

HEART

HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Rights-based approaches to increasing access to Sexual and Reproductive Health and Rights

Date: 13 July 2016

Query: How have rights-based approaches to increasing access to Sexual and Reproductive Health and Rights been measured and enhanced access?

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1. Overview

Sexual and reproductive health and rights (SRHR) can be defined as encompassing ‘the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage in sexual activity; to choose whether and when to have children; and to access the information and means to do so’¹. It includes the right to ‘reproductive health care services, good and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality’².

A rights-based approach ‘promotes three main principles: the accountability of duty bearers, the participation of right holders, and equity / non-discrimination’³. This helpdesk report provides an overview of some of the most relevant evidence on rights-based approaches to increasing access to SRHR including how they have been measured and enhanced access where information is available, disaggregated into: policy; improved services; female-

1 Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda. Boldosser-Boesch, A., Bymes, D., Carr, C., Farid, S., Lovell, K., Minchew, H., Omang, J., Russell, R., Warner, A. Family Care International. Accessed 11/07/2016. <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>

2 Sexual and Reproductive Health and Rights. OHCHR. Accessed 11/07/2016. <http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>

3 Rights-based Monitoring and Evaluation: A Discussion Paper. Thesis, J. (2003) Save the Children. <http://www.mande.co.uk/docs/Rights-basedMonitoringAndEvaluation.pdf>

focussed; male-focussed; and broader interventions. It also includes a section on other useful resources.

Policy

Section 2 of this report explores the impact of policy changes on accessing rights, and the impact that champions of SRHR within the government can have on the broader population's access to information and services. Crichton (2008) explores this subject in the context of Kenya, while Simbar (2012) discusses it in the context of Iran, both of which have had fluctuating levels of support for SRHR over the years. Rodriguez et al. (2012) also discusses this in the context of Kenya, and includes a useful framework for rights-based family planning programmes. The 2012 report from IPPF discusses a programme's success in holding the government to account in Peru and Bolivia in implementing its stated policies in support of SRHR.

Improved services

Section 3 on improved services includes a programme in Guatemala which increased patients' capacity to make informed contraceptive choices by reorganising and improving the content of consultations (Leon et al., 2005); a study by Hoke et al. (2014) on implementing a community-based injectable contraceptive programme which had considerable success in increasing access to and uptake of contraception in comparison to the standard system where women were required to access a facility-based clinician; and a study on the very successful Marie Stopes International outreach model across five countries, which notably increased access to high quality SRHR information and services to poor women living in rural settings (Eva & Ngo, 2010).

Female-focussed approaches

Section 4 on female-focussed approaches includes Luck et al.'s 2000 study which found that community-based interventions, particularly where village women provide basic health and family planning counselling to other women, had great success in overcoming barriers to access to contraception. It also includes the 2011 study by Lee et al. who found that women who received a postpartum education programme had significantly greater contraceptive self-efficacy and were more likely to choose more effective contraceptive methods. Ahmed & Khan (2011) and Arur et al. (2009) discuss the use of a voucher system to improve access to maternal and sexual health for poor women in order to increase their access to services. Bartel et al. (2010) discuss a programme which addressed both health and gender factors at household, community and facility level, recognising that gender plays a major role in influencing health outcomes, including SRHR. Erulkar & Muthengi (2009) found that following a programme involving group formation, support for girls to remain in school and community awareness, there was a reduction in the number of girls aged 10-14 who got married (though an increase among those aged 15-19, possibly indicating that marriage was being delayed) and sexually experienced girls were more likely to have used contraceptives.

Male-focussed approaches

In Section 5, two notable programmes were identified that discussed male-focussed approaches to improving access to SRHR. Pulerwitz et al. (2006) conducted a quasi-experimental study which found that addressing inequitable gender norms, particularly those which define masculinity, can be an important part of HIV prevention strategies. Blake & Babalola (2002) describe a programme to increase knowledge about quality health services and the use of them through focussing on religious leaders and married men in light of the patrilineal and male-dominated society in Guinea.

Broader Interventions

Section 6 focuses on broader approaches to increasing access to SRHR. Van Rossem & Meekers' 2007 study found that radio and television programmes in Zambia about family planning and HIV and marketing of condoms improved the odds of men having used a condom. Kim et al. (2001) found that following a multimedia campaign which promoted sexual responsibility among young people in Zimbabwe, young people in campaign areas were 4.7 times more likely to visit a health centre and significantly more likely to have used contraception at last sex. The AYA project (AYA, 2007) dramatically improved access to SRHR, with over 35 million stakeholders reached through media campaigns, almost 400,000 young people received Life Planning Skills training, and over 2.5 million visits were made by young people to static clinics and outreach services. Rohrbach et al. (2015) found that a rights-based sexuality education curriculum was very successful, with participants in the intervention arm being more likely to report use of sexual health services and more likely to be carrying a condom.

Other useful resources

Section 7 on other useful resources includes an OHCHR report providing technical guidance on a human rights-based approach to reduce preventable maternal morbidity and mortality (OHCHR, 2012); a study by Berglas et al. (2014) on the definition of a rights-based approach to sexuality education; a study by Crissman et al. (2012) which found that gendered disparities in sexual empowerment, particularly among economically disadvantaged women, need to be better addressed to achieve universal access to reproductive health services; and a paper on rights-based monitoring and evaluation by Thesis (2003), which includes both the principles of such an approach and provides a helpful example of how to implement rights-based monitoring of an HIV/AIDS programme.

2. Policy

Changing fortunes: analysis of fluctuating policy space for family planning in Kenya

Crichton, J. (2008). *Health Policy and Planning*; 23(5): 339–350.

<http://uaps2007.princeton.edu/papers/70771>

Crichton describes how population policies often receive weak or fluctuating levels of commitment from national policy elites, leading to slow policy evolution and undermining implementation. Crichton finds this to be true of Kenya, despite the Government's early progress in committing to population and reproductive health policies and successful implementation during the 1980s. This key informant study on family planning policy in Kenya found that policy space contracted, and then began to expand, because of shifts in contextual factors, and because of the actions of different actors.

Policy space contracted in the 1990s in the context of weakening prioritisation of family planning programmes in national and international policy agenda, with negative implications for sexual and reproductive rights and progress with reducing fertility rates. Champions of family planning within the Kenyan Government bureaucracy played an important role in expanding the policy space through both public and hidden advocacy activities. The case study demonstrates that policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution and the challenge of sustaining support for issues after they have made it onto policy agenda.

Holding Governments Accountable: Experiences from Five Latin American Countries

International Planning Parenthood (2012) IPPF.

https://www.ippfwhr.org/sites/default/files/Voices_english_FNL%2520new.pdf

The report describes the Voices programme in five Latin American countries. The case studies from Peru and Bolivia are of particular relevance. The report describes how in Peru, the Ministry of Health has issued guidelines to facilitate adolescents' access to information about family planning as part of its efforts to reduce maternal mortality, but so far, implementation of adolescent-friendly health policies has been slow. Since the creation of these guidelines at the national level four years ago, many youth advocates in Peru have been looking for a way to accelerate implementation of youth-friendly policies and legislation. Through the Voices project, IPPF/WHO and their Peruvian Member Association, INPPARES, invested in building a strong network of 20 youth organisations to serve as watchdogs for the implementation of adolescent health policies in three regions of Peru. Thanks to the Voices project, INPPARES has led a concentrated effort to monitor implementation of existing norms and policies, such as comprehensive sexuality education guidelines, and hold governmental agencies and other key actors accountable. According to Carrillo, this involves more than training governments in effective youth programming in SRHR. "It's actually accompanying the government to take responsibility for implementing policies," says Carrillo. "It's making sure that regional governments in the entire country are playing a role in the process and dedicating their own regional-level resources to implementation."

This regional-level focus has also led to increased political participation among young people. In northern Peru's Lambayeque region, young advocates secured a meeting with government officials to discuss implementation of the youth sexual and reproductive health programme. Following this meeting, a Regional Youth Council for citizen monitoring and oversight was established. As there are only five such citizen councils in Peru, this victory was significant. This achievement lies squarely within the objectives of the Voices project: to create and strengthen spaces for citizen monitoring and oversight. It represents a significant step toward securing the sexual and reproductive rights of youth in Peru. "In short, this project has been able to give voice to people who have traditionally been excluded from having a real voice and a visible role in the political process," says Carrillo. "It's a significant achievement: people who were invisible are now being seen, they are taken into consideration by authorities at the regional and national level. The great struggle that fuels our work is to reduce disparities so that economic growth affects everyone. And to be able to say that Peru's laws and legal frameworks are more than just symbolic commitments."

In Bolivia, the Voices programme was also very successful. In 2009, the Bolivian Government adopted a new constitution, opening unprecedented opportunities for advocacy on a range of often-ignored issues, including the sexual and reproductive health of young people. Under the Voices project, CIES used this opening to demand government accountability to its commitment to improving health programmes and services for all Bolivians, particularly youth. CIES began by organising conversations with youth groups in five regions to better understand the health challenges they and their peers faced, including unwanted pregnancy and rights violations. These conversations evolved into extensive youth networks, and the space they created became a forum for raising awareness of young people's rights and building the advocacy skills needed to demand the fulfilment of those rights from government actors. As more and more young advocates mobilised from around the country, CIES continued to forge ahead, developing working partnerships with the Government and widening opportunities for public participation at all levels of the government's decision-making process.

As the opportunities expanded, youth networks in El Alto, one of most marginalised urban communities in Bolivia, began to work closely with local authorities to guarantee the inclusion of youth-friendly sexual and reproductive health services in Bolivia's laws. This process has helped young people like Rodolfo Palermo, a young leader in El Alto's youth network, not only raise their voices, but also be heard. "In many cases, decision-makers knew nothing about the situation of young people—they believed young people didn't have any problems," he recounts. "But through the Voices project, I met with the authorities and demanded solutions for young people's health problems. They started to listen to us and saw that we

had well-grounded arguments for change. They started taking us seriously, and then things changed.” The efforts of Rodolfo and his peers have paid off: as a result of CIES and their youth network’s ongoing advocacy, a Municipal Ordinance was passed in El Alto requiring that sexual and reproductive health services be provided through health centres offering specialised adolescent care. This victory has had nationwide impact, and demands are now being made for similar changes in other parts of the country. The Ministry of Health has begun to address sexual and reproductive health publicly, particularly the need to offer specialised care for adolescents in all Bolivian health centres, and to develop a national programme for preventing teen pregnancy. In the years ahead, CIES and young people like Rodolfo will continue to hold the Government accountable for its renewed commitment to improving the sexual and reproductive health of Bolivia’s youth. “The project allowed us, young people, to take our needs and demands to the municipal government, says Rodolfo.”

Achievements of the Iranian family planning programmes 1956–2006

Simbar, M. (2012). *Eastern Mediterranean Health Journal*, 18(3), 279–286.
<http://apps.who.int/iris/handle/10665/118310>

Family planning programmes initiated in the Islamic Republic of Iran from 1966 met with limited success. Following the 1986 census, family planning was considered a priority and was supported by the country's leaders. Appropriate strategies based on the principles of health promotion led to an increase in the contraceptive prevalence rate among married women from 49.0% in 1989 to 73.8% in 2006. This paper reviews the family planning programmes in the Islamic Republic of Iran and their achievements during the last 4 decades and discusses the principles of health promotion and theories of behaviour change which may explain these achievements. Successful strategies included: creation of a supportive environment, reorientation of family planning services, expanding of coverage of family planning services, training skilled personnel, providing free contraceptives as well as vasectomy and tubectomy services, involvement of volunteers and non-governmental organisations and promotion of male participation.

Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Evidence

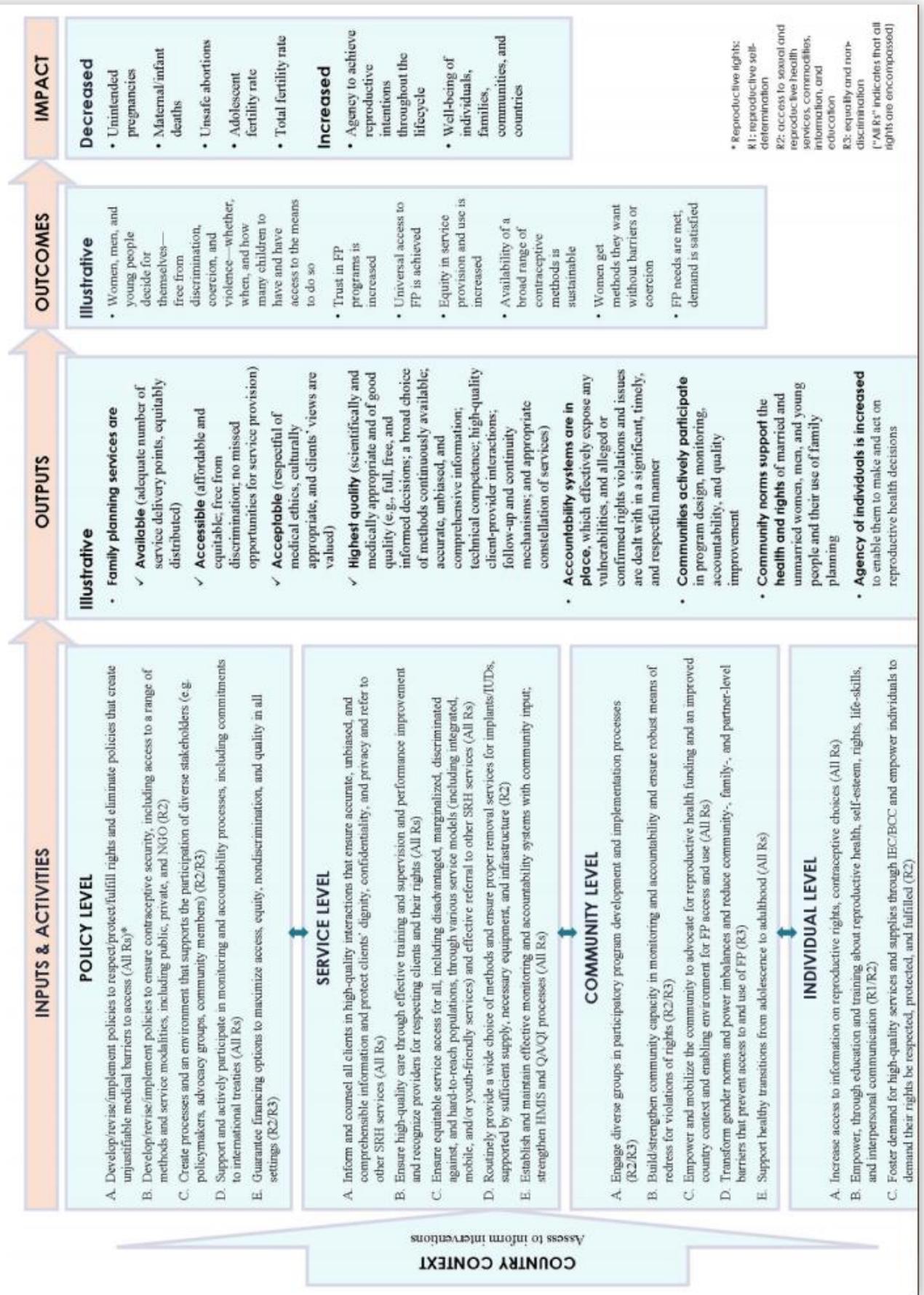
Rodriguez, M., Harris, S., Willson, K., Hardee, K. (2013). Futures Group.
https://www.engenderhealth.org/files/pubs/family-planning/human-rights-based-family-planning/EVIDENCE_Voluntary_Family_Planning_Programs_Systematic_Review.pdf

This paper includes a helpful framework (included below) for rights-based family planning programmes that was originally published in *Hardee, K., Newman, K., Bakamjian, L., Kumar, J., Harris, S., Rodriguez, M., & Willson, K. (2013). Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework. Washington, DC: Futures Group.* It separates human rights-focussed family planning programmes into policy level, service level, community level and individual level.

It also includes a key example of the development of constitutional support for reproductive rights and its impact: in 2010, the Kenyan government enacted a new constitution that states that reproductive health is the right of all citizens (Newman, 2012). Kenya’s history with family planning has been largely positive, albeit with challenges. Though many changes are taking place and policies are in place to respect, protect, and fulfil rights, Kenya has experienced stalled fertility due to a lack of availability of FP services, especially for the poorest groups. Unwanted fertility rapidly declined in 1998 and after stalling, increased slightly in 2003 (Askew et al., 2009). During the time of the fertility stall, Crichton (2008) contends that the “policy space” for family planning shrank and that it has since expanded. The right to family planning in Kenya can be traced to the inception of the family planning programme in 1967,

which subsequently saw an increase in the contraceptive prevalence rate from 7 percent in 1979 to 33 percent in 1993 (Kenya National Commission on Human Rights, 2012).

Figure 1. Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights



3. Improved services

Providers' compliance with the balanced counseling strategy in Guatemala

León, F. R., Brambila, C., de la Cruz, M., Garcia Colindres, J., Morales, C., Vasquez, B. (2005). *Studies in Family Planning*; 36(2): 117–126.

<http://www.ncbi.nlm.nih.gov/pubmed/15991649>

The balanced counselling strategy developed in Peru improved family planning care and clients' knowledge of their contraceptive method choice, but few providers adopted it. To expand its use, an algorithm was introduced and training, job aids, and reinforcement were supplied to Ministry of Health providers, most of whom were paraprofessionals, from two areas (40 clinics) in Guatemala. Previously, providers described all methods offered by the programme, regardless of the client's particular needs. Clients were expected to make a contraceptive choice by evaluating the full set of attributes, placing exaggerated demands on their information processing capabilities. Because most of the session time was spent describing all possible options, including those which were irrelevant to their specific circumstances, the clients did not have time to hear more detailed information about the method selected.

To address this problem, the balanced counselling strategy reorganises the family planning consultation with the aid of two techniques that, by means of sequential decision making, help to simplify the client's task of choosing a method. First, the consultation is reorganised around a process of elimination. At the outset, needs assessment works as a process for discarding those methods that the client and the provider identify as inappropriate in her case. In the choice phase, the provider describes only the relevant methods and conveys information that is essential for a preliminary choice. Then the provider and client focus on the chosen method. If this method is contraindicated or if the client rejects it once she learns more about it, she can return to the choice phase. Second, the balanced counselling strategy incorporates visual aids that assist client and counsellor alike. Mystery clients made pre-test and post-test visits to these clinics and to providers from a non-equivalent control group (40 clinics). The results showed that the strategy was used in 85 percent of the controlled consultations at the experimental clinics. Use of the strategy improved quality of care regardless of the provider's performance at baseline and regardless of ethnic or regional differences. Counselling session length increased by nine minutes, but real-client load did not change. Guatemalan clients can be expected to benefit from the strategy. The increased session length has not yet caused problems, but it may pose policy dilemmas in the future.

Community-based distribution of injectable contraceptives: introduction strategies in four sub-Saharan African countries

Hoke, T., Brunie, A., Krueger, K., Dreisbach, C., Akol, A., Rabenja, N.L., Olawo, A., Stanback, J. (2012). *International Perspectives on Sexual and Reproductive Health*; 38(4): 214–219.

<https://www.guttmacher.org/about/journals/ipsrh/2012/12/community-based-distribution-injectable-contraceptives-introduction>

Uganda's 2006 national survey showed that 18% of married women used modern contraceptives. Additionally, 41% had an unmet need for contraception; that is, they were sexually active, did not want to become pregnant and were not using a contraceptive method. Low use of contraceptives may be partially the result of limited access to health care facilities and services. DMPA (an injectable contraceptive) is the most popular method in Uganda, relied on by 10% of married women; however, it is reported as the preferred method by 40% of users and by 55% of women who are not using a method currently but intend to in the future. Against this backdrop, the Ministry of Health, Save the Children and FHI360 conducted a 2004–05 pilot study to assess the safety, quality and feasibility of adding DMPA

to the existing community-based distribution (CBD) family planning programme, focusing on the cadre of community health workers in Nakasongola District who are supported by NGOs. This research, conducted with 777 women, confirmed that well-trained community health workers (CHWs) who are experienced in condom and pill provision can safely provide injectable contraceptives. Further, the study showed that women were equally satisfied with quality of care, whether they received DMPA from a CHW or a facility-based clinician. The study results inspired the Ministry of Health to decide, in 2006, that CBD of injectables should continue in Nakasongola and that the practice should be expanded to other areas.

In 2006, working under a waiver of the prior national policy that had limited provision of injectables to clinicians, FHI360 continued its partnership with Save the Children to implement a community-based distribution programme in Nakaseke and Luwero, two districts that are adjacent to Nakasongola. In 2007, services were further expanded to two public-sector community-based programmes in Busia and Bugiri Districts. In the first 12 months of this expansion, 1,364 women accepted injectables from 44 trained community health workers; of these women, 30% were first-time users of the method. NGOs in Kanungu and Mubende districts also added CBD to their programming at that time, but data on client uptake were not obtained by FHI360. Throughout these phases, FHI360 worked with Ugandan partners to advocate for CBD of injectables. A national advisory committee was formed in 2006, and evidence-based promotional materials were developed and distributed to all districts nationwide in 2007. The project also identified and mobilised influential local “champions.” Typically, these were politicians who served as advocates, directing efforts to raise awareness and influence district-level decision making among local political and civil society leaders. The collective programmatic evidence derived from Uganda’s diverse field experiences influenced the Ministry of Health to issue a 2010 amendment to Uganda’s National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, thereby approving CHW provision of injectables. Countrywide scale-up of these distribution programmes continues as part of comprehensive community-based family planning programming, and the Ministry of Health is developing a national plan.

MSI Mobile Outreach Services: Retrospective Evaluations from Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam

Eva, G., & Ngo, T.D. (2010). Marie Stopes International.

https://mariestopes.org/sites/default/files/outreach_web.pdf

Over the last two decades, Marie Stopes International (MSI) has pioneered innovative approaches to reaching men and women with high quality contraceptive services. A promising model which reaches areas where traditional health services cannot reach is the use of mobile outreach health teams. The MSI outreach model generally consists of a team of nurses, healthcare assistants, counsellors and a driver visiting rural, hard-to-reach areas and providing a range of high quality contraceptive services. In 2009, MSI provided services to over 1,200,000 men and women through its outreach services. To ensure that MSI mobile outreach services are consistently providing high quality services for poor women living in rural settings, the authors conducted a retrospective cohort study to measure: the demographic characteristics of women attending outreach; their satisfaction levels; their level of knowledge of removal options; reasons for discontinuation; and the availability of follow-up services. This outreach evaluation took place in April 2010 across five MSI mobile outreach programmes (Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam) focusing on women who had IUDs and implants fitted between March 2008 and September 2009. The ultimate aim of this report is to provide information to programmes on the type of women served through outreach and whether or not they are providing a quality service, in particular with regards to the counselling provided and availability of follow-up mechanisms in case of complications or adverse side effects or for removal.

A total of 4,273 women were successfully re-contacted across the five countries (n=995 implants; n=3,278 IUDs). The demographic information of the women receiving services at outreach demonstrated that MSI mobile outreach programmes are reaching poor women and the underserved, who have the highest unmet need for family planning services. Most women were young and un-educated and had previously been using no method of contraception. A high percentage of women were satisfied with the whole experience and reported that they would reuse the services. At least 80% of all women in all five programmes would recommend the service to a friend (and in some cases nearing 100%). Discontinuation rates were generally low compared with estimates from other programmes (2.3-20.9% for IUDs, 5.7-6.2% for implants). Most women knew when and where the IUD/ implant should be removed, although this evaluation does highlight some countries in which programmatic improvements need to be made to increase the levels of knowledge. A high proportion of respondents reported experiencing side effects (an average of 32% across all countries), of whom between a quarter and a half sought medical assistance. The majority of these women had no problem finding medical assistance when needed (range: 73.2- 99.6%). However, there is a need for action in several countries to address the high proportion of women who found it difficult to find medical assistance (26.8% in Ethiopia and an average of 20.1% for IUDs and implants combined in Sierra Leone). The vast majority (>94%) of women who had had their IUD/implant removed had no problem accessing the removal service in Myanmar, Pakistan and Viet Nam. However, in Ethiopia and Sierra Leone a high proportion of women found it difficult and/or had to travel long distances for their removal. This evaluation demonstrates the generally high quality of outreach services and follow-up in five MSI programmes in Asia and Africa. Overall, the programmes are reaching the target women and providing them with the necessary information about when/where to go for removal or medical assistance.

4. Female-focussed approaches

Mobilizing demand for contraception in rural Gambia

Luck, M., Jarju, E., Nell, M.D., & George, M.O. (2000). *Studies in Family Planning*; 31(4): 325–335.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2000.00325.x/abstract>

A community trial was conducted in rural Gambia in order to determine whether a community-based intervention designed to mobilise latent demand for contraception would increase use of modern contraceptives, even in the absence of improved availability of family planning services. Data collection consisted principally of baseline and follow-up surveys administered to a random sample of women aged 15-49 residing in each of the three circuits included in the survey. 420 respondents were randomly selected each time. Analysis of trial data indicates that the demand-mobilisation intervention had a statistically significant positive effect on nonusers' adoption of modern contraception and that coterminous implementation of an intervention designed to improve access to services offered no additional benefit. The programme component found to have the greatest impact was the “kabilo approach,” in which village women provide basic health and family planning counselling to other women in their extended families. These results suggest that the principal barriers to increased contraceptive use in rural Gambia are psychosocial and that these barriers can be overcome through village-based interventions designed to provide socially appropriate counselling to potential contraceptive users.

Effectiveness of a theory-based postpartum sexual health education program on women's contraceptive use: a randomized controlled trial

Lee, J.T., Tsai, J.L., Tsou, T.S., Chen, M.C. (2011). *Contraception*; 84(1): 48–56.

<http://www.ncbi.nlm.nih.gov/pubmed/21664510>

The aim of this study was to evaluate the effectiveness of a refined theory-based Interactive Postpartum Sexual Health Education Program to enhance postpartum women's effective contraceptive behaviour. Participants (N=250) were randomised to three groups. Experimental Group A received the intervention programme via strategies that matched participants' learning preparedness, as determined by the transtheoretical model. Experimental Group B received only a pamphlet. The control group received routine education. Only Group A received health education. Data were collected at baseline, 3 days, 2 months and 3 months postpartum. Women who received the theory-based postpartum sexual health education programme had significantly greater contraceptive self-efficacy and were more likely to choose more effective contraceptive methods at 2 months postpartum than women in the routine teaching and interactive pamphlet-only groups. The authors concluded that their theory-based Interactive Postpartum Sexual Health Education Program enhanced postpartum women's contraceptive self-efficacy and effective contraceptive behaviour.

A maternal health voucher scheme: what have we learned from demand-side financing scheme in Bangladesh?

Ahmed, S., Khan, M.M. (2011). *Health Policy and Planning*; 26(1): 25–32.

<http://heapol.oxfordjournals.org/content/26/1/25.long>

Bangladesh has achieved impressive progress in reducing fertility and child mortality over the last few decades (MOHFW, 2001). Despite the improvements in child health and family planning outcomes, the maternal mortality ratio has remained relatively static at an unacceptably high level. Evidence suggests that poor individuals often do not use free public health services (UNDP, 2004). Failure of the supply-side financing strategy to reach the poor has prompted the Government of Bangladesh to initiate a pilot programme called the 'Demand-side Financing Maternal Health Voucher Scheme' (MHVS). The main purpose of the pilot programme is to reduce demand-side barriers faced by poor women so that they will be able to access quality maternal health services. Demand-side financing (DSF) is a mechanism to increase the purchasing power of voucher-recipients to obtain specified health services or goods through the market system (Pearson, 2001). This is considered an effective mechanism of targeting essential health services to specific population groups such as pregnant women, children or the poorest.

In a DSF mechanism, intended beneficiaries receive resources directly from the implementing agency. These additional resources empower the beneficiaries to obtain access to quality health care services based on their needs. Since the demand-side voucher system transfers funds to the health facilities through consumers, it is hoped that the health facilities will become more responsive to the needs of the clients. The ultimate goal of the project is to decrease maternal morbidity and mortality, particularly among poor socio-economic groups. In order to obtain information on the scheme and its implementation at the sub-district level, 13 semi-structured interviews were conducted with the stakeholders. Stakeholders interviewed were selected based on the roles they played in the programme as well as their degree of involvement with the implementation of the MHVS. In the study area, increased utilisation of maternal health services was observed only after the scheme allowed public providers to receive incentive payments for the provision of services to enrolled women.

Insights from Innovations: Lessons from Designing and Implementing Family Planning/ Reproductive Health Voucher Programs in Kenya and Uganda

Arur, A., Gitonga, N., O'Hanlon, B., Kundu, F., Senkaali, M., & Ssemujju, R. (2009) Abt Associates Inc.

http://pdf.usaid.gov/pdf_docs/Pnadb185.pdf

Health policy in developing countries has traditionally focused on public provision of free or highly subsidised services to lower the cost of seeking care and to ensure universal access to critical services such as family planning (FP) and reproductive health (RH). However, many people in developing countries, even the poor in Sub-Saharan Africa, choose to seek health care in the private sector and pay out-of-pocket to do so. Concerns about equity have sparked interest in approaches like vouchers that can lower the financial burden on individuals by targeting subsidies directly to clients of FP/ RH products and services. A health voucher is a token that can be exchanged for a pre-defined set of health services or products. Health vouchers enable public subsidies for services or products to follow the client, rather than being tied to providers. Clients buy vouchers for a specified set of services or products at a predefined price, or obtain vouchers free of charge.

The Kenya RH-OBA voucher pilot was established in 2005 and covers three rural districts and two Nairobi slums. Individuals who fall below a poverty threshold are eligible to buy a FP voucher for long-acting and permanent methods for the equivalent of about US\$1.25 and a Safe Motherhood (SM) voucher for antenatal care (ANC), institutional delivery and postnatal care (PNC) services for about \$2.50. The RH-OBA pilot is financed by the German Development Bank (KfW) and the Government of Kenya. Price Waterhouse Coopers is the Voucher Management Agency (VMA). RH-OBA vouchers can be redeemed at 54 public, private for-profit and private non-profit providers. In Kenya, uptake of RH-OBA SM vouchers has been high. Between June 2006 and October 2008, 78,651 SM vouchers were sold and 60,581 women used SM vouchers to deliver in a participating facility. In contrast, use of FP vouchers was considerably lower than expected. In the same period, only 25,620 FP vouchers were sold, and 11,296 (41 %) of these were used.

In Uganda, by contrast, the RHVP was established in late 2008 in a partnership between the Government of Uganda, KfW, and the Global Partnership on Output Based Aid. RHVP has plans to scale up a "Healthy Life" voucher for treatment of sexually transmitted infections (STIs) to six districts and has introduced a "Healthy Baby" SM voucher for ANC, delivery and PNC in 12 districts with the intention of implementing it in 22 districts of Southern and Western Uganda. The SM vouchers are sold to women for the equivalent of \$1.50. Marie Stopes International Uganda, an NGO with social marketing, FP and health services expertise, is the VMA. RHVP vouchers can only be redeemed at private for-profit and non-profit providers. Between February 2009 and June 2009, 4,034 RHVP SM vouchers were sold and close to 2,451 (61%) used for ANC, institutional deliveries, or PNC services. Uptake in the first few months of RHVP may have been low as voucher systems take a long time to set up, particularly on the large scale of the RHVP. It is also important to note the gap (61%) between the number of vouchers sold and used is now closing.

Meeting Challenges, Seeding Change: Integrating Gender and Sexuality into Maternal and Newborn Health Programming through the Inner Spaces, Outer Faces Initiative

Bartel, D., Simon, C., & Barnes, B. (2010) CARE International and International Center for Research on Women.

http://www.care.org/sites/default/files/documents/MH-2010-IND-Meeting-Challenges-Seeding-Change_Final_Web.pdf

Many believe that gender plays a large role in influencing health outcomes. Women's autonomy, mobility and control over resources have long been shown to be important predictors of maternal health outcomes. Studies have also shown that men's gender attitudes and behaviours can significantly influence reproductive health outcomes. In addition, community perceptions and norms related to gender can play a role in reproductive health outcomes, as some recent studies have shown. As a result, researchers and policy advocates have increasingly called for greater attention to gender discrimination issues as underlying social determinants of health. Many are now calling for gender "transformative"

approaches to health interventions, which aim to transform gender attitudes, behaviours, norms and systems along with health interventions.

The Inner Spaces, Outer Faces Initiative (ISOFI) was designed to address gender and sexuality factors not as a standalone model but rather as a collection of integrated and embedded components within an existing MNH project. The goal was an intervention package that addressed both health and gender factors at household, community and facility levels, allowing for multiple points of entry and reinforcement along the MNH continuum of care. All MNH behaviour-change interventions in the project were used as opportunities for exploring values and challenging assumptions related to gender and sexuality norms. For example, iterative and open-ended exercises for discussion on gender and sexuality values and beliefs were integrated with meetings of Village Health and Sanitation Committees (VHSCs) and Mothers' Committees as well as with district and sub-district health meetings. The project also worked closely with the Government of India's district health staff to build the capacity of community based health providers – accredited social health activists (ASHAs), auxiliary nurse midwives (ANMs) and Anganwadi workers (AWWs). The project also aimed to help reduce women's isolation and lack of mobility in pregnancy and postpartum by creating "New Parents' Meets" and "Couples' Meets." These events brought couples together in public settings, providing safe and interactive spaces for them to learn about health practices as well as to discuss individual attitudes and community perceptions about gender norms that play a role in MNH outcomes. These events were supplemented by community media events (e.g. puppet shows, magic shows, theatre productions and movies) that focused on gender-related discrimination in India.

The qualitative data were collected through in-depth interviews with men and women of reproductive age at baseline, midterm and endline. Data were also collected through in-depth key informant interviews with health care providers, NGO staff implementation partners, and both Mothers' Committee and VHSC members in the intervention district at endline. For the quantitative analysis, ICRW and CARE implemented a survey among women of reproductive age at both baseline and endline. This research focused on measuring changes in health behaviours and outcomes as well as key gender and sexuality attitudes and practices. Health- and gender-related indicators examined in the analysis included: skilled attendant at birth; preparation for childbirth; health-treatment-seeking behaviours; immediate and exclusive breastfeeding; family planning use; neonatal death; mobility; autonomy of decisions; gendered division of household labour; spousal communication about sex and family planning; and tolerance of domestic violence. Health indicators improved over time in both the control and intervention communities. Skilled attendance at birth, preparation for childbirth, immediate breastfeeding and family-planning use improved in both districts. Neonatal death declined. In some cases, the rate of change in the intervention community was greater than in the control community, but not in all cases. There were also improvements in the sexuality and gender indicators among women of reproductive age, including improved mobility, autonomy of decisions, gendered division of household labour, and spousal communication about sex and family planning. In many instances, the rate of improvement was greater in the intervention community than in the control community. Among factors related to gender, the greatest rates of change were related to women's reports of mobility, their attitudes about justification for refusing sex with their husband, and their ability to express their sexual needs to their husband.

Evaluation of Berhane Hewan: A program to delay child marriage in rural Ethiopia

Erulkar, A., & Muthengi, E. (2009). *International Perspectives on Sexual and Reproductive Health*; 35(1): 6–14.

<https://www.guttmacher.org/about/journals/ipsrh/2009/03/evaluation-berhane-hewan-program-delay-child-marriage-rural-ethiopia>

This is an evaluation of Berhane Hewan, a two-year pilot project conducted in 2004–2006 that aimed to reduce the prevalence of child marriage in rural Ethiopia, through a combination of group formation, support for girls to remain in school and community awareness. Early marriage limits girls' opportunities and compromises their health, yet in Sub-Saharan Africa many girls are married before the age of 18, and few programmes have sought to increase the age at marriage on the continent.

A quasi-experimental research design with baseline and endline surveys was used to measure changes in social and educational participation, marriage age, reproductive health knowledge and contraceptive use. Chi-square tests, proportional hazards models and logistic regressions were conducted to assess changes associated with the project.

The intervention was associated with considerable improvements in girls' school enrolment, age at marriage, reproductive health knowledge and contraceptive use. Particularly among girls aged 10–14, those exposed to the program were more likely than those in the control area to be in school at the endline survey (odds ratio, 3.0) and were less likely to have ever been married (0.1). However, among girls aged 15–19, those in the intervention area had an elevated likelihood of having gotten married by the endline (2.4). Sexually experienced girls exposed to the intervention had elevated odds at endline of having ever used contraceptives (2.9). The success of the Berhane Hewan programme, one of the first rigorously evaluated interventions to delay marriage in Sub-Saharan Africa, suggests that well-designed and effectively implemented programmes can delay the earliest marriages until later adolescence.

5. Male-focussed approaches

Promoting More Gender-equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy

Pulerwitz, J., Barker, G., Segundo, M. & Nascimento, M. (2006). Population Council.

http://pdf.usaid.gov/pdf_docs/Pnadf883.pdf

There is growing evidence that HIV/STI and violence risk for both young men and young women is linked to early socialisation that promotes certain gender roles as the norm. These norms include support for men to have multiple partners, or to maintain control over the behaviour of their female partners. Thus, addressing gender norms—the societal messages that dictate what is appropriate or expected behaviour for males and females—is increasingly recognised as an important strategy to prevent the spread of HIV infection. Set in Rio de Janeiro, Brazil, this quasi-experimental study compared the impact of different combinations of program activities. Three groups of young men aged 14 to 25 years, with a mean age of 17 (at baseline, n = 780), were followed over time. The sample included both in-school and out-of-school youth. The study population was based in three different but fairly homogeneous low-income communities, or favelas. The study findings indicate that addressing inequitable gender norms, particularly those that define masculinity, can be an important element of HIV prevention strategies. These findings suggest that group education interventions can successfully influence young men's attitudes toward gender roles and lead to healthier relationships. The findings also provide empirical evidence that a behaviour change intervention focused on combating inequitable gender norms is associated with improvements in HIV/STI risk outcomes.

Impact of a male motivation campaign on family planning ideation and practice in Guinea

Blake, M., & Babalola, S. (2002) Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Population Communication Services. *BMJ*; 316(7134): 805–811.

http://pdf.usaid.gov/pdf_docs/Pnacs563.pdf

The PRISM project had a strong Behaviour Change Communication (BCC) component that focused on increasing both knowledge about quality health care services and the use of them, and adopting positive health practices. The Male Motivation Campaign, the major BCC intervention of the PRISM project, focused on achieving the intermediate goals of increased access to health care services and increased demand for them, improved quality of care, and improved coordination and linkages among health care providers and services. The intended audience for Phase I was religious leaders. Within the context of the patrilineal and male-dominated society in Guinea, it was reasoned that empowering religious leaders would help ensure social support for family planning. Thus, the first phase of the campaign used advocacy interventions. The main audience for Phase II of the campaign was married men. Focusing on married men, multimedia interventions sought to promote spousal communication about family planning to increase the use of available services. In addition to the two primary audiences, the campaign also focused on women of reproductive age and service providers. The Male Motivation Campaign took place from October 1999 to May 2000 in 15 prefectures of 3 administrative regions of Guinea. With limited social support for modern contraception and little spousal communication about family planning, the campaign primarily focused on religious leaders and married men of reproductive age to increase their overt involvement in the promotion of family planning. Intensive advocacy work with religious leaders during the first phase of the campaign attempted to gain social support for family planning. The second phase focused on married men to motivate them to talk to their wives about family planning and encourage their wives to use available services.

The evaluation design consisted of two components: a panel study among religious leaders and a population-based study among men and women of reproductive age. The panel design included baseline interviews at the start of the advocacy activities of half of the religious leaders who attended seven randomly selected conferences. When the project ended 4 months later, the baseline respondents were re-interviewed. In all, 98 religious leaders were interviewed at the two points in time. The evaluation design for assessing the impact of the campaign among the general population involved identifying and re-interviewing men and women who were interviewed in the 1999 Guinea Demographic and Health Survey (GDHS) within 110 enumeration areas. The evaluation survey, conducted between August and September 2000, 14 months after the GDHS, consisted of 55 randomly selected enumeration areas. Analysis of campaign impact comprised both baseline and follow-up interviews of 1,045 respondents. In this report, eight variables measure ideation: awareness about modern family planning methods, approval of family planning, spousal communication about family planning, perceived spousal approval of family planning, perceived social support for family planning, discussion of family planning with friends and relations, social influence for using family planning, and personal advocacy of family planning. Overall, the programme was successful in achieving its goals.

6. Broader Interventions

The reach and impact of social marketing and reproductive health communication campaigns in Zambia

Van Rossem, R., & Meekers, D. (2007). BMC Public Health; 7(352).

<http://www.ncbi.nlm.nih.gov/pubmed/18088437>

Like many sub-Saharan African countries, Zambia is dealing with major health issues, including HIV/AIDS, family planning, and reproductive health. To address reproductive health problems and the HIV/AIDS epidemic in Zambia, several social marketing and health communication programmes focusing on reproductive and HIV/AIDS prevention programs are being implemented. This paper describes the reach of these programmes and assesses their impact on condom use. This paper assesses the reach of selected radio and television programmes about family planning and HIV/AIDS and of communications about the socially

marketed Maximum condoms in Zambia, as well as their impact on condom use, using data from the 2001-2002 Zambia Demographic and Health Survey. To control for self-selection and endogeneity, the authors used a two-stage regression model to estimate the effect of program exposure on the behavioural outcomes. The study found that those who were exposed to radio and television programs about family planning and HIV/AIDS were more likely to have ever used a condom (OR = 1.16 for men and 1.06 for women). Men highly exposed to Maximum condoms social marketing communication were more likely than those with low exposure to the program to have ever used a condom (OR = 1.48), and to have used a condom at their last sexual intercourse (OR = 1.23). Findings suggest that the reproductive health and social marketing campaigns in Zambia reached a large portion of the population and had a significant impact on condom use. The results suggest that future reproductive health communication campaigns that invest in radio programming may be more effective than those investing in television programming, and that future campaigns should seek to increase their impact among women, perhaps by focusing on the specific constraints that prevent females from using condoms.

Promoting sexual responsibility among young people in Zimbabwe

Kim, Y.M., Kols, A., Nyakauru, R., Marangwanda, C., Chibatamoto, P. (2001). *International Family Planning Perspectives*; 27(1): 11–19.

<https://www.guttmacher.org/about/journals/ipsrh/2001/03/promoting-sexual-responsibility-among-young-people-zimbabwe>

A 1997-1998 multimedia campaign promoted sexual responsibility among young people in Zimbabwe, while strengthening their access to reproductive health services by training providers. Baseline and follow-up surveys, each involving approximately 1,400 women and men aged 10-24, were conducted in five campaign and two comparison sites. Logistic regression analyses were conducted to assess exposure to the campaign and its impact on young people's reproductive health knowledge and discussion, safer sexual behaviours and use of services. The campaign reached 97% of the youth audience. Awareness of contraceptive methods increased in campaign areas, but general reproductive health knowledge changed little. As a result of the campaign, 80% of respondents had discussions about reproductive health—with friends (72%), siblings (49%), parents (44%), teachers (34%) or partners (28%). In response to the campaign, young people in campaign areas were 2.5 times as likely as those in comparison sites to report saying no to sex, 4.7 times as likely to visit a health centre and 14.0 times as likely to visit a youth centre. Contraceptive use at last sex rose significantly in campaign areas (from 56% to 67%). Launch events, leaflets and dramas were the most influential campaign components. The more components respondents were exposed to, the more likely they were to take action in response. A multimedia approach increases the reach and impact of reproductive health interventions directed to young people. Building community support for behaviour change also is essential, to ensure that young people find approval for their actions and have access to services.

Improving Health Improving Lives: AYA End of Year Programme Report

African Youth Alliance (AYA) (2007) United Nations Population Fund.

<http://www.bioline.org.br/pdf?rh07032>

The African Youth Alliance (AYA) was a partnership of UNFPA, PATH, and Pathfinder International (PI) with the goal to improve adolescent sexual and reproductive health (ASRH), including the prevention of HIV/AIDS, among young people aged 10-24. The AYA programme was implemented in four countries — Botswana, Ghana, Tanzania and Uganda — in partnership with their governments, NGOs, community -based organisations (CBOs), and key stakeholders including: youth, parents, religious leaders, the media and policy makers. To accomplish AYA's goal, six programme components were developed using evidence based strategies: Policy and Advocacy (P&A); Behaviour Change Communication

(BCC); Youth Friendly Services (YFS); Integration of ASRH into Livelihood Programmes; Institutional Capacity Building (ICB); and Coordination and Dissemination (C&D). AYA also integrated partnerships, youth participation, gender equity, sustainability, scaling up, and community involvement in each component. At the country level, programme components and crosscutting objectives were adapted to meet the specific needs and context. AYA developed a results framework that guided programme planning, implementation, monitoring and evaluation. Using various country-specific approaches, youth were involved and played a significant role in all stages of the AYA programme.

The evaluation was post-test only, and combined case-control and self-reported exposure design. Data was collected from early March until the beginning of June 2006 by local research organisations, using a one-stage (Tanzania) or two-stage (Ghana, Uganda) cluster sampling (cases and controls (purposive), random selection of segments, and random selection (or census) of households within segments). Household, individual and community questionnaires were applied. Case-control design data were analysed using Propensity Score Matching (PSM), and the Self-Reported Exposure design data were analysed using PSM and Instrumental Variable (two-stage regression) (IV). Results of the impact evaluation indicate evidence of significant, positive AYA treatment effects on sexual knowledge, attitudes, and behaviours. Across all three AYA countries evaluated, there were more treatment effects for females; and, among sexually active females, there were significant positive effects on: condom use at first sex, always use condom with current partner, and modern contraceptive use at first and last sex. AYA was funded for five years (2000-2005) with \$56.7 million from the Bill and Melinda Gates Foundation. Over 35,000,000 stakeholders were reached through media campaigns, almost 400,000 young people received Life Planning Skills training, and over 2,500,000 visits were made by young people to static clinics and outreach services.

A Rights-Based Sexuality Education Curriculum for Adolescents: 1-Year Outcomes From a Cluster-Randomized Trial

Rohrbach, L., Berglas, N. Jerman, P., Angulo-Olaiz, F. Chou, C.P., Constantine, N. (2015) *Journal of Adolescent Health*; 57(4):399-406.

<http://www.sciencedirect.com/science/article/pii/S1054139X15002839>

The purpose of this study was to evaluate the impact of a rights-based sexuality education curriculum on US adolescents' sexual health behaviours and psychosocial outcomes 1 year after participation. Within 10 urban high schools, ninth-grade classrooms were randomised to receive a rights-based curriculum or a basic sex education (control) curriculum. The intervention was delivered across two school years (2011–2012, 2012–2013). Surveys were completed by 1,447 students at pre-test and 1-year follow-up. Multilevel analyses examined curriculum effects on behavioural and psychosocial outcomes, including four primary outcomes: pregnancy risk, sexually transmitted infection risk, multiple sexual partners, and use of sexual health services. Students receiving the rights-based curriculum had higher scores than control curriculum students on six of nine psychosocial outcomes, including sexual health knowledge, attitudes about relationship rights, partner communication, protection self-efficacy, access to health information, and awareness of sexual health services. These students also were more likely to report use of sexual health services (odds ratio, 1.37; 95% confidence interval, 1.05–1.78) and more likely to be carrying a condom (odds ratio, 1.97; 95% confidence interval, 1.39–2.80) relative to those receiving the control curriculum. No effects were found for other sexual health behaviours, possibly because of low prevalence of sexual activity in the sample. The curriculum had significant, positive effects on psychosocial and some behavioural outcomes 1 year later, but it might not be sufficient to change future sexual behaviours among younger adolescents, most of whom are not yet sexually active. Booster education sessions might be required throughout adolescence as youth initiate sexual relationships.

7. Other useful resources

Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical Guidance

OHCHR (2012).

www.ohchr.org/Documents/Issues/Women/WRGS/Health/TGReduceMaternalMortality.pdf

This report provides technical guidance on implementing a human rights-based approach to reduce preventable maternal morbidity and mortality. Monitoring in a human rights framework requires the use of indicators, not all of which are quantitative or relate to the health sector. A rights-based approach requires systematically tracking and evaluating: (a) Changes in structural factors over time; this includes, but is not limited to, examining whether adopted laws explicitly recognise sexual and reproductive health rights; adopting a national plan; and modifying laws that discriminate against women, as well as institutions, such as creating a national human rights institution; (b) Policy and budgetary efforts within and beyond the health sector. Policy efforts include, for example, costing, resourcing and implementation measures with regard to the national plan. Resources and expenditures relating to sexual and reproductive health should also be tracked, as should the capacity to relate spending to human rights goals and commitments, such as the elimination of financial barriers to care; (c) Concrete results in terms of women's sexual and reproductive health, and maternal mortality and morbidity in particular; this includes outputs, outcomes and impact in health system categories, ranging from availability, accessibility, acceptability and quality (both through objective indicators, such as case fatality rates, and subjective measures of women's satisfaction) of health facilities, goods and services to ultimate effects, such as fertility and adolescent birth rates and maternal mortality ratios.

Effective monitoring requires functioning health information systems, civil registration systems and disaggregated data. The disaggregation of information on the basis of sex, age, urban/rural residence and ethnicity, as well as of education, wealth quintile and geographic region insofar as possible, is essential for ensuring non-discrimination and equity, and affording due protection to vulnerable and marginalised groups. Quantitative indicators should facilitate the drawing of conclusions with regard to compliance with international obligations relating to sexual and reproductive health rights. In addition to disaggregation, as stated above, quantitative indicators should be (a) continuously or frequently measurable in order that the actions taken by an administration may be measured in a timely manner; (b) objective, to permit comparison across time and countries and/or sub-regions; (c) programmatically relevant, to enable priority setting and identification of accountability gaps; and, ideally, (d) subject to local audit to promote accountability to populations served.

A Rights-Based Approach to Sexuality Education: Conceptualization, Clarification and Challenges

Berglas, N.F., Constantine, N.A. and Ozer, E.J. (2014) Perspectives on Sexual and Reproductive Health; 46:63–72.

<http://onlinelibrary.wiley.com/doi/10.1363/46e1114/abstract>

This study explores the definition of a rights-based approach to sexuality education. Although a rights-based approach to this topic has been increasingly discussed in the past decade, documented consensus regarding the goals, concepts and underlying assumptions of this approach is lacking. Differences in the assumed meaning of a rights-based approach can limit discussions of its implementation and evaluation, and impede opportunities to explore and critique a new model for sexuality education. In-depth interviews were conducted in 2012 with 21 U.S. and international sexuality education experts. Data were thematically coded and analysed using an iterative approach. Responses were compared according to respondents' professional discipline and geographic focus. The study concluded that a rights-based

approach can be defined as the intersection of four elements: an underlying principle that youth have sexual rights; an expansion of programmatic goals beyond reducing unintended pregnancy and STDs; a broadening of curricula content to include such issues as gender norms, sexual orientation, sexual expression and pleasure, violence, and individual rights and responsibilities in relationships; and a participatory teaching strategy that engages youth in critical thinking about their sexuality and sexual choices. These elements were consistently identified by respondents across professional disciplines and geographic foci. In addition, all respondents raised questions about the feasibility of implementing a rights-based approach, particularly in the United States.

Women's sexual empowerment and contraceptive use in Ghana

Crissman, H.P., Adanu, R.M., & Harlow, S.D. (2012). *Studies in Family Planning*; 43(3): 201–212.

<http://www.ncbi.nlm.nih.gov/pubmed/23185863>

Pervasive gendered inequities and norms regarding the subordination of women give Ghanaian men disproportionately more power than women, particularly in relation to sex. The authors hypothesised that lack of sexual empowerment may pose an important barrier to reproductive health and adoption of family planning methods. Using the 2008 Ghana Demographic Health Survey, the authors examine the association between women's sexual empowerment and contraceptive use in Ghana among non-pregnant married and partnered women not desiring to conceive in the next three months. Increasing levels of sexual empowerment are found to be associated with use of contraceptives, even after adjusting for demographic predictors of contraceptive use. This association is moderated by wealth. Formal education, increasing wealth, and being in an unmarried partnership are associated with contraceptive use, whereas women who identify as being Muslim are less likely to use contraceptives than those who identify as being Christian. These findings suggest that to achieve universal access to reproductive health services, gendered disparities in sexual empowerment, particularly among economically disadvantaged women, need to be better addressed.

Rights-based Monitoring and Evaluation: A Discussion Paper

Thesis, J. (2003) Save the Children.

<http://www.mande.co.uk/docs/Rights-basedMonitoringAndEvaluation.pdf>

Thesis describes how a rights-based approach promotes three main principles: the accountability of duty bearers, the participation of right holders, and equity / non-discrimination. It aims to increase impact and strengthen sustainability by addressing root causes, bringing about policy and practice changes, working together with others towards common goals and by changing power relations.

To give an example, a rights-based approach to health uses a combination of support and pressure to urge government departments to make basic health care accessible and affordable for all people in the country. It supports people and organisations to demand better health services from the government and from other duty bearers, to allocate the health budget in a way that benefits the poor rather than the rich, to make health services more patient-friendly, to make health insurance affordable for all people, to provide access to safe drinking water, or to control polluting industries. Far from creating dependency, such an approach empowers people to take action to claim what is their due, rather than passively accepting whatever the government is willing to give them. Thesis also provides several examples of rights-based monitoring, including a particularly relevant example relating to HIV/AIDS (see below).

Example rights-based monitoring of HIV/AIDS (selection of possible indicators)

Goals:

- All children have the necessary knowledge, skills, resources and power to protect themselves from HIV infection.
- All children affected by HIV/AIDS are protected from discrimination and have access to all necessary services.

	Goal 1: prevention	Goal 2: protection and non-discrimination
General	Show trends over time Disaggregate data by age and gender, different parts of the country, different groups of people (ethnic groups, rich/poor, urban/rural, etc.)	
Changes in children's lives	HIV infection rates AIDS rates AIDS deaths	
Changes in policies and practices	Budget allocations for HIV/AIDS prevention programmes Changes in attitudes towards, HIV/AIDS, children and sexuality (parents, teachers, religious leaders, policy makers) Media provide information about sexuality and HIV/AIDS to children Condoms are widely, freely and cheaply available	Budget allocations for HIV/AIDS protection, care and non-discrimination programmes No discriminatory policies Sanctions against discriminatory practices Changes in attitudes towards people affected by HIV/AIDS
Changes in equity and non-discrimination	Girls and women have the power to negotiate sex (able to say no) – gender issues	People affected by HIV/AIDS have equal access to basic services Laws and policies are not discriminatory Sanctions against discrimination of people affected by AIDS (jobs, services, media reporting, etc.)
Changes in people demanding their rights	Parents, teachers and journalists demand access to information about sexuality and HIV/AIDS prevention for children AIDS activist organisations demand free access to condoms	AIDS activists, including people affected by HIV/AIDS: speak at all relevant events demand non-discrimination and access to services are involved in designing HIV/AIDS policies and programmes
Changes in children's participation	Children have access to information about sexuality and protection from HIV/AIDS (media, schools, family) Children are actively involved in relevant events Peer education about sexuality and protection from HIV/AIDS Children are involved in policy making and standard setting regarding children's access to information	Children are actively involved in relevant events Children are involved in designing non-discriminatory HIV/AIDS policies and programmes

8. Additional information

Author

This query response was prepared by **Tessa Hewitt**

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