IPPF

From choice, a world of possibilities

UNDER-SERVED AND OVER-LOOKED

Prioritizing contraceptive equity for the poorest and most marginalized women and girls

WHO WE ARE

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Cover Photo – IPPF/Peter Caton/Nepal

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FOREWORD

This important report, *Under-served and over-looked*, sheds light on the vast unmet needs for contraception in the world and presents us with concrete recommendations for ensuring equitable access to modern methods of contraception.
The feminist government of Sweden is proud of its longstanding and firm commitment for all individuals' full enjoyment of sexual and reproductive health and rights (SRHR). It is a human right to decide over one's own body, sexuality and reproduction. Enjoyment of SRHR is also intricately linked to the enjoyment of other human rights, such as economic rights and the right to education.

Globally, an estimated 62 million girls are currently not in school. One of the primary causes of girls dropping out of school is pregnancy. Early childbearing has a significant negative impact on girls' education and long-term employment opportunities. The unmet need for contraception and restrictive laws and policies with regard to SRHR prevent women and girls from shaping their lives and futures, and are ultimately expressions and consequences of gender inequality.

That is why investing in SRHR is also the smart thing to do. When we empower women and girls, we empower their families and their future children. We empower communities. We empower nations. Ultimately, we fight poverty and foster stability and peaceful societies.

We know this from our own experience. Step by step, reforms in Swedish society enabled and empowered women as societal actors, which tremendously contributed to Sweden's social and economic development. In 1938 the Swedish Parliament lifted the ban on information about contraceptives, in 1970 the first Swedish youth clinic opened and in 1975 women gained the right to decide on abortion until the eighteenth week of pregnancy. Not only did these measures liberate girls to study and women to work, they also fostered stronger bonds of common responsibility within families and benefited children's relationships with their fathers. Involving men and boys in efforts to strengthen gender equality and SRHR is a critical factor for achieving the Sustainable Development Goals.

We are witnessing a growing and more organised resistance to SRHR. Nationalistic, religious and populist movements are pursuing old-fashioned patriarchal norms, and anti-choice movements are pushing for women's subordination. We believe these backlashes are somewhat a reaction to the great accomplishments that have been made so far for the women half. We simply cannot afford to jeopardize these gains, and more change is needed, both in my own country and globally. Cross-regional cooperation has been – and continues to be – crucial. This is why Sweden, together with Belgium, the Netherlands and Denmark, co-organised the #SheDecides conference in Brussels on 2 March. This was the beginning of a global movement for women's and girls' full enjoyment of human rights, in particular their sexual and reproductive health and rights. #SheDecides focuses on how to enable every woman to decide for herself, freely, whether she wants to have children, when and how many.

People who wish to use contraceptives must be under-served no longer. Women and girls who wish to control their own bodies must be over-looked no more. We know that altering people's attitudes and values takes time. We are fully aware that changing behaviour and social traditions requires political leadership and firm commitment. Sweden stands committed for the long-run for the under-served and for the over-looked.

Isabella Lövin, Sweden's Minister for International Development Cooperation and Climate

Under-served and Over-looked is a flag in the ground. It is a decisive declaration that IPPF stands for equity. IPPF stands for human rights for all. While IPPF has long worked to scale up family planning services, to reduce unmet need and to reach vulnerable populations, with the launch of Under-served and Over-looked we are confirming that reaching the most vulnerable and hard-to-reach groups is IPPF's top priority.

This report is a synthesis of evidence revealed from a literature review, including 68 reports from 34 countries. The results are dire: the poorest women and girls, in the poorest communities of the poorest countries are still not benefitting from the global investment in family planning and the joined up actions of the global family planning movement. Women in the poorest countries who want to avoid pregnancy are one-third as likely to be using a modern method as those living in higher-income developing countries. This is not acceptable.

We must hold ourselves accountable and right our course of action. We call on the global community, to governments everywhere, to critically appraise their own contributions and support interventions that will benefit girls and women who are being left behind.

IPPF's FP2020 pledge is to reach 60 million women and couples who have never used modern contraceptive services before. To date, we have taken the following measures to better reach the under-served and over-looked:

- Adjusted our mix of service delivery outlets so that half are community-based distributors
- Scaled up the use of IPPF's Vulnerability Assessment methodology: now 41 Member Associations are collecting data on poverty and the vulnerability status of service users
- Increased service delivery in peri-urban and rural areas, which now account for 67 per cent of our service delivery points

In 2016, nearly eight in ten of all service users were poor and vulnerable. In addition to service delivery, we have mobilized civil society in some of the poorest countries to improve the legislative, policy, regulatory and/or financial environments for family planning. If we are to reach those girls and women who are most excluded, we must keep monitoring our progress, and we must keep changing and adapting to reach out to them. Under-served and Over-looked is a good starting place to learn about or rediscover promising practices to demonstrate to their value in reaching the most hard-to-reach.

I trust and hope that by galvanizing our resources and our expertise, that we can truly deliver our mission:

A world where women, men and young people everywhere have control over their bodies and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

IPPF MISSION STATEMENT

Tewodros Melesse, Director General, IPPF

INTRODUCTION

Globally, one in 10 women and girls who want to limit their pregnancies have an unmet need for contraception today. This year alone, an estimated 85 million women and girls will face unintended and unwanted pregnancies due to their inability to access family planning services and information. Approximately 303,000 women will die due to complications from pregnancy or childbirth. Over 88 per cent of these women will come from the world's poorest countries. As women become richer, their likelihood of having an unwanted pregnancy decreases. Women in the lowest economic quintile are five times more likely than women in the highest economic quintile to have an unwanted pregnancy. In each subsequent, wealthier economic quintile, a woman's likelihood of having an unwanted pregnancy decreases.[1]

In some of the world's poorest countries, fundamental human rights are being ignored. Sexual rights are human rights. They belong to us all. The creation of structures that enable women, men and young people to access high quality rights-based family planning care has far reaching consequences that impact beyond the micro-benefits of personal wellbeing.

> *Rights to life, privacy and liberty include individuals' rights to make informed decisions about their bodies, to determine the number and spacing of their children, and to be free from coercion, discrimination and violence.*
>
> Introduction, the International Conference on Population and Development (ICPD) and Human Rights

The evidence is clear: family planning saves lives. Voluntary family planning is one of the most successful advances in public health that the past half-century has seen. Yet it is the poorest women and girls in the poorest communities of the poorest parts of the world who are left behind. Yes, the distribution of family planning services and information needs urgent strengthening. Yes, identifying areas of unmet need must become a priority. Yes, designing or adapting programmes to better serve diverse communities needs careful consideration before they are implemented. And yes, we have the technology and expertise to deliver it now. In practical and administrable terms, we have the solutions to avoid unwanted pregnancies.

1. Reeves, R. and Venator, J. (2015) Sex, contraception, or abortion? Explaining class gaps in unintended childbearing. [online] Brookings Institution, p.2. Available at: https://www.brookings.edu/wp-content/uploads/2016/06/26_class_gaps_unintended_pregnancy.pdf [Accessed 21 Apr. 2017].

222 million women and girls globally have an unmet need for modern methods of family planning

Nearly 3 in 4 women (73 per cent) of these women live in the world's poorest countries [2]

303,000 women will die in pregnancy and child birth

85 million women and girls will face unintended pregnancies

Level of unmet need in women and girls is higher in **least developed countries:**

1 in 10 (10 per cent) in **Asia**

1 in 4 (24 per cent) in **sub-Saharan Africa**

Three in four women (73 per cent) of the 222 million women in developing countries who want to avoid a pregnancy, but are not using a modern method of contraception, live in the poorest countries. Women in the poorest countries who want to avoid pregnancy are one-third as likely to be using a modern method as those living in higher-income developing countries.[3]

This report, informed by a literature review undertaken by IPPF, offers an overview of the women and girls who are being under-served and over-looked. We focus specifically on those who are being left behind by over 60 years of family planning progress and examine the most promising practices towards ensuring that all women and girls have choice over their sexual and reproductive lives. It is the inability of the world's poorest and most marginalized women and girls to fulfil their most basic human right – to choose whether or not to have children openly and freely. We analysed 68 published reports from 34 countries on four continents. We focused specifically on under-served populations – young people, women and couples living with HIV, mobile/ displaced/ crisis populations, low income, low education, and under-represented populations. The outcomes of the literature review have been used to identify the programme interventions to reach poor and marginalized women and girls, and recommendations for change.

The rights of women and girls must be at the heart of family planning programmes by serving those with the greatest need. But who are the women and girls who are being left behind?

2. Darroch, J. and Singh, S. (2013) Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys. The Lancet, pp.1756–1762.
3. Ibid

WHO ARE THE WOMEN AND GIRLS BEING LEFT BEHIND?

IPPF's vision is to ensure the inclusivity of all people to make full, free and informed choices. Vulnerability can encompass three main dimensions:

- Socio-economic deprivation: people living below the national poverty line.
- Social exclusion or marginalization: people who are unable to participate fully in society because of their culture, sexuality, language, religion, gender, education, migrant status, disability or other factors.
- Being under-served: people not adequately served because of a lack of capacity or political will.

Vulnerability can be defined as people who have an unmet need, due to barriers such as ability to pay, residence in hard-to-reach areas, age, gender identity or expression, sexual orientation, migrant status, culture, language, religion, education, or disability, among others; and who are not normally or adequately reached by sexual and reproductive health programs due to lack of political will and or institutional capacity. This includes people who are wholly or partially excluded from full participation in the society in which they live because of stigma and discrimination. Who classifies as underserved will vary from country to country, and each IPPF Member Association use local data and develop criteria relevant to their local context to determine who is vulnerable and under-served in relation to sexual and reproductive health and rights.

Evidence shows that under-served women and girls with the highest level of need for family planning include:

- Young women and adolescent girls aged 10–24 years
- Women and girls living in hard to reach areas, particularly urban slums, street dwellers and displaced populations
- Women and girls in the lowest income quintile (i.e. poorest 20 per cent)
- Women and girls impacted by disability, gender-based violence and HIV
- Women and girls who are post-partum[4]

THE GLOBAL COMMITMENT TO FAMILY PLANNING

Nearly 50 years ago, the international community recognized family planning as a basic human right. Family planning includes access to contraception that averts pregnancy, and limits the transmission of sexually transmitted infections, including HIV. In 1968, the Tehran International Conference on Human Rights recognized for the first time in a global agreement that family planning is a basic human right.[4] This became a cornerstone to the global consensus on the right to family planning information and services, and set the groundwork for incorporating these rights into international legally binding instruments.

The 1994 International Conference on Population and Development in Cairo recommended that family planning be included in the context of other sexual and reproductive health (SRH) services – including healthy and safe childbirth, care for sexually transmitted diseases, and post-abortion care. Following on from the unfinished business of the Millennium Development Goals (MDGs), family planning is recognized as a critical development intervention in the Sustainable Development Goals (SDGs). Family planning underpins the achievement of all the SDGs and is specifically referenced in Goal 3 on Health and Goal 5 on Gender Equality.

The Global Strategy for Women's and Children's and Adolescents' Health outlines sexual and reproductive health and rights (SRHR), including family planning, as a critical way of eradicating all preventable maternal, newborn and child deaths by 2030. The 2012 London Family Planning Summit and subsequently the Family Planning 2020 (FP2020) global partnership have ensured that family planning is high on the global agenda. FP2020 has reinvigorated the global commitment to rights-based family planning programmes. Equity and discrimination are critical dimensions of family planning, and must be operationalized towards the contraceptive goal of reaching 120 million additional women and girls.

Since 2012, the BRICS – the governments of Brazil, Russia, India, China and South Africa – have increasingly collaborated on policies, shared opportunities and challenges related to population. Their unique geopolitics occupy a distinct position in the international health community. In February 2015, a BRICS 'Meeting of Ministers Responsible for Population Matters' released an 'Agenda for BRICS on population matters 2015 -2020'. This document recognized maternal mortality, HIV and family planning as critical components for strengthened collaboration and development.[5]

4. UNITED NATIONS (1968) FINAL ACT OF THE INTERNATIONAL CONFERENCE ON HUMAN RIGHTS, TEHRAN, 13 MAY 1968: PARA, 16. AVAILABLE AT: HTTP://www.refworld.org/docid/3ae6b36f1b.html [accessed 21 April 2017].
5. Family Planning 2020 (FP2020) (2014) FP2020 Rights and Empowerment Principles for Family Planning. [online] FP2020, pp.1-2. Available at: http://www.familyplanning2020.org/resources/4697FP2020_Statement_of_Principles_11x17_EN_092215.pdf [Accessed 21 Apr. 2017].

> *Equity and discrimination. Individuals have the ability to access quality, comprehensive contraceptive information and services free from discrimination, coercion and violence. Quality, accessibility and availability of contraceptive information and services should not vary by non-medically indicated characteristics, such as age, geographic location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status.*
>
> Family Planning 2020: Rights and Empowerment Principles for Family Planning[6]

6. Family Planning 2020 (FP2020) (2014) FP2020 Rights and Empowerment Principles for Family Planning. [online] FP2020, pp.1-2. Available at: http://www.familyplanning2020.org/resources/4697FP2020_Statement_of_Principles_11x17_EN_092215.pdf [Accessed 21 Apr. 2017].

THE GLOBAL GAG RULE

First introduced in 1984 and reintroduced by President Donald Trump in early 2017, the Global Gag Rule, also known as the Mexico City Policy, puts non-governmental organizations from outside the United States in an untenable position, forcing them to choose between safeguarding the health and rights of women and girls or losing all official development assistance from the US. It severely restricts freedom of speech, interferes with the doctor-client relationship, and hinders consideration of abortion laws based on public health concerns and human rights. President Trump's reinstatement of the Global Gag Rule and defunding of UNFPA under the Kemp-Kasten Amendment, will have far reaching consequences beyond the provision of safe abortion services. It will impair the delivery of reproductive health services including family planning, and lead to an increase in the number of unintended pregnancies, unsafe abortions and maternal mortality.

"For decades, the sexual and reproductive health and rights community has faced hostile political opposition. The levels of resistance to sexual and reproductive health and rights risk rolling back the fundamental ability of all people to attain the highest standard of health. The direct result is that women and girls bear the brunt of policies that fail to address the nature and scale of an unmet need for contraception. The global movement must continue to mobilize and galvanize in the name of human rights to protect and promote the rights of women and girls to choice."

But positive steps are still happening. Since 2012, due to the global recommitment to family planning through FP2020, an unprecedented 290 million women and girls are using modern methods of contraception in 69 of the world's poorest countries. In March 2017, a landmark initiative called She Decides was launched by the governments of Belgium, Denmark, the Netherlands and Sweden, rallying more than 45 countries committed to filling the gap of €181 million (US$203 million) for sexual and reproductive health and rights programmes that will see their funding withdrawn because of the Global Gag Rule. The She Decides global movement for women's rights is a strong signal to the rest of the world that the rights of women and girls will not be overlooked.

IPPF/Peter Caton/Uganda

> *These are dark times for those who care about human rights. Such people are members of the global elites so reviled by today's populist politicians. They believe in international norms and standards that contradict the current rage against the global… Rights for women, children, and adolescents are especially vulnerable in this new era… Instead of provoking opponents, the human rights community should focus on safeguarding its achievements.*
>
> Richard Horton, Editor-in-Chief of The Lancet 2017 [7]

7. Family Planning 2020 (FP2020) (2014) FP2020 Rights and Empowerment Principles for Family Planning. [online] FP2020, pp.1-2. Available at: http://www.familyplanning2020.org/resources/4697FP2020_Statement_of_Principles_11x17_EN_092215.pdf [Accessed 21 Apr. 2017].

IMPROVING CONTRACEPTIVE EQUITY: LITERATURE REVIEW

To create meaningful change for women and girls being left behind, IPPF undertook a realist review of evidence-based interventions that improve equitable access to contraception. This report includes the outcomes of IPPF's review.

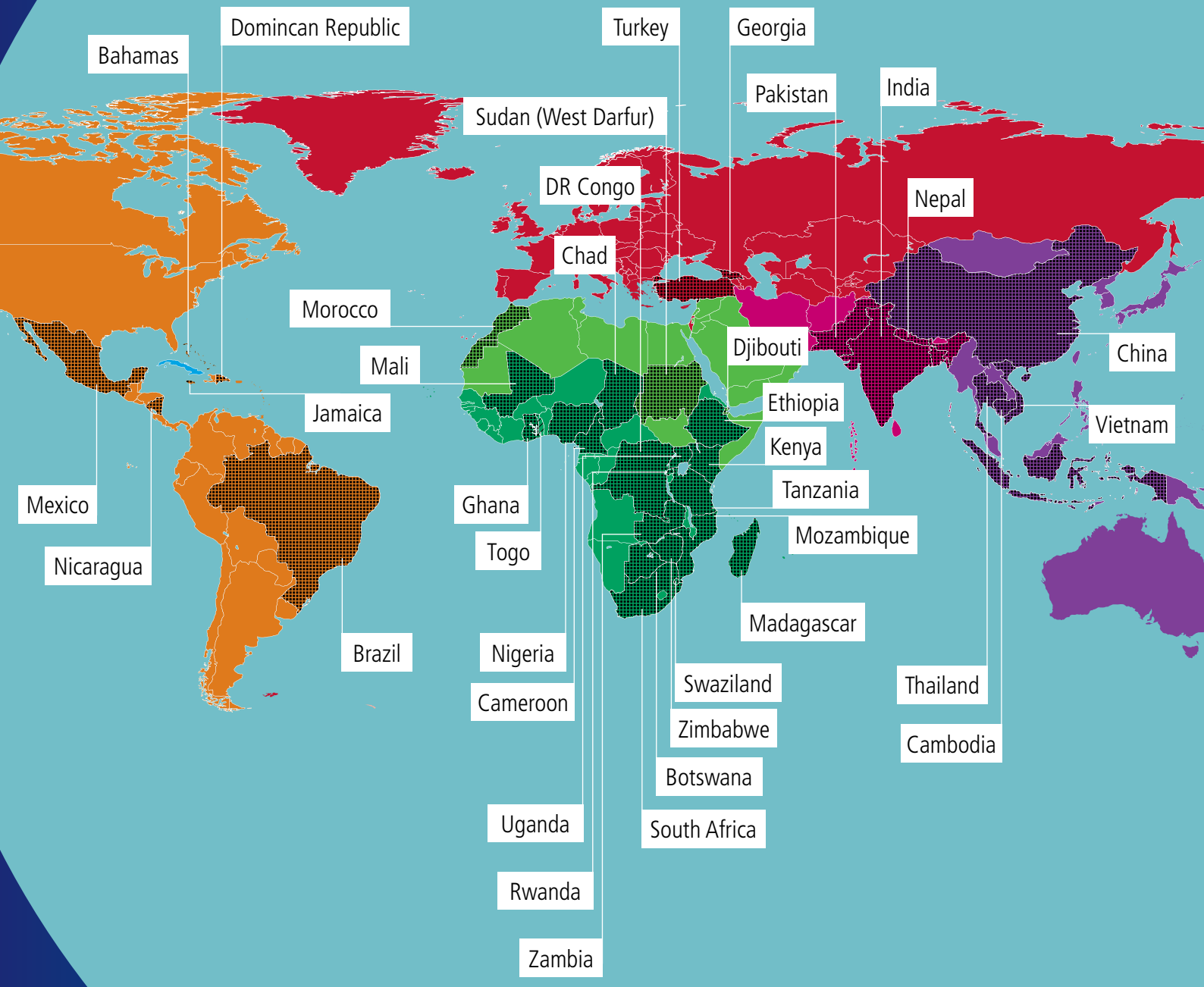
Realist reviews are used to assess complex social interventions, where one specific outcome is impossible to achieve due to variable environmental influencers. Instead of asking, 'does this work or not?', realist reviews consider, 'what works, for whom, in what circumstances?'. It is the most effective means of analysis for a report of this kind.

The review examined 68 studies, with particular attention paid to programmes that reported improvements in family planning outcomes for specific marginalized groups. The recommendations were drawn from a systematic and robust "realist review" methodology that reviewed the evidence on the most promising practices to increase equitable access to contraception for underserved populations. This is the outcome report of that review, which includes illustrative examples from IPPF's own family planning programming and other groups' programmes that increase awareness and uptake of modern contraceptive for selected segments of the population. Literature reviewed included a wide range of strategies and geography, including:

- strategies that integrated family planning into HIV care (Nyanza Province, Kenya);
- strategies for integrating sexual and reproductive health projects into the curriculum for secondary school planning into HIV care, (Nyanza Province, Kenya);
- strategies that focused on the sexual and reproductive health of adolescents (state of Minas Gerais, Brazil);
- strategies implemented on the streets with theatre health projects, delivered in part by secondary school adolescents (state of Minas Gerais, Brazil); and
- strategies implemented on the streets with theatre performances and wall paintings to reach less literate women across India.

In addition, sector experts were consulted for their first-hand experience of programmes in the field.

Geographical spread of studies included in IPPF's literature review



IPPF/Peter Caton/Nepal

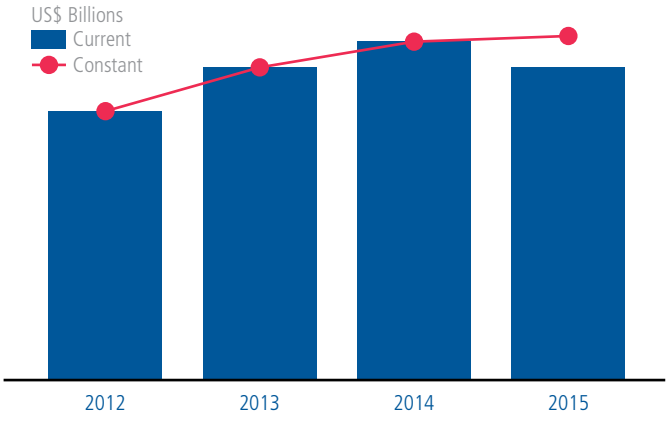
WOMEN AND GIRLS ARE BEING LEFT BEHIND

Over the last two decades, the function of health systems has emerged as a clear and consistent determinant of a country's ability to deliver high quality contraceptive care. Weak health systems are leaving behind women and girls in their ability to access high quality care. A major weakness in the functionality of health systems are human resources. The shortage of health care workers is a major challenge to service delivery. Skills imbalances and poor distribution of human resources do nothing to improve inequity. And meeting the demand of contraception relies on the availability of contraceptive products that meet the needs of individuals.

Current levels of funding for family planning are not adequate to meet the increasing number of new users of contraception. The current aid architecture is shifting and diversifying, as traditional donor assistance for family planning is decreasing. The Kaiser Family Foundation's analysis of donor government funding for family planning marks a steady increase in funding for family planning after the 2012 London Summit on Family Planning. Yet, by 2015 bilateral funding remains flat due to declines in investment in family planning by several donors.
This disparity indicates the importance of national-level advocacy to increase dedicated financing for family planning at the country level.

More emphasis is being placed on national governments to invest in the health and wellbeing of their citizens. Reaching the poorest and most marginalized can be costly, but they deliver high impact outcomes.

Below: Donor Government Bilateral Assistance for Family Planning, 2012-2015



Current projections show that the largest financial burden for contraceptives falls on women themselves. The Reproductive Health Supplies Coalition (RHSC) estimates that by 2020, out-of-pocket expenses for contraception could increase by US$238 million (from 2014), a sum far greater than will be forthcoming

from donors and governments.[8] Reinvestment in family planning programmes by donors, national governments and multilaterals is critical. Yet the poorest and most vulnerable women and girls are hard to reach, and as such can be expensive to reach.

Civil society organizations can extend the government and public sector's reach to hard-to-reach groups such as disabled people, people in vulnerable communities, people living in remote areas and people living with HIV. Governments and civil society organizations must work together to enable all women and girls to access equitable family planning care. IPPF and its Member Associations are committed to reaching under-served women and girls so they can exercise free, full and informed choice.

8. Reproductive Health Supplies Coalition (2016) Global Contraceptive Commodity Gap Analysis. RHSC. Available at: https://www.rhsupplies.org/fileadmin/uploads/rhsc/General_Membership_Meetings/Seattle_2016/2016_09_Commodity_Gap_Analysis_handout.pdf. > [Accessed December 2016].

IPPF'S COMMITMENT TO REACHING THE UNDER-SERVED

IPPF Member Associations provide information, education and services to people living in hard-to-reach areas. In 2016, IPPF provided an estimated:

- **47.2 million** services to poor and vulnerable users, accounting for 79 per cent of our service users;
- **Over 46,000** service delivery points including mobile clinics;
- **Half** of our service delivery points are community-based distributors;
- **55 per cent** of our service delivery points are in peri-urban or rural areas;
- **41 Member Associations** use IPPF's Vulnerability Assessment methodology to collect data on poverty and the vulnerability status of service users.

CASE STUDY

Measuring vulnerability to improve programmes

IPPF Member Associations around the world use our Vulnerability Assessment tool. The Moroccan Association for Family Planning (AMPF) uses it to collect data across all its clinics. Using the data from this assessment, AMPF developed a range of programmes tailored to regional variations in vulnerability, instead of a single strategy across the country. For example, AMPF now provides more HIV-related services in the two areas where the most vulnerable people are at risk of contracting HIV. AMPF has also used to this tool to propose a programme focusing on eliminating mother to-child HIV transmission among women and men who sell sex in southern Morocco where the data shows this group to be the most vulnerable population.

THE REPORT

The report is supported by the testimony of women and girls from all walks of life, who share a common right to take control of their family planning needs. City dwellers or those living off the land, affluent or impoverished, young or middle aged, regardless of gender and status of health: everyone has the right to choose when, where and whether to start a family, how many children to have and how to space them.

Using a rights-based approach, the focus is on women and girls – the poorest, most marginalized and the most vulnerable among them, who are commonly left to bear the undue burden of unwanted pregnancy. These are the people for whom systems are failing. These are the ones who are left behind.

Under-served and over-looked presents a snapshot of unmet need in family planning around the world, and shines a light on the need for equitable access to contraception. In recent years, family planning has renewed focus at the global level. This offers greater opportunities to highlight equity-driven and rights-based approaches to improving universal family planning access. The report identifies five 'promising practices' that programmes can follow to ensure better access for women and girls. And it concludes with recommendations in order to redress imbalances in family planning care. These proposals are designed for governments, policy makers, health providers and civil society organizations.

ACCESS TO CONTRACEPTIVE EQUITY: FULL, FREE AND INFORMED CHOICE

Many women and girls – married or unmarried – simply have no control over their sexual and reproductive lives. They cannot access or do not have permission to access safe and affordable family planning services. They have unequal status and are, therefore, prevented from exercising their human rights.

Equality is when everyone is treated the same. Equity recognizes that some individuals and communities need greater support to enable them to reach a given standard - and gain from the same benefits as fellow human beings living in more advantaged circumstances. This report deals in the currency of equity.

Global programmes have enabled countless numbers of women and girls to take control of their lives, through empowering them to exercise choice over their sexual and reproductive lives, and to feel confident and safe in expressing their sexual rights. But the most marginalized women and girls, the poorest and most remote, have been excluded from this story of success. Inequities in contraception are not inevitable. Evaluation, through the identification of areas of unmet need, is the key to unlocking equity.

Family planning programmes have long recognized women's fundamental right to the choices over their own body, including which method of contraception, if any, they want to use. Method choice requires that women can access a range of high-quality contraceptive methods and receive accurate and complete information on these methods to choose what is best for them.

Free, full and informed choice is when contraceptive users understand the information they're given, are made aware of any negative potential consequences, and then choose their method(s) voluntarily. It leads to safer and more effective use of contraceptive options and prolonged application of them.[9]

Decisions about family planning and contraception must be voluntary and grounded in human rights. All contraceptive users must understand the options being presented to them: information must be complete, accurate and unbiased and include the possible negative as well as beneficial outcomes. They must understand the meaning of coercion and be aware if it exists for them. Whether to take up contraception or not is their decision and their decision alone. Full, free and informed choice extends to being able to select from the widest range of contraceptive methods available, of a quality indistinguishable from those in supply in the world's most developed regions. As the number of contraceptive methods increases with new technologies, free choice becomes ever more important to ensure that all women have the right to choose the best contraception for them and their lifestyles.

Broader context, decision making and knowledge play critical roles and women and girls should know their rights before entering into a conversation with a family planning provider. Choice can be influenced by myths and misconceptions, as can social stigmas that may exist in any given community.

9. Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs (2017) Informed Choice in Family Planning Helping People Decide. The INFO Project. [online] Baltimore: Population Information Program, pp.1-33. Available at: https://www.k4health.org/sites/default/files/j50.pdf. [Accessed 19 May 2017].

> *Individuals have the ability to access quality, comprehensive contraceptive information and services, free from discrimination, coercion and violence (based on individual choice). Quality, accessible and availability of contraceptive information and services should not vary by non-medically indicated characteristics, such as age, geographic location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status.*
>
> World Health Organization, 2014 [10]

10. World Health Organization (2014) Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations. [online] WHO. Available at: www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/. [Accessed 21 Apr. 2017].

SECTION 1 – MEET THE WOMEN AND GIRLS WHO HAVE BEEN CONSISTENTLY LEFT BEHIND

Women and girls in the world's least developed countries are being excluded from family planning progress. The SDGs' commitment to leave no one behind means all people should have equitable access to the same rights and opportunities, including equitable access to contraceptive choice. This section illuminates the human face of women and girls left behind with the greatest level of unmet need.

YOUNG PEOPLE AND ADOLESCENTS

Young people meeting the need for family planning in Afghanistan

Sixteen-year-old Adla lives in a small village just outside of Kabul, Afghanistan. Although there are strong memories of war within the community there is also a future of opportunities for brave, young leaders. However, a tough hurdle stands in the way for many: child marriage.

Adla is a peer educator with the IPPF Member Association, the Afghan Family Guidance Association (AFGA), and works in the community outreach programme to spread life changing information. She regularly makes home visits to share information. She carries her training aids with her to illustrate the importance of family planning and raise awareness about maternal and newborn health care. As a result, more people have begun to visit AFGA's mobile clinic, which visits villages to deliver sexual and reproductive health services.

She says, "Now my friends come to me and discuss their problems. One of my friends was almost forced by her family into an arranged marriage with an older man. They didn't listen to me but I didn't give up. The counsellor in the mobile clinic helped convince the family. My mother is proud of my achievements."

IPPF/Jenny Matthews/Afghanistan

'Over-protected and under-served: A multi-country study on legal barriers to young people's access to sexual and reproductive health services'

In 2012, IPPF commissioned a pilot multi-country research project exploring legal barriers to young people's access to SRH services. The study was designed and implemented by Coram Children's Legal Centre.[11] While there is an extensive body of literature on social, cultural and economic barriers for young people's access, less is known about the role of the law in shaping access to SRH. Every state around the world, without exception, has developed legislation to purposefully regulate and restrict access to a range of sexual and reproductive health services, including methods of family planning like contraception and abortion, for young people.

11. Coram Children's Legal Centre and IPPF (2014) Over-protected and under-served: Legal barriers to young people's access to sexual and reproductive health services. [online] IPPF. Available at: http://www.ippf.org/taxonomy/term/217 [Accessed 21 Apr. 2017].

There are more young people (aged 10-24 years) in the world than ever before. In the world's least developed countries, children and adolescents make up the majority of the population. The median age young women around the world report having had their first experience of sexual intercourse ranges from 15-23 years old.[12] Globally, 23 million young people – married or unmarried – have a high unmet need for contraception.

Young people living in poverty, or otherwise experiencing social inequity, will have a higher unmet need for contraception and face diverse barriers to accessing contraception. Young people's access to contraception is limited by the time they have available to visit services, mobility issues and cost, and limited information about the range of services they have rights to and legal hurdles. Young people are also inhibited by social stigma, including the belief that young people should not be sexually active unless married or of a certain age, as well as hostile environments imposed by governments and policy makers.[13]

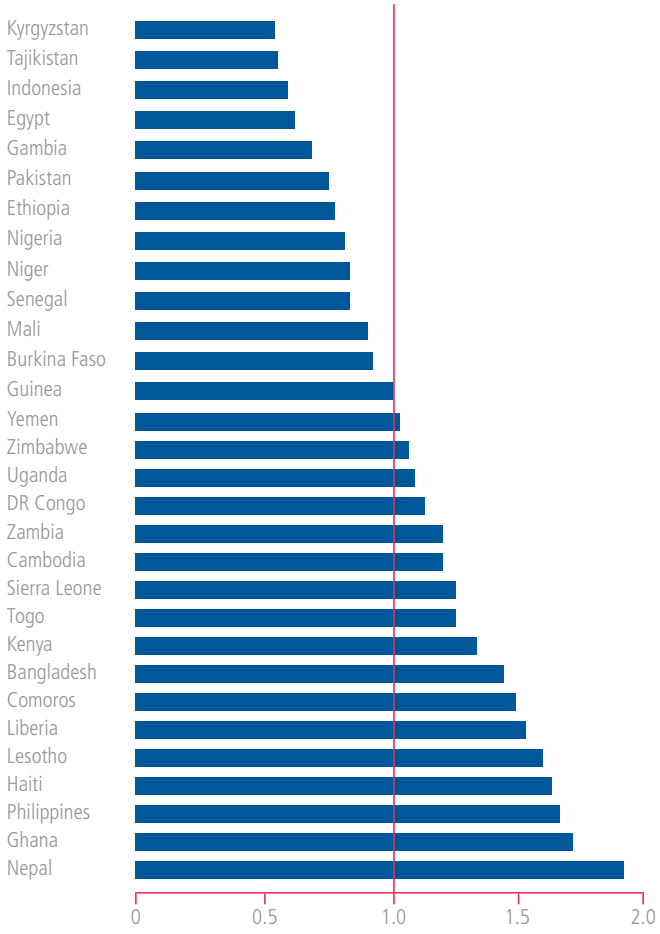
For adolescents (15 to 19 years old) who have less mobility, less money and less legal independence, these barriers to access are even more significant.[14] Young people's access to safe, affordable contraceptives is constrained by a range of factors – cultural, social, religious, logistical and legal. Young people's ability to make free and informed choice may be limited by availability, quality, cost and equitable access to contraception.[15] This may include stigma and embarrassment related to sex, gender norms and expectations of sexual behaviour, cost and practical barriers, and confidentiality among others. Laws and policies can prohibit young women and girls from accessing services, information and education.

12. USAID (2017) STATcompiler, DHS Program. [online] Available at: http://www.statcompiler.com/en/ [Accessed 24 Apr. 2017].
13. Braeken, D. and Rondinelli, I. (2012) Sexual and reproductive health needs of young people: Matching needs with systems. International Journal of Gynecology & Obstetrics 119, pp.S60-S63.
14. Darroch, J., Woog, V., Bankole, A. and Ashford, L. (2016) Costs and Benefits of Meeting the Contraceptive Needs of Adolescents. Adding it Up. [online] Guttmacher Institute. Available at: www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-adolescents-report.pdf. [Accessed 11 May 2017].
15. Reproductive Health Supplies Coalition (2016). Global Contraceptive Commodity Gap Analysis.

Unmarried young women

Unmarried young women have greater barriers in accessing contraceptive services and information, and a higher unmet need than young married women. The DHS Program, an international comparative body examines the key demographic and health characteristics of populations. Around 2 in 5 young unmarried women in Africa (almost 40 per cent)[16] have an unmet need for contraception, making them the group with the highest unmet need in the country.[17] Total demand for family planning among unmarried women aged 15 to 24 years is approximately 90 per cent in all regions. This high proportion demonstrates an urgent call to provide the family planning services that women want and need.

Below: Ratio of unmet need: young married women (ages 15 – 19 years) to all married women:



16. Unmet need among young unmarried women is highest, around 40 per cent, in the two African regions (41.7 per cent in West and Central Africa; 39.8 per cent in East and Southern Africa). Among individual countries, it is highest in Senegal (69.5 per cent) and lowest in Ukraine (7.3 per cent).
17. MacQuarrie, K.L.D. (2014). Unmet Need for Family Planning among Young Women: Levels and Trends. Rockville, Maryland, USA: ICF International. [online] Available at: http://www.dhsprogram.com/pubs/pdf/CR34/CR34.pdf [Accessed 21 Apr. 2017].

HARD TO REACH

Health in the slums: one year in Kibera, Kenya

IPPF/Kenya

Lorraine Nabwire has a hard job, in a tough place. Lorraine is the centre manager of IPPF Member Association Family Health Options Kenya's (FHOK) clinic in Kibera, Nairobi – a place best known for being Africa's biggest urban slum. Until 2015, FHOK provided sexual health care in Kibera from mobile units. In July, a permanent centre was opened. In charge since day one, Lorraine is honest about the challenges she has encountered since opening this centre in Kibera.

"At the start, we might get five people a day coming to us. Now it is more than 20." She explains the great need for better sexual health care, "People in Kibera have many children and the child bearing age is as early as 15, by 24 they have four kids or more." To address stigma, myths, and misconceptions, Lorraine has recruited community health volunteers to refer people to the centre as well as to provide feedback to FHOK on what people in Kibera say they need. Lorraine and her staff also take part in a weekly radio show on the local Swahili radio station to change attitudes. Due in part to the FHOK Kibera Centre's community outreach, daily attendance increased to up to 80 people a day by the centre's first birthday.

In hard-to-reach areas, women and girls experience difficulties in accessing contraception as first-time users, and then in their efforts to continue using contraception. Unmet need for contraception is particularly high in hard-to-reach areas, including urban slums, among street dwellers, remote communities, among migrants, refugees and displaced people.

Indigenous women have high maternal mortality and low contraceptive uptake. Voluntary contraceptive use among indigenous women is low.[18] Travelling to an urban, static clinic on any regular basis is likely to prove unachievable for many indigenous women and girls. Therefore, it is harder for static service providers to reach them. Indigenous women and girls are less likely to continue using contraception without the support of ongoing counselling and reliable access to a regular supply of a preferred contraceptive method.[19]

Women and girls need reliable and predictable family planning service provision and sustainable supply of a comprehensive method mix to meet their needs for contraception. One study found that where appointments were not readily available or women were required to travel between clinics for different services, take up and continued contraceptive use was compromised. Another study highlighted the under representation of hard-to-reach groups in public health data. Researchers concluded that public health services should extend the time they allow to plan for and reach out to hard-to-reach groups, and also allocate higher resourcing costs. They also concluded that hard-to-reach groups could often be served more effectively through community partnerships.[20]

18. Inter-Agency Support Group (IASG) on Indigenous Issues (2014). Thematic Paper on Sexual and Reproductive Health and Rights of Indigenous Peoples. [online] UN. Available at: www.un.org/en/ga/president/68/pdf/wcip/IASG%20Thematic%20Paper_Reproductive%20Health%20-%20rev1.pdf. [Accessed 21 Apr. 2017].
19. Kaunitz, A. (2017) Contraceptive Counseling and Selection. [online] Available at: www.uptodate.com/contents/contraceptive-counseling-and-selection. [Accessed 19 May 2017].
20. Bonevski, B., Randall, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I. and Hughes, C. (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. BMC Medical Research Methodology, 14(42), pp.14-42.

HIGH UNMET NEED OF DISPLACED WOMEN AND GIRLS DUE TO CONFLICT AND HUMANITARIAN DISASTERS

The UN Refugee Agency estimates more than 65 million people have been forcibly displaced from their homes as a result of armed conflict or natural disaster. Nine out of 10 countries in the world with the highest maternal mortality rates are in conflict. One in four displaced women and girls of childbearing age will be pregnant at any given time. In humanitarian crises, SRHR and family planning needs are often forgotten when disaster and conflicts strike. Already insecure from fleeing an emergency, women and girls forced to take refuge can become increasingly vulnerable. Although many are subjected to sexual violence, their access to contraceptive services is often non-existent.

IPPF/Tommy Trenchard/Uganda

Overcoming barriers to family planning in Vanuatu: Julie's experience

IPPF/Vanuatu

Julie was a midwife with 20 years' experience before she joined the IPPF Member Association, the Vanuatu Family Health Association (VFHA), as a nurse. When Cyclone Pam hit Vanuatu, the IPPF humanitarian team, known as SPRINT, sprang into action and VHFA started providing life-saving services on the island of Tanna, which was the population worst affected by the typhoon. Many communities on Tanna live remotely, in grass huts, with no immediate access to medical care. Health outcomes are very low. Every person in the village knows at least one mother who died during child birth. Access to and knowledge of family planning is overlooked as traditional practices are usually preferred. Julie explains that sex is a taboo subject in most cultures, and it was no different on Tanna. What made it harder was that most people in Vanuatu speak Bislama, but on Tanna they speak their own language.

She said, "However, we did our level best using the few words we had, improvised sign language and demos to impart knowledge about family planning. Once the women knew they could decide the size and spacing of their families, we struggled to keep up with demand for contraception."

WOMEN AND GIRLS IN THE LOWEST INCOME QUINTILE

One billion people live in extreme poverty, caused by and a consequence of vulnerability. The extent to which family planning services and information are reaching all members of a society varies both within and between countries, but common themes quickly emerge. The poorest 20 per cent of the population – those in the lowest income quintile – often have poor health status, and have not benefited from the global improvements in family planning programming. In many countries, women and girls of the poorest income quintile have a low use of contraception, and the highest unmet need for contraception and family planning. Poverty and education are inextricably linked,[21] not least because people living in poverty may stop going to school in order to enter paid work.

Female garment workers in Bangladesh: Jasmin's story

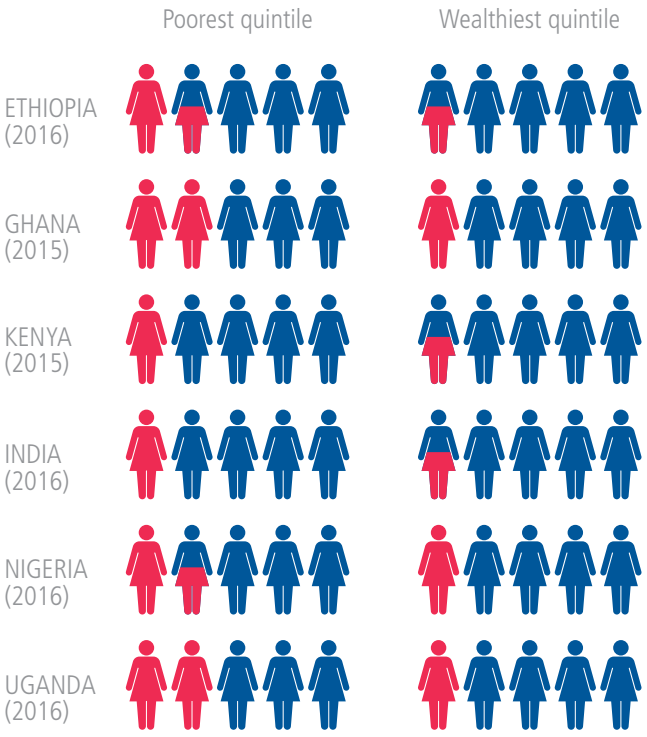
Jasmin Akter, 23, is a married female garment worker from the poverty stricken northern district of Gaibandha in Bangladesh. Jasmin was brought up there with her sister and two brothers in a small hut made of straw and bamboo, and works in an export-oriented garment factory as a as a sewing machine operator. She earns around US$300 a month. Jasmin's husband also works in the garment factory.

Unlike some other young couples, Jasmin and her husband made the decision to delay pregnancy and Jasmin chose the long-lasting family planning method 'Implanon' as contraceptive. "I met several Reproductive Health Educators from the Family Planning Association of Bangladesh (FPAB). FPAB conduct outreach works and provides information on family planning among the female community in that area. It was interesting. Family planning is not all about contraception, it is about women's health and their rights. Family planning keeps different avenues open for economic engagement and saving women's and girls' lives. If I had become a mother at an early age, I am afraid I would not be able to help my baby and hold down a job as well. I do dream of being a mother, maybe in one year, after becoming more settled in my job and conjugal life."

21. Bonevski, B., Randall, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I. and Hughes, C. (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. BMC Medical Research Methodology, 14(42), pp.14-42.

Performance Monitoring and Accountability 2020 (PMA2020) generates, analyses and disseminates key data on an array of indicators for family planning in selected countries. PMA2020's current modules include analysis of unmet need by wealth quintile. Unmet contraceptive need is the highest among women and girls in the poorest wealth quintile (at 25 per cent), and lowest for those in the wealthiest quintile. The table below demonstrates how, in the countries listed, women and girls in the lowest universal income quintile have the highest unmet need for contraception. Their unmet need is almost double that of wealthier women and girls living in the same country.[22]

Below: Unmet need by quintile



22. Bonevski, B., Randall, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., Brozek, I. and Hughes, C. (2014) Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. BMC Medical Research Methodology, 14(42), pp.14-42.

WOMEN IMPACTED BY DISABILITY, GENDER-BASED VIOLENCE, HIV STATUS, AND MEN AND WOMEN WHO SELL SEX

Access in Hebron, Palestine: Aisheh's story

During an outreach awareness session conducted in Deir Al Asal, a poor and marginalized outlying district of Hebron, the IPPF Member Association, the Palestinian Family Planning and Protection Association (PFPPA), met two women, both unemployed and married to the same 26-year-old man. One of the women, Aisheh, shared her personal experience of accessing PFPPA's services when she found herself pregnant for the second time.

Aisheh's first child was born with developmental impairments and she was worried that having a second child would overwhelm her as she cared for her first child. She was referred to PFPPA to receive family planning counselling and services. Her husband accompanied her during the visit and the couple were counselled on various SRHR issues. Aisheh decided to have an abortion. A few months later, Aisheh said she felt empowered with the new information she had received on contraceptive options. Aisheh and her friend became champions by organizing small information sessions for their neighbours at home and inviting PFPPA mobile teams to participate.

According to Aisheh, "they must know that there are numerous family planning, contraceptive options available which can make their lives much easier and they can be in control of their bodies. I am now aware of how to take care of myself and protecting my rights, as a woman… my life has changed."

IPPF/Steve Sabelle/Palestine

Women and girls may have particular vulnerabilities based on their health status including disability, mental health or HIV status.

Women and girls with disabilities encounter social, physical and attitudinal barriers to accessing family planning care.

Many are prevented from accessing family planning care due to societal perceptions that they should not be sexually active. While some people living with disabilities may have difficulties communicating their needs and desires, the autonomy of people with disabilities must be respected. There remain gaps in research have been undertaken to establish the unmet need of women and girls living with disabilities.

Women and girls living with HIV face obstacles in accessing family planning.

Women and girls living with HIV have the right to determine the number and timing of their pregnancies. Yet, a higher proportion of women and girls living with HIV have an unmet need for family planning. For women living with HIV, family planning is a critical component offering the added benefit of preventing vertical transmission and reduces mother-to-child transmission. In Kenya, high rates of unintended pregnancy are recorded among women living with HIV. Among them, contraceptive choices are affected by self-stigma, as well as external stigma, health concerns and provider bias.[23]

Gender-based violence affects women's and girls' opportunities to access family planning.

Survivors of sexual violence have a higher unmet need for family planning. According to IPPF's V2020 Report on Gender Equality, 1 in 3 women and girls are subjected to gender-based violence by their intimate partner. Two decades of research across multiple regions have documented that women experiencing violence are twice as likely to have a male partner refuse to use contraception and twice as likely to report unintended pregnancy, compared to those not experiencing such violence. Women and girls impacted by gender-based violence are up to three times more likely to give birth during their adolescent years and to have five or more births.[24] In a survey of 31 countries, an average 9 per cent of women gave partner opposition as a reason for not using contraception, with the highest in East Timor (27 per cent).[25]

Contraceptive needs of men and women who sell sex:

Evidence suggests men and women who sell sex have a higher unmet need for family planning than women in the wider population.[26] Societal barriers experienced by these women, men and young people make it difficult for them to access specific contraceptive information and services. Given the stigma directed at men and women who sell sex, and the emphasis on HIV/ STI prevention, many use condoms as their only form of protection against unintended pregnancy. Using condoms as the sole method of protection against unintended pregnancy implicates factors like condom negotiation, risk perception, consistency and method failure. Due to stigma against this group, they are often marginalized from family planning counselling and the full information they need to choose the best method of contraception for them.

Women and girls who are post-partum

During the post-partum period, most women and girls wish to delay or prevent future pregnancy. The unmet need for family planning up to a year after childbirth is higher than at any other time. It is estimated that globally, nearly 65 per cent of women and girls in their first year post-partum have an unmet need, and post-partum women under the age of 20 years have a substantial unmet need to delay or prevent pregnancy. Post-partum women and girls have unique family planning needs including considerations of amenorrhea, socio-cultural norms and expectations when to resume sexual activity after birth. They often encounter many cadres of health workers during the prenatal to postpartum timeframe, who may or may not be offering them post-partum contraceptive options. Women and girls in this period also have a high likelihood of contact with the health care system through maternity services, and child immunization programmes, indicating and opportunity to increase contraceptive uptake for women not wanting to immediately become pregnant again.

23. United Nations Population Fund (UNFPA) (2016) Universal Access to Reproductive Health, Progress and Challenges. [online] NY, US: UNFPA. Available at: http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf [Accessed 19 May 2017].
24. Silverman, J. and Raj, A. (2014) Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control. PLOS Medicine, 11(9).
25. Sedgh, G., Ashford, L.S. and Hussain, R. (2016) Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method. [online] Guttmacher Institute. Available at: www.guttmacher.org/sites/default/files/report_pdf/unmet-need-for-contraception-in-developing-countries-report.pdf [Accessed 19 May 2017].
26. Kohlway, E. (2016) All Women, All Rights, Sex Workers Included: US Foreign Assistance and the Sexual and Reproductive Health and Rights of Female Sex Workers [online] Centre for Health and Gender Equity (CHANGE). Available at: http://www.genderhealth.org/files/uploads/All_Women_Alll_Rights_Sex_Workers_Included_Report.pdf [Accessed 21 Apr. 2017].

WHERE ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION IS AVAILABLE, SOME WOMEN AND GIRLS ARE NOT USING MODERN METHODS OF CONTRACEPTION.

Qualitative studies have identified a number of barriers that indicate why women and girls are not using contraception. These include:[27]

- limited choice of modern method of contraception;
- misinformation including myths, rumours and misconceptions surrounding sexuality, pregnancy and contraception;
- infrequent sex, and postpartum amenorrhea, and or breastfeeding;
- constraints on decision-making including opposition to contraception, either by their partner or the user themselves. Traditional gender norms may prevent women and girls from making choices without permission;
- concerns regarding side effects and health risks; and
- provider bias and misinformation by service providers.

27. Sedgh et al. (2016) Ibid.

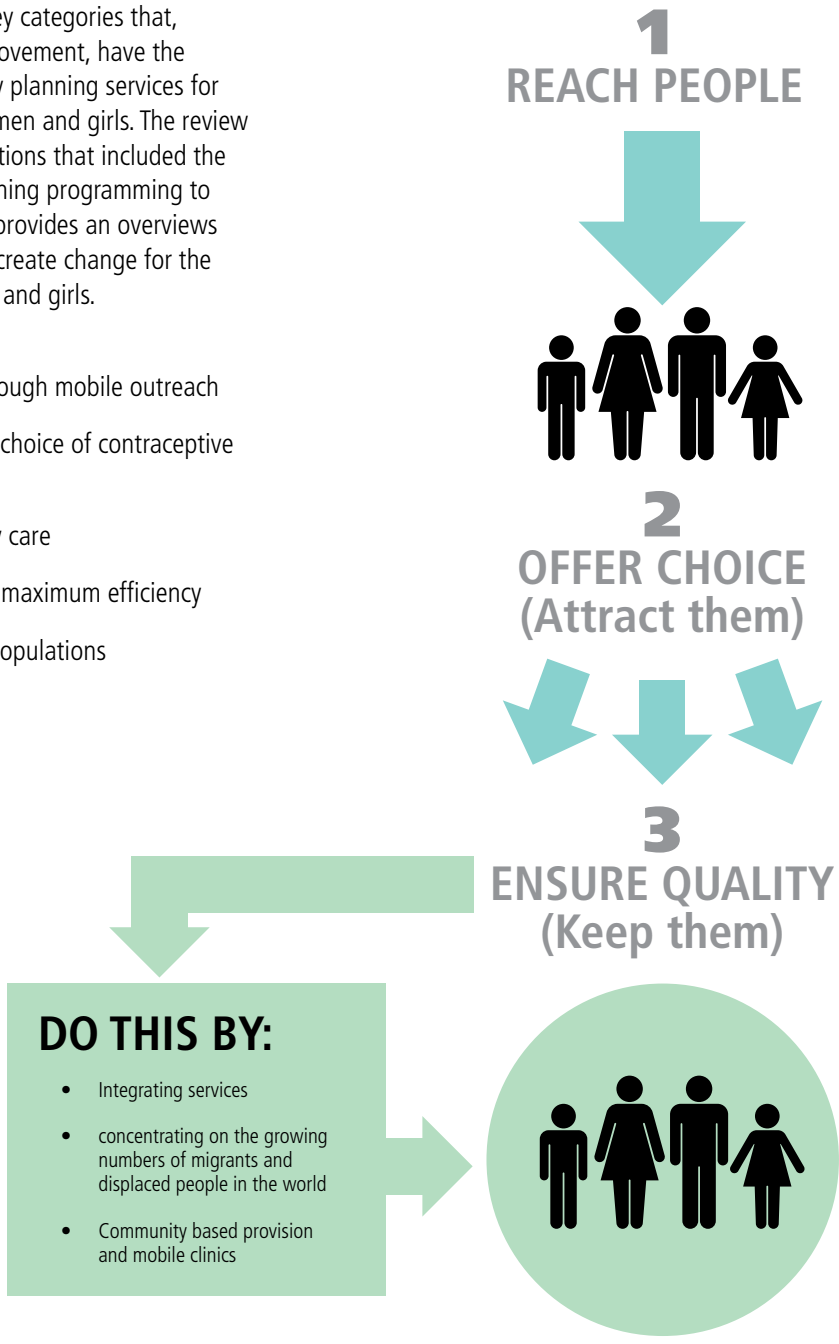
IPPF/Peter Caton/Philippines

SECTION 2 – CREATING CHANGE: EVIDENCE-BASED INTERVENTIONS FOR EQUITABLE ACCESS TO CONTRACEPTION

What could progress on equitable access to contraception look like? In order to achieve universal access to family planning, we must prioritize interventions that ensure that the poorest and most marginalized women and girls have free, full and informed choice.

IPPF's literature review identified five key categories that, if placed at the heart of efforts for improvement, have the potential to significantly enhance family planning services for the poorest and most marginalized women and girls. The review pointed to specific programme interventions that included the most promising practices in family planning programming to increase equitable uptake. This section provides an overviews of the five most promising practices to create change for the poorest and most marginalized women and girls.

1. Outreach: Reach more people through mobile outreach
2. Choice: Offer the widest possible choice of contraceptive method
3. Quality: Ensure affordable, quality care
4. Integration: Integrate services for maximum efficiency
5. Concentration: Focus on mobile populations



PROMISING PRACTICE 1: OUTREACH: REACHING MORE PEOPLE THROUGH MOBILE OUTREACH

To address inequities in contraception, family planning services must allocate resources – including planning time, supplies and budget – to ensure that they are able to support hard-to-reach areas. One way of addressing limited coverage of national health systems is to bring services directly to the communities where people live and work. Mobile outreach services – including mobile clinics, community health workers and community outreach – can reach more women and girls with information, services and contraceptives compared to static clinics. Mobile outreach can also strengthen health systems and support health workers to offer a wide range of contraceptive methods. Various models of mobile outreach services have been implemented successfully.

Mobile clinics can deliver a wide range of contraceptives to women and girls in hard-to-reach areas

One way of addressing limited coverage of the health system is to bring services directly to the communities where people live. Mobile clinics are effective at reaching remote areas and serving marginalized communities who face social barriers, such as those living in urban slums. In Nepal, in 2011, 13 per cent of all women using modern methods obtained their method from a government mobile clinic.[28]

Mobile outreach services can also be attributed with the increase in the number of women new to using contraceptive services. Mobile outreach service delivery is identified as a Family Planning High Impact Practice. Many women access contraception through mobile services, including:

- 41% of women adopting methods of family planning through mobile outreach clinics in sub-Saharan Africa,
- 36% in South Asia and the Middle East,
- 47% in Pacific Asia and
- 23% in Latin America.[29]

Mobile clinics should link with community-based initiatives like community health workers and local clinics to ensure a system of referrals is in place. People using mobile services need access to a range of short- and long-acting methods of contraception, follow up care, subsequent visits, referrals and hotlines for information. Mobile outreach services are shown to increase the confidence and trust of community they serve, empower community health workers and extend health coverage in hard-to-reach areas.

Community interventions can reach new and under-served populations

Interventions designed to raise awareness around family planning are usually comprised of multiple components. They can include networking activities, workshops, peer education, role playing, drama and theatre. Youth centres and outreach projects often play a central role in delivery.

Conceptions of sexuality and reproductive health are not neutral or factual, but are informed by cultural and moral frameworks, public health framing, and medicalization among other influences. IPPF's literature review found that educational programmes that work to grow and deepen people's understanding of sexuality and reproductive health, or 'expand their conception' of these issues are the most promising practices for creating and sustaining the negative attitude change and addressing stigma. This practice is particularly effective when this approach favours an interactive approach which encourages participants to take part in some or all of the activities outlined. Well designed and culturally appropriate community-based health communications can likewise create contraceptive demand, especially among the most vulnerable and marginalized groups.[30]

Provide comprehensive sexuality education (CSE) outside the classroom

With increasing numbers of children and young people attending schools and colleges, formal educational settings play an important role in delivering comprehensive sexuality education (CSE). But in countries where access to education remains limited, it is essential to develop innovative ways to reach people who are, or were, unable to attend school. Lower school attendance correlates with significant gaps in CSE.[31] Many opportunities exist for delivering CSE outside the classroom. Waiting areas, youth clubs and hairdressing salons are appropriate environments to display information. In less literate communities, incorporating family planning information into traditional rituals and street theatre have been shown to be effective.

28. Ministry of Health and Population (MOHP) [Nepal], New ERA, and ICF International Inc. (2012) Nepal Demographic and Health Survey 2011. [online] Kathmandu, Nepal: Ministry of Health and Population, New ERA, and ICF International, Calverton, Maryland. Available at: http://dhsprogram.com/pubs/pdf/fr257/fr257%5B13april2012%5D.pdf [Accessed 19 May 2017].
29. Marie Stopes International (2012) Global Impact Report 2012 Reaching the under-served. [online] Marie Stopes International. Available at: www.mariestopes.org/media/2164/global-impact-report-2012-reaching-the-under-served.pdf [Accessed 21 Apr. 2017].
30. Daniel, E., Masilamani, R. and Rahman, M. (2008) The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive Use Among Young Married Couples in Bihar, India. International Perspectives on Sexual and Reproductive Health, 34(4), pp.189 - 197.
31. Anderson, R., Panchaud, C., Singh, S. and Watson, K. (2014). Demystifying Data: A Guide to Using Evidence to Improve Young People's Sexual Health and Rights. [online] Guttmacher Institute and IPPF. Available at: https://www.guttmacher.org/sites/default/files/pdfs/pubs/demystifying-data.pdf [Accessed 21 Apr. 2017].

MOBILE CLINIC

Every Thursday a team from RHU Gulu district provides a mobile outreach clinic in Atega village in the Omoro district in Northern Uganda. The outreach team goes out into this poor remote area which would otherwise not have access to sexual and reproductive health services.

The night before the outreach clinic RHU driver, Robert Nyeko and Godfrey Bedimot load up tents, chairs, medical equipment and supplies. The clinic needs to be set up and by 7am ready to receive clients from 8am.

The outreach clinic provides a range of services including diagnosis, testing and treatment, family planning such as fitting implants, providing condoms and HPV vaccines. Laboratory technician, Denis Bongonyinge carries out testing for malaria, Hepatitis B, HIV/AIDS, pneumonia and other infections. Other members of the team provide immunisations and vaccinations.

Typically men, women and children start arriving at the clinic by 7:30am. Two volunteers are on hand to direct them to the appropriate place to get the services they need. Some clients need a range of services.

At 8am service provider, Anicia Filda, popularly known a 'Mama' in the community is ready with her team to start the day. There are now more than 200 clients waiting to be seen; with more people arriving to join the long queues.

The longest queue is for the immunisation and vaccination services. The majority have come for either the Hepatitis B vaccine, which is a big threat in this community. Priority is given to the many young girls lining up for the Human Papilloma Virus (HPV) vaccine.

Denis Bongonyinge takes blood samples for rapid tests for malaria, HIV, HPV and a range of other infections. Each client carries an exercise book where Denis records their results which is then taken to the staff giving out prescriptions.

32-year-Robert Otim pushes his bicycle to the outreach clinic. The single father has ridden 10 kilometres with his two young children. He lost his wife to Hepatitis B when their daughter was just six months. His four-year-old son was born prematurely and is now disabled. He has come today for his last Hepatitis B immunisation. His children need to be vaccinated as well as treated for malaria and coughs. Looking at the long queue, he says he doubts whether he will get the service today but he is lucky as one of the team who once treated his son, Geoffrey, notices Robert and they are given priority for treatment and prescriptions.

Already by midday, one of the teams delivering minor surgeries, postnatal services, family planning and post abortion care have seen 47 mothers. This is almost the same as the number of clients they would treat at the Gulu Clinic during a normal day.

Anicia Filda sends the driver to collect more supplies from the clinic; the stock is starting to run low because demand is so high There is no break for the team. Samuel Kedi, the only clinician at the outreach camp stands up, and picks up a bottle of water from his backpack for a quick drink before continuing with the next client.

The clinic continues to see clients well into the evening. The outreach clinic is scheduled to finish by 5pm but Anicia says there is not one day they have closed on time: "We cannot close when clients are still lining up. It's the same at the clinic in Gulu," she says.

As the clinic draws to a close for the day, the teams complete their report which records details of the numbers clients served, the types of services delivered and supplies of stock. It has been another busy but successful day for Anicia and her team. Provision of integrated services in such remote areas is vital for the local community; many men, women and children would not be able to receive the types of treatment and care that RHU works diligently to provide.

IPPF/Tommy Trenchard/Uganda

Medicine on the Move in Guatemala

In a region of Guatemala with high inequality, the IPPF Western Hemisphere Region and its local partners provided nearly 900,000 health services to the most underserved communities through mobile health units in 2015. These units, staffed with health professionals and equipped with contraceptive supplies, traverse dangerous mountain passes, dirt roads and rivers to provide low-cost or free health services to those who would otherwise go without.

In Guatemala, where nearly half of the population lives in rural areas, IPPF Member Association APROFAM is reaching the most underserved with quality sexual and reproductive health services and information, including short, long-acting and permanent contraception for little or no cost, as well as providing youth and women's empowerment programmes. The mobile health team cares for up to 28 people per day, though some areas have seen numbers as high as 70. Heidy Escalante, an assistant nurse with one of APROFAM's mobile health units, rises at four o'clock each morning to prepare for the day. She says:

"When the women say how satisfied and grateful they are [for our services], I feel wonderful. It's a great relief to see a woman have access to contraception, to know that I have helped avert a maternal death, and given families a choice."

Engender Health Respond Project delivers mobile outreach services in Tanzania

Engender Health's Respond Project works in Tanzania to address unmet need for contraception and to advance use of family planning and reproductive health services for women, men and adolescents. The project works at the national and district level to strengthen health systems in collaboration with the Ministry of Health and Social Welfare. Engender Health standardized training for health providers, ensured availability of multiple contraceptive methods, and improved the integration of family planning with other reproductive health services. The project has been successful in mobilizing communities, emphasizing rights and equal access to quality reproductive health services regardless of gender or age.[32]

IPPF designs comprehensive sexuality education in informal settings

IPPF's Choices and Opportunities programme implemented a rights-based approach to CSE in 17 countries.[33] The programme centered on empowerment and focused on building trust between young people and adults, and listening to and understanding young people's interests and concerns. As a result of the Choices and Opportunities programme, CSE is delivered in youth and community centres, clinics, through drama, online and with interactive apps. A specific objective is inclusivity, in order to inspire confidence in everyone to join in, regardless of their personal circumstances. IPPF is learning important lessons and devised creative ways of achieving the goal of reaching marginalized individuals:

- CSE content is most effective when it is tailored to suit different groups;
- educators need support to adopt new approaches that actively involve young people;
- CSE is more sustainable if young people who have been trained as peer educators are encouraged with incentives, such as use of a bicycle to reach their appointments.

32. Engender Health (2017) RESPOND Tanzania. [online] EngenderHealth. Available at: www.engenderhealth.org/our-work/major-projects/RESPOND_Tanzania.php. [Accessed 21 Apr. 2017].
33. IPPF European Network (2016) Lessons learned from IPPF's Choices Programme. Brussels: IPPF EN. Available at: www.ippfen.org/our-approach/programmes/choices-and-opportunities [Accessed 30 May 2017].

IPPF/Graeme Robertson/Nepal

PROMISING PRACTICE 2: OFFER THE WIDEST POSSIBLE CHOICE OF CONTRACEPTIVE METHOD

Decades of research have shown that when women and girls can choose from a greater range of contraceptive methods, this leads to greater uptake than in contexts where a limited range of methods are offered. No single type of contraceptive will serve the needs all women and girls in a community. Every modern method has limitations. Offering a comprehensive mix of various contraceptive methods is therefore crucial to ensure positive outcomes. The method mix should include methods that are short- and long- acting, permanent and reversible, hormonal and non-hormonal, self-administered and administered by a health worker. If only one or two options are available, women and girls may be discouraged from using contraception.

Service delivery points maintain a sufficient method mix, or they make a wider range of methods available through an efficient referral mechanism.

In some cases, service delivery points may not have more than one method of contraception available. Women who are unable to travel to a clinic and/or who lack of funds to purchase alternative methods tend to accept 'what is available on the day', yet evidence points to the fact that women use contraception for longer when they have chosen a preferred method for themselves, from the widest range possible.[34]

A 'skewed method mix' is where a single method of contraception accounts for 50 per cent or more of what is available in any given country. It affects poor women and those living in rural areas disproportionately, because they depend on subsidized and cost-free methods. In a study, skewed method mix was found to be the case in one-third of countries analysed.[35] Yet, there is evidence that offering a more comprehensive method mix results in higher uptake. Adding just one method of contraception to those commonly available decreases contraceptive discontinuation by between 4 per cent and 8 per cent.[36] Women and girls are more likely to use contraception when they have greater choice over the method.

34. Upadhyay, U.D. (2001) Informed Choice in Family Planning: Helping People Decide. [online] Baltimore, USA: The Johns Hopkins University Bloomberg School of Public Health. Available at: www.k4health.org/toolkits/info-publications/informed-choice-family-planning-helping-people-decide [Accessed 21 Apr. 2017].
35. Sullivan, T., Bertrand, J., Rise, J. and Shelton, J. (2005) Skewed Contraceptive Method Mix: Why it Happens, Why it Matters. Journal of Biosocial Science, 38(04), p.501.
36. Castle, S. and Askew, I. (2017) Contraceptive Discontinuation: Reasons, Challenges and Solutions. [online] FP2020 and Population Council. Available at: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/02/FP2020_ContraceptiveDiscontinuation_SinglePage_Revise_02.15.16.pdf [Accessed 21 Apr. 2017].

IPPF/Jane Mingay/Georgia

Minimize stock outs of contraceptives to ensure women and girls have uninterrupted access to a comprehensive method mix

All too often women and girls face shortages of contraceptives at a service delivery point. Unreliable supply chains and poor distribution in many countries mean clinics and community health workers routinely run out of contraceptive stock. This tends to be a greater problem in poorer and more remote districts and there are dual disadvantages: women and girls are unable to depend on their chosen method being available, and as a result are less likely to access services regularly.

CASE STUDIES

PATH and Advance Family Planning (AFP) collaborate to increase access to next generation injectables

DMPA-SC – a next generation injectable – is a contraceptive innovation that combines the drug and needle into one system that can be easily self-administered or administered by community health workers. Piloting this new injectable contraceptive, health services in Burkina Faso, Niger, Senegal and Uganda have identified a way to reach new users of family planning. In Uganda, high rates of acceptability for self-injection (90 per cent), and desire to continue self-administering (98 per cent) show that introducing this method satisfies women's need for a simple and highly accessible method.[37] For women living in rural or remote areas, young women facing stigma for contraceptive use or any women otherwise unable to attend health clinics or pharmacies, DMPA-SC is particularly advantageous.

In early 2017, Advance Family Planning, in collaboration with PATH, hosted a meeting aimed at increasing voluntary and quality access to DMPA-SC. The meeting aimed to increase knowledge among implementers/researchers, donors, advocates and policy makers regarding the experience of early adopter countries and the potential for introducing DMPA-SC in more settings. The meeting identified next steps to increase access to DMPA-SC as a way of accelerating progress towards ensuring women always have access to a high-quality contraceptive method mix.

Senegal's Push Distribution Model

Contraceptive use in Senegal is among the lowest in the world – 16 per cent in 2016[38] – and contraceptive stock-outs are common. A strong contributing factor is that public health facilities, which are attended by 85 per cent of women seeking family planning, regularly run out of stock. Until recently, these facilities relied on a 'pull-based' distribution system that was highly ineffective. In response, the Government of Senegal and the Senegal Urban Reproductive Health Initiative developed an 'informed push distribution model' and piloted it in the Pikine district. Each month, a supply truck loaded with contraceptives, accompanied by a professional logistician, delivers contraceptives to each health facility. Data on stock levels is collected and reported back to the district medical supervisor. This brings the supply chain closer to the demand. The effects of the Push Model in Pikine were immediate, and completely eliminated at all public health facilities in the district. Based on the dramatic impact on stockouts, the Push Model has been adopted and scaled-up in more districts in Senegal, countrywide stock shortages have reduced to under 2 per cent.

Uganda's Alternative Distribution Strategy

IPPF Member Association Reproductive Health Uganda, working with support from Advance Family Planning and the Ministry of Health in Uganda, put in place an alternative distribution strategy for contraceptives. The strategy gives local organizations on the ground forecasting control for contraception, because they are the entities best placed to measure contraceptive needs. Government-procured commodities are handed over to the Uganda Health Marketing Group (UHMG) which then distributes them to NGOs and other private health services. To guarantee the future of the alternative distribution system, a Memorandum of Understanding was signed in 2015 between the Ugandan government and UHMG. Under the alternative distribution strategy, 4 million couple years of protection (almost 1 million unintended pregnancies averted[39]) between January 2012 and December 2014.

IPPF/ Peter Caton/Uganda

37. PATH (2017) Sayana Press (DMPA-SC in Uniject) Self-injection Research. [online] Sayana Press Project. Available at: http://sites.path.org/rh/files/2017/02/PATH_SayanaPress_HSI_brief_2017.pdf [Accessed 21 Apr. 2017].
38. Daff, B., Seck, C., Belkhayat, H. and Sutton, P. (2017) Informed push distribution of contraceptives in Senegal reduces stockouts and improves quality of family planning services. Global Health Science Practice, 13(2), pp.245-52.
39. Estimation method from: Darroch, J. and Singh, S. (2011) Estimating Unintended Pregnancies Averted from Couple-Years of Protection (CYP). [online] Guttmacher Institute. Available at: https://www.guttmacher.org/sites/default/files/page_files/guttmacher-cyp-memo.pdf [Accessed 19 May 2017].

PROMISING PRACTICE 3: ENSURE AFFORDABLE, QUALITY CARE

All women, men and young people have the right to the same level of quality of family planning services and information. Access to high quality contraception, information and services, delivered in line with the needs, values and preferences of the client, is a human right. Quality care is also a best practice and its application across each of the Promising Practices is imperative. Quality of Care is essential to providing health services that respect, protect and fulfil human rights to the highest attainable standard of health.

Everyone who needs health care should be able to access and afford quality health care.

Improve quality of care

Reproductive health is improved when women and girls report positive experiences of visiting, or being visited by, a family planning counsellor.[40] Poor quality counselling tends to fall into one of two categories: 1) providers fail to discuss women and girls' individual wishes and go on to offer too much, irrelevant information, 2) or too little relevant information. As a result, women and girls often feel ill-informed about their chosen method, in particular regarding concerns about side-effects and warning signs of intolerance.[41] Women and girls have described these situations as their primary reason for not using contraception.

One of FP2020's core indicators is based on an index analysis called the Method Information Index (MII), which assess the extent to which women are given information when they receive family planning services. MII measures the quality of family planning services by means of a feedback system. The MII is specifically concerned with whether women are informed about their method choice and side effects. It consists of three questions: (1) were you informed about other methods? (2) Were you informed about side effects? (3) Were you told what to do if you experienced side effects? The answers produce an aggregate value, or score, to indicate whether women had received information about their contraception or not. In 15 out of 17 of the countries studied in 2016, at least 75 per cent of women reported not being given any information about their contraception during interaction with their provider. MII values ranged from 13.5 per cent in Pakistan to 71.8 per cent in Zambia. In 2016, other countries with low MII values included Indonesia with 30.4 per cent, Egypt with 28.8 per cent, Niger with 28.4 per cent, and Lesotho with 27.0 per cent.

40. Bruce, L. (2016) The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings. 3. [online] https://www.popcouncil.org/uploads/pdfs/2015RH_BCS-Plus_TrainersGuide.pdf [Accessed 21 Apr. 2017].
41. Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M. and Kays, M. (2015) Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. BMC Public Health, 15(118).

Reduce social and cultural provider biases in family planning care

Social and cultural norms may influence how health care workers interact with women and girls seeking family planning advice and can have a strong impact on quality of care. Some health workers may favour certain methods because they are most familiar with them; conversely, they may have received limited training on other methods and/or may not be fully aware of other methods available. Providers may also prefer methods that require less clinical intervention and follow-up because of workload, limited appointments and consultation times.[42] Some providers' biases in relation to contraception may also be influenced by personal values, for example beliefs about sex outside of marriage.

In urban Kenya, over half of service providers interviewed reported imposing minimum age restrictions on one or more methods. Forty-one per cent reported that they would not offer contraception to women who have not given birth. Providers at private facilities were significantly more likely to impose barriers.[43] Studies in Uttar Pradesh, India[44], and Tanzania[45] showed judgments were based on marital status and whether or not a male partner had given consent for contraception. Young people, particularly poor and marginalized young people, are very susceptible to provider bias. Many countries have laws and formal regulations that restrict adolescent access to contraception.[46]

42. Geibel, S., Hossain, S., Pulerwitz, J., Sultana, N., Hossain, T., Roy, S., Burnett-Zieman, B., Stackpool-Moore, L., Friedland, B., Yasmin, R., Sadiq, N. and Yam, E. (2017) Stigma Reduction Training Improves Healthcare Provider Attitudes Toward, and Experiences of, Young Marginalized People in Bangladesh. Journal of Adolescent Health, 60(2), pp.S35-S44.
43. Tumlinson, K., Okigbo, C. and Speizer, I. (2015) Provider barriers to family planning access in urban Kenya. Contraception, 92(2), pp.143-151.
44. Calhoun, L., Speizer, I., Rimal, R., Sripad, P., Chatterjee, N., Achyut, P. and Nanda, P. (2013) Provider imposed restrictions to clients' access to family planning in urban Uttar Pradesh, India: a mixed methods study. BMC Health Services Research, 13(1).
45. Speizer, I., Hotchkiss, D., Magnani, R., Hubbard, B. and Nelson, K. (2000) Do Service Providers in Tanzania Unnecessarily Restrict Clients' Access to Contraceptive Methods? International Family Planning Perspectives, 26(1), pp.13-22.
46. Geibel S., et al. (2017) Ibid.

IPPF/ Freddy Meert/Rwanda

Ensure that fees for family planning services and supplies are affordable

In many countries, women and girls pay out of pocket for family planning services and supplies. Sufficient attention must be made to keeping services affordable and ensuring that women and girls can choose and obtain affordable and high quality contraceptives. Many people prefer to pay for health care as they perceive that it will therefore be of a higher quality. Targeted subsidies for low-income women and girls, including vouchers, output-based vouchers systems and health insurance, may allow for increased access to quality family planning services.

The Bamako Initiative in Benin, Guinea and Mali was drawn up in 1987 with the objective of increasing the availability of essential drugs and other health care services to communities. Governments made the Initiative possible through an initial capital investment to purchase drugs and set up infrastructure.[47] As a result of the Bamako Initiative, drugs, including contraception, are sold to patients at a price sufficient to replenish drug stocks and provide running costs for the fund.[48] The initiative was sponsored by UNICEF and WHO, who aided in scaling up the number of community-managed health centers in rural areas to focus on the poor. This enabled the Initiative to reach an additional 20 million people over the following 12 years.

Thirty years on, an independent evaluation found that though the quality and availability of drugs was high (with an 80 per cent 'satisfied' rating from the community), over half of the people the Bamako Initiative targeted still saw price as a barrier.[49] These are the poorest people in each of the three countries, who still do not use key health services because the cost is too high. In Benin and Guinea the health system allowed for exemptions, and most health centres had revenue that they could have used to subsidize the poorest, but almost none did.[50] Today, user fees for health services in low-income and middle-income countries, introduced through revolving drug funds and other mechanisms, are widely deemed to have negative effects on health care access for the poor.[51]

47. Bärnighausen, T. (2015) Book review: Neoliberalism and global health – a blind alley? Review of Blind Spot by Salmaan Keshavjee. The Lancet, 3(9), pp. 685-686.
48. UNICEF, State of the World's Children 2008 (2008) The Bamako Initiative. [online] Available at: https://www.unicef.org/sowc08/docs/sowc08_panel_2_5.pdf [Accessed 24 Apr. 2017].
49. World Bank Group (2000) The Bamako Initiative. Spotlight on... [online] World Bank Group. Available at: https://openknowledge.worldbank.org/bitstream/handle/10986/5986/9780821354681_Spot%20Bamako.pdf [Accessed 19 May 2017].
50. Ibid.
51. Bärnighausen, T. (2015) Ibid.

IPPF/Jon Spaull/Colombia

CASE STUDIES

Client-centered interventions improves family planning counselling in the Philippines

The Philippines took a client-centred approach to address high rates of discontinuation of contraceptive use, and address reproductive needs with quality information and services. Through an innovative project, health care providers and their supervisors across 10 municipalities were trained on effective means of interaction and information exchange. The training led to markedly improved interactions between health care providers and women[52] and girls seeking contraception.[53] Client-centered interventions were successful in enhancing service providers' knowledge and improving the quality of information provided by providers to clients.

MSI makes family planning services affordable for the poor

Marie Stopes International (MSI) has contributed to national health targets by establishing subsidized voucher programmes to increase poor people's access to voluntary family planning services. Operational in 11 countries, the voucher programme works by giving women free vouchers that can be exchanged for family planning services. In Sierra Leone, participating clinics reported a 600 per cent increase in uptake of services per month, from 200 to 1,400. Voucher use was highest among younger and poorer people. Schemes have the additional advantage of being adaptable to specific sections of society.

IPPF expands and replicates social enterprise models to deliver affordable and quality health care

Launched in 2015, IPPF's Social Enterprise Acceleration Programme strengthens Member Associations' capacities to apply entrepreneurial best practice within the health sector. This increases their financial resilience as they generate income and increase programmatic sustainability. At the same time as creating financial value, the Social Enterprise Acceleration Programme delivers social value and improves lives, lifting women and girls out of poverty.

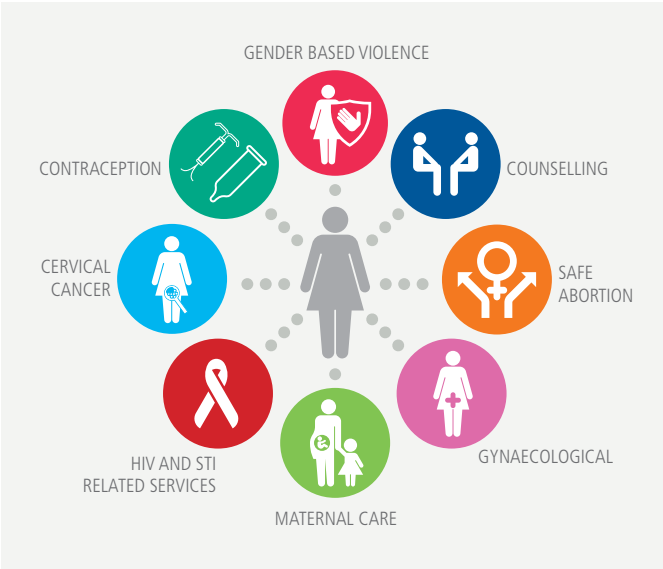
In 2012, the IPPF Member Association in Colombia – Profamilia – established business units to replace the management of all current operations. From 2012 to 2014, couple years of protection increased by 38 per cent and sexual and reproductive health services by 27 per cent, while Profamilia's local income rose by 48 per cent. Just over half of Profamilia's revenues come from its clinics and 42 per cent from a unit selling contraceptives and other sexual and reproductive health products. Profamilia's social enterprise model reinvests surpluses to expand its social mission, enhancing financial health and sustainability. Today, Profamilia is self-financed, operating 34 health centres in 28 cities, providing affordable treatment, counselling and products to more than 700,000 users a year.

52. In Pakistan, only married women were surveyed.
53. Costello, M., Lacuesta, M., RamaRao, S. and Jain, A. (2001) A client-centered Approach to Family Planning: The Davao Project. Studies in Family Planning, 32(4), pp.302-314.

PROMISING PRACTICE 4: INTEGRATE SERVICES FOR MAXIMUM EFFICIENCY

Integrating family planning services with other SRH services is a favourable means of reaching under-served populations. People often seek SRH care when they experience an immediate health issue (like discomfort or irregular periods). Offering comprehensive, preventative care at this point is an opportunity for health care providers to reach people who otherwise would not have sought services due to distance, cost, stigma or lack of information. It is also an opportunity to ensure continued use of contraception through switching rather than discontinuing use, as well as addressing care for STIs, including HIV. Integrated services are particularly important for young people. Integration ensures higher numbers of people will receive the health care services they need, whatever they may be. The requirements of differing communities and circumstances can be met through integrated services.

Realistic assessment of need and local practicalities may result in combining a range of health care and family planning services in one location, or a formal association between separate services. In various countries, family planning has been successfully integrated into clinics and outreach programmes where women receive any of the following services: post-partum care and infant immunization, HIV testing and counselling care, cervical cancer screening and post-abortion care.[54]



According to data on IPPF's integrated services, 85 per cent of first time users to FP, aged 14 to 19 years, received some non-FP related services (in the time period spanning nine months prior to nine months following their first FP service) and 70 per cent of those first-time users received a family planning and non-family planning service at the same time.[55]

54. Ringheim, K., Yeakey, M., Gribble, J., Sines, E. and Stepahin, S. (2009) Supporting the Integration of Family Planning and HIV Services. [online] Population Reference Bureau. . Available at: http://www.prb.org/pdf09/fp-hivintegration.pdf [Accessed 24 Apr. 2017].

Offer family planning services and information to women in the post-partum period through extended child immunization programmes and maternity services

Immunization and maternity services are important components of health care. Linking these services with family planning is cost-effective and highly beneficial. In the first year after a birth, demand for limiting and spacing future pregnancies is high among women and girls, who are likely to be accessing their health care system with increased regularity.[56] Evidence suggest both women and providers recognize the merits of a 'one stop shop'. In terms of convenience and cost efficiency for both women and providers, it makes sense to combine compatible services. In a single facility, travel expenses and service overheads are reduced for women and providers respectively. A formal relationship between geographically distant facilities carries the benefits of economy of scale.

Integrate HIV services and services focused on family planning to improve the health of mothers and children living with HIV, and to support those who are vulnerable to HIV infection

Integrating HIV and family planning services offers the opportunity to reach more women and girls to provide them with contraception, HIV prevention, testing, counselling and treatment. Evidence shows that integrated services can reduce unmet need for contraception, especially for women and girls living with HIV. New contraceptive technologies, including the female condom, can be an empowering method to contribute towards dual protection against unwanted pregnancies, STI and HIV transmission. Evidence also shows that integration of post-natal care, family planning and HIV services can efficiently prevent mother-to-child transmission of HIV. Family planning, where integrated into HIV care within the same clinic, demonstrates an increased uptake of family planning.[57] For example, preliminary data from across five Family Planning Association of India (FPAI) clinics shows an average of 2 in 5 women integrating their HIV screenings and treatment with abortion care, sexual and gender-based violence screenings, and maternal health care, demonstrating how women can benefit by saving time and money– from IPPF's approach – to integrating FP and non-FP services.

55. IPPF draft data for 2017 (forthcoming). IPES and first time users of modern family planning. Available upon request.
56. High-Impact Practices in Family Planning (2013) Family Planning and Immunization Integration: Reaching postpartum women with family planning services. [online] Washington, DC: USAID. Available at: www.fphighimpactpractices.org/sites/fphips/files/hip_fp_imz_brief.pdf [Accessed 24 Apr. 2017].
57. IPPF draft data for 2017 (forthcoming). Ibid.

IPPF/George Osodi/Nigeria

Provide family planning information and services in post-abortion care

> *Post-abortion family planning improves sustainability and institutionalization of post-abortion family planning counselling and services over time.*
>
> Family Planning High Impact Practice

There is growing evidence that family planning interventions have a critical role to play when a woman or girl has had a spontaneous or induced abortion. Unmet need is high among post-abortion women and girls. Offering family planning to women and girls after they have terminated a pregnancy has a high beneficial impact in meeting their future reproductive intentions.[58] Providing counselling and services at the same time and location where women receive treatment for complications related to spontaneous or induced abortion, improves maternal and child health and contributes to national family planning programmes.

When public health departments in eight countries integrated contraception and abortion care, 3 in 4 women who had an abortion chose to take up contraception following counselling.[59]

CASE STUDIES

Mali midwives offer family planning services during immunization programmes

In Mali, contraceptive use is low with less than 7 per cent of women and girls of reproductive age using contraception; 0.2% of these women using a modern method use long-acting reversible contraceptive methods (like IUDs and implants that are more effective and more cost efficient than short-acting methods). In Mali, 79 per cent of women who had recently given birth said they wanted a gap before their next pregnancy.

A programme in the country's capital, Bamako, integrates post-partum family planning services with child immunization programmes. Midwives, trained to provide family planning in public and private clinics, are placed in clinics on busy immunization days to conduct a 30-minute family planning presentation to women while they wait. Their presentations include discussions about myths and misconceptions about LARCs. Following the presentation, women have the opportunity to receive individual counselling for their method of choice and receive a LARC at a subsidized price of 500 CFA (US$1.00). Over the course of this pilot, one in ten of the women who received counselling chose a contraceptive method and were provided with a LARC. If these services were not integrated, many of these women would be unlikely to have visited a family planning provider separately.[60]

Women who sell sex in Ethiopia benefit from an integrated model of family planning and HIV services

The Government of Ethiopia has effectively integrated modern family planning services into an ongoing HIV prevention project for women who sell sex. For example, clinical services have been set up in tents in the areas where most of these women live and work. Over an 18-month period, over 11,000 women chose to access modern family planning services. Almost 1 in 5 of these women said they had never used a contraceptive method before.[61]

IPPF in Nigeria's Cluster Plus Model increased access to family planning services

IPPF Member Association, the Planned Parenthood Federation of Nigeria (PPFN), adopted a 'cluster model' to expand geographic coverage and increase access to quality family planning services. Through this model, partnerships were created between five clinics within a 20km radius. These included private providers and government clinics, community-based distributors and faith-based organizations.

Each cluster has a leader to coordinate logistic supplies, data capture, handling of fees and training. The cluster model transformed the Member Association from simply being a provider of services to building institutional capacity across a network of clinics. Today, there are 230 clinics and the network has seen a seven-fold increase in the number of clients they serve.

58. High Impact Practices in Family Planning (2012) Postabortion family planning: strengthening the family planning component of postabortion care. [online] Washington, DC: USAID . Available at: https://www.fphighimpactpractices.org/resources/postabortion-family-planning-strengthening-family-planning-component-postabortion-care [Accessed 24 Apr. 2017].
59. Benson, J., Andersen, K., Brahmi, D., Healy, J., Mark, A., Ajode, A. and Griffin, R. (2016) What contraception do women use after abortion? An analysis of 319,385 cases from eight countries. Global Public Health, pp.1-16.
60. Ringheim, K., Gribble, J. and Foreman, M. (2011). Integrating Family Planning and Maternal Health Care: Saving Lives, Money, and Time. [online] Population Reference Bureau. Available at: http://www.prb.org/pdf11/familyplanning-maternal-child-health.pdf [Accessed 24 Apr. 2017].
61. Population Services International (2016) An Effective Model for the integration of Modern Family Planning Services into Community-Level HIV Programming for Female Sex Workers in Ethiopia. Available at: www.psi.org/wp-content/uploads/2016/07/SIFPO_EthiopiaTechnicalBrief_052516-final1.pdf

PROMISING PRACTICE 5: FOCUS ON MOBILE POPULATIONS

In 2016, WHO reported that 65.3 million people around the world were displaced after fleeing their homes because of conflict or persecution. It is the highest number since records began and showed an increase of 5 million people since just 12 months earlier.[62]

Mobile populations include migrants and refugees. This includes people who are living in a camp, travelling in search of settlement, taking refuge with family members, or paying out of pocket for temporary accommodation – in fact anyone on the move for an extended period. Whatever the exact circumstances, health care services are extremely difficult to access for unsettled people, and they are limited in conflict settings and areas of humanitarian crisis. This extends to family planning.

Unmet need in this category will rise and therefore must become a priority in the allocation of family planning resources. Of all displaced women of childbearing age, it is estimated that 1 in 4 will be pregnant at any given time.[63] Public and private service providers are beginning to address the specific vulnerabilities of displaced people, but there are not enough programmes to meet the need. Fragile settings where family planning services are most in demand include areas of Chad, the Democratic Republic of Congo (DRC), Guinea, Nigeria, Sudan, Syria and Yemen.

CASE STUDIES

Migrants and refugees in China

Chinese people moving from rural to urban China recently become entitled to free family planning services. However, many of these migrants are unaware of their entitlement and their family planning needs remain largely unmet. Rural migrants settled in Shanghai, for example, showed a high incidence of unintended pregnancy soon after giving birth, compared to long-term residents of the city. A tailored, free contraception programme was introduced to support these women for 12 months after childbirth. As a result, these women began using contraception with fewer unwanted pregnancies.[64]

Improving family planning for mobile and displaced people in post-earthquake Nepal

Nearly 3 million people needed humanitarian assistance following the Nepal earthquake of 2015. IPPF formed an Emergency Response Team to bring critical family planning services to those affected. The IPPF humanitarian team, SPRINT, was mobilized to bolster IPPF Member Association, the Family Planning Association of Nepal.

During the crisis, 5,500 women and girls visited specially created female-friendly spaces. These spaces offered information about any SRH related issues, from personal hygiene to support for gender-based violence. Seventy women accessed antenatal and post-natal care in special 'maternity transit homes', where they could stay before and after their delivery. This significantly reduced complications and ensured that medical staff were available when required.

Specialist training in Chad, the Democratic Republic of Congo (DRC), Dijbouti, Mali and Pakistan

The Supporting Access to Family Planning and Safe Abortion Care (SAFPAC) programme supports government health systems at the sub-national level to ensure best practice is applied in crisis-affected settings. Analysis of service delivery data in the crisis-affected settings of Chad, DRC, Dijbouti, Mali and Pakistan showed a sharp increase in first-time users of contraception, shortly after the first trained teams arrived in the field. This upward trend continued, showing the importance of training family planning counsellors to operate within this discrete category of unmet need.[65]

62. Edwards, A. (2017) Global forced displacement hits record high. [online] Press release. United Nations Refugee Agency. Available at: www.unhcr.org/afr/news/latest/2016/6/5763b65a4/global-forced-displacement-hits-record-high.html [Accessed 24 Apr. 2017].
63. Demographic and Health Surveys (1995-2006). Of all displaced women of childbearing age, it is estimated that one in four will be pregnant at any given time.
64. Huang, Y., Merkatz, R., Zhu, H., Roberts, K., Sitruk-Ware, R. and Cheng, L. (2014) The free perinatal/postpartum contraceptive services project for migrant women in Shanghai: effects on the incidence of unintended pregnancy. Contraception, 89(6), pp.521-527.
65. Curry, D., Ratan, J., Huang, S. and Noznesky, E. (2015) Delivering High-Quality Family Planning Services in Crisis-Affected Settings II: Results. Global Health Science Practices, 3(1), pp.25-33.

SECTION 3 – CREATING CHANGE: KEY INTERVENTIONS FOR EQUITABLE ACCESS TO CONTRACEPTION

Contraception has the ability to transform the lives of women and girls. Investing in family planning is key to unlocking a world of possibilities. By 2030, universal access to family planning could be achieved if we channel our energies to reach those previously left behind. No women or girl should be under-served by contraceptive services and information, or over-looked in her ability to exercise her most basic of human rights: to prevent unwanted pregnancy.

This report shines a light on the inequalities in contraceptive choice, and highlights the most promising practices towards ensuring the poorest and most marginalized women and girls can make free, full and informed choice. Inequalities in contraceptive choice are not inevitable. All women, men and young people must have a right to choose, and not be compromised by unwarranted intrusion from the law or provider bias.

TOWARD 2020, FOUR IMMEDIATE INTERVENTIONS TO ENSURE NO ONE IS LEFT BEHIND

1. Ensure contraceptives are delivered to the last mile by filling the global funding shortfall for contraceptive commodities.
2. Address the highest level of unmet need during the post-partum period by integrating family planning services and information with child immunization programmes and maternity services.
3. Provide critical sexual and reproductive health services to mobile populations.
4. Ensure that integrated services include family planning, safe abortion, comprehensive sexuality education, maternal and child health and STI and HIV treatment, prevention and care.

This report highlights the need to create political will to ensure equitable access to contraception for all. We call on decision-makers to:

1. Close the gap in unmet need for women and girls between the highest and lowest wealth quintiles by 2030.

> *To establish national health inequality monitoring, not only should data collection processes be equity oriented, but technical capacities should be strengthened for analysis and reporting on health inequality, as well as using disaggregated data in policy-making and effective targeting of interventions.*
>
> World Health Organization, 2016 [66]

66. World Health Organization (2016) Country Data Universal Accountability: Monitoring Priorities for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). [online] World Health Organization. Available at: http://www.who.int/life-course/partners/global-strategy/gs-monitoring-readiness-report.pdf?ua=1 [Accessed 24 Apr. 2017].

The most important message from this report for governments is to understand that the poorest and most marginalized women and girls are being left behind. Women and girls – of all ages, geography, income and education – must have access to high quality, voluntary family planning care and information.

Data presented in this paper has demonstrated that the poorest and most marginalized women and girls have the highest unmet need for contraception. If we are to achieve universal access to family planning as outlined in Sustainable Development Goal 3, the poorest and most marginalized women and girls cannot be left behind.

- FP2020 partnership must use their convening power to redouble their efforts to reach the poorest and most marginalized women and girls. FP2020 must use key global data on contraceptive inequalities to inform decision-making and country commitments.
- National decision-makers must use evidence and data - including the outcomes of national surveys - to assess whether family planning policies, programmes or practices are feasible, affordable and acceptable to the fulfilling the rights of the poorest and most marginalized women and girls.

2. Value the impact created by the increased contraceptive uptake of the poorest and most marginalized women and girls on key health, development and economic indicators.[67]

Governments have a duty of care to improve the health and wellbeing of all their citizens. To meet current levels of unmet need would require a doubling of current global investments. Family planning is a health and development 'best buy' intervention, unlocking many economic benefits. Reaching the poorest and most marginalized people can have a higher cost, yet doing so has the potential to yield a high impact.

- Donors must increase investments for contraceptive care by US$548 million more than current costs to meet the unmet need for family planning. Donors should recognize the high impact of meeting the needs of the world's poorest and most marginalized women and girls.
- National governments should invest US$21 per woman and girl, per year, to provide contraceptive information and supplies, as a way of fostering sustainable economic development.

3. Invest in girls by creating youth-friendly sexual and reproductive health services and remove legal barriers around young people's access to contraception and universal comprehensive sexuality education.

All young people need access to good quality comprehensive sexuality education in order to better understand and realize their rights. Girls have the right to improved access to youth-

67. Darroch, J., Woog, V., Bankole, A. and Ashford, L. (2016) Adding it up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents. [online] Guttmacher Institute. Available at: www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-adolescents-report.pdf [Accessed 11 May 2017].

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friendly, integrated sexual and reproductive health services, including contraceptive services that do not discriminate based on age, social or marital status. Girls' needs must be central to the provision of these services, and youth-led input to increase access to services must be prioritized.

- Global leaders must recognize the importance of empowered, educated and healthy girls in sustainable development, and the significance of empowered, educated girls and women in unlocking economic growth and development.
- National decision-makers must seek to eliminate laws, policies and practices that limit high quality contraceptive services and sexual and reproductive health services, especially those linked to age or marital status.

4. *Support community-based provision of contraceptive services, including mobile clinics, community health workers and community outreach, to serve hard-to-reach groups.*

Providing family planning services through community-based distribution stands to revolutionize contraceptive outcomes. In hard-to-reach areas, community health workers bring services, supplies and information directly to where women and girls live and or work. Community-based provision must be integrated as a critical component of national care systems, and focus on shifting tasks related to contraceptive services to lower cadre health workers.

- Donors invest in long-term, country-led training programmes, and recognize task shifting as a critical component in achieving more widespread quality service delivery.
- National governments place community health provision and service integration at the heart of health policy, and invest and train health workers to offer more than an efficient transaction of contraceptive care. Support community-based provision by using geographic information system (GIS) to map under-served communities within an outreach catchment area. This would enable service providers to identify appropriate outreach sites and plan and delivery mobile outreach.

5. *Empower the poorest and most marginalized women and girls to participate in citizens' social accountability actions to improve family planning programmes and services.*

All women, men and young people have the right to ensure all health care, including family planning respects, protects and promotes human rights. Citizens' social accountability is a critical way of engaging community voices to improve, expand and sustain family planning services. Community voices – including poor and marginalized women and girls - must be engaged as a critical partner to ensure family planning care at all levels of decision making.

- Donors routinely include and actively advocate for the inclusion of community voices in the drafting, implementation, monitoring and evaluation of global policy initiatives.
- National governments encourage service provider feedback from users, and open a channel for discussion through which complaints and possible rights violations can be addressed.

6. *Emphasize the link between family planning and sustainable development, and recognize the interlinkages in delivering key development and health outcomes.*

The SDG framework specifically sets out that no one – no woman, man or young person – should be left behind global progress. Family planning, while explicitly named in SDG Goals 3 and 5, underpins the achievement of all other goals including poverty, education and environment.

- Global leaders ensure that family planning is recognized as a key adaptation strategy, and included in climate change adaptation funding and policies including the 2017 UN Climate Change Conference, COP23.
- National governments recognize the value of investing in family planning as part of a rights-based adaptation strategy to climate change in National Adaptation Programmes of Action (NAPAs).

In the face of opposition, the sexual and reproductive health movement continues to fight for the human rights of women and girls to choose and access comprehensive sexual and reproductive health services and information. Together, the movement must persevere in their dedication and quest to improve the lives of women and girls and to protect and promote their rights.

Girls and IUD - Mustafa Quraishi

UNDER-SERVED AND OVER-LOOKED

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