, implemented, and evaluated. Furthermore, a focus on providing more women with access to contraceptives will not negate the broader reproductive health and rights focus of ICPD. Instead, this focus will draw attention and resources to family planning, a key component of reproductive health that has received insufficient attention and resources for nearly two decades.

Although comprehensive, not all aspects of the framework need to be implemented in their entirety by all organizations. Some organizations may focus on the supply side and others on the demand side of family planning programming. Some may work at the service-delivery level and others may specialize in programming at the community level or work to affect policy change. Likewise, donors may decide which aspects of the programming their mandates and strategies support. Adopting a comprehensive, systems-level framework enables actors to see how their programming contributes to meeting the needs of women and men for voluntary, human rights–based family planning. These organizations can use the framework to identify and address gaps in their programs.



To progress further toward realizing and safeguarding family planning programs that respect, protect, and fulfill human rights, the following actions are recommended. First, the framework can foster discussion at the global and country levels regarding the critical issues of expanding access to family planning—particularly to underserved population groups—and respecting, protecting, and fulfilling human rights. The framework helps stakeholders understand the complexity of such programming and enables them to identify their programs' strengths and weaknesses and areas requiring more investment. The framework also provides a foundation for monitoring and accountability of policies and programs. Second, the conceptual framework can serve as a guide for donor assistance and country program design according to FP2020. Third, regularly updating and expanding the accompanying reviews of evidence and tools will be important to ensure inclusion of the latest material, so that programs have access to the most relevant and up-to-date information for programming. Fourth, the further documentation and evaluation of rights-based approaches will be important in filling the gaps in our knowledge concerning human rights-based programming and in evaluating both human rights outcomes and public health outcomes. Fifth, at the same time, evidence and tools should be made available to stakeholders for use in programming and advocacy and for guiding additional research and tool development. Finally, fostering innovation in rights-based public health approaches will be important, as will additional investment in interventions that are explicitly rights-based.

The renewed global commitment to provide support for family planning offers the opportunity to transform family planning programs and reach those most vulnerable and in need of these life-changing services. Adopting and applying the proposed framework offers the potential to close the gap between the rhetoric and the reality of reproductive rights, expanding equitable access to, and use of, high-quality family planning services that enable women and men to exercise their rights and achieve their reproductive intentions.

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