



A GLOBAL STRUCTURAL EXAMINATION OF QUALITY AND RIGHTS

Q|U|E|S|T
Quality Upheld: Every Service, Every Time

**CHAMPIONS
OF GLOBAL
REPRODUCTIVE RIGHTS**
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TABLE OF CONTENTS

Introduction.....	1
Background: Quest Countries.....	3
Democratic Republic of the Congo (DRC).....	3
Ethiopia.....	3
India.....	5
Myanmar.....	5
Pakistan.....	5
Influencing Environment.....	6
Coherence and Coordination of Reproductive Health Policies.....	6
Political Systems and Governance.....	7
Strength of Civil Society.....	9
Health System Strength and Management.....	11
Funding.....	11
Supply Chain Management and Procurement.....	11
Health Workforce.....	12
Health Care Ethics.....	13
Values and Community Norms.....	16
Reproductive Health Quality and Rights of Youth.....	17
Conclusion.....	19
Appendices.....	21

INTRODUCTION

The reproductive health of women and girls—particularly their ability to access modern contraception—is a critical factor for improving their lives and overall well-being. Preventing unintended pregnancies reduces maternal and infant deaths, decreases unsafe abortions, and allows many adolescent girls to continue their education. Access to and use of contraception also gives women control over their sexuality and reproduction, which results in a healthy, productive life.

However, high-quality contraceptive services, information and supplies remain out of reach for 214 million women and girls around the world who want to prevent pregnancy.¹ This reality not only paralyzes progress for women, but it also reflects a fundamental disregard of their rights. As duty-bearers, governments have a responsibility to respect, protect and fulfill the reproductive health and rights of their citizens—including provision of high-quality services and care. Yet despite rising national and international interest in expanding reproductive health access, policymakers often fail to emphasize the importance of the quality of care delivered and the rights of the women and girls receiving it.

The notion of quality is captured under the right to sexual and reproductive health services, information and education. Anchored in the needs of clients, quality of care is a multifaceted approach that adheres to high standards.² These standards include, but are not limited to:

- Access to a full choice of contraceptive methods.
- Clear and medically accurate information, including the risks and benefits of a range of methods.
- Availability of equipped provider(s) who are technically and culturally competent.
- A client-provider interaction that respects informed choice, privacy and confidentiality, as well as client preferences and needs.

A woman receives high-quality care when she can choose from the full range of contraceptive options that fit her needs, and when the information she receives is accurate, appropriate and timely. This means that the clinical and other personnel she interacts with are technically competent and free of judgment. Any follow-up services she needs must be available and of equal caliber.

Donors, governments and civil society have shown a renewed interest in assessing the quality of contraceptive services from the client-provider perspective.³ While these analyses have revealed important information about quality, they have not addressed the systemic drivers of and barriers to quality. Nor has there been an examination of the current legal, policy and regulatory spheres affecting the quality of care delivered and the rights of individuals receiving that care.

To better understand the factors influencing the quality of care and the fulfillment of women's rights, PAI has embarked on a multiyear initiative called QUEST (Quality Upheld, Every Service, Every Time). The effort aims to strengthen the capacity of local advocates to assess and monitor the quality of family planning programs and make the case for quality and rights to be a national priority. PAI worked with partners to analyze the gaps, opportunities and challenges of providing high-quality, rights-based reproductive health care at the national and subnational levels in five countries: Democratic Republic of the Congo, with a focus on Kinshasa; Ethiopia, with a focus on Oromia; India, with focuses on Uttar Pradesh and Bihar; Myanmar, with a focus on Shan; and Pakistan, with a focus on Sindh. Unlike many of the other examinations of quality at the client and provider level, QUEST takes a unique approach by examining barriers and opportunities to improved quality and rights at the health systems, policy and governance level. While rarely integrated into considerations of quality at the client-provider level, macro-level systems' issues can have a profound effect on a woman's ability to exercise her rights and receive high-quality reproductive health care.

This report draws on the findings from landscape assessments of health systems' legal, policy and governance frameworks conducted by partner organizations in each country between 2016 and 2017. The findings from the individual landscape assessments are supplemented with additional research conducted by PAI staff to provide context and thematic alignment among partner organizations' findings.

Despite significant variation in legal, economic and socio-political contexts, the following common themes emerged in all geographies:

- **Delivery of quality health services is dependent on a functional and coordinated government at the national and subnational levels.**
- **The absence of an open, constructive relationship between government and civil society inhibits the ability of the health system to deliver quality services that meet community needs. It also impedes the government and health system from being accountable for ensuring reproductive health and rights.**
- **The gap between written policies and implementation, as well as a lack of harmonization among legal and policy systems, hinders the provision of high-quality services. Existing policies and laws governing health services and rights are difficult to reverse or override with new frameworks.**
- **Commodity stockouts, inadequately trained health care staff and unethical practices negatively impact quality of care and women's rights.**
- **The best efforts of legal, regulatory and policy frameworks to address quality and rights are easily overridden by values and social norms.**
- **Youth and unmarried women are disproportionately affected by social and cultural taboos around sex and reproductive health.**

Drawing on examples from the five QUEST countries, this report expands on the themes listed above and frames them through an examination of the **Influencing Environment, Health System Strength and Management, as well as Values and Community Norms**. Through this analysis, PAI aims to understand quality in reproductive health programs, as well as support changes in policies and health systems, correct imbalances and replicate conditions that drive quality.

PAI would like to thank the QUEST partners and PAI staff who contributed to this report. These include Heartfile, Si Jeunesse Savait (SJS), The Center for Catalyzing Change (C3) and The Consortium of Christian Relief and Development Associations (CCRDA). This report draws heavily on several of the country synthesis reports produced by these partner organizations.^{4,5,6,7}

BACKGROUND: QUEST COUNTRIES

The following provides a snapshot of the family planning and reproductive health landscape in each QUEST country.

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

The DRC is home to nearly 80 million people, and expected to grow to 124 million by 2030.⁸ The epicenter of this growth is the capital, Kinshasa, home to an estimated 11.8 million people.⁹ Although the DRC was one of the few African nations to adopt family planning in the 1970s, political unrest and humanitarian crises hobbled these efforts, with attention to the issue beginning in earnest in 2004.^{10,11} Despite a 2013 peace agreement to end fighting in the Eastern regions, the DRC still struggles with instability, which has serious implications for health within the country.¹² The conflicts have prevented significant investment in the health system, leading to limited access to essential services—including reproductive health services—and poor health outcomes. For instance, the country has one of the highest maternal mortality rates in the world, and more than one quarter of married women have an unmet need for family planning.¹³

According to a 2013-2014 Demographic and Health Survey, 19 percent of women used contraceptives, eight percent of which were considered to be modern methods. The prevalence of modern contraceptives is 15 percent in urban areas—Kinshasa has the highest rate at 19 percent—compared to five percent in rural locations. Modern contraceptive use among women in a union rose slightly from six percent in 2007 to eight percent in 2013. The DRC's overall contraceptive prevalence rate was just eight percent in 2012.¹⁴ However, a national strategic plan for family planning aims to increase the utilization of modern contraceptives to 19 percent and ensure that a minimum of 2.1 million women have access to such methods by 2020.¹⁵ As the DRC strives to rebuild, there is an opportunity to ensure programs and policies prioritize the delivery of quality reproductive health services. This also represents a critical time to address healthy sexual and reproductive health following the conflict period characterized by widespread sexual and gender-based violence.

ETHIOPIA

Although more than 90 percent of Ethiopians have access to family planning, challenges remain. For example, Ethiopia is one of the seven nations worldwide that make up half of all adolescent pregnancies.^{16,17} In the Oromia region, the most populous in the country, short-acting contraceptive methods such as pills and injectables are most popular and the use of long-acting contraceptives is very limited.¹⁸ Quality care is best available in antenatal and postnatal care clinics. However, there is a dearth of providers as well as information about family planning and reproductive health in Oromia's primary health care centers. Despite impressive growth in contraceptive use across Ethiopia over the past two decades, quality of care is still considerably compromised in health facilities and there are few fully functioning community monitoring mechanisms in Oromia. While contraceptive use has increased by more than 20 percent since 2000, the rates of unmet need and high discontinuation rates suggest more needs to be done to ensure high-quality reproductive health coverage.¹⁹



Medecins du Monde (MDM) display this African wrap in their clinic, which is printed with the main issues related to health and rights in the DRC. MDM says public health must integrate a rights-based approach and incorporate challenges to gender norms.

ALTHOUGH MORE THAN 90 PERCENT OF ETHIOPIANS HAVE ACCESS TO FAMILY PLANNING, CHALLENGES REMAIN. FOR EXAMPLE, ETHIOPIA IS ONE OF THE SEVEN NATIONS WORLDWIDE THAT MAKE UP HALF OF ALL ADOLESCENT PREGNANCIES.



INDIA

India is home to more than 1.2 billion people—nearly 57 percent of which are women and girls.²⁰ Over time, India has made improvements in providing women and girls with essential quality reproductive health services, but there is still a high degree of inequity in health outcomes and access to services, particularly in the northern states of Bihar and Uttar Pradesh. Although India has had longstanding family planning programs, quality is still a concern. In 2014, quality of services received global attention when at least a dozen women died following sterilization procedures.²¹

Bihar is one of India's poorest states, with more than a third of the population living below the poverty line.²² It struggles with ensuring access to contraception, as well as high rates of child marriage and maternal and neonatal mortality.²³ Approximately one quarter of married women have an unmet need for family planning, which is greater than the national average.²⁴ Even within the state, socio-economic and district-level disparities exist and quality of care continues to be an issue.

Uttar Pradesh is India's most populous state, where women face high unmet need for family planning and reproductive health services. Nearly 21 percent of married women need family planning, and only 38 percent of them use modern contraceptives.²⁵ Early marriage, limited access to education for girls, poverty and lack of decision-making power contribute to poor reproductive health for women and girls. There is also an acute need to improve access for a range of contraceptive methods in Uttar Pradesh, where 18.4 percent of married women ages 15 to 49 have been sterilized—in part due to limited access, demand or knowledge of other methods.²⁶

MYANMAR

Myanmar is home to 51.4 million people according to the 2014 census—the country's first in 31 years.²⁷ Developments in the country have been increasingly visible following its first election in two decades, which took place in 2010. Although maternal deaths in Myanmar dropped by 43 percent over the past two decades, the maternal mortality rate remains high at 282 deaths for every 100,000 live births.²⁸ Additionally, in 2009, the government of Myanmar adopted a five-year plan for improving reproductive health, which included strategies on birth spacing, prevention of unsafe abortion and adolescent reproductive health.²⁹ Despite these steps, significant reproductive health disparities remain, especially for internally displaced people, and unmarried and rural women. Myanmar renewed the plan for 2014-2018, expanding the initial scope to respond to the UN Secretary General's 2010 Global Strategy for Women and Children's Health.³⁰

While these policies indicate a commitment from Myanmar's government to improve reproductive health across the country, the recent Rohingya crisis and the country's reported treatment of ethnic minorities raises questions about equitable implementation of these policies. Gender disparities exist throughout Myanmar—including access to health services—but women and girls are particularly impacted in remote areas and those areas which are affected by conflict. These same women are particularly vulnerable to gender-based violence and discrimination.³¹ Recent reports indicate that up to 70 percent of Rohingya fleeing the crisis are women, with most identifying either as survivors or witnesses of sexual and gender-based violence.³²

PAKISTAN

Although knowledge of contraception is almost universal in Pakistan, one in five women has an unmet need for family planning.³³ The use of modern contraception has increased dramatically from nine percent between 1990 and 1991 to 26 percent between 2012 and 2013.³⁴ However, women still do not have access to the quality contraceptive services they need, which is reflected in stagnating rates of contraceptive use.³⁵ Regional disparities also persist and individuals rely heavily on only three types of contraception: male condoms, female sterilization and injectables.³⁶ The quality of services also remains a key impediment to women who want to use contraceptives. Many women never hear about family planning from health workers—and for those who do receive information, often they are not properly counseled. Inequitable gender dynamics in Pakistan continue to limit women's mobility and decision-making, and contribute to women's inability to access contraception.

INFLUENCING ENVIRONMENT

Many dynamics that define quality, including the political and legal context, are at play before a woman seeks care at a clinic. PAI and partners found that the delivery of quality health services in many QUEST countries is affected by both the past and current political ideology as well as governance at the federal level. Importantly, the influence of former policies often remains strong even after new progressive laws and policies to promote quality and protect rights are developed. We also found that in almost every location, inconsistent legal and policy frameworks govern reproductive health and rights at the national and subnational levels. Although individual laws and policies in some geographies attempted to strengthen women's autonomy and agency, implementation of these policies has not fully materialized. These challenges greatly inhibit the provision of quality services by hampering decision-making around health policy and health financing.

These factors are further compounded by the complicated relationship between government and civil society actors in all QUEST geographies. The limited voice and ability of civil society to hold federal or subnational governments accountable were evident in all countries.

COHERENCE AND COORDINATION OF REPRODUCTIVE HEALTH POLICIES

In Pakistan, the current transition to a decentralized governance structure provides a good example of how inconsistency at the federal level intersects with provincial decision-making and policy.³⁷ Instead of being driven by the needs of the population, Pakistan's policy agendas have historically been designed and fueled by the interim objectives of ruling parties, institutional leaders and goals of bilateral and multilateral donors.³⁸ The dearth of a clear strategic vision for family planning has been detrimental to the quality of reproductive health services and has created institutional chaos.

“The Ministry of Health is attempting to invite donors on its own, bypassing provincial stakeholders, which is leading to confusion among donors and hampering the development of provincial capacity.”
—Provincial Official in Sindh, Pakistan

While devolution offers the opportunity for more coherent and locally driven health strategies at the provincial level, it presents the challenge of ensuring subnational policy aligns with an overarching national vision. This has created confusion over the distinct mandates of federal and provincial governments. For example, stakeholders interviewed by QUEST partner organizations highlighted international funding and donor coordination as areas where the federal government continues to take unilateral actions, thereby undermining provincial ownership over family planning priorities.

However, Pakistan's new National Health Vision demonstrates some direction for family planning efforts and is a good example of federal-provincial cooperation.³⁹ Although it is still too early to determine the vision's impact, Pakistani government officials produced the plan in consultation with provinces in order to provide a coordinated strategic direction for the country's health sector. Provinces are now responsible for designing and implementing their own policies, and Sindh is a leading region in the effort. Approved in December 2015, its Costed Implementation Plan (CIP) lays out a comprehensive framework to guide all family planning activities in the province through 2020—with specific strategic focus on quality of services.⁴⁰

Like Pakistan, effective execution of health policy remains a major challenge in Myanmar. Encouraged by the international community, the country's leaders signed commitments to improve reproductive health and rights. This was initially done with informal pro-population growth policies intact, which created policy incongruence. Myanmar committed to the 1994 International Conference on Population and Development, the 2000 Millennium Declaration, and more recently, the UN Sustainable Development Goals and FP2020 goals.⁴¹ These commitments were initially made with informal pro-population growth policies intact, creating policy incongruence with the basic tenets of the reproductive health and family planning policy that had previously existed in Myanmar.^{42,43} On the other hand, more recent Myanmar documents—such as their strategic plan for FP2020—contain language of rights and freedom of choice.

In spite of the fact that state and township health officials were largely responsible for promoting family planning and implementing the FP2020 strategies, interviews revealed that most of these officials were unaware of the goals to which Myanmar committed the country. Therefore, townships and states have not

yet devised strategic plans to carry out these FP2020 goals—nor have township health teams received the information, resources and guidance to implement and monitor reproductive health services in their regions. This lack of awareness among states and townships, as well as the challenge faced by national health officials to disseminate the new policy at lower administrative levels, suggests that Myanmar might encounter difficulties in achieving its FP2020 goals. Moreover, the discord between federal policies and local practices was visible throughout the country. Examples included the role of midwives, who had not been officially allowed to provide women with Depo-Provera, yet were the de facto administrators of the contraceptive in villages. Newer contraceptive methods such as emergency contraceptive pills, implants and Sayana Press hold the potential to significantly improve women's access to contraception and long-acting methods. However, policies surrounding these contraceptives were often opaque, inconsistent and contentious, exacerbating the disconnect between local practices and central policies.

QUEST partner SJS observed a similar gap between policy and practice in the DRC due to government leaders' inability to harmonize, disseminate and implement reproductive health approaches. Additionally, many newly developed health policies, plans and strategies were often incoherent, contradictory or irrelevant to the same programmatic cycles, thereby decreasing their usefulness in providing effective strategic guidance. However, the DRC is taking steps toward more policy coherence through its comprehensive National Multisectoral Strategic Plan for Family Planning, which aims to improve the wellbeing of Congolese through increasing and ensuring the sustained use of modern contraceptives by 2020.⁴⁴ In addition, the National Program of Reproductive Health, which was instituted in 2001, offers an overall strategic vision for reproductive health and family planning—intended to move from an ad hoc approach to a more sustainable and long-term vision.⁴⁵ Providing high-quality services and a minimum health package that includes family planning are captured within the program's strategies.

By contrast, Ethiopia has experienced some success in family planning policy coherence. A variety of laws and policies address women's rights, family planning and reproductive health. For instance, the Ethiopian Constitution states that citizens have a right to family planning education and information.⁴⁶ This sets a foundation for political support and legislation, such as Ethiopia's 1993 National Health Policy, which provided a roadmap for services nationwide.⁴⁷ Updated in 2013, the policy also provides guidance on how to improve the quality of family planning and integrate it with other reproductive health services. Through such pioneering strategic initiatives, the prevalence rate for modern contraceptives in Ethiopia skyrocketed from 6.3 to 27.3 percent between 2000 and 2011—an impressive ninefold increase.⁴⁸

On an international scale, Ethiopia has committed to coordinating efforts over the next three years to strengthen adolescent and youth-friendly health services in order to reach its FP2020 goals. These goals include reducing unmet need for family planning among women ages 15 to 19 years from 20 to 10 percent, and among women ages 20 to 24 years from 18 to 10 percent.⁴⁹ As of July 2016, the country's family planning expenditures for the 2015-2016 fiscal year amounted to nearly USD 27 million, which represents a significant increase from an allocation of approximately USD 2 million in 2008.^{50,51} Still, there is more work to be done—although national budget lines have increased, leaders are striving to garner more support for regional family planning budgets.

POLITICAL SYSTEMS AND GOVERNANCE

Although all QUEST countries officially employ some form of democratic governance, the implementation of democratic principles varies greatly. The oldest democracy among the countries is India, with Ethiopia, the DRC and Myanmar making the transition much more recently. Pakistan, although democratic, has struggled with military and authoritarian interference.⁵² Recent or incomplete transitions from authoritarian governments are important in that they affect how quality of health services and reproductive rights are perceived and prioritized.

In addition to a country's governance structure, its laws present an important framework to protect, respect and fulfill human rights—and advance reproductive health rights and freedom for all citizens. Findings from the QUEST analyses show that laws can either drive or deter rights and quality, as well as determine how they are defined and translated into policy action in a specific country context. Interestingly, even with amendments, the continued contradictions and absence of reconciliation between old and new laws can perpetuate an unfavorable operational environment.

For instance, the DRC is not only affected by a proliferation of policies, but it is also burdened with remnants of a legal system created under colonial rule. Like all other QUEST countries—with the exception

SAROJNI DEVI IS AN ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA). ASHAS ARE TRAINED COMMUNITY MEMBERS WHO PROVIDE A RANGE OF SERVICES IN RURAL AREAS, INCLUDING FAMILY PLANNING COUNSELING AND INFORMATION ABOUT NUTRITION AND IMMUNIZATION.



of Ethiopia—the DRC was at one time colonized by a European power. This has had a lasting influence on government systems, country stability and the legal frameworks that govern advancement or inhibition of people’s rights, including reproductive rights. Findings from country assessments also demonstrate that a history of colonization may still impact the legal and policy framework governing quality health services and reproductive health rights in the DRC. For example, the 2005 Constitution reaffirms the DRC’s commitment to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and ensures the protection and promotion of women’s rights.⁵³ However, the 1941 penal code established during Belgian colonial rule penalizes reproductive rights and diminishes women’s equity.⁵⁴

While the DRC has since promulgated progressive policies, the discord between the different legal and policy systems continues to hamper quality and rights. One example is the law drafted by the Permanent Consultative Framework of Congolese Women (CAFCO), which is a legal instrument favorable to family planning and reproductive health. However, it has been languishing in the government corridors, undergoing a series of legislative and judicial reviews since 2012.⁵⁵

Myanmar only recently transitioned from conservative military rule to a democratic model, and previously crafted reproductive health and population policies have significantly impacted quality of care. The National Population Policy drafted by the military regime in 1992 was pronatalist, a focus that remained in subsequent policies and sentiment. In this context, “birth spacing” replaced “family planning” in all policy documents. Until recently, leaders considered sexual health topics too “culturally sensitive” to act upon, resulting in ad hoc decision-making rooted in principles of population control. While shifting rapidly under the democratic government, the sensitivity of population politics has delayed the acceptance of long-acting modern family planning methods. Ultimately, little attention has been paid to the quality of services provided. However, the country’s recent democratic political shifts and its FP2020 commitment offer opportunities to pivot from previous practices and promote rights-based policy implementation.

On the opposite end of the spectrum, India has had a long and difficult history of population control policies. Although the central government formally abandoned numerical targets for family planning and an incentive-based approach to reproductive health care in the mid-1990s, these approaches are still central to policy and practice at the state level.⁵⁶ The influence of these past policies is significant. While government documents contain language consistent with ensuring quality—for example, by encouraging spacing rather than limiting methods—this narrative rarely translates to quality and rights in practice.

STRENGTH OF CIVIL SOCIETY

Findings from the QUEST country assessments revealed that civil society organizations (CSOs) in the QUEST countries lack the influence and involvement necessary to drive reproductive health quality, equity and justice. To be sure, reconciling inconsistencies in policies and financing between the national and subnational levels is challenging—in part because of the complicated relationship between government and civil society actors. Across the countries, few CSOs partner with governments to determine how best to meet community needs. Civil society also has limited ability to hold governments accountable for their decisions. Other aspects of the influencing environment also affect the strength and efficacy of civil society. For example, the DRC, Myanmar and Pakistan are either transitioning out of conflict or in the midst of ongoing conflict and insecurity—both of which contribute to a weakened civil society.⁵⁷ However, even in countries such as Ethiopia and India, which are relatively stable, civil society is often ostracized from participating in decision-making processes or punished for attempting to hold governments accountable through advocacy on quality and reproductive rights.⁵⁸

Ethiopia provides an interesting case study: despite the influx of international donor attention and funds for family planning and reproductive health, the country’s civil society is experiencing assaults—this has grave implications for health and development initiatives, as well as for quality and rights in reproductive health. In spite of Ethiopia’s historically strong presence of community-based organizations and a substantial rise in the number of registered nongovernmental organizations (NGOs) in the 1990s, the government’s continued surveillance of charities and CSOs is a concern.^{59,60} Charities and CSOs that receive more than 10 percent of their funding from foreign sources are prohibited from participating in human rights and advocacy activities, which may be an attempt by the government to mute CSOs and limit their resources, essentially curtailing their overall right to expression.⁶¹

Meanwhile in Myanmar, civil society’s voice is often missing. For decades, the government has been making decisions among a handful of powerful individuals and has demonstrated little interest in community input

on policies and programs.⁶² Although there are efforts to seek input from technical working groups, many members of those groups are former ministry employees, and participation often remains a formality. For instance, although there have been efforts to include the voices of high-risk populations in HIV/AIDS policies by sending representatives to the parliament, this has not led to a sustained change that promotes the principle of inclusion.⁶³ Health-related expenses, personnel costs and other financing details in states and townships have been considered confidential and difficult to obtain by CSOs or the public.⁶⁴ However, as reforms continue in Myanmar, community-based organizations are creating more platforms for inclusion—as well as the potential for the development of high-quality sexual and reproductive health programs tailored to meet the specific needs of citizens.

For the majority of Pakistan's citizens, decisions about health and family planning services and budgets have been—and continue to be—made without their input, and CSOs continually face challenges holding decision-makers accountable.⁶⁵ These realities are due in part to the country's history of prolonged periods of military rule and centralized policymaking, among other factors. In Sindh, political shifts and transitions of power resulted in a local government that operated sporadically until 2009, followed by elections in 2015.⁶⁶ With the trend toward decentralization in Pakistan, there is hope that citizens' voices will gain strength, helping an environment of greater government accountability to take hold.

“Consultation is still ad hoc and not mandated as a matter of policy. Governments reach out to experts when they are pressured to... not because they are required to.”

—Health Policy Academic in Pakistan

In Sindh, CSOs have participated more in the province's policymaking processes in the last few years. This has been especially true with the Sindh Health Sector Strategy and the CIPs being established through collaborative efforts among donors, NGOs, academics and practitioners.^{67,68} The development of new family planning task forces and provincial forums for oversight and implementation—including those focused on FP2020 commitments—are also positive steps toward engaging nongovernment actors in policy decisions.⁶⁹

HEALTH SYSTEM STRENGTH AND MANAGEMENT

Providing quality reproductive health care services that honor women's rights requires a health system underpinned by a strategic vision. Strategies must be carried out through an efficient management system that plans and budgets based on the needs of the population it serves. Country assessments revealed various management issues in the QUEST geographies, including challenges with planning, budgeting, ethics, participation and accountability.

In several QUEST countries, CSOs and health care professionals reported that systemic and needs-based approaches have been neglected by governments in favor of ad hoc decision-making. This has led to the health system's inability to respond to the evolving needs of communities. Weak, inaccurate and fragmented health information systems present a distinct set of challenges, particularly when making projections and estimations to enable planning. Interagency or ministry coordination and communication are also lacking as well as convergence and harmonization of policies and strategies. In some countries, such as India, policies are in place but implementation has faltered. These findings reflect a vital connection between the dysfunctional management systems—specifically for planning, budgeting, dispensing and monitoring reproductive health services and supplies—and poor quality reproductive health outcomes at the subnational level.

FUNDING

There is an acute need to improve the national planning and budgeting systems, which have a large impact on resource allocation for health—including family planning and reproductive health—in all QUEST countries. Even when resources are allocated for health, investments lag far behind objective needs. Furthermore, family planning and reproductive health are insufficiently prioritized from a needs-based perspective within health budgets.⁷⁰ In Myanmar, for instance, while the health budget increased fourfold between 2012 and 2013, the increase was minuscule compared to the larger needs of the country.⁷¹ Health-related costs amounted to about 5.7 percent or USD 405 million of total government spending (approximately USD 7.06 billion), most of which was allocated to overdue salary increases. Budgeting focused almost exclusively on financial control, with limited or no consideration to policy-based earmarks or efficient service delivery. In addition, the budgeting process remains centralized with limited connections between financial allocations and implementation plans, according to a 2013 UNICEF report.⁷²

QUEST partners observed similar practices in the DRC and India. For example, although the Congolese health ministry allotted USD 760,000 to purchase reproductive health supplies in 2013, the budget did not include a fixed line of activity for the allocation.⁷³ In India, interviews revealed lagging disbursements from the central government to states such as Bihar and Uttar Pradesh, resulting in the underutilization of funds. This impacted the implementation of family planning and reproductive health programs.

SUPPLY CHAIN MANAGEMENT AND PROCUREMENT

The process of accurately predicting, procuring, housing and distributing reproductive health commodities can be hindered by inadequate financial planning and supply management systems, which diminish a country's ability to deliver quality reproductive health services. Such is the case in India, where contraceptive supplies are procured and sent from a central facility to state or district-level locations and from district to lower-level facilities.⁷⁴ However, fund disbursement issues, corruption, delivery delays and inaccurate measurement of needed supplies continue to create barriers for short-term methods. Government reports from 2011 noted significant corruption in the procurement system in Uttar Pradesh, despite the existence of departments to manage and monitor procurements.⁷⁵ In Bihar and Uttar Pradesh, quality assurance committees are set up to conduct surprise checks on district-level health facilities for supplies monitoring. While this was meant to be a mechanism for continued monitoring, informants reported these checks may happen only once, and stockouts of contraceptives remains a pressing problem in Bihar. In both focal states for QUEST, contraceptive stockouts hamper the delivery of short-acting methods in communities, leading to a reliance on postpartum IUDs and sterilization. An interview with key informants revealed that the lack of supplies left community health workers with few options and was a primary factor for suggesting to women that they consider sterilization.

In 2007, Ethiopia created a dedicated budget line for contraceptive supplies after the country waived its import tax on contraceptives.⁷⁶ While an important advocacy win, CSOs do not have the ability to track

what types of contraceptives have been purchased, or how many. Key informants at the zonal level reported stockouts of contraceptive commodities, which points to either a lack of funds, corruption, inaccurate forecasting or inadequate disbursement. This absence of accountability and monitoring is leading to continued stockouts throughout the country and a skewed method mix, as long-acting methods are rarely available.

“Donors tend to dump commodities in townships without monitoring or follow up. We don’t know what to do with them.”
—Nurse in Shan State, Myanmar

In Myanmar, acquiring a mixture of methods and an accurate amount of contraceptive supplies at the right time is a significant challenge due to inadequate supply chain information and management. As a result, health workers may face a shortage or surplus of certain contraceptives, or a cache of expired products.⁷⁷ Health care providers in townships must find ways to access supplies from remote locations, since the country does not budget for product deliveries beyond capital cities.⁷⁸ As Myanmar emerges from military regime—and similarly, the DRC, from a post-conflict environment—more donors and NGOs are interested in investing in family planning and reproductive health in both countries. However, most donor-funded programs have established their own procurement and distribution systems to circumvent the challenges in the larger health system, where acquiring contraceptive commodities is significantly challenging. Uncoordinated efforts to improve the supply chain have resulted in multiple parallel systems that have further complicated the overall health management system.⁷⁹ The health ministries in both countries are now confronted with the additional challenge of working towards a unified system, which requires coordinating international organizations with differing goals and objectives.

Finally, effective management of family planning programs in Pakistan is hindered by the separation of health and family planning functions, which operate in two parallel systems that lack a shared agenda. This fragmentation impedes the provision of high-quality services, particularly in ensuring an appropriate constellation of services and adequate continuity and follow-up with patients. While the federal government has made a commitment to increasing coordination among health programs at the national level, separation at the provincial level continues to be a challenge.⁸⁰ Recent health and population policies in Sindh reflect a welcomed effort for more coordination and functional integration.

HEALTH WORKFORCE

High-quality health services cannot be delivered without adequate human resources. An effective health system requires an appropriate number of well-trained, ethical providers capable of delivering family planning and reproductive health services to the population without judgment. The analysis from all five QUEST focal countries reveals glaring gaps in these important parameters. In the DRC, although human resources are concentrated in Kinshasa, neither the infrastructure nor the workforce has kept pace with the growing population. A shortage of doctors and nurses is common, and many physicians are uninterested in engaging in family planning services. Through QUEST, a similar shortage of health care workers was documented in Myanmar—including midwives, who are often the sole public sector provider in hard-to-reach villages. A 2013 World Health Organization (WHO) study found that an average midwife served about 5,000 people—far exceeding WHO’s recommended number of people served by one health worker.⁸¹ In all QUEST countries, health worker recruitment, training and continuing competence, compensation, utilization and overall management emerged as critical issues in meeting the evolving reproductive health and family planning needs of populations, as well as focusing on quality as an element of health care.

Across the board, governments are attempting to improve these workforce challenges, but they are far from being adequately addressed. To effectively do so requires a greater degree of political will, financial resources and governance mechanisms to ensure that quality reproductive health services reach those who greatly need them. Ethiopia is perhaps the most successful example of this effort—their Health Extension Worker program has received international acclaim for reaching both rural and urban populations previously marginalized from the health care system.⁸² The community health extension workers have been responsible for helping to reduce Ethiopia’s once staggering maternal mortality rates and improving contraceptive prevalence from 6.3 to 27.3 percent between 2000 and 2011.⁸³ Despite these successes, Ethiopia’s army of health providers continues to struggle with stockouts and training, which is particularly important for increasing method mix with regard to long-acting methods. Only 37 percent of health extension workers received training on implant insertion and only three percent were educated about implant removal.⁸⁴

Pakistan and India also have community health worker programs that have had modest success. The Lady Health Worker (LHW) Programme in Pakistan and the Accredited Social Health Activists (ASHAs) in India exemplify how human resource constraints can impact the quality of services. Pakistan introduced the program in 1994 as part of a national strategy to reduce poverty, accelerate progress on the Millennium Development Goals and achieve universal health care.⁸⁵ In addition to providing communities with an array of preventive, curative and rehabilitative services, LHWs were expected to provide family planning education as well as methods and maternal and child health services. After 2010, funding gaps and post-devolution institutional disarray left the program inactive for several years.⁸⁶ An assessment of LHW competencies found that while they performed better than other cadres in terms of knowledge, “only 50 percent of them secured a competency scale in counseling skills and newborn care.”⁸⁷ In interviews with stakeholders for this report, many said that health workers are overburdened with other duties—such as addressing polio cases—which have steered them away from their primary responsibilities. Few reproductive health commodities are supplied to LHWs, which has also impacted family planning efforts in Pakistan. Indeed, only 3.5 percent of clients in Sindh received their contraceptives from health workers, according to the 2012-2013 Demographic and Health Survey.⁸⁸

In India, the National Rural Health Mission seeks to provide one ASHA per 1,000 rural residents.⁸⁹ They work to improve community access to public health services through efforts that include the provision of free contraceptives through door-to-door distribution. ASHAs are the depot holders for oral contraceptive pills and condoms and they are responsible for following up on sterilizations and IUD insertions.⁹⁰ While India is one of the few countries where choice has expanded to include eight contraceptive methods with multiple touch points, in reality, ASHAs do not have adequate and accurate information on methods—despite efforts to improve their technical skills through private sector and CSO partnerships.⁹¹ ASHAs also lack the “soft skills” necessary to educate and counsel patients. In-service training for ASHAs generally does not include an interpersonal communication and counseling skills component, and guidance on how to provide supportive supervision to clients remains missing from the curriculum. The insufficient availability of contraceptive supplies is yet another barrier that significantly affects the work of ASHAs. In addition, issues of performance-based incentives for ASHAs, concerns about their compensation and the absence of a clear roadmap for their career progression have significantly impacted ASHAs’ motivation and performance.⁹²

HEALTH CARE ETHICS

Ethical health care practices are vital to safeguarding the interests and rights of clients—especially women and girls seeking reproductive health and family planning services. Medical ethics includes the four principles of respect for autonomy, nonmaleficence, beneficence and justice, and implicitly embedded within them is the client’s right to well-being, dignity, choice and self-determination, confidentiality and informed consent.⁹³

QUEST partners reported weak, neglected and grossly underserved health ethics in the reproductive health arena across all the five countries. Issues surrounding lack of consent, patient respect and confidentiality abound, most discernible among them being informed consent. Notably, these gaps in effective implementation of ethics are rooted in poor communication between the clients and their health care providers, which can be attributed to deficiencies in the overall health system, such as inadequate health worker training that neglects the importance of ethics. As a result, service providers spend minimal consultation time with clients, and lack appropriate training in family planning counseling.

Even India and Pakistan—with their long and advanced histories of reproductive health and family planning—grapple with health ethics in ensuring quality of care. Despite several regulatory organizations that develop, monitor and maintain ethical standards in India, the dialogue on ethics remains largely disparate. Frequent compromises on ethical standards are made at the state level where the tenets of quality of care and ethics are routinely neglected.⁹⁴ More often than not, consent is treated as a hurried formality because of the limited time available with providers.

Perhaps the most blatant violation of patients’ rights and medical ethics are mass female sterilizations where little care is given to informed consent and other tenets of quality. Nationally, there were more than 350 deaths and a staggering 15,000 failures of sterilization were reported from 2010-2013.⁹⁵ It is dependent upon clients to report misconduct to the Medical Council of India, which helps set standards of practice.⁹⁶ But state chapters of the council do not provide a system for medical practitioners to re-register or to offer mandatory continuing medical education. Many cases of misconduct therefore go unreported because clients do not know what is considered professional conduct or how to file a grievance.⁹⁷ The issue of ethics in India is an impending and grievous one needing urgent attention, especially in the context of quality and rights.



"A GREAT CHALLENGE IS THAT MANY PARENTS BELIEVE THEIR CHILDREN DO NOT HAVE THE RIGHT TO GET SEXUAL HEALTH SERVICES. WE NEED TO GET INFORMATION, SERVICES AND HELP TO THESE YOUTH. INFORMATION IS A BETTER PREVENTION THAN SILENCE."

**—MBADU MUANDA, PNSA DIRECTOR,
DEMOCRATIC REPUBLIC OF THE CONGO**

In Pakistan, medical ethics have been sparingly mentioned in policies and strategies for much of the country's history. Although Pakistan has committed through the FP2020 framework to ensuring that "facilities, providers and methods are respectful of medical ethics; sensitive to gender and life cycle requirements and confidentiality," the Sindh CIP does not acknowledge medical standards.⁹⁸ And despite a national code of ethics for medical and dental practitioners, it is not widely applied and the legal consequences for malpractice are few.⁹⁹ Indeed, a review of standards in Pakistan's health sector found a material shortage of policies, legislation and literature on medical ethics and that discussions about the topic are often influenced by religious values.¹⁰⁰

In the still-evolving health systems of Myanmar and the DRC, ethics remain more or less a theoretical concept. For example, ethical considerations in Myanmar's public health practices are not the norm, although bodies such as the country's Ethical Review Board have recently become more engaged due to the growing health research needs of international agencies.¹⁰¹

VALUES AND COMMUNITY NORMS

Inequitable and harmful gender norms and practices are among the most critical factors that prevent women from accessing high-quality health care and family planning services in the five QUEST countries. In each country, actions to counter the patriarchal structures that underpin constraints on women's autonomy and mobility are insufficient—especially in the context of reproductive health policy and service delivery. The lack of responsiveness towards women's empowerment in the domestic and public spheres has meant that women remain passive, dependent recipients of family planning services, rather than rights-bearing citizens.¹⁰² Moreover, the conservative attitude toward sex prevalence in these societies has resulted in stigmatization and severe limitations for access to and choice of quality reproductive health services, supplies and information—particularly for unmarried women and young people.¹⁰³

In societies plagued with deep-rooted inequalities such as India and Pakistan, the intersections of caste, class, gender and sexuality further perpetuate the marginalization of women. The hierarchies of class and caste also limit a woman's opportunity to access quality reproductive health care. Notably, the family planning system in these countries continues to be characterized by a stark divide across public and private sector facilities, with the latter being more likely to offer higher quality services, better trained staff and greater method choice—much of which is out of the financial reach of the poor.¹⁰⁴ Studies show that class and caste hierarchies also create a social distance between LHWs and their clients, therefore restricting their abilities to provide family planning services.¹⁰⁵ The caste of a community health worker vis-à-vis clients—such as ASHAs in India—can also be a significant deterrent in their health services outreach and overall performance.¹⁰⁶ For example, an ASHA of a higher caste may neglect to reach out to clients of a lower caste, thereby inhibiting their access to contraceptive services and supplies.

Similarly, Pakistan's patriarchal society is characterized by entrenched gender inequalities that hinder women's decision-making autonomy. Social norms dictate that women should not associate with unrelated men—they face the threat of harassment and social stigmatization if they do—and restrict women's movement in the public sphere.¹⁰⁷ Such an environment not only limits women's agency in terms of their sexual and reproductive health, but it also impedes family planning efforts. For instance, women are hesitant to visit Family Welfare Clinics because of the social stigma attached to seeking the type of services offered in such clinics.¹⁰⁸ In addition, women's lack of autonomy prevents them from banding together to demand higher quality family planning care, which helps perpetuate an unaccountable system. Although Pakistan has utilized community health workers to directly address women's mobility constraints, the effort has had intermittent success because outreach and resources have primarily focused on other areas, such as polio and malaria control—not family planning.¹⁰⁹

The situation for women in Ethiopia is also dire, particularly for girls and young women. Women are half as likely to be literate, less likely to be employed, and more likely to marry earlier than their male counterparts.¹¹⁰ They have little autonomy over their reproductive health, as it can be considered taboo for them to make decisions about their health without their husband's consent.¹¹¹ Women's disadvantageous position is perpetuated by ingrained harmful cultural norms and practices such as child marriage and female genital mutilation (FGM), the latter of which a striking 60 to 80 percent of women have experienced.¹¹² Although both practices are forbidden by law, they remain prevalent across regions, including Oromia, and within Ethiopia's numerous ethnic groups.¹¹³ The Ethiopian government is slowly attempting to combat some of these inequities through targeted policies and programs with a strong recognition of the need for both health sector and community engagement to tackle harmful social norms. Consequently, policies include language on family planning and reproductive health, with important references to a woman's ability to choose the family planning method that works best for her.¹¹⁴

In the DRC, social norms that dictate women's status in society and harmful practices such as child marriage, polygamy and levirate marriage continue to paralyze reproductive choice.¹¹⁵ Congolese women are generally expected to stay in the home, have children and yield to their husband's decisions in all aspects of life, including reproductive health.¹¹⁶ Community norms reduce women's agency, rendering it very difficult for them to receive quality, patient-centered care.

Large gaps exist between the presence of statutory protections for Congolese women and girls and the actual implementation of these laws. Enforcement is complicated by community norms, with different expectations for women's roles in society than those reflected in the law.¹¹⁷ This lack of political, social and economic equality inhibits women from receiving quality care because they have little agency and

autonomy, especially once they are married. Additionally, early marriage is very common, so from a young age girls are often subject to the will of their husband and have limited decision-making power—even over their own health care.¹¹⁸

REPRODUCTIVE HEALTH QUALITY AND RIGHTS OF YOUTH

QUEST country findings indicate that the interplay of socio-cultural norms as well as gender discriminatory attitudes and practices are of particular concern for ensuring the reproductive rights of young people, particularly unmarried youth. Interestingly, almost all focal geographies have dedicated national sexual and reproductive health policy for youth or include components of it as part of a larger youth policy. Policies recognize the existing challenges of unmet need for contraception and low condom use among adolescents, adolescent pregnancy and unsafe abortion. Some focal countries even have well-delineated reproductive health programs for young people.¹¹⁹ However, social norms continue to override actual needs, leaving youth on the periphery and primarily dependent on a highly unregulated and unsafe private sector to meet their reproductive health needs.

Indeed, in the DRC, community norms and societal values have a disastrous effect on adolescents' and young people's access to family planning services. Reproductive health quality and rights for youth are limited by several factors: the lack of knowledge about their own bodies and beliefs, erroneous rumors about the effects of some contraceptives, and social norms about the role of girls and women in society—including the ironic stigmatization of both contraceptive use and pregnancy outside of marriage.¹²⁰

Although the DRC's 2014 national policy on youth and adolescent health acknowledged the possibility of youth being sexually active for the first time, practice has not followed.¹²¹ Parental consent is still needed to access contraceptives and many family planning providers refuse to serve the unmarried. Meanwhile, virginity is seen as a value and pregnancy out of wedlock is heavily stigmatized.¹²² In addition, the limited number of youth-friendly services plus the cost of contraceptives and weak purchasing power of women further hinders their access to quality services and negatively affects their health.¹²³ Rampant gender-based violence is a critical barrier as well.¹²⁴ Sexual violence and cultural beliefs related to virginity—and the “benefits” of taking a girl's virginity—have resulted in sexual abuse of teenage girls in the DRC. According to the Second Demographic and Health Survey, 16.4 percent of girls aged 15 to 19, and 27.6 percent of women and girls aged 20 to 24, reported experiencing sexual violence.¹²⁵

As in all other QUEST geographies, norms around youth and sexuality in the DRC often result in health workers being judgmental toward young people seeking sexual health services, and at times refusing to provide them with contraceptive methods. Religious beliefs and cultural mores also paint modern contraceptives as controversial or prohibit them outright.¹²⁶ With the increasing number of small fundamentalist Christian churches throughout the country, the anti-family planning sentiment in some areas is growing.¹²⁷ However, it should be noted that religion is not in itself an obstacle to contraceptive use in the DRC. Some Catholic groups have privately condoned the distribution of condoms and contraceptives, and several Protestant groups have played a groundbreaking role in family planning in the country.¹²⁸

The government's National Strategy aims to reach all of the 516 Health Zones with youth-friendly services by 2020.¹²⁹ Several clinics provide welcoming, youth-friendly services in better-resourced areas in Kinshasa and the eastern regions of north and south Kivu. This leaves many young Congolese who live in remote, rural zones—many of which have the highest figures in teenage pregnancy in the country—with few options.¹³⁰

The government is also working with social marketing organizations to target young people with information and services on sexual health and offer contraceptives at subsidized prices. In 2015, the DRC's parliament received a draft reproductive health law that includes language about providing access to contraception for all Congolese of child-bearing age, without an age minimum.¹³¹ For many Congolese youth, this draft bill may be lifesaving. The bill has been caught up in parliamentary discussion for the past few years but in its most recent 2017 commitment to FP2020, the DRC recommitted to moving this bill forward, by 2020 at the latest.¹³²

Youth-centered legislation is also on the policy radar in Myanmar: the leading priority of the Five Year Strategic Plan for Young People's Health is to improve the sexual and reproductive health of the country's youth.¹³³ Achieving this may not be easy, due to inadequate planning and budgeting, as well as social norms which—according to UNFPA—deem the topic of sexual and reproductive health to be “strongly considered taboo, making it challenging for young people to access accurate information that helps them

make informed choices for their future.”¹³⁴ Young women fearful of the social stigma associated with using contraceptives are forced to obtain them with the help of men, thereby losing control over the choice and timing of methods they use. Additionally, unmarried youth in need of contraception face a highly judgmental public health system that does not value clients’ privacy and provides little access to information and services. This environment eventually leads young people to turn to unregulated and unsafe private drug providers.¹³⁵

Socio-cultural norms also influence access to and quality of reproductive health for young people in Ethiopia. Youth aged 10 to 24 comprise about 35 percent of Ethiopia’s population, and while the country has made progress in improving health for youth, access and utilization of services by young people is still very limited. This results in high rates of maternal mortality, unsafe abortion, fistula and other pregnancy-related complications among youth due to non-use of contraceptive methods.¹³⁶ Pervasive gender inequalities and traditional harmful practices—including FGM and child marriage—contribute to these health challenges.¹³⁷ In a highly judgmental social environment, fewer young people access accurate information and contraceptives from a trained health care provider and instead, depend on their friends for information.¹³⁸ Many travel to neighboring communities to obtain contraceptives for fear of being recognized and stigmatized in their own communities.

The Ethiopian government has demonstrated its support and commitment to advancing adolescent sexual and reproductive health through the National Adolescent and Youth Reproductive Health Strategy that was adopted in 2006.¹³⁹ As part of the youth-friendly services, efforts have been made to create safe spaces in government-run health centers and through “youth corners” in primary schools, where free reproductive health services are provided.¹⁴⁰ The health ministry recently developed the Adolescents and Youth Health Strategy 2016-2020 to scale up an adolescent and youth-friendly reproductive health service package at all levels within five years. The National Reproductive Health Strategy has also been extended to the year 2020.¹⁴¹

Like Ethiopia, India has a booming youth population. With 28 percent of Indians between 10 and 24 years old, the country is home to the largest population of young people in the world.¹⁴² India’s traditional and conservative social fabric as well as taboos around sex impedes young people’s abilities to access reproductive health services. At the same time, the central government continues to resist the introduction of comprehensive sexuality education in schools. Premarital sex is widely discouraged and adolescent reproductive health remains a source of social stigma.¹⁴³

India’s 2014 National Adolescent Health Program mandates Adolescent Friendly Health Clinics, which should provide young people with counseling, preventative and curative services at the primary, secondary and tertiary levels of care.¹⁴⁴ Peer educators and frontline workers such as ASHAs are actively engaged in the program, which also aims to address the unmet need for contraception and low condom use among adolescents. However, in reality, awareness and utilization of the health clinics are abysmally low among adolescents and youth, even if the clinics are located nearby. Studies also show that information provided to the clients is not comprehensive and at times, delivered in a moralistic, judgmental fashion—resulting in very low condom use among adolescents in premarital sexual relationships.¹⁴⁵

CONCLUSION

Findings in the five QUEST countries demonstrate the challenges of and opportunities for accessing and delivering quality reproductive health care that fulfills women's rights. Guaranteeing a woman's right to high-quality information and services is a complex task that requires a multifaceted, coordinated approach at the national and subnational levels. It requires an army of properly trained health workers who deliver services in a respectful manner and honor women's privacy, needs and preferences. It calls for harmony between policy and practice, as well as a vocal civil society that holds decision-makers to account. And it demands persistence in combating entrenched gender and social norms as well as inequities that inhibit women's access to quality contraceptive services.

The focal geographies analyzed continue to struggle with delivering such rights-based quality health care. Political structures and policies—including the remnants of former legislation or leadership—have a clear influence on countries' abilities to advance quality and rights. Most of the QUEST geographies may have established national policies to ensure high standards of care. However, these often do not translate on the ground, or there is confusion or disinterest among those delivering services—from physicians to community health workers—which perpetuates a fragmented, inefficient health care system. Many civil society actors have limited influence in reproductive health and family planning policy decisions. In every country examined, the power of deep-rooted gendered norms and harmful cultural practices remains an unrelenting, invisible force that constrains women's and adolescent girls' abilities to make decisions about their own reproductive health and access the services and contraceptive methods they demand.

The DRC, Ethiopia, India, Myanmar and Pakistan have all taken steps toward ensuring the right to access high-quality contraceptive services. Each has made commitments to meet certain family planning goals by 2020. They have all created strategies to coordinate efforts in the health sector, including family planning. And each is taking the steps to ensure that the health care workforce is properly equipped with the skills and infrastructure to serve both urban and rural populations, especially those who traditionally have been marginalized from the health system. It is critical that policymakers, CSOs and advocates continue to support these and other important advancements while simultaneously addressing the challenges of providing patient-centered reproductive services, information and education.

It remains to be seen if each of these countries will be able to implement these steps and commitments equitably across all populations. To be truly rights-based, health systems should provide quality services for all, regardless of age, ethnicity, religion, caste, sexual orientation or marital status. Only then are governments upholding the rights of women and girls to reproductive choice and quality health care—which contributes to their physical, social and economic well-being—and, importantly, to enhancing the strength of the nations in which they live.



my self
your self
him self
her self
it self

our selves
your selves
them selves

SOME EXAMPLES

APPENDICES

CONCEPTUAL FRAMEWORK

The 1994 International Conference on Population and Development (ICPD) Program of Action (POA) provides an internationally recognized and accepted conceptualization of reproductive health and rights.

“Reproductive health is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and to its functions and processes. Reproductive health therefore implies that all people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.”¹⁴⁶

The POA establishes several overarching reproductive rights, which when fulfilled, enable individuals to achieve reproductive health:

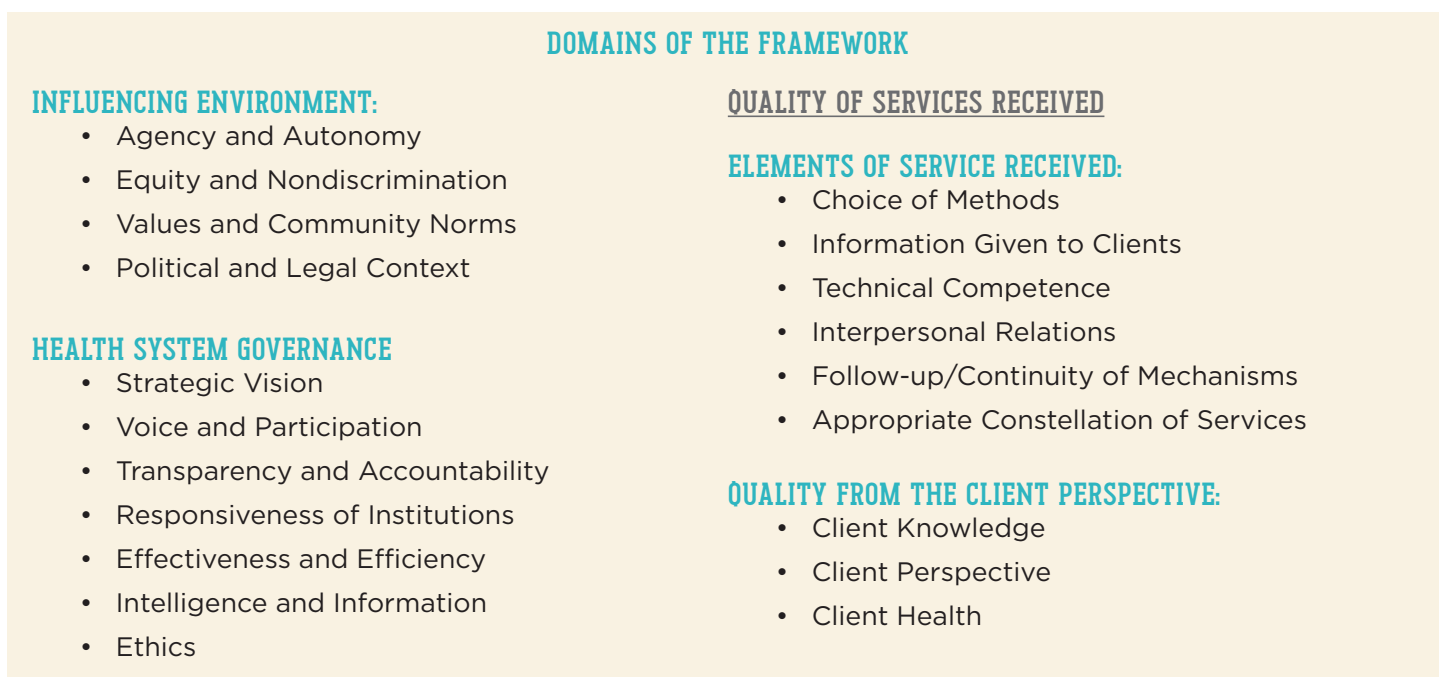
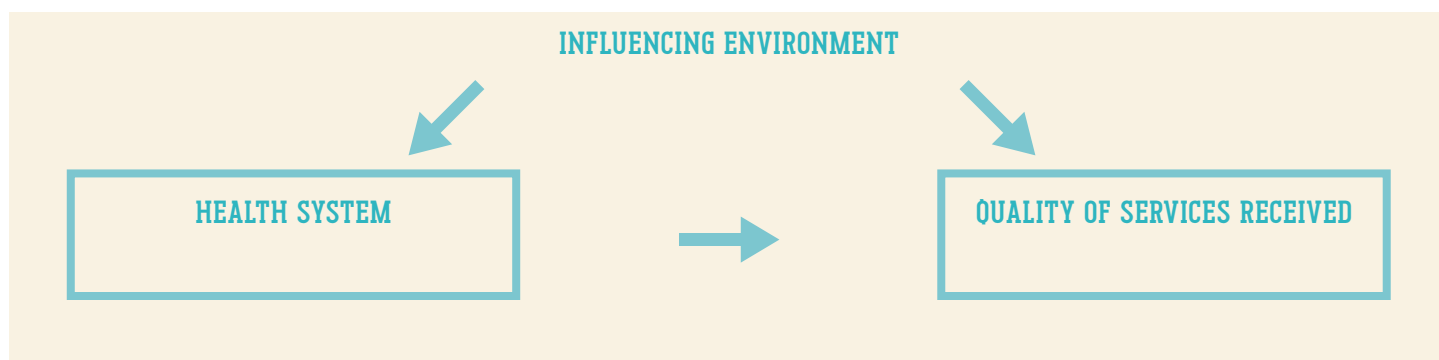
- Right to reproductive self-determination: right to bodily integrity and security of person, and the right of couples to “decide freely... the number and spacing of their children.”¹⁴⁷ This right also encapsulates the concepts of agency and autonomy, as well as voice and participation of beneficiaries in reproductive health policy and program design, implementation and evaluation.
- Right to sexual and reproductive health services, information and education, including the highest attainable standard of health: the principles of accessibility, availability, acceptability, quality and informed choice fall under this reproductive right.
- Right to equality and nondiscrimination: “the right to make decisions concerning reproduction free of discrimination, coercion and violence [equity and nondiscrimination].”¹⁴⁸

As duty-bearers, governments have a responsibility to respect, protect and fulfill the reproductive health and rights of their citizens. Quality is captured under the right to sexual and reproductive health services, information and education—including the highest attainable standard of health. Quality of care adheres to high standards and meets the needs of clients.¹⁴⁹ It is a multifaceted element that includes, but is not limited to:

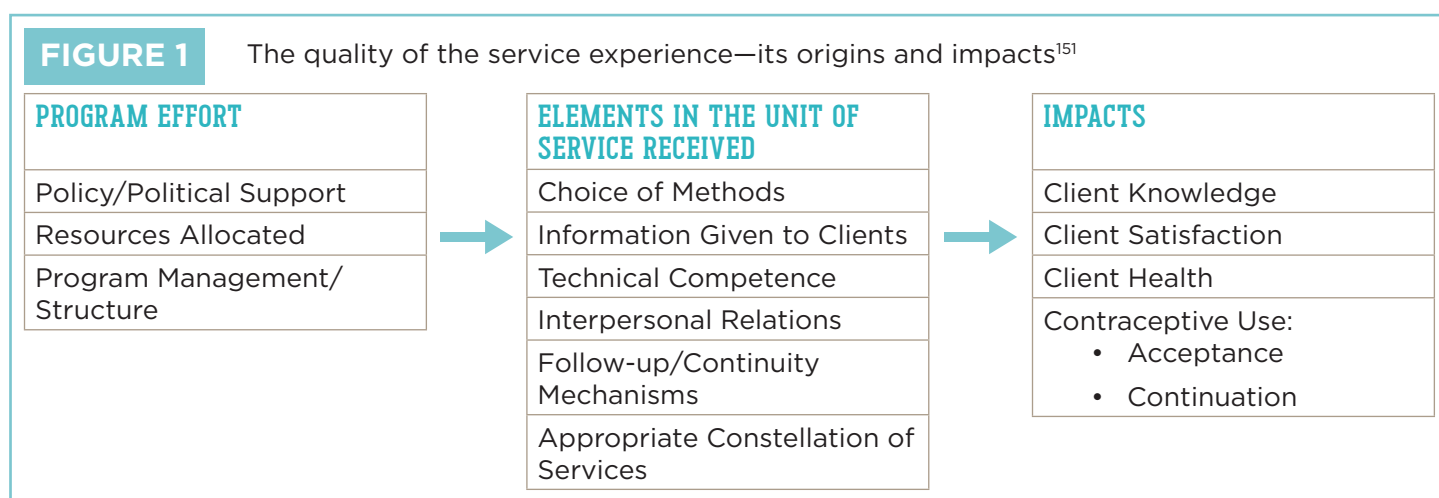
- Access to a full choice of contraceptive methods.
- Clear and medically accurate information, including the risks and benefits of a range of methods.
- Availability of equipped provider(s) who are technically and culturally competent.
- A client-provider interaction that respects informed choice, privacy and confidentiality, as well as client preferences and needs.

However, before reaching the one-on-one client-provider exchange, there are a range of systemic factors that influence the capacity and ability of the health system to provide quality reproductive health care. This conceptual framework informs a methodology for assessing the realization of quality reproductive health, and seeks to explore larger structural determinants that shape the quality of services received.

There are two components of Quality of Services Received: **Elements of Service Received** (Choice of Methods; Information Given to Clients; Technical Competence; Interpersonal Relations; Follow-up/Continuity of Mechanisms; Appropriate Constellation of Services) and the **Quality from the Client Perspective** (Client Knowledge; Client Satisfaction; Client Health).¹⁵⁰



This framework reflects key aspects of Judith Bruce’s quality of care for family planning framework and also utilizes certain principles of health system governance. The framework has expanded out the “program effort” component of Judith Bruce’s framework (below).



As a result, three interrelated spheres that affect the end client's experience with reproductive health care are identified: Influencing Environment, Health System Governance, and Quality of Services Received (Elements of Service Received and Quality from the Client Perspective). Within each of the spheres, domains that influence quality and the fulfillment of reproductive rights are presented and will comprise the assessment parameters.

The Influencing Environment refers to the overarching socio-cultural context within a country or subnational entity (e.g. state or region). Specifically, the Influencing Environment will be measured by four domains: Agency and Autonomy; Equity and Nondiscrimination; Values and Community Norms; and Political and Legal Context. While broad, the category of Political and Legal Context should be used to capture relevant issues in the country that are not reflected in the other domains, such as the institutional status of women, or conflict and insecurity. The assessment does not need to include an exhaustive analysis of every aspect of the political and legal context. For example, the extent to which women are included in participatory decision-making vis-à-vis the health system is connected to social norms surrounding gender equity and women's autonomy.

In addition, the framework employs principles of Health Systems Governance as an organizing model.^{152,153} **Health System Governance principles and their operationalization affect the functioning of the health system and have the potential to perpetuate or eliminate institutional barriers.** Subsequently, the domains within the Health System Governance sphere drive the health system's ability to transform quality from a rhetorical value into a cornerstone of reproductive health care. The Health System Governance domains incorporated into this framework include: Strategic Vision; Voice and Participation; Transparency and Accountability; Responsiveness of Institutions; Effectiveness and Efficiency; Intelligence and Information; and Ethics (see Annex 1 for Siddiqi et al.'s definitions of health system governance principles, as well as questions for assessing these principles, which will serve as a guide for this assessment.) These have been distilled from a broader set of principles to reflect those that most directly influence the quality of reproductive health.

The Influencing Environment and Health System Governance represent the distal determinants of quality. These spheres drive the Quality of Services Received (Elements of Service Received and Quality from a Client Perspective). Elements of Service Received represents the proximate determinants of quality. These proximate determinants—Choice of Methods; Information Given to Clients; Technical Competence; Interpersonal Relations; Follow-up/Continuity Mechanisms; and Appropriate Constellation of Services—are the components with which the client ultimately engages. The client's experience with quality is most directly influenced by these elements, which are a manifestation of the more upstream, distal determinants.

While much research has been conducted to better understand Quality from the Client Perspective, less evidence has been generated on more distal determinants. **Consequently, the series of country-specific assessments under this project will focus on understanding how the Influencing Environment and Health System Governance affect and shape quality of reproductive health, centering on family planning and paying special attention to adolescents and postpartum family planning.** While these components may seem far removed from the client, in practice they contribute significantly to how reproductive health services are provided and thereby experienced by the client.

APPROACH

PAI, in collaboration with in-country QUEST partners, conducted strategic assessments at the national and subnational level based on the conceptual framework. **Thus, the guiding research questions of this project were:**

- How do the domains of the health system affect the quality of services received for family planning?
- How do the domains of the influencing environment affect the health system and quality of services received?

The framework was refined based on input from partners that ensured it incorporated and reflected country context in the focal geographies. The assessments were focused on the DRC, with a focus on Kinshasa; Ethiopia, with a focus on Oromia; India, with focuses on Uttar Pradesh and Bihar; Myanmar, with a focus on Shan; and Pakistan, with a focus on Sindh.

METHODOLOGY

To assess the context of quality for reproductive health and rights at the national and subnational levels according to the conceptual framework, this research drew on a range of tools and methods.

1. With support from PAI, QUEST partners conducted landscape analyses to understand the critical component of clients' experiences with quality of services received and the fulfillment of reproductive rights. Data was collected through a desk review of existing literature on the domains of quality of services received in each focal geography, supplemented by key informant interviews.

QUEST partners did not interview individual clients, relying instead on existing evidence as a key resource for fleshing out the client component of the framework.

2. QUEST partners conducted a review of policies that impact quality and rights at the client-provider level. The policy review was conducted through a multistep process:
 - a. Compiling a list of policies to be reviewed. These included national and subnational laws; Ministry of Health policies; national and subnational strategy documents; training curricula and other guidelines;
 - b. Developing the assessment parameters, or a set of questions based on the domains of the health system and influencing environment as outlined in the conceptual framework. Data from the preliminary landscape analysis was used to frame assessment questions on the health system and influencing environment. Assessment questions were both qualitative and quantitative. The questions identified in the assessment parameters were used to guide the document review, as well as the development of an interview guide for key informant interviews and focus group discussions;
 - c. Developing a list of key informants for interview and focus group discussion participants. Interview guides and assessment questionnaires were created to gather insights on policies and practice from informants working inside the health—as well as sexual and reproductive health—field. Assessment questions were both qualitative and quantitative.
3. PAI synthesized the landscape assessments and policy analyses developed by QUEST partners into a comprehensive, cross-country review of the structural determinants of quality.

ENDNOTES

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- 1 Guttmacher Institute. (2017). *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017*. Retrieved from: <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>
 - 2 World Health Organization (WHO). (2014). *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. Geneva: WHO.
 - 3 Kols, A. J., & Sherman, J.E. (1998). Family planning programs: improving quality. *Population Reports J*, (47), 1-39.
 - 4 Heartfile. (2016). *Examining the Context of Quality in Family Planning Services in Pakistan – A Literature Review*. Unpublished manuscript.
 - 5 Si Jeunesse Savait. (2016). Final Report. Unpublished manuscript.
 - 6 The Center for Catalyzing Change. (2016) *Quality Upheld: Every Service, Every Time Project Report – Quality of Health Services in Bihar and Uttar Pradesh*. Unpublished manuscript.
 - 7 The Consortium of Christian Relief and Development Associations. (2016) *Synthesis Report on Gaps, Challenges and Opportunities of Quality Reproductive Health in Ethiopia, Focusing on Oromia Regional State*. Unpublished manuscript.
 - 8 Population Reference Bureau. (2016). *2016 World Population Data Sheet*. Retrieved from: <http://www.prb.org/pdf16/prb-wpds2016-web-2016.pdf>
 - 9 Demographia. (2017). *Demographia World Urban Areas, 13th Annual Edition*. Retrieved from: <http://www.demographia.com/db-worldua.pdf>
 - 10 Advance Family Planning. (2015). *Democratic Republic of the Congo Commits to Family Planning through the Global FP2020 Partnership*. Retrieved from: http://advancefamilyplanning.org/sites/default/files/resources/drc_EN.pdf
 - 11 Mooney, A. (2016). Leveraging the Private Sector to Improve Access to Family Planning in the Democratic Republic of Congo. Retrieved from: <http://psiimpact.com/2016/01/leveraging-the-private-sector-to-improve-access-to-family-planning-in-the-democratic-republic-of-congo>
 - 12 Associated Press in Addis Ababa. (February 3, 2013). Eleven states sign United Nations deal for peace in Congo. *The Guardian*. Retrieved from: <https://www.theguardian.com/world/2013/feb/24/eleven-states-sign-congo-deal>

- 13 Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP), & ICF International. (2014). *Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014*. Retrieved from: <http://www.dhsprogram.com/pubs/pdf/FR300/FR300.pdf>
- 14 MPSMRM, MSP, & ICF International. (2014). *Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014*. Retrieved from: <http://www.dhsprogram.com/pubs/pdf/FR300/FR300.pdf>
- 15 Government of the Democratic Republic of Congo. (2013). *Democratic Republic of Congo Engagements FP2020/FP2020 Commitment*. Retrieved from: <http://www.familyplanning2020.org/democratic-republic-of-the-congo>
- 16 The Federal Democratic Republic of Ethiopia Ministry of Health. (2015). *Health Sector Transformation Plan: 2015/16-2019/20*. Retrieved from: <http://midwives.org.et/sites/default/files/HSTP%20Final%20Print%202015-10-19%20Small%20size.pdf>
- 17 Garoma, S. (2012). Assessment of the Levels of Communication between Youth, Parents, Peers and Teachers about Reproductive Health Issues and HIV/AIDS in Nekemte Town, West Ethiopia. *Ethiop J Health Dev*, 26(2), 86- 92. Retrieved from: <https://www.ajol.info/index.php/ejhd/index>
- 18 Mota, K., Reddy, S., & Getachew, B. (2015). Unmet need of long-acting and permanent family planning methods among women in the reproductive age group in shashemene town, Oromia region, Ethiopia: a cross sectional study. *BMC Women's Health*, 15(51), 1-8. doi:10.1186/s12905-015-0209-y
- 19 Olson, D.J., & Piller, A. (2013). Ethiopia: An Emerging Family Planning Success Story. *Studies in Family Planning*, 44(4), 445-459. Retrieved from: <http://www.dktinternational.org/wp-content/uploads/2013/12/sifp369.pdf>
- 20 Census Organization of India. (2011). *Population Census 2011*. Retrieved from: <http://www.census2011.co.in>
- 21 Kalra, A. (November 12, 2014). At least a dozen women dead after Indian sterilization camps. *Reuters*. Retrieved from: <http://www.reuters.com/article/us-india-health-sterilisation-idUSKCN0IWOK020141112>
- 22 World Bank. (2016). *Bihar – Poverty, growth and inequality*. Washington D.C.: World Bank Group. Retrieved from: <http://documents.worldbank.org/curated/en/781181467989480762/Bihar-Poverty-growth-and-inequality>
- 23 Kumar, A., & Singh, A. (2013). Trends and Determinants of Unmet Need for Family Planning in Bihar (India): Evidence from National Family Health Surveys. *Advances in Applied Sociology*, 3(2), 157-163. doi:10.4236/aasoci.2013.32021
- 24 International Institute for Population Sciences. (2015). *National Family Health Survey, India*. Retrieved from: <http://rchiips.org/NFHS/contact.shtml>
- 25 Office of the Registrar General & Census Commissioner, India, & Ministry of Home Affairs, Government of India. (2013). *Annual Health Survey 2012-13 Fact Sheet: Uttar Pradesh*. Retrieved from: http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET-UTTAR_PRADESH.pdf
- 26 Ibid.
- 27 Ministry of Immigration and Population Myanmar. (2014). *Myanmar Population and Housing Census*. Retrieved from: <http://themimu.info/census-data>
- 28 Ipas Myanmar. (2016). Reducing Unsafe Abortion, Improving Care, Saving Lives. Retrieved from: <http://www.ipas.org/en/Resources/Ipas%20Publications/Ipas-in-Myanmar-reducing-unsafe-abortion-improving-care-saving-lives.aspx>
- 29 World Health Organization (WHO) Myanmar. (2017). *Formulation of Five Year Strategic Plan for Reproductive Health 2009-2013*. Retrieved from: <http://www.searo.who.int/myanmar/areas/rh5yrstrategicplanformulation/en/>
- 30 MCH Section, Public Health Division, Department of Health, Ministry of Health, Myanmar. (2014). *Myanmar Five year Strategic Plan for Reproductive Health 2014-2018*. Retrieved from: http://themimu.info/sites/themimu.info/files/documents/Core_Doc_Five-Year_Strategic_Plan_for_Reproductive_Health_2014-2018.pdf
- 31 United Nations (UN) Office for the Coordination of Humanitarian Affairs. (2017). 2018 Interim Humanitarian Response Plan for Myanmar. Retrieved from: <https://reliefweb.int/report/myanmar/2018-interim-humanitarian-response-plan-myanmar>
- 32 United Nations (UN) Women Asia and the Pacific. (2017). *Gender Brief on Rohingya Refugee Crisis Response in Bangladesh*. Retrieved from: <http://asiapacific.unwomen.org/en/digital-library/publications/2017/10/gender-brief-on-rohingya-refugee-crisis>
- 33 Guttmacher Institute. (2015). *Unintended Pregnancy and Induced Abortion In Pakistan*. Retrieved from: <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-and-induced-abortion-pakistan>
- 34 National Institute of Population Studies [Pakistan] & ICF International. (2013). *Pakistan Demographic and Health Survey 2012-13*. Calverton, Maryland, USA: National Institute of Statistics and ICF International. Retrieved from: <http://dhsprogram.com/pubs/pdf/SR208/SR208.pdf>
- 35 Ibid.
- 36 Ibid.
- 37 Jamil, R. R. (2016). Making the State Local: The Politics of Decentralized Governance in Pakistan. *Agenda for International Development*. Retrieved from: <http://www.a-id.org/en/news/making-the-state-local-the-politics-of-decentralized-governance-in-pakistan/>
- 38 Ibid.
- 39 Ministry of National Health Services, Regulation and Coordination, Government of Pakistan. (2016). *National Health Vision: Pakistan 2016-2025*. Retrieved from: http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf
- 40 Department of Population Welfare, Government of Sindh. (2015). *Costed Implementation Plan for Family Planning in Sindh (2015-2020)*. Retrieved from: <http://pwdssindh.gov.pk/Publications/e-books/CIP%20Sindh-03%2015%2016-final.pdf>
- 41 Government of Myanmar. (2013). *Family Planning 2020 Commitment*. Retrieved from: <http://www.familyplanning2020.org/Myanmar>
- 42 The Republic of the Union of Myanmar Ministry of Health and Sports. (1992). *National Population Policy (Draft)*. Retrieved from: <http://mohs.gov.mm/Main/content/publication/national-population-policy-draft>

- 43 World Health Organization (WHO) Myanmar. (2012). Maternal and Child Health. *Health in Myanmar 2012*. Retrieved from: http://www.searo.who.int/myanmar/documents/HealthinMyanmar_2012_9a_MCH.pdf?ua=1
- 44 Family Planning 2020. (2014). *DRC: Family Planning National Multisectoral Strategic Plan (2014-2020)*. Retrieved from: <http://www.familyplanning2020.org/resources/5614>
- 45 Republique Democratique du Congo Ministere de la Sante Publique, & Programme National de Sante de la Reproduction. (2008). *Politique Nationale de Sante de la Reproduction*. Retrieved from: http://familyplanning-drc.net/docs/5_PolitiqueNationaleDeSanteDeLaReproduction_Juillet_2008.pdf
- 46 Federal Democratic Republic of Ethiopia. (1995). *Constitution of the Federal Democratic Republic of Ethiopia*. Retrieved from: <http://www.wipo.int/edocs/lexdocs/laws/en/et/et007en.pdf>
- 47 Government of Ethiopia. (1993). *Health Policy of the Transitional Government of Ethiopia*. Retrieved from: <http://www.cmpethiopia.org/page/433>
- 48 Olson, D. J., & Piller, A. (2013). Ethiopia: An Emerging Family Planning Success Story. *Studies in Family Planning* 44(4): 445-459. Retrieved from: <http://www.dktinternational.org/wp-content/uploads/2013/12/sifp369.pdf>
- 49 Government of Ethiopia. (2017). *2017 FP2020 Commitment Update*. Retrieved from: <http://www.familyplanning2020.org>
- 50 Government of Ethiopia. (2016). *2016 FP2020 Annual Commitment Update Questionnaire Response*. Retrieved from: <http://www.familyplanning2020.org/entities/56>
- 51 Government of Ethiopia. (2015). *2015 FP2020 Annual Commitment Update*. Retrieved from: <http://www.familyplanning2020.org/entities/56>
- 52 Zyck, S. A., & Mohsin, M. (September 8, 2014). Pakistan's democracy on the rocks. *Open Democracy*. Retrieved from: <https://www.opendemocracy.net/steven-zyck-maryam-mohsin/pakistan%E2%80%99s-democracy-on-rocks>
- 53 Committee on the Elimination of Discrimination against Women. (2006). *Report on the implementation of the Convention on the Elimination of All Forms of Discrimination against Women by the Democratic Republic of the Congo*. Retrieved from: http://www.omct.org/files/2005/09/3072/cedaw36_drc_en.pdf
- 54 Office of the President of the Democratic Republic of Congo. (1940). *Code pénal*. Retrieved from: http://www.wipo.int/wipolex/en/text.jsp?file_id=194348
- 55 Thibaut Mukaba, Arsene Binanga, Sarah Fohl, Jane T Bertrand. (2015). Family Planning Policy Environment in the Democratic Republic of the Congo: Levers of Positive Change and Prospects for Sustainability. *Global Health: Science and Practice* 2015, Volume 3, Number 2
- 56 United Nations Population Fund (UNFPA) India. (n.d.) *Sexual & reproductive health*. Retrieved from: <http://india.unfpa.org/en/topics/sexual-reproductive-health-10>
- 57 Brahm, E. (2007). Transitional Justice, Civil Society, and the Development of the Rule of Law in Post-Conflict Societies. *The International Journal of Not-for-Profit Law*, 9(4), 62-72. Retrieved from: http://www.icnl.org/research/journal/vol9iss4/special_2.htm
- 58 Civil Society Initiative, External Relations and Governing Bodies, WHO. (2002). *WHO and Civil Society: Linking for better health*. Geneva, Switzerland: WHO. Retrieved from: <http://apps.who.int/iris/handle/10665/67713>
- 59 Mulataa, Z. (2010). *Political nongovernmental organizations (NGOs) and governmental companies in Ethiopia*. Retrieved from: [http://www.oromoliberationfront.org/news/2010/Fake_NGO_of_the_TPLF_\(gullaala_xummuraa\)%5B1%5D.pdf](http://www.oromoliberationfront.org/news/2010/Fake_NGO_of_the_TPLF_(gullaala_xummuraa)%5B1%5D.pdf)
- 60 The International Center for Not-for-Profit Law. (2017). *Civic Freedom Monitor: Ethiopia*. Retrieved from: <http://www.icnl.org/research/monitor/ethiopia.html>
- 61 Ibid.
- 62 Zin, M. (November 26, 2014). Can Burma's Civil Society Find Its Voice Again? FP. Retrieved from: <http://foreignpolicy.com/2014/11/26/can-burmas-civil-society-find-its-voice-again/>
- 63 International Crisis Group (ICG). (2004). Myanmar: Update on HIV/AIDs Policy, Crisis Group Asia Briefing. Yangon/Brussels: ICG. Retrieved from: <https://d2071andvip0wj.cloudfront.net/myanmar-update-on-hiv-aids-policy.pdf>
- 64 Sein, T. T., Myint, P., Tin, N., Win, H., Aye, S. S., & Sein, T. (2014). The Republic of the Union of Myanmar Health System Review. *Health Systems in Transition*, 4(3). Manila, Philippines: Asia Pacific Observatory on Health Systems and Policies, WHO. Retrieved from: http://www.wpro.who.int/asia_pacific_observatory/hits/series/myanmar_health_systems_review.pdf
- 65 United Nations Population Fund (UNFPA). (2016). *Population Situation Analysis of Pakistan*. Retrieved from: <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/03/PSA-Printed-Report-1.pdf>
- 66 Armytage, R., & Javed, U. (July 11, 2012). Local Government Critical in Pakistan's 2013 Political Landscape. *The Asia Foundation*. Retrieved from: <http://asiafoundation.org/2012/07/11/local-government-critical-in-pakistans-2013-political-landscape/>
- 67 Department of Health, Government of Sindh. (2012). *Sindh Health Sector Strategy 2012-2020*. Retrieved from: <http://www.trfpakistan.org/Portals/18/TRF%20reports/Strategies/Sindh%20Health%20Sector%20Strategy%202012.pdf?ver=2017-03-22-181031-467>
- 68 Population Welfare Department, Government of Sindh. (2015). *Costed Implementation Plan on Family Planning for Sindh (2015-2020)*. Retrieved from: <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/CIP-Sindh-03-15-16-final-1.pdf>
- 69 Government of Pakistan. (2012). *Family Planning 2020 Commitment*. Retrieved from: <http://www.familyplanning2020.org/Pakistan>
- 70 Guttmacher Institute. (2017). *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017*. Retrieved from: <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>
- 71 The Asia Foundation. (2014). *Public Financial Management in Myanmar*. Retrieved from: <http://asiafoundation.org/resources/pdfs/MMPublicFinancialManagement.pdf>

- 72 United Nations Children's Fund (UNICEF). (2013). Snapshot of Social Sector Public Budget Allocations and Spending in Myanmar. Retrieved from: https://www.unicef.org/myanmar/Final_Budget_Allocations_and_Spending_in_Myanmar.pdf
- 73 Mukaba T., Binanga A., Fohl S., & Bertrand J. T. (2015). Family Planning Policy Environment in the Democratic Republic of the Congo: Levers of Positive Change and Prospects for Sustainability. *Global Health: Science and Practice*, 3(2), 164-173. doi:10.9745/GHSP-D-14-00244
- 74 Beer, K., & Armand, F. (2006). *Assessment of India's Locally Manufactured Contraceptive Product Supply*. Retrieved from: http://pdf.usaid.gov/pdf_docs/PNADF989.pdf
- 75 Comptroller and Auditor General of India. (2011). *Report of 2011 - Performance Audit on National Rural Health Mission of Government of Uttar Pradesh*. Retrieved from: <http://www.cag.gov.in/content/report-2011-performance-audit-national-rural-health-mission-government-uttar-pradesh>
- 76 Nambatya, D. (2012). *Family Planning in Ethiopia*. Uganda: Partners in Population and Development, Africa Regional Office. Retrieved from: http://www.healthpolicyproject.com/pubs/93_EthiopiaFPAugust.pdf
- 77 Thant, H. (June 30, 2016). Health officials want better contraception supply chain. *Myanmar Times*. Retrieved from: <http://www.mmtimes.com/index.php/national-news/21127-health-officials-want-better-contraception-supply-chain.html>
- 78 Sciortino, R. (2010). *Achieving Contraceptive Security and Meeting Reproductive Health Needs in Southeast Asia*. Bangkok, Thailand: Asia Pacific Alliance for Sexual and Reproductive Health and Rights. Retrieved from: <https://youthsextion.files.wordpress.com/2011/05/contraceptivesecurityreproductivehealthneedsweb.pdf>
- 79 PATH & World Health Organization (WHO). (2012). *Reducing the need for parallel supply chains*. Retrieved from: http://www.who.int/immunization/programmes_systems/supply_chain/optimize/supply_chain_integration.pdf
- 80 Government of Pakistan. (2014). *Pakistan Economic Survey 2012-13: Health and Nutrition*. Retrieved from: http://finance.gov.pk/survey/chapters_14/11_Health_and_Nutrition.pdf
- 81 World Health Organization (WHO). (n.d.). *Health workforce*. Retrieved from: http://www.who.int/hrh/workforce_mdgs/en/
- 82 United States Agency for International Development (USAID). (2015). *All Eyes on Ethiopia's National Health Extension Program*. Retrieved from: <https://www.usaid.gov/results-data/success-stories/all-eyes-ethiopia%E2%80%99s-national-health-extension-program-0>
- 83 Index Mundi. (2014). *Ethiopia - Contraceptive prevalence*. Retrieved from: <https://www.indexmundi.com/facts/ethiopia/contraceptive-prevalence>
- 84 Federal Democratic Republic of Ethiopia Ministry of Health (FMOH). (2012). *A Situation Analysis of Family Planning in Ethiopia - June 2011*. Retrieved from: http://pdf.usaid.gov/pdf_docs/PA00J353.pdf
- 85 World Health Organization (WHO) & Global Health Workforce Alliance. (2008). *Country Case Study: Pakistan's Lady Health Worker Programme*. Geneva, Switzerland: WHO. Retrieved from: http://www.who.int/workforcealliance/knowledge/case_studies/CS_Pakistan_web_en.pdf?ua=1
- 86 Zhu, N., Allen E., Kearns A., Caglia, J., & Atun, R. (2014). *Lady Health Workers in Pakistan: Improving access to health care for rural women and families*. Boston, MA: Maternal Health Task Force, Harvard School of Public Health. Retrieved from: <https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH-Pakistan5.pdf>
- 87 Ariff, S., Soofi S. B., Sadiq, K., Feroze A. B., & Khan, S. (2010). Evaluation of health workforce competence in maternal and neonatal issues in public health sector of Pakistan: an Assessment of their training needs. *BMC Health Services Research*, 10, 319. Retrieved from: <http://www.biomedcentral.com/1472-6963/10/319>
- 88 National Institute of Population Studies (NIPS) [Pakistan], & ICF International. (2012-13). *Pakistan Demographic and Health Survey (PDHS) 2012-13*. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International. Retrieved from: http://www.nips.org.pk/abstract_files/PDHS%20Final%20Report%20as%20of%20Jan%2022-2014.pdf
- 89 Ministry of Health and Family Welfare, Government of India. (2005). *National Rural Health Mission: Meeting people's health needs in rural areas, Framework for Implementation 2005-2012*. New Delhi, India: Ministry of Health and Family Welfare. Retrieved from: http://jknrmh.com/Guideline/Frame_Work.pdf
- 90 Bajpai, N., & Dholakia, R. H. (2011). *Improving the Performance of Accredited Social Health Activists in India*. Mumbai, India: Columbia Global Centers South Asia, Columbia University. Retrieved from: http://globalcenters.columbia.edu/files/cgc/pictures/Improving_the_Performance_of_ASHAs_in_India_CGCSA_Working_Paper_1.pdf
- 91 PTI. (March 15, 2016). Govt expanding basket of choice for contraceptives: J P Nadda. *ETHealthworld*. Retrieved from: <http://health.economictimes.indiatimes.com/news/industry/govt-expanding-basket-of-choice-for-contraceptives-j-p-nadda/51410666>
- 92 Bajpai, N., & Dholakia, R. H. (2011). *Improving the Performance of Accredited Social Health Activists in India*. Mumbai, India: Columbia Global Centers South Asia, Columbia University. Retrieved from: http://globalcenters.columbia.edu/files/cgc/pictures/Improving_the_Performance_of_ASHAs_in_India_CGCSA_Working_Paper_1.pdf
- 93 Global Network of World Health Organization (WHO) Collaborating Centres for Bioethics. (2015). *Global Health Ethics: Key Issues*. Retrieved from: http://apps.who.int/iris/bitstream/10665/164576/1/9789240694033_eng.pdf
- 94 Chatterjee, C., & Srinivasan, V. (2012). Ethical issues in health care sector in India. *IIMB Management Review*, 25, 49-62. doi:10.1016/j.iimb.2012.11.004. Retrieved from: <http://www.sciencedirect.com/science/article/pii/S0970389612001231>
- 95 Sharma, D.C. (December 20, 2014). India's sterilisation scandal. *The Lancet*, 384(9961), 68-69. Retrieved from: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)62224-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62224-8/fulltext)
- 96 Medical Council of India. (2002). *Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations*. New Delhi: Gazette of India. Retrieved from: http://www.udayfoundationindia.org/Medical_Ethics.pdf
- 97 Desai, P. N. (1988). Medical Ethics in India. *Journal of Medicine and Philosophy*, 13(3), 170-223. doi:10.1007/978-1-4020-4425-0. Retrieved from: http://shodhganga.inflibnet.ac.in/bitstream/10603/26000/10/10_chapter%204.pdf
- 98 Family Planning 2020. (2015). *Rights and Empowerment Principles for Family Planning*. Retrieved from: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/08/FP2020_Statement_of_Principles_11x17_EN_092215.pdf

- 99 Government of Sindh, Pakistan. (2016). Costed Implementation Plan (CIP) on Family Planning for Sindh, Pakistan. *Family Planning 2020*. Retrieved from: <http://www.familyplanning2020.org/resources/15412>
- 100 Hyder, A., & Nadeem, S. (2001). *Health Ethics in Pakistan: A Literature Review of Its Present State*. *Journal of Health Population and Nutrition*, 19(1), 6-11. Retrieved from: <http://www.jhpn.net/index.php/jhpn/article/viewFile/67/56>
- 101 World Health Organization (WHO) Regional Office for South-East Asia. (2002). *Agenda Item 2.1.3 – Ethics in Health Research – An update on Ethical Review Mechanisms*. Dhaka, Bangladesh: WHO South-East Asia Advisory Committee on Health Research. Retrieved from: <http://apps.who.int/iris/bitstream/10665/127117/1/SEA-ACHR-27-08.pdf>
- 102 Hardee, K., K. Newman, L. Bakamjian, L., Kumar, J., Harris, S., Rodriguez, M., & Wilson, K. (2013). *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights*. Washington, D.C.: Futures Group. Retrieved from: https://www.engenderhealth.org/files/pubs/family-planning/Voluntary_Family_Planning_Programs_A_Conceptual_Framework
- 103 Bhugra, D., Mehra, R., de Silva, P., Bhintade, V. R. (2007). Sexual attitudes and practices in North India: A qualitative study. *Sexual and Relationship Therapy*, 22(1). doi:10.1080/14681990600920770. Retrieved from: <http://www.tandfonline.com/doi/abs/10.1080/14681990600920770?scroll=top&needAccess=true&journalCode=csmt20>
- 104 Nair, P. S., Feeney G., Mishra V. K., & Retherford R. D. (1999). Factors Affecting Source of Family Planning Services in India. *National Family Health Survey Subject Reports, No. 12*. Mumbai, India: International Institute for Population Sciences. Retrieved from: http://www.eastwestcenter.org/sites/default/files/filemanager/Research_Program/NFHS_Subject_Reports/subj-12.pdf
- 105 Mumtaz Z., Salway S., Nykiforuk C., Bhatti A., Ataullahjan A., & Ayyalasomayajula B. (2013). The role of social geography on Lady Health Workers' mobility and effectiveness in Pakistan. *Social Science and Medicine*, 91, 48-57. doi:10.1016/j.socscimed.2013.05.007. Retrieved from: <http://www.sciencedirect.com/science/article/pii/S0277953613002815>
- 106 Santosh Kumar S., Kaushik A., Kansal S. (2012). Factors Influencing The Work Performance of ASHA Under NRHM A Cross Sectional Study from Eastern Uttar Pradesh. Retrieved from: <http://www.iapsmupuk.org/journal/index.php/IJCH/article/view/373>
- 107 Vyborny, K. & Field, E. (2015). *Female Labor Force Participation in Asia: Pakistan Country Study*. Draft.
- 108 Ghulam M., Azmat S. K., Hameed, W., Ali, S., Ishaque M., Hussain Q., Ahmed A., & Munroe E. (2015). Family Planning Knowledge, Attitudes, and Practices among Married Men and Women in Rural Areas of Pakistan: Findings from a Qualitative Need Assessment Study. *International Journal of Reproductive Medicine*, 2015. doi:10.1155/2015/190520. Retrieved from: <https://www.hindawi.com/journals/ijrmed/2015/190520/>
- 109 World Health Organization (WHO). (2017). *Pakistan*. Retrieved from: <http://www.who.int/countries/pak/en/>
- 110 Oxfam Canada. (2012). *Country Profile: Ethiopia*. Retrieved from: https://www.oxfam.ca/sites/default/files/Country%20Profile_Ethiopia.pdf
- 111 Korra, A. (2002). *Attitudes toward Family Planning, and Reasons for Nonuse among Women with Unmet Need for Family Planning in Ethiopia*. Calverton, MD, USA: ORC Macro. Retrieved from: <https://dhsprogram.com/pubs/pdf/FA40/ETFA40.pdf>
- 112 United Nations Children's Fund (UNICEF). (2013). *Ethiopia: Statistical Profile on Female Genital Mutilation/Cutting*. New York, USA: UNICEF. Retrieved from: https://data.unicef.org/.../country_profiles/Ethiopia/FGMC_ETH.pdf
- 113 World Bank & Convention on the Elimination of All Forms of Discrimination Against Women. (2011). *Concluding observations of the Committee on the Elimination of Discrimination against Women - Ethiopia*, 27 July 2011. Retrieved from: www.unhcr.org/refworld/docid/4eeb4c8c2.html
- 114 United Nations Population Fund (UNFPA) Ethiopia. (n.d.). *Female Genital Mutilation*. Retrieved from: <http://ethiopia.unfpa.org/en/topics/female-genital-mutilation-0?page=1>
- 115 United Nations (UN) Women Africa. (n.d.). *Democratic Republic of Congo*. Retrieved from: <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/democratic-republic-of-congo>
- 116 Caritas Australia. (2014). *Fearless Voices: Speaking Up for Peace, Equality, and Justice in the Democratic Republic of the Congo*. Retrieved from: <http://www.caritas.org.au/docs/campaigns/fearless-voices.pdf?sfvrsn=6>
- 117 Women's International League for Peace & Freedom (WILPF). (2010). *Gender Inequality and Social Institutions in the D.R.Congo*. Retrieved from: http://www.peacewomen.org/sites/default/files/hrinst_genderinequalityinthedrc_wilpf_december2010english_0.pdf
- 118 United Nations (UN) Women Africa. (n.d.). *Democratic Republic of Congo*. Retrieved from: <http://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/democratic-republic-of-congo>
- 119 Department of Child and Adolescent Health and Development, World Health Organization (WHO). (2009). *Generating demand and community support for sexual and reproductive health services for young people*. Geneva, Switzerland: WHO. Retrieved from: http://apps.who.int/iris/bitstream/10665/44178/1/9789241598484_eng.pdf
- 120 The Population Council & United Nations Population Fund (UNFPA). (2009). *The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People*. New York, USA: Population Council. Retrieved from: http://www.popcouncil.org/uploads/pdfs/PGY_AdolDataGuides/CongoDemRep2007.pdf
- 121 Emina, J. B. O., & Blum, J. (2015). *Promoting Adolescent Sexual and Reproductive Health in the Democratic Republic of Congo: Analysis of Youth Sex Education and National Policy for Adolescent Health Documents*. Retrieved from: <http://paa2015.princeton.edu/abstracts/151550>
- 122 The Population Council & United Nations Population Fund (UNFPA). (2009). *The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People*. New York, USA: Population Council. Retrieved from: http://www.popcouncil.org/uploads/pdfs/PGY_AdolDataGuides/CongoDemRep2007.pdf
- 123 Population Reference Bureau. (2015). *Democratic Republic of the Congo, Youth Reproductive Health: Satisfying Unmet Need for Family Planning*. Retrieved from: <http://www.prb.org/pdf15/unmetneed-factsheet-DRC.pdf>
- 124 International Trade Union Confederation (ITUC). (2011). *Violence against women in Eastern Democratic Republic of Congo: Whose responsibility? Whose complicity?* Belgium: ITUC. Retrieved from: http://www.ituc-csi.org/IMG/pdf/ituc_violence_rdc_eng_lr.pdf.pdf

- 125 Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP), & and ICF International. (2014). *Democratic Republic of Congo Demographic and Health Survey 2013-14: Key Findings*. Rockville, MD, USA: MPSMRM, MSP, & ICF International. Retrieved from: <https://dhsprogram.com/pubs/pdf/SR218/SR218.e.pdf>
- 126 Muanda, M. F., Ndongo G. P., Messina L. J., & Bertrand J. T. (2017). Barriers to modern contraceptive use in rural areas in DRC. *Culture, Health & Sexuality*. doi:10.1080/13691058.2017.1286690. Retrieved from: <http://www.tandfonline.com/loi/tchs20>
- 127 Bertrand, J. T., Binanga A., Mujani Z., & Herdoiza M. (n.d.). *Family Planning in the DRC: Socio-Cultural Factors*. New Orleans, LA: Tulane University School of Public Health and Tropical Medicine. Retrieved from: <http://familyplanning-drc.net/factors-socio-culturels.php>
- 128 Ibid.
- 129 Republique Democratique du Congo. (2014). *Planification Familiale: Plan stratégique national à vision multisectorielle*. Retrieved from: <http://www.familyplanning-drc.net/docs/Final%20Plan%20Strategique%20version%20officielle.pdf>
- 130 Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP), & and ICF International. (2014). *Democratic Republic of Congo Demographic and Health Survey 2013-14: Key Findings*. Rockville, MD, USA: MPSMRM, MSP, & ICF International. Retrieved from: <https://dhsprogram.com/pubs/pdf/SR218/SR218.e.pdf>
- 131 Advance Family Planning. (2016). The DRC Constitutional Court Rules in Favor of the Proposed Law for Reproductive Health. Retrieved from: <https://advancefamilyplanning.org/drc-constitutional-court-rules-favor-proposed-law-reproductive-health>
- 132 Government of the Democratic Republic of Congo. (2017). Family Planning 2020 Commitment. Retrieved from: <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/08/Engagements-FP2020-DRC-Revision-de-2017-2.pdf>
- 133 Department of Public Health Ministry of Health, Myanmar, & United Nations Population Fund (UNFPA). (2015). *Five-Year Strategic Plan for Young People's Health (2016-2020)*. Retrieved from: http://myanmar.unfpa.org/sites/default/files/pub-pdf/Adolescent%20Health%20NSP_2016-2020.pdf
- 134 United Nations Population Fund (UNFPA) Myanmar. (n.d.). *Young people*. Retrieved from: <https://myanmar.unfpa.org/en/node/15283?page=0%2C2>
- 135 Hla-Soe-Tint, Phyo-Maung-Thaw, Yin-Thet-Nu-Oo, Ko-Ko-Zaw, Than-Tun-Sein, & Thein-Tun. (2008). Sexual and reproductive health needs of vulnerable youth in Myanmar. *Southeast Asian Journal of Tropical Medicine and Public Health*, 9(6), 1126-1138. Retrieved from: https://www.researchgate.net/publication/23638131_Sexual_and_reproductive_health_needs_of_vulnerable_youth_in_Myanmar
- 136 World Health Organization (WHO). (2011). *Guidelines for RMNCH-GET: A Reproductive, Maternal, Newborn, and Child Health Government Expenditure (and budget) Tracking tool. Working Document*. Retrieved from: <http://www.who.int/choice/gettool.pdf>
- 137 United States Agency for International Development (USAID). (2017). *Gender Equality and Women's Empowerment*. Retrieved from: <https://www.usaid.gov/ethiopia/gender-equality-and-womens-empowerment>
- 138 Garoma S. (2012). Assessment of the Levels of Communication between Youth, Parents, Peers and Teachers about Reproductive Health Issues and HIV/AIDS in Nekemte Town, West Ethiopia. *Ethiop. J. Health Dev*, 26(2), 86- 92. Retrieved from: <https://www.ajol.info/index.php/ejhd/article/view/115641>
- 139 Guttmacher Institute. (2014). *Sexual and Reproductive Health of Young Women in Ethiopia*. Retrieved from: <https://www.guttmacher.org/fact-sheet/sexual-and-reproductive-health-young-women-ethiopia#3a>
- 140 United Nations Population Fund (UNFPA), & Ministry of Health and Sports, Government of Myanmar. (2017). *Nationwide Youth Information Corners Situation Analysis Report*. Retrieved from: https://myanmar.unfpa.org/sites/default/files/pub-pdf/YIC_preview.pdf
- 141 Federal Democratic Republic of Ethiopia (FDRE). (2016). *Reproductive, Maternal, Newborn, child, Adolescent Health-Nutrition (RMNCAH-N), Annual review meeting*. Addis Ababa, Ethiopia.
- 142 Population Reference Bureau. (2013). *Population of Youth Ages 10-24*. Retrieved from: <http://www.prb.org/DataFinder/Topic/Rankings.aspx?ind=19>
- 143 Gupta, S. D. (2003). *Adolescent and Youth Reproductive Health in India: Status, Issues, Policies, and Programs*. Retrieved from: http://pdf.usaid.gov/pdf_docs/PNACT789.pdf
- 144 The Partnership for Maternal, Newborn & Child Health. (2014). *Government of India Launches New Health Programme for Adolescents*. Retrieved from: http://www.who.int/pmnch/media/events/2014/india_new_rsk/en/
- 145 Santhya K. G., Prakash R., Jejeebhoy S. J., & Singh S. K. (2014). *Assessing Adolescent Friendly Health Clinics in India: The Perspectives of Adolescents and Youth*. Retrieved from: http://www.popcouncil.org/uploads/pdfs/2014PGY_AFHC-IndiaReport.pdf
- 146 United Nations. 1995. Programme of Action of the International Conference on Population and Development. A/CONF.171/13/Rev.1
- 147 Ibid.
- 148 Ibid.
- 149 World Health Organization (WHO). *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. Geneva: WHO, 2014.
- 150 Bruce, J. "Fundamental Elements of the Quality of Care: A Simple Framework." *Studies in Family Planning* 21, no. 2, March/April 1990, p64.
- 151 Ibid.
- 152 Siddiqi et al. "Framework for assessing governance of the health system in developing countries: Gateway to good governance." *Health Policy*, 2009, 90:1.
- 153 Kaplan et al. "Human resource governance: what does governance mean for the health workforce in low- and middle-income countries?" *Human Resources for Health*, 2013, 11:6.

