

# CONSULTATION ON REALIZING SUSTAINABLE PROGRAMMING FOR RIGHTS-BASED FAMILY PLANNING

LONDON, UK/JUNE 9-10, 2016  
MEETING REPORT



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## I. INTRODUCTION

Although the intersection of human rights and family planning (FP) has long been recognized, efforts to make the abstract concrete by intentionally embedding human rights in the design, implementation, monitoring and evaluation of service delivery programs are fairly new. By summarizing the proceedings of a consultation in London in June 2016 on realizing sustainable programming for rights-based FP, this paper captures the state-of-the art of this transformative approach. It highlights the resources, results and learning of current rights-based service delivery and monitoring efforts, and shares the outcomes of discussions of critical tensions that need to be balanced to find a way forward. It concludes with key insights, long-term needs and recommendations for immediate action generated by leading donors and technical experts.

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## II. OVERVIEW

Since the London Family Planning Summit in 2012, rights-based family planning (FP) has become a focal issue commanding the attention of donors, governments, civil society and service delivery programs in many parts of the world. Significant progress has been made on several fronts. Building upon earlier work, the World Health Organization (WHO) and FP2020 distilled the essential rights and related principles that pertain to FP programs. Programmers have taken these abstract concepts out of the legal realm to explain them in the healthcare context in terms familiar to public health professionals to make them concrete and applicable to service delivery programs. Groups including PMA2020, WHO, the Evidence Project, CARE and MSI have developed and tested indicators and instruments to explicitly capture elements of human rights. There is an increased level of programmer and donor interest in embedding human rights in FP programming and monitoring human rights in program performance. A number of governments have put human rights explicitly in their FP Costed Implementation Plans. Over the last few years there has been a significant increase in the number of guidance documents, frameworks and training materials available to help policymakers and program managers operationalize a rights-based approach. The SDGs (3 and 5), provide added impetus for taking this approach. And a growing number of implementing partners are engaged in going beyond rhetoric to apply and to measure a rights-based approach to FP in practice. Their efforts are beginning to generate evidence and lessons essential for advocacy, informed investments, program design and program improvement.

However, knowledge of these advances is not yet widespread. In addition, evidence about what it takes to operationalize and to measure this approach, and of what difference it makes, is still thin. This constrains appeals to the pragmatic interests of donors and governments. Moreover, there is no platform for groups working independently on these issues to share their works-in-progress so that they can learn from one another and avoid duplication of effort.

To address these needs, on June 9-10, 2016, FP2020 gathered 30 representatives of donor organizations, technical assistance agencies and research groups to focus on the practicalities of applying the rights-based approach. The aim of this “*Consultation on Realizing Sustainable Programming for Rights-based Family Planning*” was to advance progress in rights-based FP programming by engaging actors from these different constituencies as champions to share their experience in operationalizing and measuring this approach. The meeting took place at IPPF’s central office in London. The USAID-funded Evidence Project provided significant technical support for the event.

The consultation was marked by a high level of energy, consensus and commitment to advancing a rights-based approach to FP both as the right thing to do and as an enlightened strategy to achieve the SDGs and meet individuals’ needs. The fact that participants funded their own travel to this event was testament to the level of enthusiasm around this issue. Presentations highlighted different organizations’ focus and approach to achieving a common aim. Discussions explored the complexity of human rights in healthcare and the many challenges and tensions inherent in applying rights-based FP programming in various contexts.

The meeting provided a safe space for frank discussion in which participants clarified concepts and interrogated their own programs through a human rights lens: What does this mean for us? What should and could we do to promote the empowerment of women and girls and ensure that their human rights are respected, protected and fulfilled in FP programs? How should we engage with communities to address social norms and promote accountability? What more is needed to advance this work in practice and to generate the evidence needed to inform donors, governments and program design?

The meeting advanced the realization of rights-based FP programs through the following outcomes:

- Achieved a growing consensus across organizations on the essential elements of a rights-based approach to FP
- Supported a dialogue among donors, implementers and research groups that embraced the complexity of the issue and created the nucleus of an ongoing collaborative platform to link organizations engaged in independent rights-based efforts
- Demonstrated that human rights *can* be and *are* being measured by multiple organizations, which are generating a growing body of results. There is wide interest in sharing and harmonizing indicators.
- Reached the recognition that numerical goals do not preclude taking a rights-based approach, though they necessitate an intentional focus on respecting, protecting and fulfilling individuals' human rights.
- Identified long-term needs and generated short-term recommendations for the progressive realization of a rights-based approach to FP

This consultation is a critical milestone in the movement to transform FP programs to make them client-centered and rights-based to serve women and girls more effectively. It galvanized the energy around rights-based programming, which the FP2020 Secretariat pledged to sustain and expand through multiple electronic platforms and future convenings.

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### III. MEETING OBJECTIVES

The specific meeting objectives were to:

1. Reach a common understanding of what a rights-based family planning program looks like and what it takes to operationalize it;
2. Establish where we are in defining, implementing and measuring a rights-based approach to family planning, including identifying existing resources and gaps;
3. Plan for moving forward: formulate recommendations for collaboratively advancing a rights-based approach to family planning related to:
  - a. Messaging and communication;
  - b. Operationalizing the approach in FP programs;
  - c. Research, monitoring and measuring human rights in FP programs;
4. Explore how we can hold ourselves accountable – both for integrating a rights-based approach into existing family planning programs and for donors and countries to support these efforts.

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### IV. SUMMARY OF SESSIONS

#### Setting the stage

During the opening session (*Session 1.1*), participants were asked about their hopes for the meeting; specifically, to identify issues they would be disappointed if the meeting did not address. Prominent themes of interest included: addressing demand for services as well as supply (including the themes of gender and agency); operationalizing a rights-based approach and existing challenges (noting the particular challenges of protecting rights in conflict, post-conflict and post-disaster settings); various aspects of monitoring (data collection, participatory monitoring, social accountability); how to address human rights in a political environment; including

the politics of using the word ‘rights’; how to communicate coherently about a rights-based approach to different audiences; and the special issues related to the rights of young people (See page 19, presentation a). The need to balance numerical goals, which are necessary to spur and to demonstrate progress in meeting more people’s FP needs, with the risk of creating “perverse incentives” arose more than once. All of these themes were explored in some depth over the course of the two days.

To set the stage for the discussions, Beth Schlachter, Executive Director of FP2020, affirmed the centrality of human rights to FP and the Secretariat’s commitment to fostering collaboration to advance rights-based programs. (*Session 1.2: The importance of promoting rights-based FP for FP2020 and the SRH community writ large*). There was general agreement that numbers are not inherently bad. Numerical goals can be aspirational to motivate action and also serve as reference points against which to track progress, but they must be pursued with deliberate efforts to respect, protect and fulfill individuals’ human rights.

Given the varied guidance available and the different ways in which terms related to rights-based programming are used, an early session (*Session 1.3: Essential elements, key concepts and challenges to a rights-based approach to FP – See page 19, presentation b*) was devoted to establishing a common understanding of the essential elements of a rights-based approach and the meaning of key concepts. The group recognized that FP is more than a health issue; that it relates as much to women’s agency and dignity as it does to quality of care. Quality is a pillar of human rights in FP. While this is a familiar and comfortable zone for our community, it is not sufficient. Human rights is a broader construct that addresses clinical quality and informed choice plus accessibility, availability, acceptability, agency, equity, participation and accountability. Participants were encouraged to embrace the complexity of a rights-based approach to FP, which spans disciplines, sectors and levels of the health system. We should resist the tendency to reduce the issue to a few simple points. The group discussed the need to be thoughtful about how we communicate about human rights. We are often constrained by the rhetoric. It is important to know our audiences and be careful about language. While we should own and use the term “rights”, there was agreement that in some settings it may be more practical to refer to programmatic elements of rights, which may be less sensitive and more widely understood.

#### Where are we programmatically?

The meeting provided a platform to share current efforts to incorporate a rights-based approach into service delivery programs (*Sessions 1.4 & 1.5: Current programmatic efforts*). A substantial amount of effort is currently underway to implement and test this approach. Overviews of the following resources and projects were shared:

- WHO: Programmatic guidance for rights-based contraceptive services, presented by Rajat Khosla: details 24 recommendations aligned with nine human rights principles and standards. (See page 19, presentation c)
- UNFPA: Training on the implementation guide, presented by Rajat Khosla on behalf of UNFPA: a joint UNFPA/WHO resource designed to translate the WHO recommendations into action by aligning them with key considerations and action points, outcomes and measures. (See page 19, presentation d)
- USAID’s approach to gender, rights and empowerment, presented by Michal Avni: details a draft framework for reproductive empowerment that is based on user/client agency in a relational context, and incorporates male engagement to promote gender equality. (See page 19, presentation e)
- EngenderHealth: Integrating Across sectors and Levels in Cote d’Ivoire, presented by Elizabeth Arlotti-Parish: a status update on a project in Cote d’Ivoire, with potential for replication in Togo and across West Africa, that uses the Voluntary Rights-based FP Conceptual Framework<sup>1</sup> to support actors at different levels of the ecological model to integrate rights-based approaches to sexual and reproductive health in general, and FP in particular, into strategies, policies, and programs. (See page 19, presentation f)
- The Palladium Group: Testing interventions from the VRBFP Conceptual Framework in Kaduna, Nigeria, presented by Kaja Jurczynska: overview of the design and progress to date of a project that is generating and documenting evidence of how implementing a voluntary, rights-based family planning approach at the facility level impacts family planning outcomes across Kaduna state, Nigeria. The intervention component of the project applies/ leverages the Voluntary Rights-based FP Conceptual Framework, and the research component of the project utilizes the Rights-based Family Planning Service Delivery (RBFP SD) Index (explained below). (See page 19, presentation g)

<sup>1</sup>Hardee, K. et al. Voluntary, Human Rights–Based Family Planning: A Conceptual Framework. *Studies in Family Planning* 45(1):1-18, March 2014, <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2014.00373.x>;abstract;jsessionid=10377C2FD9A15A2E94E1FB35771EE8FE.f02t04

- Reproductive Health Uganda (RHU)/ SIFPO II/ IPPF: RBA to FP interventions in Uganda under SIFPO II/IPPF, presented by Kate Gray: overview of a collaboration among RHU, the Ugandan MOH, the Evidence Project and SIFPO II to support the national FP Costed Implementation Plan (CIP) by strengthening and measuring approaches to rights-based FP programming at national, district and lower levels. The VRBFP conceptual framework and the RBFP SD Index are being used in this project as well. (See page 19, presentation h)

### Monitoring and measuring human rights

It is widely believed that human rights are too abstract to monitor and measure. This misperception was dispelled in two robust sessions devoted to an exchange of organizations' efforts to develop and test measures for human rights in FP programs and to assess the impact of a rights-based approach on program outcomes (*Sessions 1.6 & 1.7: Current measurement efforts*). Table 1 summarizes the monitoring agenda being pursued at different levels in the system. The various presentations made it abundantly clear that human rights concepts can be measured and that a growing body of data on how to do this already exists. The group expressed interest in harmonizing indicators, and agreed that the data collected should be useful to program managers, and that negative findings should be used for quality improvement rather than to penalize programs.

*Table 1: Monitoring Agenda*

Organization	Focus/ Status
<b>National level</b>	
The Evidence Project – Population Council/IPPF	Developed an approach for analyzing how rights and related principles figure in national FP Costed Implementation Plans at the different levels of the health system defined by the VRBFP Conceptual Framework. Details from a comprehensive analysis of Uganda's CIP were shared, tallying the number of times that rights and rights principles are explicitly cited or addressed. Frequency analysis by theme, by principle and by level of the system show where energy is being focused and where more may be needed. Summary results from analysis of CIPs from selected other countries are also reported. (See page 19, presentation i)
WHO	Following a process to explicitly link human rights and health concerns, and then to develop and test national level indicators that are explicitly linked to human rights to determine the combined impact on the effectiveness and outcomes of health policies and programs. The indicators cover policy and user perspectives. Indicator tools have been developed and are being tested. Focused on quantitative indicators first, and have arrived at a list of 12. Now focusing on indicators that are qualitative, aspirational, and possibly new. (See page 19, presentation j)
Track 20	Developed a new composite index, which is a comprehensive management tool that covers strategy, data use, quality, equity and accountability. The index has been used in 90 countries. Results are available for 2014. While it needs refinement, the Index it confirms that it is possible to measure quality, equity and accountability. (See page 19, presentation k)

PMA2020	Consists of national/ sub-national surveys that have been conducted in 10 countries using mobile phone-assisted data collection and resident enumerators. New indicators around access, quality, equity and choice are being tested. New questions are under consideration. All indicators can be disaggregated by age, marital status, wealth quintile, education, region, urban/rural. (See page 19, presentation l)
Service delivery level	
The Evidence Project	Developing and validating a Rights-based Service Delivery (RBFP SD) Index to measure a facility's readiness to apply a rights-based approach and the results of rights-based interventions. The Index covers 29 indicators based on WHO and FP2020 Rights and Empowerment Principles for FP and is aligned with the VRBFP conceptual framework. A study is underway in Uganda to implement measures and test the instruments in a range of facilities, to assess interventions undertaken by RHU/SIFPO-II, and to assess the potential for scale-up. (See page 19, presentation m)
Palladium	Utilizing an adapted version of the RBFP SD Index- adapted for Kaduna, Nigeria- for baseline and end-line data collection for the VRBFP Project. Baseline data will inform the intervention component of the project, as well as contribute to the Evidence Project's validation of the Index. (See page 19, presentation n)
Community level	
CARE	Measuring women and health workers' empowerment in sexual, reproductive and maternal health programs and social accountability mechanisms involving participation, voice, transparency and accountability. The WE-MEASR tool evaluates agency, social capital and relations (women's empowerment constructs). CARE's Women's VOICES and Health Worker's VOICES measures governance/social accountability constructs (See page 19, presentation o)
Individual level	
EngenderHealth	Studies conducted in the Democratic Republic of the Congo, India, Tanzania, and Uganda to assess contraceptive choice from the client's perspective with the aims of developing and adapting a measure that can be used in variable contexts to routinely monitor contraceptive choice and for program improvement and global learning. (See page 19, presentation p)
Marie Stopes International	Using enhanced, client-centered choice metrics centered around a client exit interview that collects data on service uptake, access, availability, counselling and choice, marketing, SRH behavior, client satisfaction and demographics. Findings are used to inform strategy and operations, monitor progress and assess change over time. (See page 19, presentation q)
Harvard School of Public Health	Developing and testing the quality of contraception counselling using a framework that aligns the process of assessing clients' FP needs, supporting their decision making, method choice and follow-up with key elements of a rights-based approach. The scale used in the framework has been validated in Mexico. (See page 19, presentation r)

## Donor perspectives

Following a recap of Day 1 (*Session 2.1*), Day 2 started with a panel that engaged representatives of three bilateral donors and a foundation (DFID, the Foreign Affairs Department of the Netherlands, USAID and the Packard Foundation) in a discussion to share overviews of how human rights figure in their SRH policies and portfolios, how they frame the issue and the resistance and challenges they have encountered in advancing a human rights agenda (*Session 2.2: Donor Panel*). Both DFID and the Netherlands government frame their policy very deliberately in terms of sexual and reproductive health and rights. USAID promotes rights in terms of constituent elements, notably increasing quality and access of FP, strengthening the workforce and supply systems, expanding method choice, informed choice, gender transformation (*See page 19, presentation s*), SRH programs for youth, behavior change communication and supporting a total market approach. Packard's focus is on quality reproductive healthcare. Their definition of quality encompasses human rights. Themes that emerged in the lively discussion included:

- Concern about the promotion of long-acting reversible contraceptive methods (LARCs) and postpartum contraception, both of which are intended to increase method choice and access, but could foster provider bias, directive behaviors and possibly coercive practices.
- The rights imperative of equity and the challenge of serving the most vulnerable; serving nulliparous women and adolescents, internally displaced persons, refugees and asylum seekers.
- The need to focus more attention on rights related to abortion as part of the SRHR agenda.
- The need for simple ways to convey the complex concepts related to human rights in healthcare programs.
- The need to work both at the ground level and to work as well politically with policy-makers at district and national levels.

## Critical tensions and questions

The group delved deep into exploring the following four critical tensions that need to be balanced in rights-based programming (*Sessions 2.3 & 2.4: Critical tensions*):

1. Quality is necessary, but is it sufficient?
2. How to identify and address problems without jeopardizing relationships with or between governments and donors?
3. Unintended consequences: Can efforts to increase uptake of a particular method with the intention of increasing choice have the effect in practice of decreasing choice?
4. Can we focus on rights even as we are working toward a time bound deadline and the focus on an aspirational numerical goal?

The aim was not to resolve the tensions, but to explore the issues that contribute to them with an eye toward balance to find a way forward. See the next section of this report for a synthesis of the discussion .

## Who is doing what, where?

Over the two days the group completed a mapping exercise to document the rights-specific activities that all represented organizations are engaged in, and indicated the level or levels of the health system (policy, service delivery, community or individual) at which efforts are being carried out. Results revealed that substantial effort is underway at the service level, and that significant investments are being made at the policy level, but much less so at the community and individual levels. The group recognized that this was only a sample of explicitly rights-based efforts. It did not capture the more routine work that is being done in elements of rights-based FP (like quality improvement, counseling to ensure informed choice, programming for youth, expanding method options, integration and task-sharing to increase access) that may not be intentionally rights-supportive. There is a wealth of activity and information; we need a platform that enables sharing and collaboration to minimize duplication of effort and maximize learning and results.



Policy Level		Rights and Empowerment Principles (check all that apply)										Contact Person	
Organization	Brief description of intervention, tool, or resource	Acceptability	Accessibility	Availability	Quality	Transparency and Accountability	Agency/Autonomy	Empowerment	Informed Choice/ Decision-making	Equity and non-discrimination	Participation		Privacy and Confidentiality
CARE	Advocacy for participatory accountability mechanisms to institutions to track and respond to their CE/FC/E.../NAC					X					X		care@care.org
IPPF													Howard@ippf.org
NL													
IPPF/KORAM	Overprotected - Under-served legal barriers to young people's access to RH services		X	X		X			X	X	X	X	shroeder@ippf.org
WFP/UNFPA	GUIDELINES IMPLEMENTATION GUIDES	X	X	X	X	X	X	X	X	X	X	X	LSH@UNFPA
MST	ADVOCACY FOR FP/SA CONCEPTS EVIDENCE												
MSI	ADVOCACY FOR RESEARCHING FP/SA EVIDENCE, POLICY GUIDELINES, TRAINING CURRICULUM, DISSEMINATION	X	X	X	X	X	X	X	X	X	X	X	Siddhanta@msi.org

### Going Forward

Looking to the future, participants worked in small groups on the second afternoon to formulate recommendations related to advocacy and messaging, operationalizing a rights-based approach, monitoring, measuring and research (*Sessions 2.5 & 2.6: Advancing the rights-based programming agenda.*) Outputs are detailed in the Section, *Going Forward* (see pg. 15), which also captures priorities and next steps discussed in the last two sessions (*Session 2.7: Prioritizing and coordinating efforts; holding ourselves accountable and Session 2.8: Next steps and conclusion.*)

## V. CRITICAL TENSIONS, QUESTIONS, AND THEMES

Throughout the meeting we focused on different perspectives on various flashpoints or tensions related to this work. A number of themes recurred as discussion of different aspects were stimulated by the various presentations, and this section brings those discussions and observations together, grouping them around ten critical tensions, questions, and themes.

### a. The importance of promoting rights-based approach to family planning programs

Much attention has been focused on rights-based approaches to family planning programs, and a number of resources now exist on what rights-based means in policy and practice<sup>2,3,4</sup>. Despite this growing literature on the value of rights-based approaches to family planning programs, views persist, particularly among those not familiar with the literature, that rights are a bit “fluffy”; that they are impossible to measure, and that family planning programs of the highest possible quality are automatically “rights-based”. During the meeting these issues and others were assessed and addressed; the following key points emerged:

A rights-based approach involves taking concepts that have been refined by the human rights community, such as the obligation of government signatories to human rights treaties to respect, protect and fulfil human rights<sup>5</sup>, or the core components of the right to the highest attainable standard of health, and applying them to the ways in which family planning information, education and service delivery programs are conceptualized, implemented, managed and evaluated.

Several frameworks exist to facilitate the identification of key actions to take at the various levels – policy, service, community and individual levels, to ensure that rights are respected, protected, and, to the extent possible, fulfilled. Identifying these actions, and putting into practice the changes needed at the various levels can be a complex process, involving commitment, capacity-building and collaboration, but the process itself – working across agencies, disciplines, sectors, etc. to identify what precisely needs to be done, and what needs to be in place to ensure that it is done – can be valuable in itself.

“What’s the strategy for the “high-hanging” fruit?” – what about the hard-to-reach? Among other things, such as an obligation to treat all clients equally and with respect, a rights-based approach demands an equitable approach that ensures that the hardest, most marginalized, possibly most expensive to reach populations, are not left behind, and can still access services. In an environment increasingly focused on cost recovery and minimizing per capita costs, a rights-based approach, on the basis of non-discrimination, renders more visible the needs of the hard-to-reach, forcing program managers to ask who is not using their services, and identify reasons as to why that might be the case. Managing these conflicting priorities – obviously an urban clinic is not set up to reach rural populations, but does the district/regional/national program as a whole have some obligation to people with no access to services? – is part of delivering rights-based services; a human rights analysis will not provide the answer, but it should make the underserved, and the fact that they are underserved, more visible in the planning process.

Humanitarian crises resulting from conflict, climate change or other disasters are increasingly settings within which people spend significantly longer than days or weeks; people can spend up to 20 years in refugee camps. During the discussion arising from the donor panel session, it was observed that migration, and even the Zika virus, present opportunities for family planning, and the importance of respecting and protecting human rights in these situations have relevance for others in the health and wider development sectors.

“Rights-based” is a way of working, not another technical area; it is best seen as responding to questions not about what programs to undertake, but how to undertake them. Family planning’s comfort zone is quality of care (although there is more to do in that regard); a rights-based approach takes this as a given, with all it implies, but then demands additional ways of interrogating programs to ensure that core human rights principles make program managers ask how programs can make themselves more accountable to the people they serve, and need to reach. A rights-based approach can also contribute to addressing issues that aren’t being adequately considered (e.g., empowerment, discrimination, etc.) and can help to fulfill broader program goals.

<sup>2</sup> Family Planning 2020, Rights and Empowerment Principles for Family Planning, Washington, DC: Family Planning 2020, No Date, [http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/12/FP2020\\_Statement\\_of\\_Principles\\_FINAL.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/12/FP2020_Statement_of_Principles_FINAL.pdf)

<sup>3</sup> Newman, K. and Feldman-Jacobs, C., Family Planning and Human Rights: What’s the Connection and Why is it Important?, Washington DC: Population Reference Bureau, July 2015, <http://www.prb.org/pdf15/family-planning-rights-brief.pdf>

<sup>4</sup> Kumar, Jan and Hardee, Karen., “Rights-Based Family Planning: 10 Resources to Guide Programming,” Resource Guide. Washington, DC: Population Council, The Evidence Project., 2015, <http://evidenceproject.popcouncil.org/wp-content/uploads/2015/07/Resource-Guide-of-RBA-to-FP.pdf>

<sup>5</sup> The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights.

## b. Essential rights elements and concepts

The basic legal building blocks of a rights-based approach to family planning programs are relatively well established. The right to the highest attainable standard of health is derived from the International Covenant on Economic, Social and Cultural rights; the committee that monitors the implementation of this covenant issued a General Comment on the Right to Health<sup>6</sup>, identified four key obligations of governments which have signed and ratified the treaty (*Please also refer to General Comment 22, updated March 2016*<sup>7</sup>). These obligations are also relevant for family planning service providers, and their obligation to make services:

- Available
- Accessible
- Acceptable
- Of the highest possible Quality (AAAQ)

The General Comment gives more details about how these terms should be interpreted – e.g., “available” means available to a significant proportion of the population; “accessible” includes financial and geographical access; “acceptable” means culturally acceptable, but also implies a need to learn from clients how acceptable they find the services they use, and “quality”, of course, embraces all of the Quality of Care work familiar to family planning practitioners, including, for example, youth-friendly services, male involvement, attention to method mix, etc.

FP2020 has endorsed Rights and Empowerment Principles for Family Planning<sup>8</sup>, which embrace human rights-based approaches, and, in addition to AAAQ, include:

- Agency and Autonomy
- Empowerment
- Equity and Non-discrimination
- Informed Choice
- Transparency and Accountability
- Voice and Participation

These principles have immense value as tools to use to interrogate programs, to find gaps and potential for improvement.

Non-discrimination, for example, is relevant for program managers and service providers. As indicated above, it forces program managers to recognize that people who are hard to reach, or marginalized, or more expensive to reach per capita than others in, for example, densely urban areas, still have a right to services. This can potentially lead to creative solutions for reaching out to these people and populations. Service providers can unwittingly discriminate against particular people or contraceptive methods on the basis of personal convictions or preferences which might, for example, make them unwilling to give contraceptives to young teenagers, or prescribe implants.

Rights-based approaches also include revisiting family planning program lessons from the past. It is, for example, widely accepted that family planning should be provided on the basis of full, free and informed choice; each of these concepts have value for interrogating programs to identify areas of potential improvement:

- **Full:** Selection has to be from among a range of contraceptive options...
- **Free:** A voluntary decision freely made without pressure being applied, or barriers to negotiate...
- **Informed:** based on objective information about the risks and benefits of several options...
- **Choice:** An exercise in agency.

<sup>6</sup> United Nations Economic and Social Council, Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, Geneva: Committee on Economic, Social and Cultural Rights, 2000, [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en)

<sup>7</sup> United Nations Economic and Social Council, General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2016, <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=17168&LangID=E>

<sup>8</sup> Family Planning 2020, Rights and Empowerment Principles for Family Planning, Washington, DC: Family Planning 2020, No Date, [http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/12/FP2020\\_Statement\\_of\\_Principles\\_FINAL.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/12/FP2020_Statement_of_Principles_FINAL.pdf)

Full choice implies close attention to the range of contraception options available; the optimum method mix will include short-acting, long-acting, reversible and permanent methods of hormonal/non-hormonal contraception, provider- or client-dependent.

Supply chain issues are clearly critical; contraceptives must be available at the time and place when the individual women and men are present and accessing the services.

Rights language has its own jargon, but also its own detractors; sometimes it can be more fruitful to identify the key issues in a particular country or setting, and address them without using 'rights language' as such.

As indicated above, rights are a way of conceptualizing, implementing, monitoring and evaluating programs, not a new technical area of work. When rights attract global attention, it is often in the context of rights violations. Nevertheless, it is important to emphasize the positive aspects of a rights-based approach, e.g. the right to make choices, as well as the right to be free from rights violations. A rights-based approach will empower clients to shape and use the family planning services that enable them to choose whether and when to have children, and contribute to the economic, social and economic well-being of their families, communities and countries.

Several of these insights arose from discussions following presentations from Karen Newman and Rajat Khosla.

### **c. Operationalizing a rights-based approach**

Currently several efforts are underway to operationalize a rights-based approach to family planning. There are several frameworks that seek to break down what needs to happen at the various levels – national/policy/legal context, and the service delivery, community and individual levels.<sup>9</sup> It is important to identify clearly the benefits of investing in rights at the various levels, as several agencies and practitioners have done.

A critical element is capacity development at policy, programmatic and community levels; talking about rights, but not supporting and financing the capacity development needed to ensure that they are fully respected, protected and fulfilled within family planning programs is a mistake. Service providers, for example, need to see a complaining client as an asset – someone who thinks they deserve better, and a potential ally to work with service managers to secure additional resources for the program, but the provider will not easily see this, if they are, for example, paid via a system which rewards maximum throughput of clients seeing each for as little time as possible. Capacity development, therefore, must include program managers and supervisors, as well as service providers.

Terminology can be a barrier; it is important to recognize that rights buzzwords, such as empowerment, can feature, sometimes prominently, in policy documents, with little or no manifestation in the implementation of programs. It is often more useful to deconstruct what the concepts mean for services in particular contexts – possibly by asking a series of focused questions, e.g.:

- What are the equity issues here? Who isn't using our services?
- Are staff trained to implement a rights based approach? What help would they need to do that?
- What method mix is available? Which methods are used most? Does this mean something? (provider bias? Certain methods particularly used by certain population groups?)
- What supervision exists for service providers? Is it supportive? Do service provider skills need upgrading? How can performance be improved? How would "improved performance" be defined? Supervision/performance evaluation must be consistent with a rights-based approach, which will be challenging if, for example, pay is directly linked to the number of implants or IUDs inserted.
- What services are available across the sectors – public, private, NGO, pharmacy?
- How can a rights-based approach take into account the time constraints of service providers? Is it important that extra data collection yield direct benefits for the service provider?
- What is being done in capacity development for demand creation to create client confidence?

<sup>9</sup> Hardee, K. et al. Voluntary, Human Rights-Based Family Planning: A Conceptual Framework. *Studies in Family Planning* 45(1):1-18, March 2014, <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2014.00373.x/abstract;jsessionid=10377C2FD9A15A2E94E1FB35771EE8FE.f02t04>

#### **d. Yes, we can measure rights**

The report section on the measurement agenda summarizes ongoing research work in this area. During discussion of these issues, it was agreed that:

- There is a demand at program level for tools to measure rights, and it is important to respond to this; donors and agencies are not the sole drivers of the quest to measure rights. Equally important is the need to feed the results of data collection back to communities.
- The assertion that rights cannot be measured can now be confidently refuted; several efforts to measure human rights in family planning programs are now underway. This work is yielding evidence on a range of indicators across the spectrum of rights issues.
- It is clear that rights are being measured; they are not abstract concepts impossible to implement in practice, the measurement agenda is not only up and running; it is delivering results.

#### **e. Embrace complexity**

Human rights are multidisciplinary; implementing a rights-based approach to health care services is multifaceted, and takes place across sectors and agencies at multiple levels. In short, it's complicated; rights-based approaches tend not to have magic bullets; there are no three things we can do that will guarantee that services respect, protect and fulfil human rights. It is important to recognize the complexity, but not be intimidated by it; what needs to be done at the specific levels – policy, service delivery, community, etc. isn't always complicated in itself, but the need for multiple actions at these various levels must be acknowledged in implementation plans, budgets, etc. Partnership programs increase the complexity, but can also be valuable for harnessing different skills, and working with varying groups on different issues.

It is also important to show the difference that rights-based approaches can make in terms of outcomes, e.g. health-seeking behaviors, empowerment, etc., which are themselves complex to define and measure - this measurement task is ongoing, and needs accelerating, but it is underway. Measurement of rights-based approaches is complex because numerical indicators will not necessarily help to measure social change, and the lived realities of the individual women and men who access family planning services.

#### **f. Engage communities**

Ultimately, empowerment is linked to individual and community change, and the need to change social norms. More community/ social indicators will be required in order to strengthen social accountability, and to measure that change. Community engagement is critical to this process, and to ensuring that family planning services respect and protect human rights; community is the space where service accountability happens. Working at the community level with women, men and young people is important to build the bridge between service providers, users and the community; community engagement will help to answer context-specific questions such as what is the role of men in the context of the broad social change that will lead to women's empowerment. Community engagement is also the first step to critically interrogate, and determine how to address social norms and practices.

Community engagement also plays an important role in the "demand side", as opposed to the supply side of family planning services. This Consultation focused more on the perspective of service providers, but a rights-based approach necessarily embraces and indeed encourages access to family planning independently of service providers, and empowering women, men, and, especially young people to access and demand such services. Empowering clients to recognize their right to services of high quality, and to believe themselves entitled to demand such services is an important part of rights-based programming.

The final four issues were "workshopped" at the meeting, and while there are no definitive answers, capacity-building should include exercises to anticipate and manage some of the issues that may arise.

### **g. Single method family planning programs: increasing access and options or denying choice?**

Family planning programs that promote a particular method or contraceptive option are clearly increasing access to that method. There may, however be unintended consequences: efforts to increase access to a particular method with the intention of increasing contraceptive choice could, in practice, have the effect of constraining choice, particularly in contexts where other methods may not be readily available. An example was mentioned from a program where a country director of a technical assistance agency routinely asked facility managers about the number of IUDs that were inserted, rather than asking about data for all methods. Although the intention was to track method mix, the message received by service providers was that they were expected to promote increased use of that particular method.

Long-Acting Reversible Contraceptives (LARCs), while being the method of choice for many women, can give rise to other rights-based concerns, including, for example, limited access to services to remove implants, or the limited availability of training to reduce provider bias in favor of, or against, specific methods. Where remuneration is tied to uptake of specific methods, it becomes more challenging, but correspondingly more important to ensure that clients are encouraged to make their own choice from a range of methods presented in an unbiased manner – i.e. are enabled to make a full, free and informed choice. As indicated above, external-driven funding for particular contraceptive methods or performance expectations also has the potential to lead to provider bias, even as it increases access to those methods.

Concern was expressed about the “salami-slicing” of the comprehensive sexual and reproductive health and rights agenda that was agreed at the International Conference on Population and Development in Cairo in 1994. FP2020 focuses on the family planning part of that; the extent to which other elements, such as sex education, or sexually transmitted infections (let alone abortion) feature is unclear. On the other hand, refocusing global attention onto family planning has been valuable, and lessons learned from rights-based family planning programs are relevant for the wider sexual and reproductive health and rights agenda, and also for other humanitarian international development initiatives, such as working with refugees, etc., suggesting potentially valuable areas for collaboration.

Certain funders favor particular methods, and provider bias can be an additional factor that may, in practice, decrease options for women, especially since it tends to be long-acting methods that are, in effect, funded in this way. To what extent are clients' contraceptive decisions in these programs the result of a full, free and informed choice – how free were they to choose another method?

Allied to this issue is the perceived or actual difficulty within programs dominated by single methods of raising discussion of other methods, whether they be vasectomies- particularly in countries where it has been associated with coercive programs in the past, or basic education about withdrawal, or fertility awareness methods.

### **h. Quality: necessary, but is it sufficient?**

Quality is home territory for family planning program managers; the critical components are known from the Bruce-Jain framework, which identified six elements: choice of contraceptive methods, information given to patients, technical competence, interpersonal relationships, continuity and follow-up, and the appropriate constellation of services. These have been further refined, and a range of tools have since been developed to assess the concept, but quality overwhelmingly focuses on the quality of clinical services. As such, it doesn't cover some rights issues such as non-discrimination, since people who do not use the services are not subject to this quality analysis, whereas a human rights analysis would assess whether efforts have been made to ensure that marginalized or hard-to-reach populations have access to services. Clearly not all clinics can serve all people, but a rights analysis can help to identify people whom the clinic could reach, but isn't at the moment.

The AAAQ formula is helpful for identifying that quality is necessary, but not sufficient to guarantee a rights-based approach to family planning programs. It can be useful for responding to the myth that, if you take care of quality, rights will take care of themselves. Other core concepts that are missing, include participation, accountability, agency and autonomy. Research into quality tends to focus on clinical services; community research will yield valuable information on what the community would value in those services, which could further inform service provider actions and decisions, as well as empower clients to define what quality means to them. It was noted that the word quality is technical, and devoid of the political connotations that agency and autonomy carry. This is both a strength and a weakness.

### **i. You've identified a rights violation. Now what?**

Rights violations tend to hit the headlines to a far greater degree than examples of how rights have been fulfilled. To a certain degree that is good; one violation is one too many. But coercive practices are often easy to spot; more difficult and sometimes as pernicious are practices that have the effect of reducing agency and autonomy, but are not self-evidently coercive. Medically unwarranted barriers that block access to services, e.g., for young people or otherwise marginalized populations would fall into this category. Ultimately, rights are not about finger-pointing; rights-based programs seek to increase trust and understanding between service providers, clients, and the communities to which both belong – rights need to be seen as a management tool, not a stick to beat programs with.

Nevertheless, rights violations do occur, and it is a sign of a healthy program that such occurrences are recognized and addressed; that is a core component of accountability. The question arises as to how to identify and address problems without jeopardizing relationships with or between governments and donors? If the brave act of recognizing and drawing attention to a rights violation could manifest itself in a foolhardy action which could shut down your program, what incentive is there for a program manager to recognize the right, and provide some kind of redress?

It is important to recognize the real pressures on service providers, from governments, donors, society, community norms, community leaders and others. Are there numerical targets or “expected levels of achievement”; do community norms make programs for adolescents impossible to implement? It is particularly important to recognize these pressures, and the effect they may ultimately have on the freedom or agency with which the client makes a contraceptive choice, even as we work with communities to empower women and change social norms, and treat clients as autonomous, respected and knowledgeable individuals.

Some promising approaches have come from community mobilization, social accountability and facilitating dialogue between service providers and the community, so that continually assessing the program is a process, not a disciplinary judgement, and issues are addressed in a non-punitive or accusatory way, in the spirit of quality improvement. Relatively little exists with regard to redress and remedies for rights violations; constructive accountability efforts have involved communities in audits, and in identifying system failures, rather than individual provider failures. More research is needed in this area. The objective should not be to victimize health care providers - fear and shame rarely promote effective programmatic change – but to focus on what needs to change in order to reduce or eliminate the possibility of the rights violation occurring again.

Rights literacy and civic education is vital in promoting social accountability; this can unlock the space for ongoing dialogue between the community and service providers.

### **j. Are rights intrinsically incompatible with working towards time-bound deadlines and the focus on an aspirational numerical goal?**

Deadlines lend focus, while numbers can sharpen aspirations, and help to show progress. Can deadlines, and the quest for 120 million additional users be compatible with a rights-based approach to family planning? Ultimately, it isn't either/or – it's a tension that must be managed through programs which increase the numbers of people who have access to rights-based family planning services that enable them to make a full, free and informed choice. The tension is very real; project time-frames tend to be short, with an expectation of results within that time-frame, whereas the social changes that will lead to women's empowerment will take much longer.

What is a result, in a rights-based world? Is it possible to place a value on a woman who leaves a family planning clinic without a contraceptive, but with knowledge of where to return, and a feeling that she was heard and respected? Is establishing a mechanism through which community representatives and family planning service providers regularly meet to discuss the services, and how they might be improved a result? Does it count as much as a new or continuing user? Obviously no donor or program manager wants rights violations, but it is important that programs are evaluated in ways that recognize that enabling and empowering clients to make full, free and informed choices takes time – usually significantly more time than offering and providing a single method. Is this taken into account in remuneration systems for service providers? Client volume is clearly a constraint on the amount of time service providers can spend with clients, but it is important that remuneration systems do not act in ways that have the effect of reducing the extent to which clients are in a position to make a full, free and informed choice.

Some donors are seeing 2020 as a milestone towards universal access to family planning. Linking FP2020 to the Sustainable Development Goals may be an important strategy for family planning moving forward. Striving to reach 120 million out of 225 million women and girls with an unmet need for family planning is important; there are also risks associated with not meeting women's family planning needs.

Rights are about how programs are delivered; if FP2020 can be a catalyst for identifying as positive results the spaces for dialogue that have been opened up to raise awareness about, and increase access to family planning, and progress in measuring the extent to which rights are respected, protected and fulfilled in family planning programs, these would be significant results in addition to progress against reaching the 120 million additional users.

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## VI. GOING FORWARD

### Take-home messages

The consultation generated a number of broad insights about rights-based programming:

- Human rights in healthcare is a complex, multidisciplinary, multidimensional issue with medical, social and legal dimensions that cut across sectors. Consider all levels of the health system; look for strategic alliances across sectors.
- Taking a rights-based approach involves a shift in mindset using a different lens through which we view our work. It is human-centric as opposed to focusing on methods or systems. Much can be done to safeguard human rights within existing action plans and resources by doing the same work differently, being mindful about respecting, protecting and fulfilling human rights.
- Language matters. We should own and use the term 'rights', though in some settings it may be more practical to refer to programmatic elements of rights, which are less sensitive and more easily understood. We should talk about programs rather than just services, and individuals, not just clients.
- Yes, you can measure human rights in family planning programs. And what gets measured gets done. Respecting, protecting and fulfilling human rights should be made explicit performance expectations that are routinely monitored. Make sure data collected is useful for program managers.
- Though the focus of this meeting was on FP, all issues discussed pertain to SRHR writ large.
- It is important to stay positive about human rights and to use this approach as a management tool to improve programs, not as a stick to identify and punish deficiencies.

### What is needed?

Over the course of the meeting, participants identified steps that are needed to fully operationalize a rights-based approach over the long-term:

1. Appeal to the enlightened self-interest of different stakeholders (What's in it for me?) by demonstrating the outcomes and value added of a rights-based approach; support evidence-based advocacy tailored to different audiences
2. Change social, gender and cultural norms and attitudes. Engage men and boys to achieve gender empowerment for women and girls as well as for men
3. Ensure human rights-supportive laws and policies
4. Develop awareness and competence of policymakers, program managers, service providers and community members through rights literacy training and capacity development
5. Document and disseminate evidence of what an intentional, comprehensive right-based approach takes and what difference it makes



6. Develop simple ways to communicate complex, abstract rights concepts; deconstruct the issue to make it concrete, practical and measurable at all levels of the health system; translate legalistic jargon into programmatic terms and actions; develop simple images or Emojis with short explanatory phrases
7. Adjust as needed from a development context to a humanitarian context to protect the human rights of key populations (migrants, internally displaced people) in conflict, post-conflict or disaster settings
8. Strengthen accountability and redress mechanisms, including social accountability, and work to incorporate them as a critical component of a comprehensive rights-based family planning program
9. Standardize and institutionalize measures and indicators for both the macro, or programmatic, level and the micro, or individual client, level
10. Think in terms of full, multidimensional programs, not just service delivery; and in terms of individuals, not just clients
11. Make information about rights-based programming accessible to a broader audience, including the development, health, human rights, gender, SRH and other communities
12. Allow adequate time to effect all these fundamental changes; recognize progressive realization, doing as much as you can now to generate some results as soon as possible, knowing that achieving a fully rights-based program will take time

## Recommendations

In addition, the group generated the following specific recommendations for steps that could and should be taken over the next year to advance rights-based programming:

### Advocacy and messaging

- Have communications staff from different organizations coordinate to develop consistent messages
- Develop symbols that easily convey key concepts, similar to the icons developed for the MDGs and SDGs
- Revive the population dynamics discussion and position rights-based FP to preclude a focus on numbers at the expense of rights
- Connect with communications advocates at local levels
- Use PRB's network of global women journalists more strategically
- Seek input from young people to develop key messages

### Operationalizing the approach

- Prioritize adolescents; involve youth in design and collaborate with other sectors like the Ministries of Education and of Youth to think about reaching youth in and out of school; ensure policies are rights-supportive and that no policies bar young people from obtaining the FP information and services they want.
- Focus on the nexus between the community and service delivery; foster understanding of one another's perspectives; promote social accountability
- At the level of the health system, promote rights-based approaches in supportive supervision, including values clarification for providers; ensure high quality counseling based on clients' reproductive intentions
- Support deep social normative change, including gender norms; seek strategic partnerships to aid this process
- Adopt or develop operational guidelines for project design and project reform, a tool for bilateral programming; we have the Voluntary, Rights-based Family Planning Framework and other resources; develop a simple "cheat sheet" that lists essential considerations when designing or updating a program based on distillation of these materials; possibly develop a HIP on rights-based FP
- Embed rights into the design of RFAs

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### Monitoring and measuring human rights, and research

- Establish a platform for sharing works in progress and interim results and to prevent duplication of effort
- Communicate results in a way that is easy to understand and apply
- Hold ourselves accountable to the places in which research is conducted; put results in the hands of people who can demand change
- View global indicators as a work in progress. Don't oversell what we are measuring. Add new, more nuanced measures as they are developed
- Emphasize implementation research to get at "How?" and take different contexts into consideration
- Invest in different research methods and studies. Support quantitative monitoring while advocating for other research and special studies
- Develop a research agenda; seek locally-driven questions to generate evidence for advocacy to convince policymakers of the added value
- For issues related to youth, consider training young people as researchers

### **Next steps**

As the host organization of the consultation, FP2020 affirmed its wholehearted commitment to advance human rights in family planning and noted that FP2020 is a vehicle designed and available to move this agenda forward. Beth Schlachter, Executive Director of FP2020, and Sandra Jordan, Director of Rights, Advocacy and Youth, pledged to support and to grow the collective forged at this consultation and invited the group to set bold goals that FP2020 can work to advance. They stand ready to foster coordination and collaboration among donors, technical agencies and governments. The intention is to expand from this initial group to grow an inclusive community that engages our partners at the country level.

Specifically, FP2020 is releasing this report in conjunction with the launch of a broader conversation through a website and other platforms, where all of the presentations and resources from this meeting will be housed, to be followed by a series of webinars. This platform will be expanded over time.

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## LINKS TO PRESENTATIONS

- a. <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/Doortje-Bracken.pdf>
- b. <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/Karen-Newman.pdf>
- c. [http://ec2-54-210-230-186.compute-1.amazonaws.com/wpcontent/uploads/2016/06/Rajat\\_Guidelines.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wpcontent/uploads/2016/06/Rajat_Guidelines.pdf)
- d. [http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/Rajat\\_Guidelines.pdf](http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/Rajat_Guidelines.pdf)
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