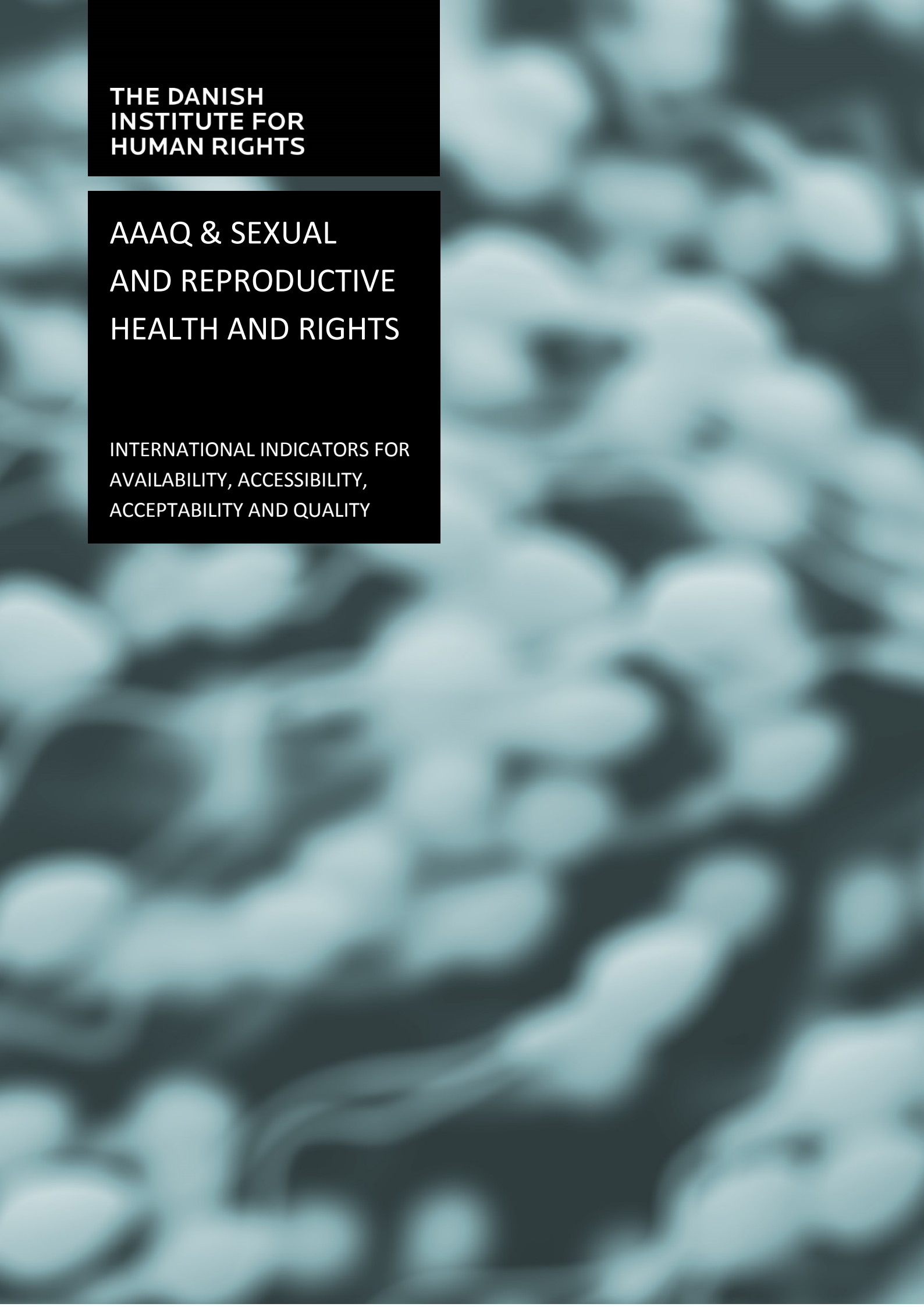

THE DANISH INSTITUTE FOR HUMAN RIGHTS

AAAQ & SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

INTERNATIONAL INDICATORS FOR AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY

AAAQ & SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
International Indicators for Availability, Accessibility, Acceptability and Quality

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CONTENTS

ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability, Quality
ART	Antiretroviral treatment
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CRC	Convention on Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
DIHR	Danish Institute for Human Rights
HRBA	Human rights-based approach
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICCPED	International Convention for the Protection of All Persons from Enforced Disappearance
ICCPR	International Covenant on Civil and Political Rights
ICMRW	International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD PoA	International Conference on Population and Development, Program of Action
NHRI	National Human Rights Institution
OHCHR	Office of the High Commissioner for Human Rights
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually Transmitted Infections
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Populations Foundations
WHO	World Health Organization

EXECUTIVE SUMMARY

Millions die every year of preventable maternal, neo-natal conditions and sexually transmitted infections. Women and girls find themselves in miserable situations, caused by sexual abuse, unwanted pregnancies and unsafe abortions.

Sexual and reproductive health and rights (SRHR) constitute a global commitment to fight against these wrongs – not as a charity, but because every human being is entitled to a life in freedom and dignity. Sexual and reproductive health and rights is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and a wide range of other international human rights instruments. Moreover, SRHR are firmly acknowledged in the 2030 Agenda for the Sustainable Development Goals (SDGs). In particular, protection and promotion of SRHR stands out as a core pledge under SDG 3 on health, and SDG 5 on gender equality.

But SRHR is a vast, complex and sensitive issue area and the principles conceived at UN level are often a far cry from the realities on the ground. There is a need to build operational links between principles and realities and this paper aims to contribute to that. Specifically, the paper wishes to illustrate an approach by which elements of SRHR can be made more tangible by means of the human rights criteria of AAAQ. The AAAQ approach supports assessment of standards and adequacy levels in terms of Availability, Accessibility, Acceptability and Quality and these criteria are derived directly from ICESCR and other human rights instruments and authoritative interpretations. Thus, the AAAQ approach builds operational links between principles and realities, as it conveys the principles in tangible terms that offer useful, practical guidance.

To scope the area of specific analysis the paper outlines key definitions in the field of SRHR and maps the overall area of SRHR and on that basis proposes sexual and reproductive health (SRH) services as a specific focus of a detailed AAAQ mapping and analysis. As an overall point of reference for detailed analysis of a number of specific categories of SRH services, the paper posits the following generic AAAQ principles:

Availability:	SRH services must be available in sufficient quantity and continuous supply.
Accessibility:	SRH services must be accessible to everyone, in terms of physical access, affordability, access to information and non-discrimination.
Acceptability:	SRH services must be acceptable to consumers, culturally appropriate and be sensitive to vulnerable groups.
Quality:	SRH services must comply with applicable quality standards.

To set the background of the analysis, the paper starts out with an introduction to SRHR and the human rights system. Moreover, it describes the principles of a Human Rights Based Approach (HRBA), which are observed in development cooperation across the UN system and by many donors and which is key to the realization of SRHR.

The following chapter presents the AAAQ approach and methodology. The chapter also maps out five SRH service areas: Voluntary family planning, Education and information, Safe abortion, Ante- and post-natal care and safe delivery and Prevention and treatment of sexually transmitted infections. The mapping is supported by guidance on how to extract and organize information from human rights sources to conceptualize and operationalize SRH services. General reflections on human rights principles and concepts relevant to SRHR are presented in the following chapter. In particular, this chapter offers an illustrative AAAQ analysis of SRH services.

The paper concludes with a comprehensive table, which is setting out illustrative AAAQ indicators for each of the SRH service areas. It is the aim of the table to demonstrate how SRH services can be articulated by means of the AAAQ approach in clear, measurable terms.

The paper does by no means provide a conclusive analysis of the complex issue area of SRHR. The AAAQ analysis of SRH services should be positioned within the broader SRHR perspectives reflected in international human rights instruments and development commitments. But while acknowledging all the limitations, the paper pursues the modest, yet ambitious, aim of illustrating how the AAAQ approach may contribute to building operational links between principles and realities. As such, it is intended as inspiration for actors in the field of SRHR, who wish to apply the AAAQ approach to protect and promote these human rights.

INTRODUCTION

Fulfilment of sexual and reproductive health and rights (SRHR) is crucial for the development of societies and for women and girls to live a life in dignity. The UN human rights system has repeatedly confirmed that sexual and reproductive health is a human right, established in the core human rights conventions and further elaborated in soft law. The Beijing Declaration and the Programme of Action of the International Conference on Population and Development (ICPD PoA)[1] outlines that SRHR is a crucial part of the right to the highest attainable standard of physical and mental health[2]. In a broader development perspective, SRHR is also among the key objectives of the Sustainable Development Goals (SDGs)[3] and direct references to human rights treaties on SRHR are found in the targets themselves[4].

However, adequate implementation of state commitments to realise SRHR remains a challenge, especially in developing countries. Every year, an estimated 287,000 women die from being pregnant or giving birth and 99% of these women live in developing countries. On a global scale, 225 million women experience an unmet need for contraceptives, and in sub-Saharan Africa and South Asia, fewer than half of the pregnant women receive adequate antenatal care. In addition to the current high maternal mortality rate in developing countries, the unmet need for sexual and reproductive health (SRH) services also has less fatal yet still crucial impacts on women and societies. High prevalence of sexually transmitted disease such as HIV, and high rates of unsafe abortions and girls forced to drop out of school due to an unwanted pregnancy are the detrimental realities of many developing countries[5].

Realising SRHR is a complex and comprehensive task, which requires efforts in both the health sector and wider society. A number of problems arise in the practical work with SRHR. Firstly, the scope of the rights are very broad and encompasses elements of a wide range of civil, political, economic, social and cultural rights ranging from the ability to have a satisfying and safe sex life to the right of couples to decide freely on the number and spacing of their children[6].

Secondly, there is no clear consensus among international stakeholders with regards to the precise interpretation of the contents of SRHR. For instance, sexual rights continue to be a controversial topic and a former Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on health) notes that, “while there is an intimate relationship between sexual health and reproductive health (…) sexual and reproductive health are also different and distinct dimensions of human health”[7]. However, it is difficult to pinpoint exactly what is in the intersection and what belongs separately to each dimension. Thirdly, given the diversity of country contexts and situations, general human rights instruments cannot be prescriptive as to how specifically the rights have to be achieved, and need to grant states certain flexibility in choosing the most appropriate means for realisation of SRHR. For example, the International Covenant on Economic, Social and Cultural Rights (ICESCR) stipulates that states must take steps to ensure “the creation of conditions which would assure to all medical service and medical attention in the event of sickness”[8]. However, the level and scope of these services e.g. in relation to reproductive health, is not specified in the Covenant, but rather developed in other forums, such as the International Conference on Population and Development (ICPD), held in Cairo in 1994.

Sexual rights – reading of interest

WHO 2015: Sexual health, human rights and the law

WHO 2014: Sexual and reproductive health and rights: a global development, health, and human rights priority

WHO 2010: Using human rights for sexual and reproductive health: improving legal and regulatory frameworks

UNFPA 2014: Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions

UNFPA 2014: UNFPA Operational Guidance for Comprehensive Sexuality Education

UNFPA 2014: From Commitment to Action on Sexual and Reproductive Health and Rights

CESCR 2000: General Comment no. 14 on the right to health

CESCR 2016: General Comment no. 22 on sexual and reproductive health and rights

Special Rapporteur on the right to health 2011: Report to the General Assembly A/66/254 (main focus: criminalization of sexual and reproductive health)

Special Rapporteur on the right to health 2010: Report to the Human Rights Council A/HRC/14/20 (main focus: right to health and criminalization of same-sex conduct and sexual orientation, sex work and HIV transmission)

Special Rapporteur on the right to health 2004: Report to the Commission on Human Rights E/CN.4/2004/49 (main focus: the right to sexual and reproductive health)

Websites:
www.sexualrightsinitiative.com (the Sexual Rights Initiative also runs a UPR database: http://sexualrightsinitiative.com/universal-periodic-review)
www.who.int/reproductivehealth/topics/sexual_health

The human rights system seeks to address these challenges through continuous efforts to elaborate on the content and interpretation of SRHR. In particular, the Committee on Economic, Social and Cultural Rights (CESCR), the Special Rapporteur on health and the Office of the High Commissioner for Human Rights (OHCHR) have been instrumental in promoting consensus on the different human rights perspectives on sexual and reproductive health. Within the development field, UN agencies such as the World Health Organization (WHO) and the United Nations Population Fund (UNFPA) have elaborated on the different elements of SRHR and developed implementation frameworks and guidance for stakeholders [9]. Additionally, the SDG framework, in particular goal 3 (Ensure healthy lives and promote well-being for all at all ages) and 5 (Achieve gender equality and empower all women and girls), also articulate SRHR[10]. While these global frameworks define the normative content, goals and targets for SRHR, they offer limited operational guidance on appropriate steps to be taken in country and local contexts. The ICPD PoA has contributed to operationalising the high-level policy commitments into specific actions to be taken. Most recently, the ICPD Beyond 2014 Review of progress, gaps and challenges in the delivery of the promises made in 1994 led to the UN General Assembly adopting the ICPD Beyond 2014 Framework of Action. The process also established the strong and unequivocal links between the ICPD Beyond 2014 Framework of Action and the post-2015 Agenda for Sustainable Development.

The Human Rights Based Approach to Development (HRBA) marks a decisive step towards consolidating operational links between human rights and the realities of international development cooperation. As a hallmark of HRBA, members of the UN Development Group, including UNDP, WHO and UNFPA, adopted the Stamford Common Understanding in 2003. This places human rights firmly as the goal of development efforts and applies human rights principles of participation, accountability and non-discrimination to all development processes. Furthermore, it has brought increased attention to the importance of incorporating human rights at all stages of programming, including in policies, goals, processes and activities. Thereby the HRBA has helped move discussions around SRHR from a matter of “doing good” to a question of realising universal human rights. HRBA is observed in development cooperation across the UN system and by many donors and is key to the realization of SRHR.

As summarized above, there is a rich documentation and practical experiences that different actors can draw upon in their efforts to progressively realise SRHR. Building on these existing resources, this paper presents the Availability,

Accessibility, Acceptability and Quality (AAAQ) approach, which can be used to further concretise and articulate specific elements of SRHR. Specifically, this paper will apply the AAAQ approach to sexual and reproductive health services (voluntary family-planning; sexual and reproductive health education and information, abortion and post-abortion care; ante- and post-natal care for both mother and child, and the prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS)[11]. The aim is to demonstrate a simple and user-friendly methodology for identifying and organising high-level legally binding obligations and policy commitments and translating these into specific indicators for service delivery. The AAAQ indicators can complement existing indicator frameworks and guide the actions of states, National Human Rights Institutions (NHRIs), civil society and business in the field of SRHR.

To set the background of the analysis, the paper starts out with an introduction to SRHR and the human rights system. Moreover, it describes the principles of a HRBA. Chapter 2 presents the AAAQ approach and methodology. The chapter also maps out the five identified SRH service areas. The mapping is supported by guidance on how to extract and organize information from human rights sources to conceptualize and operationalize SRH services. General reflections on human rights principles and concepts relevant to SRHR are presented in the following chapter. In particular, this chapter offers an illustrative AAAQ analysis of SRH services.

The paper concludes with a comprehensive table, which is setting out AAAQ indicators for each of the SRH service areas. It is the aim of the table to demonstrate how SRH services can be articulated by means of the AAAQ approach in clear, measurable terms.

1 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS & THE HUMAN RIGHTS SYSTEM

This chapter first introduces human rights, including the human rights system and HRBA to development. Building upon this introduction, SRHR is outlined in a human rights context and its underlying themes and issues are discussed.

Human rights are a set of universal rights meaning that they apply equally to all human beings without discrimination of any kind. Additionally, human rights are indivisible (all rights have equal status and are equally important) and interdependent (each right is partly or fully dependent on realisation of other rights). For example, for girls, entering into early marriage and motherhood may have adverse impact on their right to education. Human rights are expressed in international treaties, customary international law as well as national constitutions, laws, regulations and policies.

1.1 THE GENERAL HUMAN RIGHTS FRAMEWORK AROUND SRHR

State obligations

Human rights obligations of states are set out in treaties, which are binding on ratifying states. The International Bill of Human Rights consists of the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). In addition, core human rights treaties set out obligations on specific themes and for specific groups. In the human rights field, the state is the duty bearer – the signatories of the treaties. The state is accountable to the people – the rights-holders – whose rights are protected by the treaties.

The established understanding of state obligations under the ICESCR (and other international human rights treaties) refers to a framework in which the Covenant imposes three types of obligations on the state: to Respect, Protect and Fulfil.[12]

The obligation to respect means that the state should not interfere with the enjoyment of the right. The obligation to protect means that the state through legal and judicial measures has to make sure that third parties do not interfere with the enjoyment of the right. The obligation to fulfil means to take steps towards the realization of the rights. It is often disaggregated into obligations to facilitate, promote and provide. The obligation to facilitate means to take positive measures and adopt enabling strategies aimed at creating the conditions necessary for people's ability to fulfil own demands. The obligation to promote means to raise awareness of rights by way of education and the dissemination of information. The obligation to provide includes a direct provision of goods and services to people who, through conditions beyond their control, are not able to fulfil their own needs.[13] When evaluating state compliance with human rights, this typology is of particular importance due to the ability to pinpoint more precisely the possible non-compliance and guide the actions needed.

The level of fulfilment of the social, economic and cultural rights in ICESCR will depend on the state's resources and infrastructure. Acknowledging that states might have insufficient resources to fully realise all the rights in the ICESCR, a set of *core obligations* have been established for each right. States must prioritise these obligations immediately. SRHR is partly covered by the core obligations as they include "reproductive, maternal and child health care"[14]. However, it is not enough for states to comply with the core obligations, and therefore an approach of *progressive* realisation of all the rights enshrined in the ICESCR should be applied – only over time can these rights gradually be fully realised. In order to achieve this, the state must utilise the *maximum available resources*, which include the state's own resources as well as assistance from other countries. The principle of progressive realisation gives states some flexibility in terms of making necessary prioritisations, including in the health care sector. Examples of such prioritisations could be to limit the number of hospitals offering particularly costly health services or combining classes of family planning and sexual education to reduce costs.

The human rights system

The UN human rights system comprises different instruments, mechanisms and institutions to support and monitor states' implementation of human rights. Each of the UN treaties establishes a Treaty Body (Committee of Experts) to monitor states' implementation and elaborate on the interpretation of the treaties. The Treaty Body of the ICESCR is the CESCR. The Committee reviews all state parties at regular intervals based on national reports on economic, social

and cultural rights. During this process, civil society and NHRIs can submit shadow reports, which are taken into account when the Committee makes recommendations to the state. SRHR has been addressed in several of the Committee's reports, for example regarding Chile, Kuwait and Brazil[15].Treaty bodies also publish their own interpretations their respective treaties in the form of General Comments. For example CESCR has issued General Comment No. 14 on the right to health and General Comment no. 22 on sexual and reproductive health and rights. Besides the Treaty Bodies, the Human Rights Council has established a number of Special Procedures (e.g. Special Rapporteurs), which are mandated to report and advise on specific human rights themes or specific countries. Of particular importance for SRHR is the Special Rapporteur on Health. The mandates of the Special Procedures vary and can include country visits, recommendations to states in response to reports submitted by civil society or other human rights actors, compilation of good practices, cooperation with development practitioners etc.

Human Rights Based Approach (HRBA)

The emergence of Human Rights Based Approach (HRBA) has changed the way development issues are articulated and has strengthened the position of ESCR within the global human rights agenda.

The HRBA is a method that enables development practitioners and other actors to firmly place human rights as a goal for development, to explicitly link development efforts to human rights standards and to enable key human rights principles to systematically guide the process of development. The HRBA draws on the human rights system and clarifies the rights, obligations, roles and capacities of rights holders and duty bearers. The approach takes its point of departure in human rights instruments and mechanisms as legally binding and/or legitimately guiding the work of states, private sector providers and civil society. Through the HRBA, human rights become an integral part of human development because development goals are related to relevant human rights standards and human rights principles are applied to all stages of the planning and implementation of projects and programmes. The core principles of HRBA are described further below.

1.2 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Despite the vast literature confirming and elaborating on SRHR, it can be difficult to determine exactly what this set of rights entails and what rights holders are

entitled to in terms of service delivery. This section outlines key definitions in the field of SRHR and proposes SRH services as a specific focus of a detailed AAAQ mapping and analysis.

SRHR are grounded in a range of fundamental human rights guarantees found in international and regional human rights treaties. The relevant core human rights treaties, within the overall right to health, have the following specific provisions concerning SRHR:

Figure 1: provisions concerning sexual and reproductive health

Human rights treaty	Provisions concerning sexual and reproductive health
International covenant on economic, social and cultural rights	Art. 12 (1): the states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2):the steps to be taken by the states parties to the present covenant to achieve the full realization of this right shall include those necessary for: a): the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; b): the improvement of all aspects of environmental and industrial hygiene; c): the prevention, treatment and control of epidemic, endemic, occupational and other diseases; d): the creation of conditions which would assure to all medical service and medical attention in the event of sickness.
Convention on the elimination of all forms of discrimination against women	Art. 12: 1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. 2. (...) States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
Convention on the rights of persons with disabilities	Art. 25 (a): provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other

	persons, including in the area of sexual and reproductive health and population-based public health programmes;
Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Art. 28: migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the state concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment. Art. 43: 1. Migrant workers shall enjoy equality of treatment with nationals of the state of employment in relation to: (e) access to social and health services, provided that the requirements for participation in the respective schemes are met;

SRHR also embrace a number of civil and political rights set out in the ICCPR, such as the right to life (art. 6), the right to liberty and security (art. 9), the right to privacy (art. 17) and the right to receive and impart information (art. 19)[16]. SRHR-related freedoms include a right to control one's health and body. Rape and sexual violence, forced sterilisation and abortion and forced marriages represent breaches of sexual and reproductive freedoms[17].

Building on the momentum established in the human rights treaties on SRHR, the International Conference on Population and Development held in Cairo in 1994 cemented the equal rights of women and girls and recognised that universal achievement of SRHR is a necessary precondition for sustainable development[18]. With a strong focus on SRHR as a matter of rights and well-being rather than a means to population control, the ICPD PoA is one of the most comprehensive documents on the topic. The ICPD PoA is referenced in the General Comment No. 14 on the right to health and General Comment no. 22 on sexual and reproductive health and rights and is frequently cited by the Special Rapporteur on the right to health in relation to SRHR. Furthermore, ICPD PoA is explicitly cited in target 5.6 of the SDGs, thus reaffirming its importance as a key source in the area of SRHR[19].

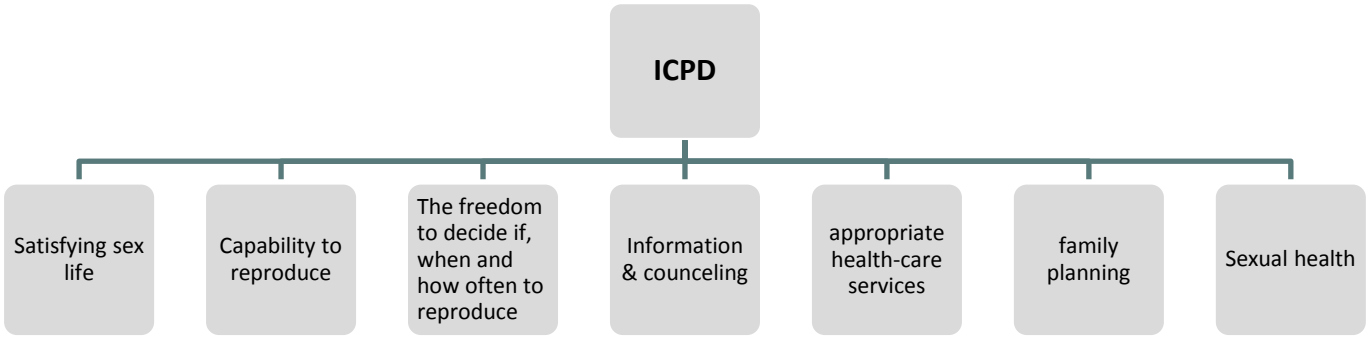
The ICPD PoA establishes that:

Reproductive rights "embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights 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 standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."[20]

Sexual and reproductive health is "a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual and reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant"[21]

The ICPD PoA contains a range of thematic issues that together constitutes a comprehensive approach to SRHR.

Figure 2: Thematic issues included in the ICPD PoA



Among the actions needed to realise SRHR, the ICPD PoA stipulates that states should strive to make available certain SRH services. These services include voluntary family-planning; sexual and reproductive health education and information, abortion and post-abortion care[22]; ante- and post-natal care both for mother and for child and the prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS (see figure 2)[23]. These services are not only incorporated into the work of states, but also key UN agencies such as UNFPA[24] and WHO[25].

Figure 3: Sexual and reproductive health services, ICPD 1994

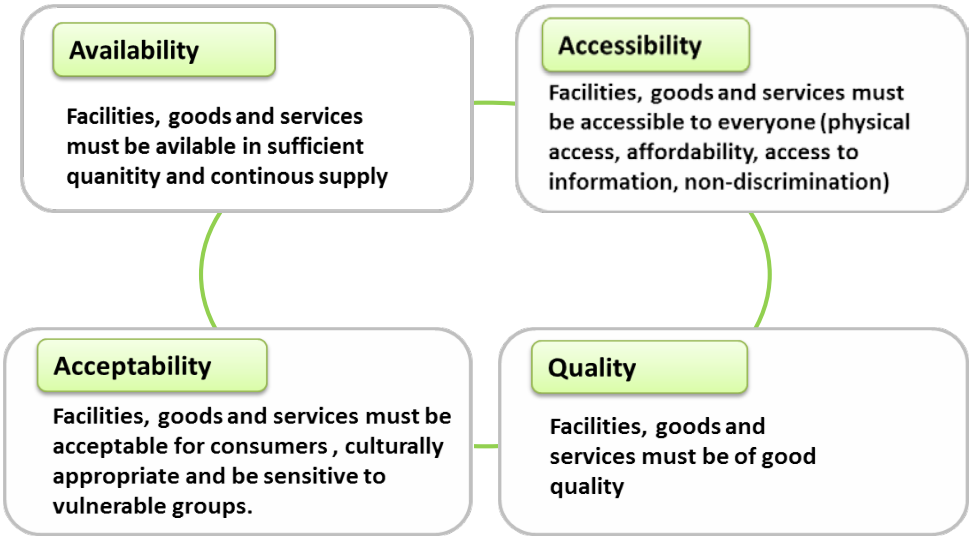
The remaining parts of this issue paper, will focus on the group of SRH services derived from the ICPD and illustrated in figure 3 above. The aim is to conceptualise the meaning of the services in order to make way for an AAAQ analysis and identification of illustrative AAAQ indicators. The focus on the service delivery aspect of SRH should not be considered as an attempt to narrow down the broad scope of SRHR as comprising both freedoms and entitlements. However, as the AAAQ approach is especially suitable for assessing human rights compliance in service delivery, the SRH services referenced in the ICPD PoA are selected as subjects for analysis. The AAAQ analysis of SRH services should be positioned within the broader SRHR perspectives reflected in international human rights instruments and development commitments.

2 THE AAAQ APPROACH

All human rights are interdependent and interrelated, implying that the realization of one right often depends, wholly or in part, upon the realization of others. For instance, realization of the right to health may depend, in certain circumstances, on realization of the right to education or of the right to information. This principle lies at the heart of human rights and it is emphasized in e.g. General Comment no. 22[26]

Therefore, the purpose of the AAAQ methodology is by no means to compartmentalise or narrow down the scope of human rights, but to provide explicit guidance on how to adequately operationalise the AAAQ criteria related to certain social rights. It must thus be understood from the outset that the AAAQ methodology focuses on the AAAQ criteria as they pertain to social rights, without exhaustively covering all aspects of these rights, and without limiting these rights to the AAAQ criteria. The core area of application of the AAAQ approach is social rights, where states, inter alia, have an obligation to ensure certain facilities, goods and services.

The four AAAQ criteria



The starting point for undertaking an analysis of the AAAQ criteria of a given right is to identify the specific provisions of the relevant human rights instruments, which in broad terms stipulate the content and the scope of that right. In this process, special attention is given to the Universal Declaration of Human Rights (1948), which is considered customary international law, and to the core human rights treaties, which represent the core of the international human rights system, and which are binding on a vast majority of States (see figure 4).

Figure 4: The ten core international human rights treaties[27]

International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	1965
International Covenant on Civil and Political Rights (ICCPR)	1966
International Covenant on Economic, Social and Cultural Rights (ICESCR)	1966
Convention on the Elimination of All forms of Discrimination Against Women (CEDAW)	1979
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	1984
Convention on Rights of the Child (CRC)	1989
International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families (ICMRW)	1991
Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	2002
International Convention for the Protection of All Persons from Enforced Disappearance (ICCPED)	2006
Convention on the Rights of People with Disabilities (CRPD)	2006

The reading of these key human rights instruments results in an initial identification of the core elements and attributes pertaining to a given right. Subsequently, the understanding of the scope, content and operational

implications of a given right can be further detailed by mapping and studying other authoritative sources that have further contributed to the body of knowledge In this context, the treaty monitoring bodies, established to monitor implementation of the core human rights treaties, are of particular importance. For example, the Committee on Economic, Social and Cultural Rights (CESCR), in General Comments Nos. 14 and 22, have provided invaluable insight into the AAAQ criteria pertaining to the right to health. Other sources comprise intergovernmental agreements, such as the Beijing Declaration and Platform for Action, ICPD PoA and SDGs, as well as documents elaborated by internationally acknowledged human rights institutions, UN Agencies, International NGOs, academia etc.

The Commission on Population and Development, the monitoring body of the outcome document of the ICPD and main contributor to the ICPD Beyond 2014 report[28] suggests the following typology of sources for a comprehensive human rights mapping:

1. **Binding Instruments:** Conventions, Covenants, Treaties (ICESCR, CEDAW, CRPD, CRC)
2. **Intergovernmental Human Rights Outcomes:** Declarations, Resolutions
3. **Other Intergovernmental Outcomes:** Conference Outcome and Consensus Documents (ICPD, SDGs)
4. **Other Soft Law Documents:** Guiding Principles, General Comments, Recommendations, Concluding Observations of the Treaty Monitoring Bodies

In order to further organise and prioritise these sources, the AAAQ approach operates with a hierarchy of authority and a line of deduction, which starts in the core human rights treaties, through the intergovernmental human rights outcomes and other intergovernmental outcomes. Lastly, other soft law documents such as General Comments are reviewed. Through this process, the core contents, scope and operational implications of the right in question are identified, thereby establishing the main attributes to be considered. Furthermore, the literature review enables identification of generic indicators, which can be used to systematically assess the AAAQ criteria pertaining to the right in question. AAAQ indicators are directly linked to human rights norms and standards, and thereby qualify as 'human rights indicators' as defined by the OHCHR, as they can generate "specific information on the state or condition of an object, event, activity or outcome that can be related to human rights norms and standards; that addresses and reflects human rights principles and concerns;

and that can be used to assess and monitor the promotion and implementation of human rights"[29]. The AAAQ approach follows the recommendations by OHCHR that human rights should be assessed on the basis of structural, outcome and process indicators. The complementarity of structure, process and outcome indicators is explained in figure 5 below[30].

Figure 5: Structure, Process, Outcome indicators

Structural indicators	Address whether key structures and mechanisms necessary for the realisation of a given right are in place. Examples of such structures and mechanism could be the ratification of international treaties that include SRHR, a national plan of action for implementation of SRHR and existence of a complaints handling mechanism to address violations of SRHR
Process indicators	Measures the state's efforts to implement a given right through programmes, activities and interventions. Examples of process indicators could be the percentage of pregnant women counselled and tested for HIV and the percentage of people provided with health information
Outcome indicators	Measures the impact of the programmes, activities and interventions initiated to realise SRHR. Examples of outcome indicators could be the maternal mortality ratio or HIV prevalence rate

3 OPERATIONALISING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

This chapter is divided in three sections. First, considerations and reflections on SRHR in relation to human rights principles and concepts are introduced. SRHR embrace a number of already established human rights principles and concepts and the first part explores the specific meaning and applications of these concepts in relation to SRHR. Secondly, an illustrative AAAQ analysis of the SRH services identified above 2 is presented. The analysis offers a description of the AAAQ criteria in relation to each of the identified services, (voluntary family-planning; sexual and reproductive health education and information, abortion and post-abortion care[31]; ante- and post-natal care both for mother and for child, and the prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS). Third, building on the AAAQ analysis, illustrative AAAQ indicators are listed with reference to key SRHR sources. Collectively, the three sections seek to operationalise key service delivery aspects of SRHR by applying the AAAQ approach and listing AAAQ indicators on key SRH services.

3.1 REFLECTIONS ON SEXUAL AND REPRODUCTIVE HEALTH AND HUMAN RIGHTS PRINCIPLES

Before presenting the illustrative AAAQ analysis and related indicators for the SRH services, it is relevant to reflect upon some human rights principles and concepts, which play a vital role in the delivery of SRH services. The human rights principles include non-discrimination, participation and accountability while concepts concern cultural appropriateness, informed decision making and matters of privacy and confidentiality. These principles are commonly referred to as the HRBA principles.

3.1.1 NON-DISCRIMINATION

All individuals are equal as human beings and all human beings are entitled to their human rights without discrimination of any kind. Priority must be given to

those who are more likely to suffer discrimination and those who are more negatively affected by economic, social and political inequality. Gender constitutes a fundamental ground of inequality and has to be taken into consideration at all times and at all levels.

The AAAQ criteria include the notion of non-discrimination as a sub-criterion under "accessibility" alongside physical, economic and information accessibility. In line with a HRBA, non-discrimination is also a crosscutting human rights principle, which applies equally to all AAAQ criteria. This includes for example the provision of information in relevant local languages or tailoring interventions to the particular needs and preferences of vulnerable groups (acceptability). Observance of the crosscutting principle of non-discrimination entails that data on all indicators should be disaggregated on prohibited grounds of discrimination. According to General Comment no. 22, "health facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers." [32] It states alignment with General Comment no. 14, which outlines the prohibited grounds of discrimination as: race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status[33]. Besides the generally prohibited grounds of discrimination, the Beijing declaration and CEDAW call for special attention to adolescents, rural women, and women in difficult circumstances, such as those trapped in situation of armed conflict and female refugees[34]. In a broader SRHR perspective, other vulnerable groups may include sex workers, trafficking victims, female migrants, rural women and indigenous peoples[35].

3.1.2 PARTICIPATION

Every person has a right to active, free and meaningful participation in economic, social, cultural and political development. Participation aims to ensure a systematic inclusion of rights holders by empowering them to articulate their needs and rights, hold duty bearers accountable and take charge of their own development. Participation mechanisms must be accessible to everyone, including the most vulnerable groups. Effective participation requires access to information; freedom of expression, association and assembly; and transparent and accessible governance. Effective participation often depends on a principle of subsidiarity, meaning that decisions are taken as close as possible to those most affected by them.

In relation to sexual and reproductive health services, public participation is crucial to ensure successful outcomes. According to the ICPD, "reproductive health-care programs should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Governments and other organizations should take positive steps to include women at all levels of the health-care system."[36] CEDAW specifically requires countries to ensure that women have the right to participate fully and be represented in the formulation of public policy in all sectors and at all levels[37].

3.1.3 ACCOUNTABILITY

Accountability is an overarching principle derived from many different human rights and entails responsibility, answerability and enforceability[38]. Responsibility entails that those in positions of authority have clearly defined duties and performance standards, enabling their behaviour to be assessed transparently and objectively. Answerability requires public officials and institutions to provide reasoned justifications for their actions and decisions to those they affect. Enforceability requires establishment of mechanisms to monitor compliance with established standards by service providers and public institutions, impose sanctions for non-compliance and ensure that appropriate corrective and remedial action is taken when required.

Effective accountability mechanisms would include monitoring, remedies and participation. Monitoring is a prerequisite for politicians to make informed health policies on, for example, SRHR. States should also set up supervisory bodies, which can monitor actions of the health system and its personnel in order to ensure that policies are followed[39]. Effective accountability requires participation from society including the participation of vulnerable groups. This is especially relevant to SRHR, which to many is a sensitive issue. Hence, only by ensuring participation of women and girls can services be delivered in an acceptable manner. Without participation, women and girls cannot obtain the knowledge and information needed about their SRHR, which can empower them to claim these rights[40].

3.1.4 CULTURAL APPROPRIATENESS

According to General Comment No. 14 "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". An example of the right to receive culturally appropriate health services can be found in the UN Declaration on the Rights of Indigenous Peoples, which stipulates that indigenous peoples have "the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals"[41]. In the case of SRHR, the term "culturally appropriate" is often misinterpreted. Culturally appropriate health services relate to being respectful to the culture and cultural perceptions of the right-holders, thus it is not to be interpreted as a loophole for duty-bearers or others to obstruct or not respect women's SRHR based on an argument that it goes against cultural or religious norms and systems. The Committee on the Elimination of All forms of Discrimination against Women emphasises that neither states nor service providers may refuse to deliver sexual and reproductive health services due to "conscientious objections" and should such situations occur, it must be ensured that the woman is referred to an alternative health provider[42]. Furthermore, irrespective of cultural appropriateness, states and others must not "restrict women's access to health services on the grounds that women do not have the authorization of husbands, partners, parent or health authorities, because they are unmarried or because they are women"[43].

3.1.5 INFORMED DECISION-MAKING

In order to respects women's SRHR it is crucial to ensure that choices taken in relation to sexual and reproductive health are taken autonomously. Reproductive autonomy is a well-known principle within health law and ensures that a human being is not subjected to unwanted interventions[44]. Access to free, prior, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law. Information, counselling and support should be made accessible for all people without discrimination and with special attention to young people[45]

3.1.6 PRIVACY AND CONFIDENTIALITY

The right to privacy is a human right ensured in the ICCPR[46], and includes the right to personal autonomy. In relation to SRHR, the right to privacy means that when people seek health information and services, they should not be subject to interference with their privacy. According to the Beijing Declaration, the right to privacy also includes the right to control and to freely and responsibly decide on aspects of sexuality and sex life[47]. Sexual and reproductive services is for many a sensitive topic, thus confidentiality - the duty of health personnel not to disclose private health information and data – is crucial to ensure SRHR[48].

3.2 AAAQ & SEXUAL AND REPRODUCTIVE HEALTH SERVICES

This section outlines the AAAQ criteria in relation to key SRHR services. The analysis is by no means exhaustive. Rather, it is intended as inspiration to actors in the field of SRHR wishing to apply the AAAQ approach to programmatic work.

3.2.1 AAAQ & FAMILY PLANNING

The aim of ensuring universal access to a full range of safe and reliable family planning methods and related health services is to assist couples and individuals to achieve their reproductive goals and have full opportunity to have children by choice[49]. Family planning relates to the possibility of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. Women's ability to space and limit their pregnancies has a direct impact on their health and well-being as well as the health and well-being of the babies[50]. The ICPD PoA speaks strongly against coercion and forced measures of family planning and stresses the principle of informed free choice as essential to long-term success of family planning programmes[51]. According to the General Comment No. 14 on the right to health, family-planning in relation to sexual and reproductive health must live up to the AAAQ criteria:

Availability Refers to the existence of family planning education, information and services in sufficient quantity. This includes prevention methods such as for example contraceptives.

Accessibility Refers to the distance to and cost of family planning, as well as whether family planning services are provided on a non-discriminatory basis and with proper information. Thus, family planning facilities must be within safe physical reach of its users and should be affordable for all, especially the poor. Everyone should have access to information related to family planning such as prevention methods, while also ensuring the right to privacy and the protection of personal data. Family planning services must always be free of discrimination of any prohibited ground.

Acceptability Refers to the respect of family planning information, education and services to medical ethics and the culture of different groups. This could include gender-sensitive counselling and education on family planning to ensure that it is tailored to meet the specific needs of communities and individuals for example young women and girls.

Quality Refers to the requirements of family planning information, education and services to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled health workers with family planning training, quality assurance of the standards of the family planning methods provided e.g. the validity of birth control pills or contraceptives as well as counselling on side-effects.

In essence, providing voluntary family planning in accordance with the AAAQ criteria revolves around ensuring that effective methods of contraception as well as information and education related to one's sexual and reproductive health is available, accessible, acceptable and of good quality.

3.2.2 AAAQ & SAFE ABORTION

Abortion is a sensitive topic within the SRHR field as the legality and laws of abortion vary between countries. According to the ICPD PoA, abortion services as well as post-abortion care are among the responsibilities of the health system, where this is not against the law. Former Special Rapporteur on health, Anand Grover, has pushed for abortion to be legalised, at least in cases of medical emergency or sexual assault[52] General Comment no. 22 signals a resolute position in favour of legalisation: "A wide range of laws, policies and practices undermine the autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example criminalization of abortion or restrictive abortion laws."[53] According to General Comment No. 14 on the right to health, abortion services and post-abortion care in relation to sexual and reproductive health must comply with the AAAQ criteria:

Availability Refers to the existence of health facilities with personnel and equipment to undertake safe and effective abortions whether it is medical or surgical, as well as post-abortion care[54].

Accessibility Refers to the distance to and cost of abortion services as well as whether abortion services are provided on a non-discriminatory basis and with proper information. Thus, facilities undertaking abortions must be within safe physical reach of its users; the WHO recommends no more than two hours of travel time[55]. The affordability criteria require that women can access legal abortion services regardless of their ability to pay, and the WHO

recommends that woman should never be denied or delayed in receiving an abortion due to inability to pay[56]. Women should have access to information regarding abortion services and be offered counselling in the process of deciding upon an abortion. However, it is crucial that the provision of counselling to women should be voluntary, confidential and non-directive. Abortion and post-abortion care must always be free of discrimination of any prohibited ground and potential discrimination against women seeking abortion services should be addressed.

Acceptability Refers to the respect of medical ethics and the culture of individuals in the provision of abortion and post-abortion care. According to WHO guidelines on abortion[57], women are more likely to find a method of abortion (medical or surgical) acceptable if they have chosen it themselves. Thus, ensuring that the woman is included and informed in the decision making process is one way of ensuring acceptability.

Quality Refers to the requirements of abortion and post-abortion care to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled health personnel who can undertake abortions in accordance with WHO recommended methods for abortions and abortion complications, as well as the equipment needed to undertake abortion, including the underlying health determinants e.g. safe water.

In essence, providing abortion services and post-abortion care in accordance with the AAAQ criteria revolves around ensuring that health facilities and personnel, equipped to undertake abortions as well as trained to provide information and counselling to women upon request, are available, accessible, acceptable and of good quality.

3.2.3 AAAQ & ANTE- AND POST-NATAL CARE AND SAFE DELIVERY

Ante- and post-natal care is concerned with the services provided in the critical period of time for mother and child up to and after the birth. Ante-natal care includes screening, prevention and treatment for a range of diseases e.g. malaria and hypertension, which could harm the health of the woman or unborn child. Proper ante- and post-natal care is crucial in ensuring that complications in pregnancies, around delivery or following the birth do not have fatal

consequences for neither the mother nor the new-born child[58]. According to General Comment No. 14, ante- and post-natal care in relation to sexual and reproductive health must comply with the AAAQ criteria:

Availability Refers to the existence of health facilities with personnel and equipment to undertake ante-natal visits. The WHO recommends at least four ante-natal visits during pregnancy, of which at least one has to take place within the first trimester of the pregnancy[59]. Post-natal care must be in place within two days of the birth. Additionally, to ensure a safe delivery, the availability of a health facility as well as skilled personnel is crucial.

Accessibility Refers to the distance to and cost of ante- and post-natal care, and whether this care is provided on a non-discriminatory basis and with proper information. Thus, ante- and post-natal care facilities must be within safe physical reach of its users. Ante- and post-natal care should be affordable for all and not disproportionally burden the poor. Information about health and well-being during and after pregnancy and delivery are key to good maternal health. Delivery of ante- and post-natal care must always be free of discrimination of any prohibited ground

Acceptability Refers to the respect of medical ethics and the culture of individuals in the provision of ante- and post-natal care. Ensuring that women find health facilities acceptable in terms of e.g. culture, religion, gender etc. is crucial to the objective of increasing the probability of women receiving ante- and post-natal care as well as choosing to deliver under skilled attendance.

Quality Refers to the requirements of ante- and post-natal care to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled health personnel and that care is provided according with WHO guidelines[60].

In essence, providing ante- and post-natal care in accordance with the AAAQ criteria revolves around ensuring that equipped health facilities and skilled health personnel as well as information about delivery, ante- and post-natal care is available, accessible, acceptable and of good quality.

3.2.4 AAAQ & PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

Among a range of sexually transmitted infections (STIs), HIV is perhaps the most well-known. Effective prevention and treatment of STIs require a combination of services including preventive (sexual education, distribution of contraceptives and promotion of care-seeking behaviour) and treatment services (detection of symptoms, diagnostics and diseases management). In combination, the preventive and treatment related services are referred to as comprehensive case management of STIs by the WHO[61]. According to General Comment No. 14 on the right to health, the prevention and treatment of STIs in relation to sexual and reproductive health must comply with the criteria of AAAQ:

Availability Refers to the existence of health facilities, goods and services for STI prevention and treatment. This would, among other things, include prevention services (e.g. contraceptives), equipment for diagnostics and drugs for treatment in accordance with the comprehensive case management.

Accessibility Refers to the distance to and cost of seeking STI management as well as whether prevention and treatment services are provided on a non-discriminatory basis and with proper information. Thus, STI management facilities must be within safe physical reach of its users. STI management should be affordable for all and not disproportionally burden the poor. The provision of information around STIs, including healthy sexual behaviour and compliance with medication course, is key to both prevention and treatment of STIs. The comprehensive case management of STIs must always be free of discrimination on any prohibited ground

Acceptability Refers to the respect of medical ethics and the culture of groups in the provision of comprehensive STI case management. Persons living with HIV or other STIs, constitute a vulnerable group as they are often subject to stigmatization and sometimes even human rights violations such as e.g. coercive diagnostics and treatment. Ensuring that STI prevention and treatment are acceptable and provided with respect for privacy and confidentiality is thus crucial.

Quality Refers to the requirements of comprehensive STI case management to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled health personnel,

reliable diagnostic tools and compliance of care with the WHO guidelines on the topic[62].

In essence, providing STI prevention and treatment in accordance with the AAAQ criteria revolves around ensuring that equipped health facilities, essential drugs as well as information about sexual behaviour and STI prevention are available, accessible, acceptable and of good quality.

3.3 ILLUSTRATIVE AAAQ INDICATORS ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The AAAQ analysis of the SRHR services may be further operationalised by identifying specific AAAQ indicators. The purpose of the indicators is to serve as a supportive tool in applying a HRBA to planning, monitoring and evaluation of sexual and reproductive health projects, thereby placing human rights standards firmly as a goal of development efforts.

The illustrative indicators are organised around the structure, process and outcome framework.

Structural indicators: measure the state's acceptance and commitment to realisation of human rights through adoption of legislative, policy and regulatory frameworks, policies and mechanisms to respect, protect and fulfil human rights. The structural indicators relate to the status on certain documents (ratification of treaties, enactment of laws and adoption of policies). Structural indicators rarely address specific AAAQ criteria, but it is relevant to analyse the different legal and policy documents to assess whether they adequately address the AAAQ criteria; e.g. by checking whether the national policy on sexual and reproductive health covers all four AAAQ criteria.

Process indicators: measure the state's ongoing efforts to transform legal and policy commitments into the desired results through design, implementation and monitoring of programmes for progressive realisation of human rights. The process indicators relate to the state's obligation of conduct, which requires state action to realise the enjoyment of a right through implementation of policies and allocation of resources. The process indicators often address specific AAAQ criteria although some can be used to assess several criteria; e.g. the indicator "% of primary health care facilities offering SRH and family planning services" relate to all four AAAQ criteria.

Outcome indicators: measure the actual level of realisation of human rights from the perspective of the rights holders, and capture the effects of the state's structural and process oriented initiatives to respect, protect and fulfil human rights. The outcome indicators relate to the state's obligation of result, which requires states to achieve specific targets to satisfy a specific human rights standard. The outcome indicators often measure the combined results of addressing the AAAQ criteria combined with other complementary processes, such as development of the health infrastructure and improvement of the primary and secondary education. For example, the outcome indicator 'maternal mortality rate' is influenced by a variety of factors, such as the general level of education, adequate nutrition and the infrastructure of the health system. Therefore it is not always possible to specifically assess the four AAAQ criteria individually in the outcome indicators.

The AAAQ indicators should not be considered a stand-alone indicator system that operates independently from existing global and national indicator frameworks. Rather, it is a complementary analysis that can be used to supplement and fill gaps in existing indicator frameworks. For instance, some of the indicators defined by other indicator and monitoring frameworks focus at the outcome level without directly addressing the causes of success or failure in achieving the indicator. As an example, the indicator 'unmet need for contraception' offers little help in terms of identifying why there is an unmet need. An analysis of the availability, accessibility, acceptability and quality of contraception may shed light on the root causes[63]. Acknowledging the need to avoid duplication, it has been a priority to make use of existing indicators, when identifying the illustrative AAAQ indicators. This includes those suggested for monitoring ICPD[64] and SDGs, as well as those used in WHO health statistics. The indicators are extracted from the sources reviewed according to the AAAQ methodology and include elements from all sources in the typology outlined above. However, important sub-criteria of the AAAQ are not included in current international monitoring of SRH services. These include, for example, distance to health facilities, goods and services (physical accessibility) and the subjective perception of the acceptability of health facilities, goods and services. In these cases, additional indicators derived from authoritative and secondary sources, are added to the table of generic AAAQ indicators.

The suggested generic AAAQ indicators are presented in the table below. Some indicators are shared across the range of SRH services, while others pertain to a particular service component. The origin of the indicator is clearly marked with references in the table and the symbol “#” is added to indicate limited availability of data on the suggested indicator. A table listing the sources is provided below the indicator table.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – STRUCTURAL INDICATORS				
SPO*AAAQ Indicators	**Family planning including sexual education**	**Abortion**	**Pre- & post-natal care & safe delivery**	**Prevention & treatment of STIs**
GENERAL	• Time frame and coverage of national policy on sexual and reproductive health[4] • Government share of total spending on sexual and reproductive health services[1] • Dedicated budget line for contraceptive commodity procurement[1] • New and/or increased resources are committed to sexual and reproductive health services in the last two years[1] • International human rights treaties relevant to the right to health ratified by the State (ICESCR/CRC/CEDAW/ICERD)[4,7] • % of government *health expenditure* directed to sexual and reproductive health[7] • Per capita *expenditure* on sexual and reproductive health[7] • Does the State have a law to ensure *universal access* to sexual and reproductive health care?[7] • Does the State have a national sexual and reproductive health strategy and plan of action?[7] • Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education3			
	• Dedicated budget line for family planning[1] • Does State law require comprehensive sexual health education during the compulsory school years?[7]	• Grounds on which abortion is permitted[1] • Time frame and coverage of national policy on abortion and foetal sex determination[4] • Does State law allow abortion[7]		

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS				
	Family planning including sexual education	**Abortion**	**Pre- & post-natal care & safe delivery**	**Prevention & treatment of STIs**
Availability Functioning public health services have to be available in sufficient quantity	• % of primary health care facilities offering SRH and family planning services[1]			
	• % of facilities reliably offering a range of methods, encompassing 4 categories of contraceptive methods: short term; long acting reversible; permanent; and emergency contraception[1] • % of facilities that report not experiencing a stock-out of a modern form of contraception in the past 6 months[1] • Availability of gender-sensitive counselling and educational interventions [6#] • % of primary health-care facilities providing comprehensive family planning services (full range of contraceptive information, counselling and supplies for at least six methods, including male and female, temporary, permanent and emergency contraception)[7] • Number of condoms available for distribution nationwide (during the preceding 12 months) per population aged 15-49 years[7] • % of family planning service delivery points	• Number of facilities offering safe abortion services per 500 000 population[5] • % of service delivery points providing abortion and/or post-abortion care[7]	• Number of facilities offering ante-natal care per 10 000 population[2] • Number of facilities offering post-natal care per 10 000 population[2] • % of births attended by skilled health personnel[1,2,3,7] • Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn	• % of primary health care facilities with STI rapid diagnostic tests available[1] • % of health facilities with post-exposure prophylaxis available[8] • % of health facilities that offer ART[8] • % of health facilities dispensing ART[8] • % of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral[8]

	offering counselling on dual protection from sexually transmitted infections/HIV and unwanted pregnancies[7]		and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)3	

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS				
Accessibility	**Family planning including sexual education**	**Abortion**	**Pre- & post-natal care & safe delivery**	**Prevention & treatment of STIs**
Physical accessibility Health services must be within safe physical reach	• % of population living within two hours travel time from health facilities that offer SRH services[1]			
	• Are mobile outreach services in place to improve access for populations who face geographical barriers to access?[6#]	• Population living within 2 hours travel time from a facility providing safe abortion services[5]		
Economic accessibility Health services must be affordable for all	• Out-of-pocket payment for health (% of current expenditure on health)[2] • % of the population protected against catastrophic/impoverishing out-of pocket health expenditure[#] • % of the population protected against impoverishment by out-of-pocket health expenditures[#] • % of households protected from incurring catastrophic out-of-pocket health expenditure[#]			
Information accessibility	• Provision of evidence-based, comprehensive information, education			

The right to seek, receive and impart information and ideas concerning health issues	and counselling to ensure informed[6#]			
	• % of people exposed to information on: (a) maternal and newborn care (b) family planning services (c) abortion/post-abortion care (d) prevention and treatment of sexually transmitted infections[7#]			
Non-discrimination Health services must be accessible to all, especially the most vulnerable or marginalized, without discrimination	• Rate of refusal of medical consultation, by target group[4#]			

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS				
	Family planning including sexual education	**Abortion**	**Pre- & post-natal care & safe delivery**	**Prevention & treatment of STIs**
Acceptability Health services must be respectful of medical ethics and culturally appropriate and sensitive to gender and life-cycle requirements	• Are health facilities equipped with personnel, physical space for counselling and educational materials appropriate for different levels of literacy, comprehension and cultural diversity and acceptability including language and format that is accessible to clients?[9] • Do health facilities provide an enabling			

	environment for safeguarding privacy and confidentiality including for disclosure and discussions by clients experiencing intimate partner violence and/or sexual violence? (for example posters in public spaces such as waiting rooms, examination rooms, hallways)[9]			

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS				
	Family planning including sexual education	**Abortion**	**Pre- & post-natal care & safe delivery**	**Prevention & treatment of STIs**
Quality Health services must be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment	• Procedures ensuring informed choice[1#] • Is privacy respected throughout the provision of information and services, including confidentiality of medical and other personal information?[6#] • Is quality assurance in place to ensure compliance with medical standards?[6] • Are health care personnel trained in delivery of education, information and services in accordance with WHO standards? [6#] • % of health professionals who have received training on: the confidentiality of personal health information and the requirement of informed consent to accept/refuse treatment[7#] • % of people who believe that personal information disclosed to health professionals remains confidential[7#]			
		• Service-delivery points that use WHO-recommended methods for induced abortion[5]		

		• Service-delivery points that use WHO-recommended methods for management of abortion complications[5]		

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS	
Accountability The right to health must be subject to the principles of respect, protect and fulfil + access to effective judicial remedies	• Are programmes being monitored and evaluated to ensure the highest quality and respect for human rights? [6#]
Participation The participation of the population in all health-related decision making at the community, national and international levels	• Are communities, particularly people directly affected, given the opportunity to meaningfully engage in all aspects of programming and policy design, implementation and monitoring? [6#]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES – PROCESS INDICATORS				
OUTCOME	• Proportion of never married women and men aged 15-24 using a condom at last sex[1] • Adolescent birth rate[1,2,3] • Stillbirth rate (per 1000 total births)[2] • Maternal mortality ratio[2,3,4,7] • Neo-natal mortality rate (deaths per 1,000 live births)[3,7] • Perinatal mortality rate[4]			
	• Proportion of adolescents who have received comprehensive sexuality education and on sexual and reproductive health, gender equality and human rights among adolescents in or out of school[1] • Contraceptive prevalence rate[2] • Demand for family planning satisfied with modern methods[2] / Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care[3] • Percentage of women who know about contraceptive methods[7] • % of women at risk of pregnancy who are using (or whose partner is using) a contraceptive method (all methods)[7] • % of people ages 15-19 years who have received comprehensive sexual health education in school[7]	• Obstetric and gynaecological admissions due to abortion[5] • Hospitalization rate for unsafe abortion per 1000 women[5] • Abortions per 1000 live births[5] • Maternal deaths attributed to abortion[5] • Abortion rate (number of abortions per 1,000 women of reproductive age)[7]	• Antenatal care coverage[2] • Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group[3] • Postpartum care coverage[2] • Under-five mortality rate[3] • Neonatal mortality rate[3]	• Mother to child HIV transmission rate[1] • Percentage of young women and men age 15-24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV[1] • Youth HIV prevalence rate[1] • Sexually transmitted infections (STIs) incidence rate[2] • Antiretroviral therapy (ART) coverage[2] • Number of people tested HIV positive linked to care in the last 12 months[2] • Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations[3] • % of people ages 15-24 who know how to prevent HIV infection[7]

				HIV prevalence in subpopulations with high-risk behaviour[7]

SOURCES OF INDICATORS	
1	ICPD Beyond 2014
2	WHO 2015. 100 Core Health Indicators
3	SDG indicator
4	OHCHR 2012. Illustrative indicators on the right to health
5	WHO 2012: Safe abortion: technical and policy guidance for health systems
6	WHO 2014: Ensuring human rights in the provision of contraceptive information and services Guidance and recommendations
7	Report by the Special Rapporteur on the right to health 2006: E/CN.4/2006/48
8	UNAIDS 2007: Core indicators for national AIDS programmes. UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators.
9	WHO/UNFPA 2015: Ensuring human rights within contraceptive service delivery, Implementation guide
#	Limited data availability (indicator currently not assessed/poor data availability/not received “A” rate in feasibility by the UN statistical committee

END NOTES

[1] Beijing Declaration art 30; ICPD art 7.3

[2] ICESCR art. 12; further substantiated in CEDAW, CRPD

[3] UN General Assembly, 2015: Transforming Our World: The 2030 Agenda for Sustainable Development. For in depth analysis of the links between human rights and the SDGs, please refer to the Human Rights to the SDGs at http://sdg.humanrights.dk/, and analysis of the key thematic issue areas within the 2030 agenda at www.humanrights.dk/our-work/sustainable-development/human-rights-sdgs

[4] Goal 3 on ensuring healthy lives and promote well-being, and Goal 5 on gender equality and empowerment of women and girls.

[5] ICPD 1994, UNFPA 2014, A/66/254 2011

[6] ICPD 1994, UNFPA 2014

[7] E./CN.4/2004/49 para 20(c)

[8] ICESCR Art. 12 (2)(d)

[9] For example: Adding It Up 2014 (UNFPA); Ensuring human rights in the provision of contraceptive information and services, 2014 (WHO); Ensuring human rights within contraceptive service delivery, Implementation guide, 2015 (WHO & UNFPA)

[10] https://sustainabledevelopment.un.org/sdg3 and https://sustainabledevelopment.un.org/sdg5 For general analysis of the links between human rights and the SDGs, please refer to http://sdg.humanrights.dk/

[11] ICPD para 7.3

[12] In Human Rights literature, these are generally known as “The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights” (1997), which builds on the “The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights”, 1987

[13] OHCHR (2006: 2)

[14] General Comment No. 14 on the right to health, para. 44

[15] E/C.12/1/Add.105; E/C.12/1/Add.98; E/C.12/BRA/CO/2

[16] ICCPR, 1966

[17] Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2004

[18] ICPD Beyond 2014

[19] Target 5.6: "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences". The two indicators related to target 5.6 further affirms the SRHR imprint: 5.6.1: "Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care" and 5.6.2: "Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education" https://sustainabledevelopment.un.org/sdg5

[20] ICPD, 1994, para. 7.3

[21] ICPD, 1994, chapter 7.A.

[22] Where it is not against the law

[23] ICPD para 7.3

[24] UNFPA 2014: Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions; WHO/United Nations Secretary General 2010: Global Strategy for Women's and Children's Health

[25] Family Planning – A Global Handbook for Providers. WHO. 2011

[26] General Comment, para 9-10.

[27] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx

[28] ICPD Beyond 2014, p. 11

[29] OHCHR: Human Rights Indicators – a Guide to Measurement and Implementation, 2012: 16

[30] E/CN.4/2006/48

[31] where it is not against the law

[32] General Comment No. 22, para 15-19, in alignment with General Comment no. 14, para 12 (b)

[33] General Comment No. 14 on the right to health para 18

[34] The Beijing Declaration para 95; Convention of the Elimination of All forms of Discrimination against Women, para 14.

[35] UNFPA 2014; E/CN.4/2006/48, para 49

[36] ICPD para 7.7.

[37] WHO 2015: Ensuring human rights within contraceptive service delivery: implementation guide

[38] United Nations Office of the High Commissioner for Human Rights and the Centre for Economic and Social Rights (2013): Who Will Be Accountable?

[39] Toebes et al. 2012. Health and human rights in Europe. Intersentia.

[40] WHO 2015: Ensuring human rights within contraceptive service delivery: implementation guide

[41] UN Declaration on the Rights of Indigenous Peoples, art. 24

[42] Committee on the Elimination of All forms of Discrimination against Women, General Recommendation No. 24, para 11.

[43] Committee on the Elimination of All forms of Discrimination against Women, General Recommendation No. 24 para 14. The following qualification provided by General Comment no. 22, para 20, is relevant in this context: "All facilities, goods, information and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycles requirements. However, this cannot be used to justify the refusal to provide tailored facilities, goods, information and services to specific groups."

[44] Toebes et al. 2012. Health and human rights in Europe. Intersentia.

[45] WHO 2015: Ensuring human rights within contraceptive service delivery: implementation guide

[46] ICCPR art. 23

[47] Beijing Declaration para 96

[48] WHO 2015: Ensuring human rights within contraceptive service delivery: implementation guide

[49] ICPD PoA, paragraph 7.16

[50] WHO 2014: Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations

[51] ICPD 1994 para 7.12

[52] Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2011, Country visit to Guatemala

[53] General Comment no. 22, para 34

[54] WHO 2012: Safe abortion: technical and policy guidance for health systems

[55] WHO: Safe abortion: technical and policy guidance for health systems

[56] WHO: Safe abortion: technical and policy guidance for health systems

[57] WHO: Safe abortion: technical and policy guidance for health systems

[58] WHO 2012: Recommendations on maternal and perinatal health
[59] WHO 2015: Global Reference List of 100 Core Health Indicators
[60] WHO 2012: Recommendations on maternal and perinatal health
[61] WHO 2003: Guidelines for the management of sexually transmitted infections
[62] WHO 2003: Guidelines for the management of sexually transmitted infections
[63] WHO 2015: 100 Core Health Indicators
[64] ICPD Beyond 2014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