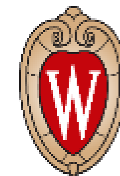
TAKING THE POPULATION CONTROL OUT OF FAMILY PLANNING MEASUREMENT: THE CASE OF UNMET NEED

Leigh Senderowicz [she/her]
IDM Symposium
Bill and Melinda Gates Foundation
May 24th, 2023

HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH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BACKGROUND

DIVERSE RATIONALES FOR EXPANDING FAMILY PLANNING

Feminist

- Contraception as a matter of rights

Environmentalist

- Alleviate climate change & protect biodiversity

Public Health

- Improve maternal and child health

Economic

- Promote economic growth and reduce poverty

The New York Times

A CONVERSATION WITH

For Melinda Gates, Birth Control Is Women's Way Out of Poverty

Melinda Gates says contraceptives are one of the "greatest anti-poverty innovations in history"

By Lila MacLellan • February 16, 2017

Nov. 1, 2016

April 2, 2012

FAMILY PLANNING: THE SMARTEST INVESTMENT WE CAN MAKE

Funding for international family planning and reproductive health is a proven and cost-effective way to meet a broad range of international development goals. Increased access to contraception for women in developing countries is critical to improving maternal and newborn health, preventing HIV/ AIDS, and reducing unintended pregnancies and the need for abortion. Family planning programs yield improvements in other key development areas such as education, water and sanitation.

Invest in Family Planning, Save in Development Costs

Analysis by the U.S. Agency for International Development (USAID) shows that family planning investments save money in other development areas including education, immunization, water and sanitation, maternal health, and malaria. Data from seven countries across three continents shows that for every dollar invested in FP/RH, there is significant savings across sectors. Every dollar invested in family planning has shown savings in other development areas ranging from $2 in Ethiopia to more than $6 in Guatemala and Bangladesh, and up to $9 in Bolivia.

ANTECEDENTS

USAID
FROM THE AMERICAN PEOPLE

Family Planning TIMELINE

Before 1965

After passing the Foreign Assistance Act in 1961, Congress authorizes research on family planning and population issues, including the provision of family planning information to couples who request it.

1963

Addressing the World Food Congress, President Kennedy recognizes that rapid population growth in under-developed countries has become a serious concern. It is "too often the highest where hunger is already the most prevalent."

1965–1969

In 1965, President Johnson declares that he will "seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity of world resources."

1965

USAID population and reproductive health program begins.

The U.S. Government adopts a plan to reduce birth rates in developing countries through its War on Hunger and investments in family planning programs.

1966

Congress amends the Food For

1969

President Nixon describes population growth as "one of the most serious challenges to human destiny in the last third of this century."

The Office of Population is established to provide leadership, initiative, coordination, technical guidance, and assistance in developing and conducting population/family planning activities.

1970s

USAID sponsors pilot projects and develops community-based distribution systems that bring family planning information and services door-to-door.

1972

USAID's Office of Population begins supporting reproductive health training and international surveys, such as the Demographic and Health Surveys (DHS). DHS are large national household surveys that provide data for program monitoring and evaluation.

1973

Programme of Action

Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994

THE POST-CAIRO SHIFT

Pre-Cairo FP

- Population control
- Fertility reduction
- Demographic targets

Post-Cairo FP

- Reproductive health
- Reproductive rights
- Access to services
- Quality of care
- Gender equity

30:24

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Transcript

WORLD

How China's One-Child Policy Led To Forced Abortions, 30 Million Bachelors

February 1, 2016 · 1:43 PM ET
Heard on Fresh Air

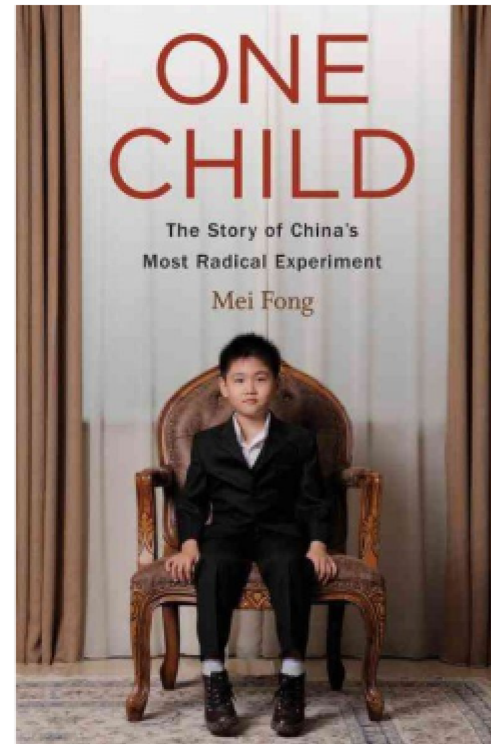
FRESH AIR

Last October, China ended its 35-year-old policy of restricting most urban families to one child. Commonly referred to as the "one-child" policy, the restrictions were actually a collection of rules that governed how many children married couples could have.

"The basic idea was to encourage everybody, by coercion if necessary, to keep to ... one child," journalist Mei Fong tells *Fresh Air's* Terry Gross.

Fong explores the wide-ranging impact of what she calls the world's "most radical experiment" in her new book, *One Child*. She says that among the policy's unintended consequences is an acute gender imbalance.

"When you create a system where you would shrink the size of a family and people would have to choose, then people would ... choose sons," Fong says. "Now China has 30 million more men than women, 30 million bachelors who cannot find brides. ... They call them *guang guan*,



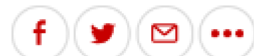
One Child
The Story of China's Most Radical Experiment

India

India mass sterilisation: women were 'forced' into camps, say relatives

Brother-in-law of one victim says women were 'herded like cattle' after 12 die and scores injured following botched operations

Jason Burke *in Delhi*
Wed 12 Nov 2014 02.52 EST



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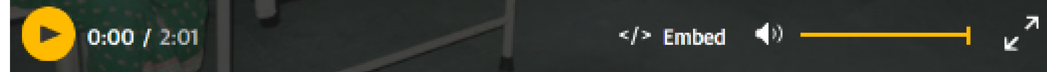

▲ Indian government investigates sterilisation deaths

Relatives of the 12 women who died after a state-run mass sterilisation campaign in India went horribly wrong have told local media they were forced by health workers to attend the camp.

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Forced sterilisation haunts Peruvian women decades on

By Javier Lizarzaburu
Lima

2 December 2015

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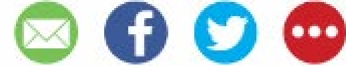
JAVIER LIZARZABURU

Sabina Huillca is one of the women who was forcibly sterilised in Peru

Namibian women were sterilized without consent, judge rules

From Nkepile Mabuse, CNN
Updated 12:18 PM ET, Tue July 31, 2012



HIV moms forced to sterilize in Namibia 02:10

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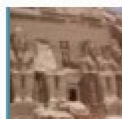
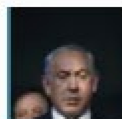

How ancient Egypt saved the rest of the Middle East...


The final days of Benjamin Netanyahu's rule

'Man, she's pretty Syrian rebels' gru

Trending Now

Israel Admits Ethiopian Women Were Given Birth Control Shots

Health Ministry director general instructs all gynecologists in Israel's four health maintenance organizations not to inject women with long-acting contraceptive Depo-Provera if they do not understand ramifications of treatment.

Talila Nesher | Jan 27, 2013 2:29 AM

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The Washington Post

Many European countries won't recognize transgender people unless they're sterilized

By Rick Noack
Paris correspondent

February 25, 2017

People take part in the 16th Existrans, a parade to fight for the rights of transsexual and transgender people on Oct. 20, 2012 in Paris. A banner reads "Identity papers if I want, when I want." (Francois Guillot/AFP/Getty Images)

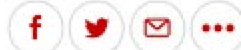
Welfare in Australia

Welfare recipients should be forced to take birth control, says ex-Labor MP

Gary Johns' suggestion that compulsory contraception 'would help crack intergenerational reproduction of strife' has been slammed by welfare groups

Shalailah Medhora

Mon 29 Dec 2014 23.04 EST



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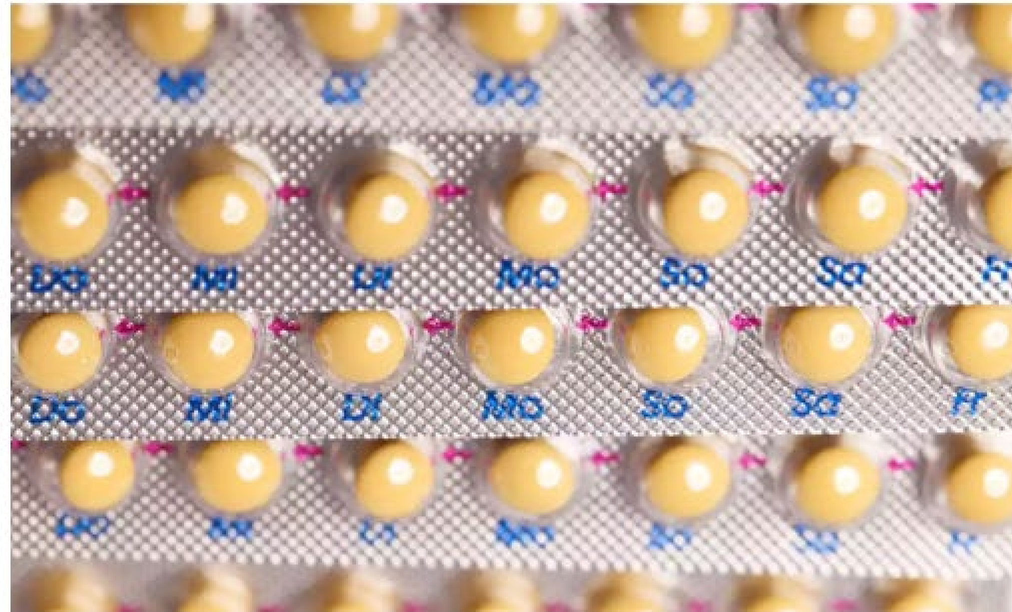


▲ Gary Johns has written an opinion piece for the Australia saying people should only receive the dole if they are taking contraception. Photograph: YAY Media AS/Alamy/Alamy

A former Labor MP has been slammed for suggesting people should only receive welfare payments if they are on forced contraception.

BMJ 2015;350:h728 doi: 10.1136/bmj.h728 (Published 6 February 2015)

Woman with IQ of 70 should be sterilised for her own safety, court rules

Clare Dyer

The BMJ

A mother of six with an IQ of 70 and an “extraordinary, tragic, and complex” obstetric history should be sterilised for her own safety, a High Court judge has ruled.

Mr Justice Cobb held that the 36 year old, DD, who has an autistic spectrum disorder, lacked the capacity to decide for herself and should be sterilised rather than have an intrauterine device (IUD) inserted.

Giving judgment in the Court of Protection in London, the judge said, “This case is not about eugenics. This outcome has been driven by the bleak yet undisputed evidence that a further pregnancy would be a significantly life threatening event for DD.”

He said that it would be a rare case in which the more radical alternative of sterilisation would be preferable to the insertion

Morning Mix

Tenn. judge reprimanded for offering reduced jail time in exchange for sterilization

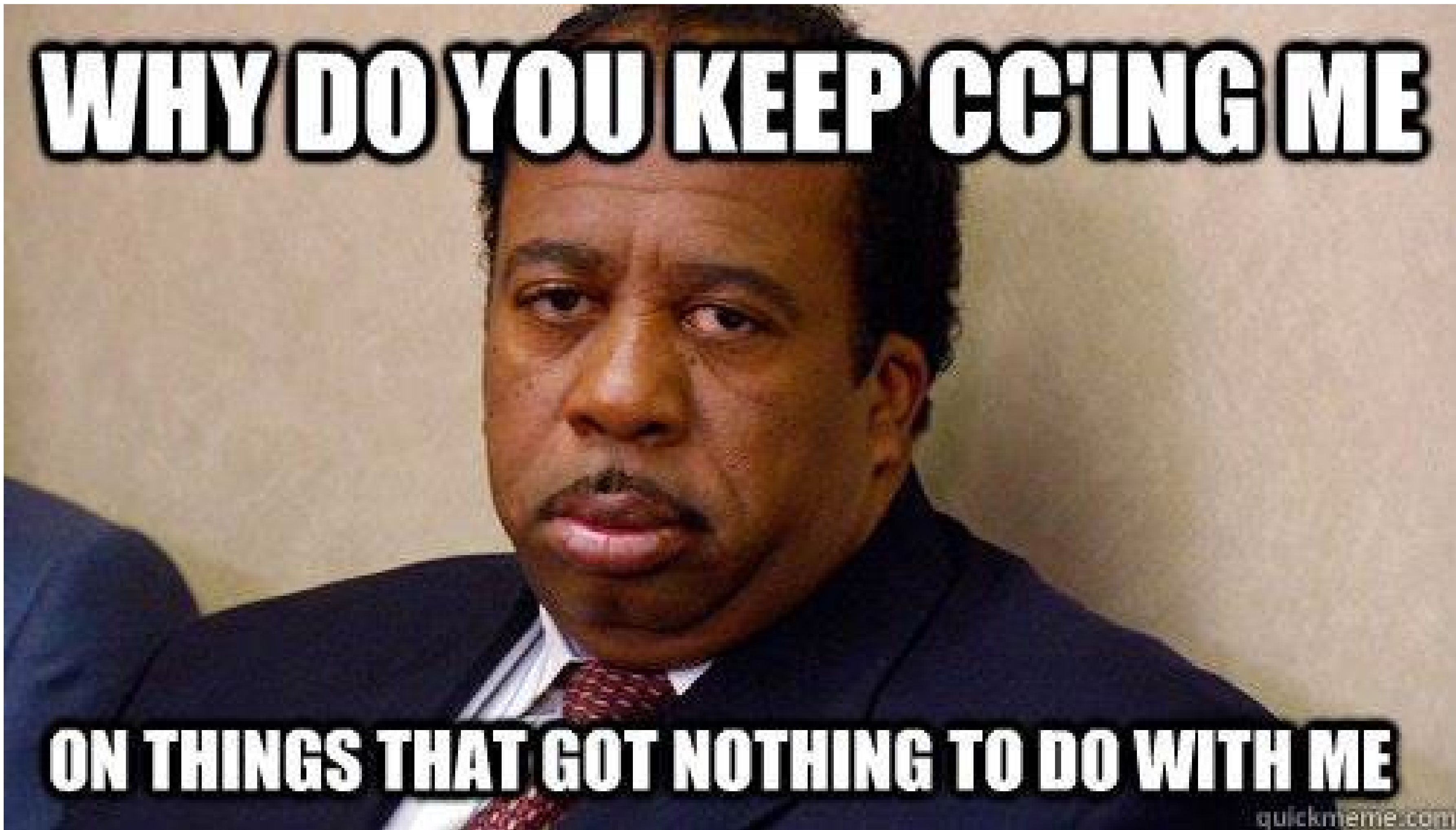
By **Derek Hawkins**

November 21, 2017 at 4:45 a.m. EST

Judge Sam Benningfield
 (Image via News 5)

When Judge Sam Benningfield of White County, Tenn., offered to shave off jail time for inmates who volunteered for sterilization, a chorus of attorneys, advocates and public officials reacted with horror.

Benningfield said his goal was to break a “vicious cycle” of repeat drug offenders with children. But many argued that the proposal, outlined in a May order, was nothing short of eugenics. Not to mention it seemed unconstitutional on its face. Civil rights lawyers brought legal actions and a local prosecutor told his staff to avoid the judge’s program at all costs.


WHY DO YOU KEEP CC'ING ME
ON THINGS THAT GOT NOTHING TO DO WITH ME
quickmeme.com

Family planning in sub-Saharan Africa: progress or stagnation?

John G Cleland,[a] Robert P Ndugwa[a] & Eliya M Zulu[b]

Introduction

Fertility and future projected population growth are much higher in sub-Saharan Africa than in any other region of the world, and the decline in birth rates, which was already modest, has slowed even further over the past decade.[1–3] Concern that uncontrolled population growth will hinder the attainment of development and health goals in Africa led to the present study, which rests on the assumption that fertility will decline only if the population at large adopts effective modern methods of contraception, as witnessed in other parts of the world.

Bull World Health Organ 2011;89:137–143 | doi:10.2471/BLT.10.077925

A global research agenda for family planning: results of an exercise for setting research priorities

Moazzam Ali,[a] Armando Seuc,[a] Asma Rahimi,[b] Mario Festin[a] & Marleen Temmerman[a]

Bull World Health Organ 2014;92:93–98 | doi: http://dx.doi.org/10.2471/BLT.13.122242

Table 2. **Research topics that achieved the 15 highest priority scores**

Rank	Topic	Score
1	Identify the main barriers to uptake and use of modern contraceptives in settings with very low prevalences of contraceptive use	86.23
2	Identify mechanisms to integrate postpartum FP services with other interventions – such as child vaccination and control of HIV infection – to improve health care and uptake of FP services	83.90
3	Determine strategies to increase post-abortion contraception uptake and continuation	83.80
4	Identify effective strategies to overcome the barriers to contraceptive uptake in the postpartum period	82.68
5	Develop mechanisms to improve the physical, financial and social access of marginalized populations[a] to FP products and services	81.13
6	Investigate the determinants of the discontinuation and switching of contraceptive methods	80.81
7	Evaluate the unmet need for FP, particularly that among marginalized populations[a]	79.89
8	Investigate the determinants of acceptability and continuation of use of FP	78.48

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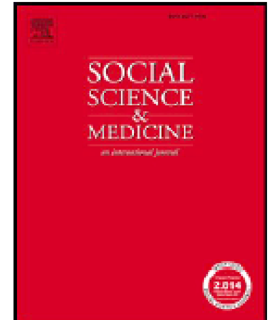

"I was obligated to accept": A qualitative exploration of contraceptive coercion

Leigh Senderowicz

Harvard University T.H. Chan School of Public Health, Department of Global Health and Population, 677 Huntington Avenue, Building 1, 11th Floor, Boston, MA 02115, USA

CENTRAL QUESTIONS:

How did that pre-Cairo agenda of population control inform the creation of our family planning measurement tools?

How can we design new tools that measure/ promote reproductive justice instead?

THE CASE OF “UNMET NEED”

No access to contraception for 200 million women worldwide

25 January 2016 | General News

Download

Some 200 million women around the world who want contraception have no access to it, according to the United Nations.

The findings come in the Trends in Contraceptive Use Worldwide 2015 report which says that family planning is a fundamental right.

Ann Biddlecom is one of the authors, who spoke to Daniel Dickinson ahead of an International Family Planning Conference, which starts on Monday in Indonesia.

Duration: 3'07"

Photo Credit: UNFPA/Micka Perier

ASIA | HEALTH | REGIONS-ALL | WOMEN, CHILDREN, POPULATION | ANN BIDDLECOM | CONTRACEPTION | FAMILY PLANNING | HEALTH | INTERNATIONAL FAMILY PLANNING CONFERENCE | TRENDS IN CONTRACEPTIVE USE WORLDWIDE 2015 REPORT | UN NEWS | UN RADIO | UNITED NATIONS | WOMEN

- Target 5.B: Achieve, by 2015, universal access to reproductive health
  - *Indicators*
    5.3 Contraceptive prevalence rate
    5.4 Adolescent birth rate
    5.5 Antenatal care coverage (at least one visit and at least four visits)
    5.6 Unmet need for family planning

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SDG Indicator 3.7.1: Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

What is unmet need for contraception?

Currently married women

Using contraception

Not using contraception

Pregnant or postpartum amenorrheic (period not returned since last live birth in last 2 years)

Not pregnant or postpartum amenorrheic

GROUP 1

- Wants no more children; sterilized; or said "can't get pregnant" on wantedness of future children = USING TO LIMIT
- All others using contraception = USING TO SPACE

GROUP 2

- Did not want current pregnancy/ last birth at all = UNMET NEED FOR LIMITING
- Wanted current pregnancy/last birth later = UNMET NEED FOR SPACING
- Wanted current pregnancy/ last birth at that time = NO UNMET NEED
- Wantedness of current pregnancy/ last birth missing = MISSING

GROUP 3

- Married 5+ yrs ago, had no children in past 5 yrs, and never used contraception = INFECUND
- Said "can't get pregnant" on wantedness of future children = INFECUND
- Said "menopausal/hysterectomy" on reason not using contraception = INFECUND
- Response to time since last period is ≥ 6 months and not postpartum amenorrheic (0-59 months) = INFECUND
- Response to time since last period is "menopausal/hysterectomy" or "never menstruated" = INFECUND
- Response to time since last period is "last period was before last birth" and last birth 5+ yrs ago = INFECUND

GROUP 4

No to all (fecund)

- Wants child within 2 yrs = NO UNMET NEED
- Wants no more children = UNMET NEED FOR LIMITING
- Wants next child in 2+ yrs; wants child and undecided timing, or undecided if wants child = UNMET NEED FOR SPACING
- Wantedness of future children missing = MISSING

11

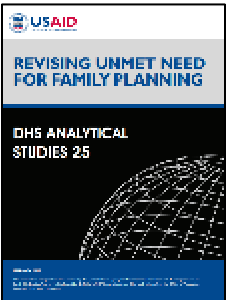


Figure 2. **Revised** definition of unmet need, currently married women

(Bradley, Croft, Fishel, and Westoff, 2012. Revising Unmet Need for Family Plan[illegible])

REASONS FOR NOT USING CONTRACEPTION WHEN NOT SEEKING A PREGNANCY:

- Lack of geographic access
- Cost barriers
- Gaps in information
- Not sexually active (or infrequent sex)
- Sex doesn't involve risk of pregnancy
- Ambivalent/conflicted pregnancy desires
- Simply chooses not to use contraception

CONTRACEPTIVE AUTONOMY STUDY

Data collection: July 2017 - July 2018

Sequential mixed methods study design

1) Formative qualitative phase

2) Population-based household survey

- Pre-testing with cognitive interviews respondent debrief
- Women ages 15-49
- Response rate: 97% in Nouna and 80% in Ouagadougou
- n=3929

Outcome 1

- Unmet need for contraception
  - Measured by the standard DHS algorithm refined by Bradley et al. in 2012

Outcome 2

- Desire to use contraception
  - Self-reported answer to the question "Do you wish you were currently using a method of family planning?" among current contraceptive nonusers

Outcome 3

- Lack of access to a broad, affordable contraceptive method mix
  - Calculated using the 'contraceptive attribute groups' methodology elaborated by Senderowicz in 2020. We asked respondents about their access to 14 different family planning methods, and used their answers on self-reported perceptions of method availability and affordability.

Outcome 4

- Desire to use and lack of access to contraception
  - Calculated by combining outcomes 2 and 3, for any woman who wishes she were using a method and lacks access to a broad method mix

METHODS

		Condition		
		Yes	No	
Test result	Positive	A – True positive	B – False positive	Positive predictive value: A/(A+B)
	Negative	C – False negative	D – True negative	Negative predictive value: D/(C+D)
		Sensitivity: A/(A+C)	Specificity D/(B+D)	

RESULTS

		Outcome 2: Desire to use a method of contraception		
		Yes	No	
Outcome 1: Conventional unmet need	Yes	277	573	Positive predictive value: 32.6%
	No	146	1,421	Negative predictive value: 90.7%
		Sensitivity 65.5%	Specificity 71.3%	

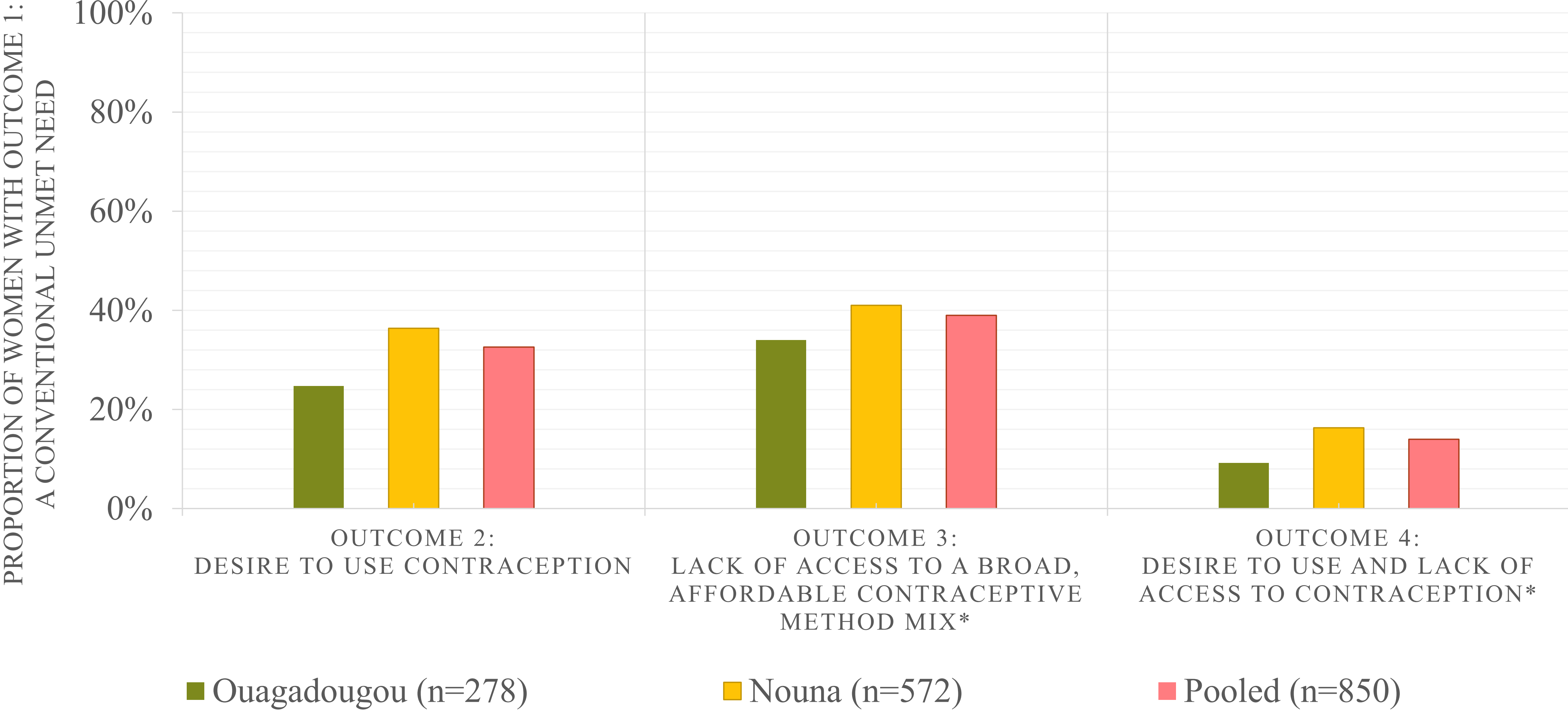
RESULTS

		Outcome 3: Lack of access to a broad, affordable contraceptive method mix		
		Yes	No	
Outcome 1: Conventional Unmet Need	Yes	332	518	Positive predictive value: 39.1%
	No	703	864	Negative predictive value: 55.1%
		Sensitivity 32.1%	Specificity 62.5%	

RESULTS

		Outcome 4: Have desire to use method and lack access to a broad, affordable contraceptive method mix		
		Yes	No	
Outcome 1: Conventional Unmet Need	Yes	119	731	Positive predictive value: 14.0%
	No	55	1,512	Negative predictive value: 96.5%
		Sensitivity 68.4%	Specificity 67.4%	

PROPORTION OF WOMEN WITH A DESIRE TO USE AND/OR A LACK OF ACCESS TO CONTRACEPTION AMONG THOSE WITH CONVENTIONAL UNMET NEED (PPV)



DISCUSSION

Like other FP measures, unmet need was expressly designed NOT to measure women's own preferences and desires

Unmet need is imbued with the racialized, colonial & misogynist logic that we know women's contraceptive "needs", better than they know themselves

"The marginality of women to a discourse ostensibly about them"

Lata Mani, *Contentious Traditions* (1992)

Most of the women to whom researchers ascribe an unmet need do not have thwarted desire to use contraception

It is feasible/practical to measure lack of access and desire to use contraception directly

We need to radically reconceptualize our family planning measurement agenda

AUTHORSHIP TEAM

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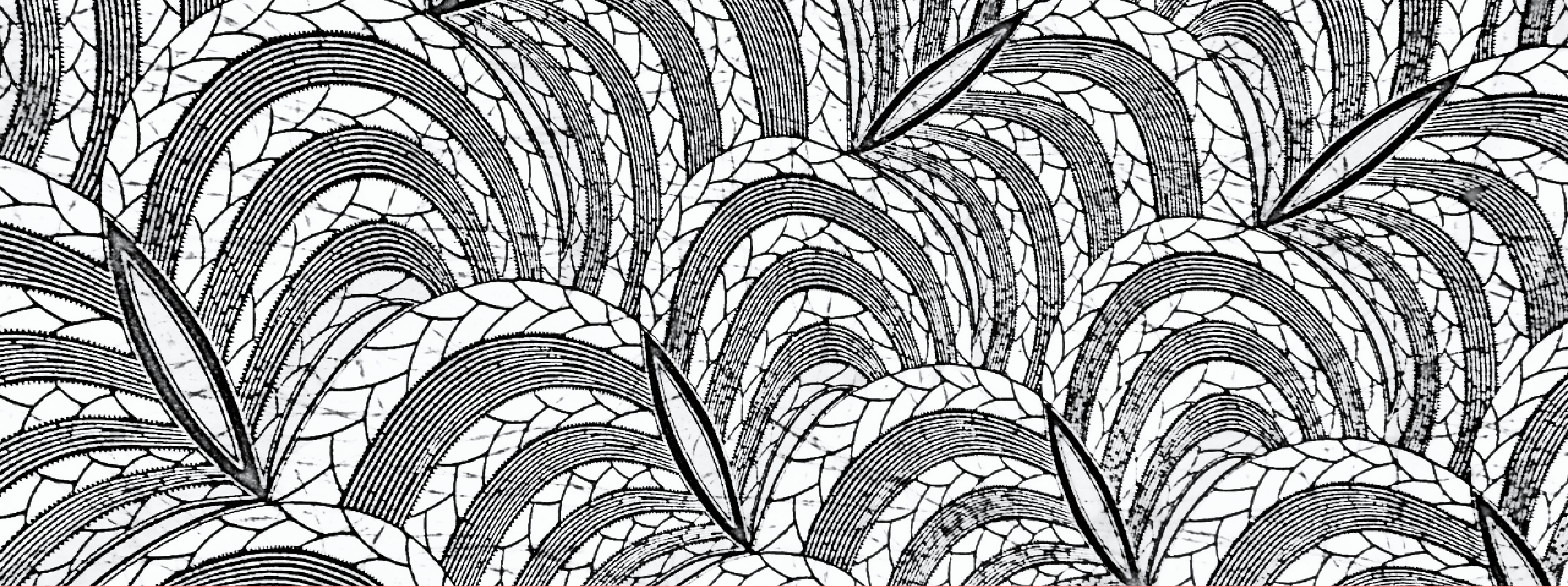
  - Population Research Infrastructure grant (P2C HD047873)

The content is solely the responsibility of the authors and does not necessarily represent the official views of the Eunice Kennedy National Institute of Child Health and Human Development or the National Institutes of Health.

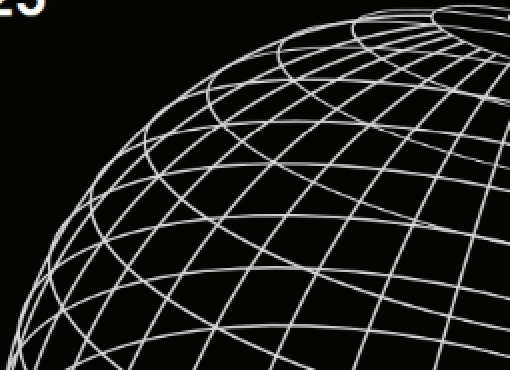


THANK YOU

senderowicz@wisc.edu

REVISING UNMET NEED FOR FAMILY PLANNING

DHS ANALYTICAL STUDIES 25



JANUARY 2012

This publication was produced for review by the United States Agency for International Development. It was prepared by Sarah E.K. Bradley, Trevor N. Croft, and Joy D. Fishel of ICF International and Charles F. Westoff of the Office of Population Research, Princeton University.

"Unmet need is an extremely complex indicator that is difficult to fully understand, and even more difficult to calculate…

"Unmet need **does not indicate a woman's access to family planning** information or services, her desire to use contraception, or other factors that may affect contraceptive use."

THE TACIT IDEOLOGY OF MEASUREMENT

"Statistical knowledge is often viewed as nonpolitical by its creators and users.

"It flies under the radar of social and political analysis as a form of power.

"Yet how such numerical assessments are created, produced, cast into the world, and used has significant implications for the way the world is understood and governed."

-Sally Engle Merry

The Seductions of Quantification (pg. 5)

COERCION IN POPULATION CONTROL

POPULATION
AND
DEVELOPMENT
REVIEW

Government Efforts to Influence Fertility: The Ethical Issues

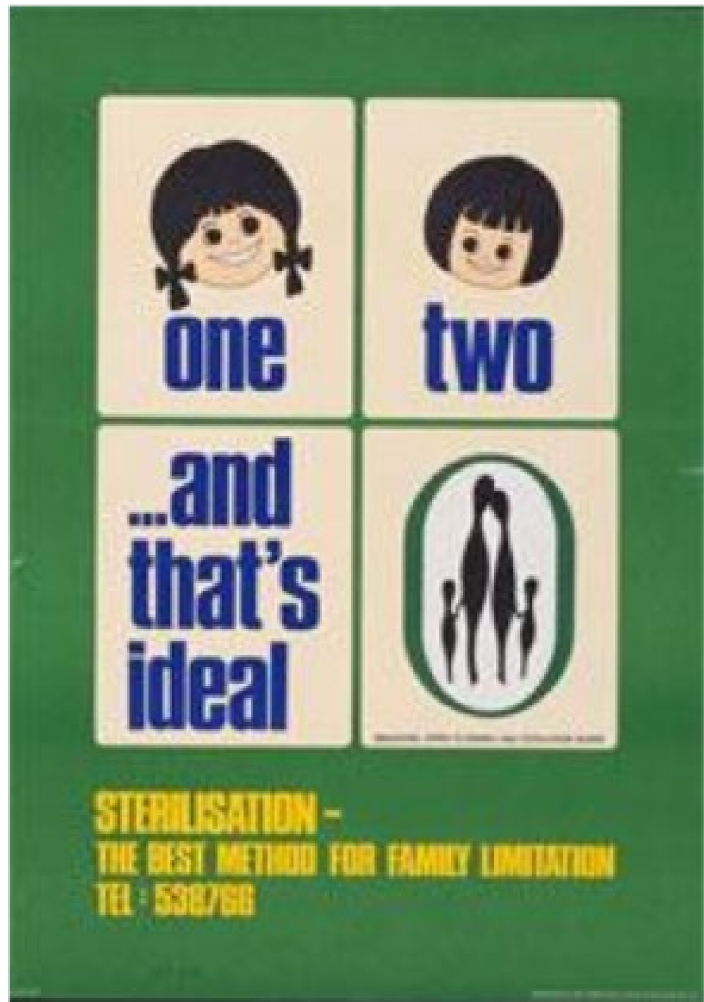
BERNARD BERELSON
JONATHAN LIEBERSON

"There are undoubtedly cases of justified coercion"

"Overt violence or other potentially injurious coercion is not to be used before noninjurious coercion has been exhausted."

Source: Berelson B, Lieberson J. Government Efforts to Influence Fertility: The Ethical Issues. *Popul Dev Rev*. 1979;5(4):581.

COERCION IN POPULATION CONTROL



FEMINIST OPPOSITION TO POPULATION CONTROL

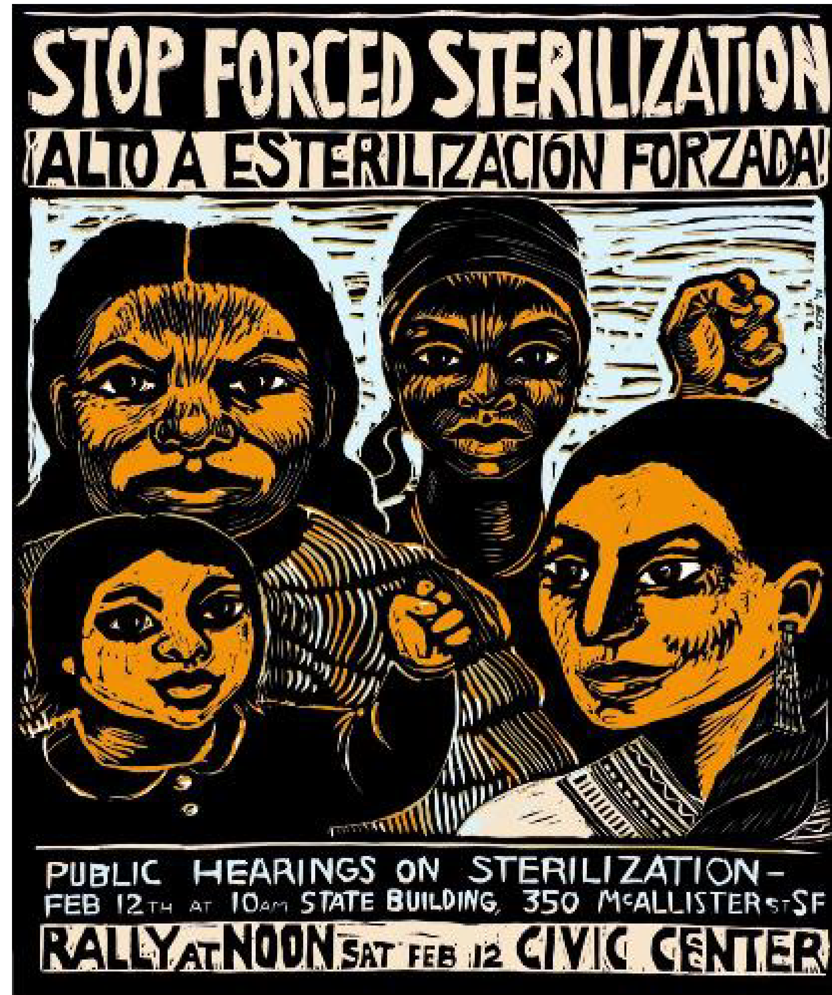


Image credit: Rachael Romero

Most common FP indicators:

- Total fertility rate
- Modern contraceptive prevalence
- Unmet need for contraception
- Proportion of nee
- protection
- Contraceptive discontinuation rate

Health? Rights? Access? Equity?

REPORT

Developing the "120 by 20" Goal for the Global FP2020 Initiative

Win Brown, Nel Druce, Julia Bunting, Scott Radloff, Desmond Koroma, Srishti Gupta, Brian Siems, Monica Kerrigan, Dan Kress, and Gary L. Darmstadt

(Studies in Family Planning 2014; 45[1]: 73–84)

This report describes the purpose for developing a quantitative goal for the London Summit on Family Planning held in July 2012, the methodology behind its formulation, and the lessons learned in the process. The London Summit has evolved into the global initiative known as FP2020, and the goal has become "120 by 20," or reaching 120 million additional users of modern contraceptive methods by 2020 in the world's poorest countries. The success of FP2020 will first be evaluated on the basis of quantitative verification to determine that the "120 by 20" goal was reached. More important, however, is the extent to which the goal today serves as a global rallying cry to mobilize resources and leadership around current family planning programs, with a focus on voluntary fam-

Unmet need calculation rests on untenable assumptions about fertility desires and contraceptive need

SELECT SOCIODEMOGRAPHIC CHARACTERISTICS

	Ouagadougou n=851		Nouna n=1,566		Overall n=2,417	
	median	[IQR]	median	[IQR]	median	[IQR]
Age	28	[20, 37]	25	[18, 35]	26	[19, 36]
	n	%	n	%	n	%
Married	515	61	938	60	1,452	60
Education						
None	324	38	872	56	1,196	49
At least some primary school	198	23	354	23	552	23
At least some secondary school	300	35	339	22	639	26
Missing	29	3	1	0	30	1
Primary mode of transport						
Foot or other	70	8	392	25	462	19
Bicycle	121	14	1,081	69	1,202	50
Motorcycle	582	68	93	6	675	28
Car	78	9	0	0	78	3
Unmet need (conventional)	278	33	572	37	850	35

PRIMARY REASONS FOR NONUSE OF FAMILY PLANNING AMONG CONTRACEPTIVE NONUSERS, BY UNMET NEED STATUS

	No unmet need n=1,567		Unmet need n=850		Overall n=2,417		p-value
	n	%	*n*	%	*n*	%	
Does not want to use family planning	873	55.7	469	55.2	1,342	55.5	0.8
Is currently pregnant	21	1.3	76	8.9	97	4.0	<0.01
Provider refused	1	0.0	6	0.7	7	0.3	<0.01
Partner or family member will not allow	37	2.4	66	7.8	103	4.3	<0.01
Does not know where to get family planning	2	0.1	0	0.0	2	0.1	0.5
Cannot afford family planning	8	0.5	28	3.3	36	1.5	<0.01
Does not think they are fertile	89	5.7	57	6.7	146	6.0	0.3
Cannot get to the clinic	1	0.0	3	0.4	4	0.2	0.1
Not sexually active	422	26.9	23	2.7	445	18.4	<0.01
Health reason for nonuse	20	1.3	12	1.4	32	1.3	0.8
Not married	19	1.2	7	0.8	26	1.1	0.4
Afraid of side effects	24	1.5	39	4.6	63	2.6	<0.01
Does not have enough information	8	0.5	11	1.3	19	0.8	0.04
Other	42	2.7	53	6.2	95	3.9	<0.01

DIMENSIONS OF A BROAD CONTRACEPTIVE METHOD MIX

	Duration	Presence of Hormones	Coital Dependence	Provider Dependence	Locus of Control	Immediate Return to Fertility	Tier 1 Effectiveness
Female Sterilization	Permanent	No	No	Yes	Woman		Yes
Male Sterilization	Permanent	No	No	Yes	Man		Yes
IUD (copper)	Long-acting	No	No	Yes	Woman	Yes	Yes
Injectables	Short-acting	Yes	No	Yes	Woman		
Implants	Long-acting	Yes	No	Yes	Woman	Yes	Yes
Pill	Short-acting	Yes	No	No	Woman	Yes	
Condom	Short-acting	No	Yes	No	Man	Yes	
Emergency Contraception	Short-acting	Yes	Yes	No	Woman	Yes	
Diaphragm	Short-acting	No	Yes	No	Woman	Yes	
Cervical Mucus	Short-acting	No	Yes	No	Woman	Yes	
Calendar-Based	Short-acting	No	Yes	No	Woman	Yes	
Lactational Amenorrhea	Short-acting	No	No	No	Woman		
Withdrawal	Short-acting	No	Yes	No	Man	Yes	

Adapted from Festin, Mario Philip R., et al. "Moving towards the goals of FP2020—classifying contraceptives." *Contraception* 94.4 (2016): 289-294.

Contraceptive Attribute Groups

Duration of use	• Long-acting and short-acting
Presence of hormones	• Hormonal and non-hormonal
Coital dependence	• Coitally dependent and independent
Provider dependence	• Provider dependent and independent
Locus of control	• Male controlled and female controlled
Return to fertility	• Immediate return to fertility
Effectiveness	• Tier 1

ENVIRONMENTAL JUSTICE IS

GENDER IDENTITY IS

BUILDING FAMILY ON YOUR OWN TERMS IS

RACIAL JUSTICE IS

ENDING INCARCERATION IS

SUPPORTING TEEN PARENTS IS

FREEDOM FROM VIOLENCE IS

FOOD SECURITY IS

IMMIGRATION JUSTICE IS

ACCESSIBLE ABORTION IS

SUPPORTING BIRTHPARENTS IS

PAID LEAVE IS

DISABILITY JUSTICE IS

QUEER FAMILIES ARE

SAFE COMMUNITIES ARE

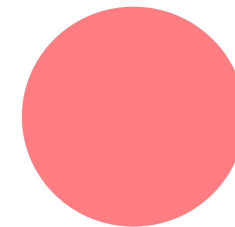
DECOLONIZATION IS

REPRODUCTIVE JUSTICE.

REPEAL HYDE ART PROJECT

Image credit: M. Jay Smith of the Repeal Hyde Art Project

THE CONTRACEPTIVE AUTONOMY STUDY



CONTRACEPTIVE AUTONOMY STUDY

Data collection: July 2017 - July 2018

Exploratory sequential
mixed methods study design

1) Formative qualitative phase

2) Large quantitative household
survey

METHODS

1) Formative qualitative phase

- Semi-structured in-depth interviews with women 15-49 (49)
- Focus group discussions (17)
- Key informant input (3 health administrators)

2) Large household survey

- Pre-testing of survey with cognitive interviews and respondent debrief
- Population-based household survey with women ages 15-49
- n=3929

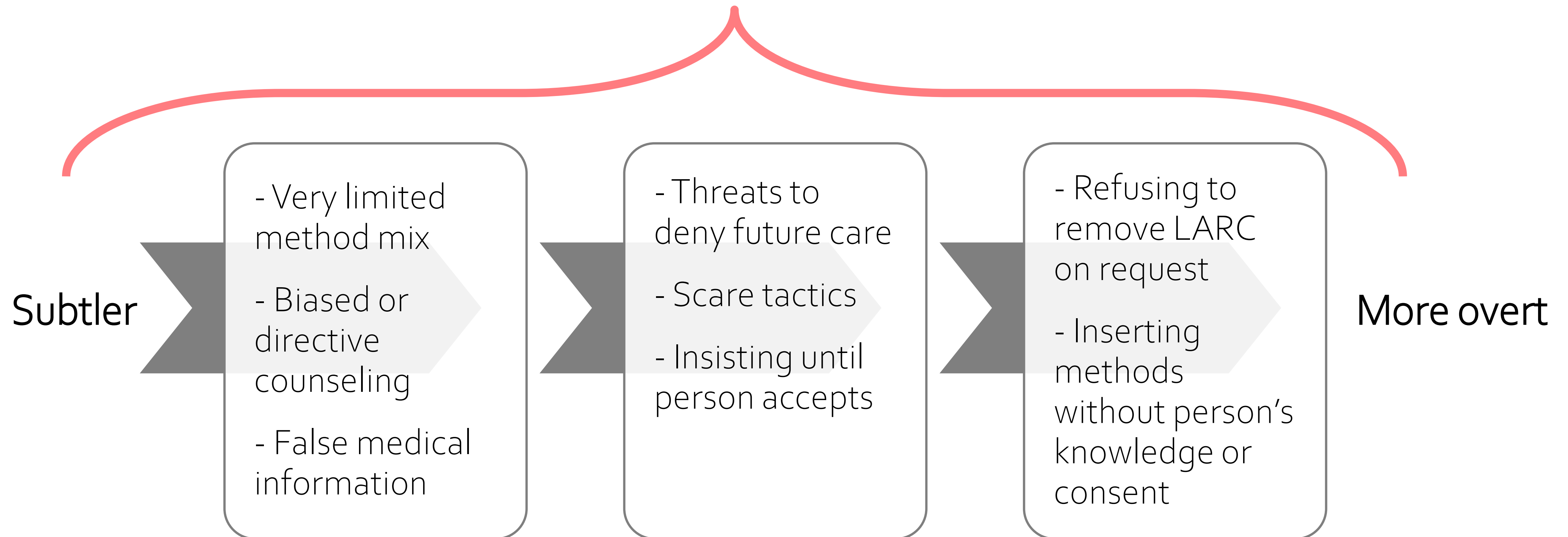
Theory of coercion

1) Sitting on a spectrum

2) Structural

3) Bi-directional

Spectrum of Coercion



SUBTLE COERCION

Maria: Well! The health workers normally counsel you that if you want to choose, you have to choose the "5 years" [the implant]. Now, if that method isn't suitable for you, you can take it out and get the "three months" [injectables], but if you don't like that, you can't take it out. You have to wait for the three months to be over, otherwise you can't remove it.

Interviewer: So, it's the providers who told you?

Maria: It's true that there's counseling and they tell you to choose what you like, but what they think is best, it's only the "5 years" [the implant].

EXAMPLE OF OVERT COERCION

Jessica: When I got pregnant with my 10th [child]… the midwife told me that I have a lot of children and that I would have a difficult delivery…The health workers in [a nearby town] said that I needed to get the implant by force…

I was obligated to accept, and they gave me the implant. The nurse told me that it would be 5 years, and even before the date of the 5th year, I started to feel illnesses due to the implant…

I went to tell the hospital [that I got headaches from the implant], and it's there that the health worker told me that the date to remove it hasn't yet arrived, so he can't remove it…

He refused, he said that it hasn't yet been five years, and there are two months that still remain.

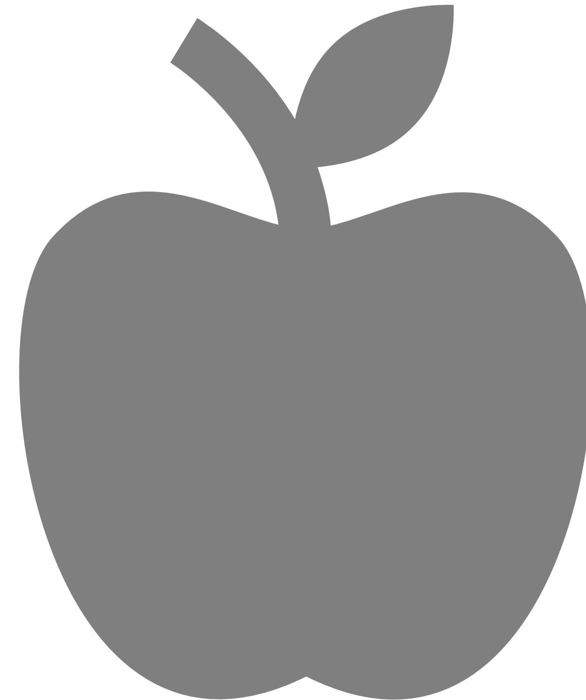
STRUCTURAL COERCION

Administrator 2: At the district level, we also give goals to each [health center] so that they can attain the targets, those that are concerned with all the methods mixed together but above all the long-acting methods that we're really emphasizing.

COERCION IS STRUCTURAL

It is not helpful or accurate to conceptualize coercion as the result of "bad apples"

These outcomes come from a donor-driven system that explicitly promotes, measures and rewards contraceptive uptake



COERCION IS BI-DIRECTIONAL

		Has FP method	
		No	Yes
Wants FP method	No	[No coercion]	Upward coercion
	Yes	Downward coercion	[No coercion]

Theory of coercion

1) Sitting on a spectrum

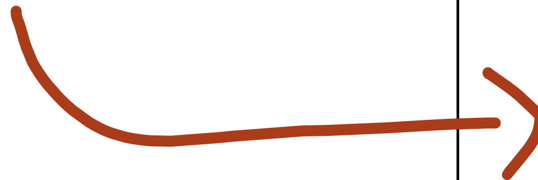
2) Structural

3) Bi-directional

CONCEPTIONS AND MEASUREMENT OF CONTRACEPTIVE AUTONOMY

SUCCESS IN FAMILY PLANNING

FAILURE



Has FP method	
No	Yes
A	B

GOOD

SUCCESS IN FAMILY PLANNING

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

Still bad? Still good?

CONTRACEPTIVE AUTONOMY

The factors that are necessary for a person to decide for themself what they want, and then to realize that decision

		Has FP method	
		No	Yes
Wants FP method	No	A ✓	B ✗
	Yes	C ✗	D ✓

CONTRACEPTIVE AUTONOMY

Informed Choice

A decision based on sufficient, unbiased information about a range of family planning options, including benefits and risks of both use and non-use

Full Choice

A decision made with access to a sufficiently wide range of methods from which to choose

Free Choice

A decision made about whether or not to use contraception and what method to use made voluntarily, without barriers or coercion

Adapted from Newman and Feldman-Jacobs, 2015

CONTRACEPTIVE AUTONOMY

A – Made free, full and informed decision not to use family planning

B – Has a family planning method, but did not make a free, full and informed choice to use it

C – Does not use family planning, but did not make a free, full and informed choice not to use

D – Made a free, full and informed decision to use family planning

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

CONTRACEPTIVE AUTONOMY

A – Made free, full and informed decision not to use family planning

B – Has a family planning method, but did not make a free, full and informed choice to use it

C – Does not use family planning, but did not make a free, full and informed choice not to use

D – Made a free, full and informed decision to use family planning

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

CONTRACEPTIVE AUTONOMY

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D – Made a free, full and informed decision to use family planning

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

CONTRACEPTIVE AUTONOMY

A – Made free, full and informed decision not to use family planning

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C – Does not use family planning, but did not make a free, full and informed choice not to use

D – Made a free, full and informed decision to use family planning

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

CONTRACEPTIVE AUTONOMY SCORE

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

A measure that focuses exclusively on autonomy

Acknowledges that non-use of FP is a perfectly good outcome if the person does not want it and gives programs credit for respecting this choice

Contraceptive autonomy= (A+D)/(A+B+C+D)

AUTONOMY-ADJUSTED CPR

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

Does not distinguish “B” from “D”

Can create perverse incentives to achieve uptake or prevalence targets at the expense of autonomy

Standard CPR= (B+D)/(A+B+C+D)

AUTONOMY-ADJUSTED CPR

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

Autonomy adjustment to CPR

Removed "B" from the numerator

Only autonomous users would "count" towards the CPR

aCPR= D/(A+B+C+D)

LONG-TERM VISION FOR THE AUTONOMY INDICATOR

Integrate final module into existing population-based surveys

- Demographic and Health Survey (Global South)
- National Survey of Family Growth (United States)

Routine/repeated measurement:

- comparison between contexts
- changes over time

CONCLUSION

5

CONCLUSION

- RACIALIZED, GENDERED AND CLASSED LOGICS OF FAMILY PLANNING PROGRAMS
- END TO THE INSTRUMENTALIZATION OF REPRODUCTIVE CAPACITIES
- NEW MODES OF MEASUREMENT AND RESEARCH AGENDAS NEEDED

FUNDING

- The David and Lucile Packard Foundation (2016-64774)
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- The University of Wisconsin Prevention Research Center
- The Eunice Kennedy Shriver National Institute of Child Health & Human Development
  - Ruth L. Kirschstein National Research Service Award (T32HD049302)
  - Population Research Infrastructure grant (P2C HD047873)

The content is solely the responsibility of the authors and does not necessarily represent the official views of the Eunice Kennedy National Institute of Child Health and Human Development or the National Institutes of Health.

GHSP GLOBAL HEALTH: SCIENCE AND PRACTICE
Dedicated to what works in global health programs
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COMMENTARY

Investing in Family Planning: Key to Achieving the Sustainable Development Goals

Ellen Starbird,[a] Maureen Norton,[a] Rachel Marcus[a]

BOX. The Central Role of Family Planning in Achieving the Sustainable Development Goals Across the 5 Themes of People, Planet, Prosperity, Peace, and Partnership

PEOPLE

- Family planning advances human rights.
- Family planning helps reduce poverty.
- Family planning contributes to improved nutrition outcomes.
- Family planning saves lives.
- Family planning prevents HIV/AIDS transmission.
- Family planning supports women's and girls' education.
- Family planning advances gender equality and empowerment.

PLANET

- Family planning mitigates population growth's effects on access to water and sanitation.
- Integrated population, health, and environment projects can expand access to clean and renewable energy.
- Family planning contributes to building resilient infrastructures.
- Family planning contributes to building safe, resilient, sustainable cities.
- Family planning helps reduce population effects on food and chemical waste.
- Family planning helps address the challenges of climate change.
- Family planning helps to protect declining marine resources.
- Family planning helps mitigate the effects of deforestation and unhealthy interaction among humans, domestic animals, and wildlife.

PROSPERITY

- Family planning contributes to economic growth.

PEACE

- Family planning promotes inclusive societies by addressing the needs of disadvantaged populations.
- Family planning contributes to peace and stability.

PARTNERSHIP

- Family planning partnerships can support the achievement of the SDGs.

Informed Choice	Full Choice	Free Choice
Knows how to use a method from each group#	A method from each group# is available to them	Made the choice to use/not use family planning voluntarily
Knows a benefit/ advantage of non-use of family planning	A method from each group# is affordable to them	Was not offered incentives to use/not use method
Knows a risk/ disadvantage of non-use of family planning	Could get the method removed if they wanted**	Felt that they were able to refuse method*
Knows a benefit/ advantage of their method*	Could afford to get the method removed if they wanted**	Is not using the method against their will*
Knows a risk/ disadvantage of their method*		Has not met provider refusal to discontinuation**
Knows what to do in case of side-effects*		
Was told about method removal / permanence** ^		

* Current method user **Current LARC user ^Permanent method user

CONTRACEPTIVE AUTONOMY SCORE

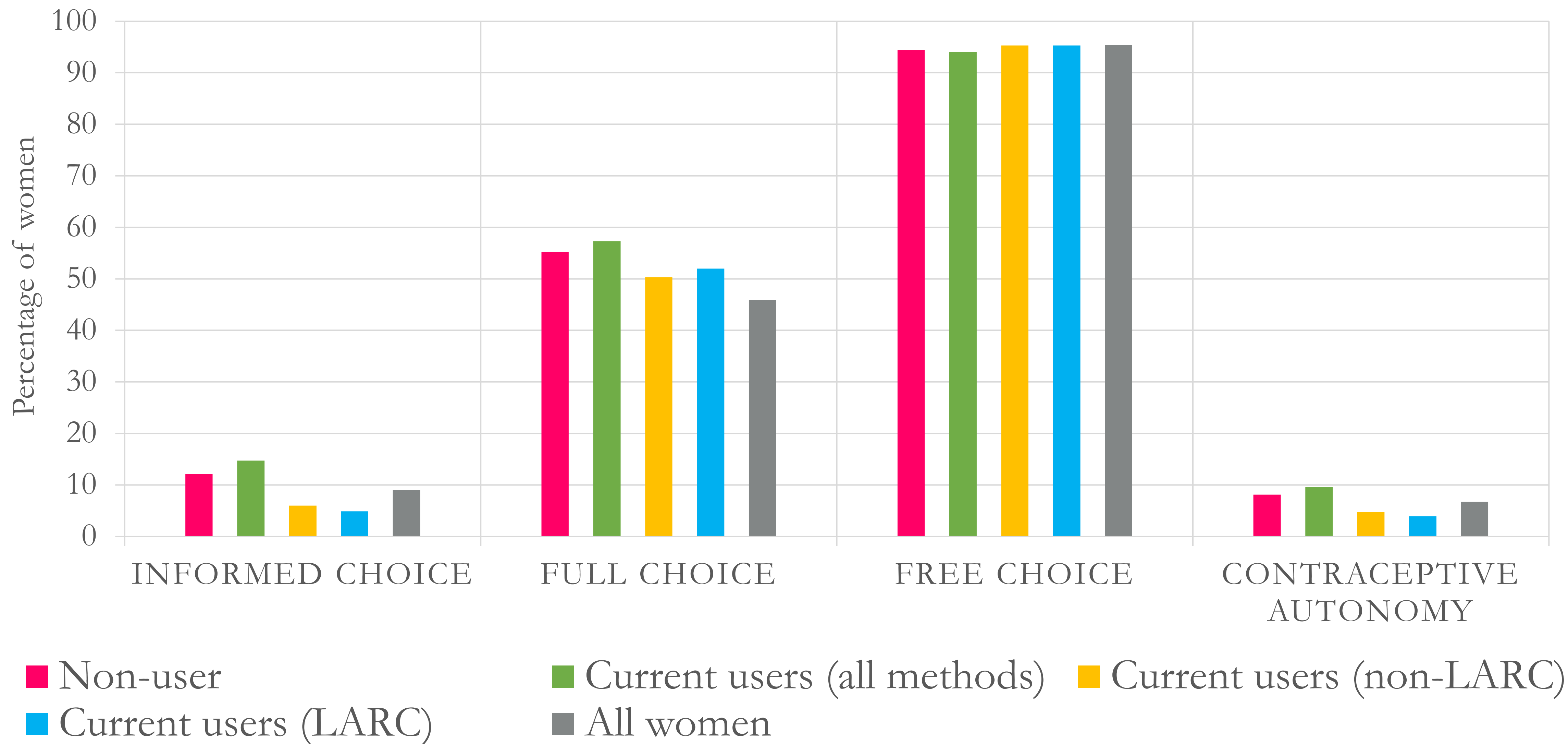
All or nothing :

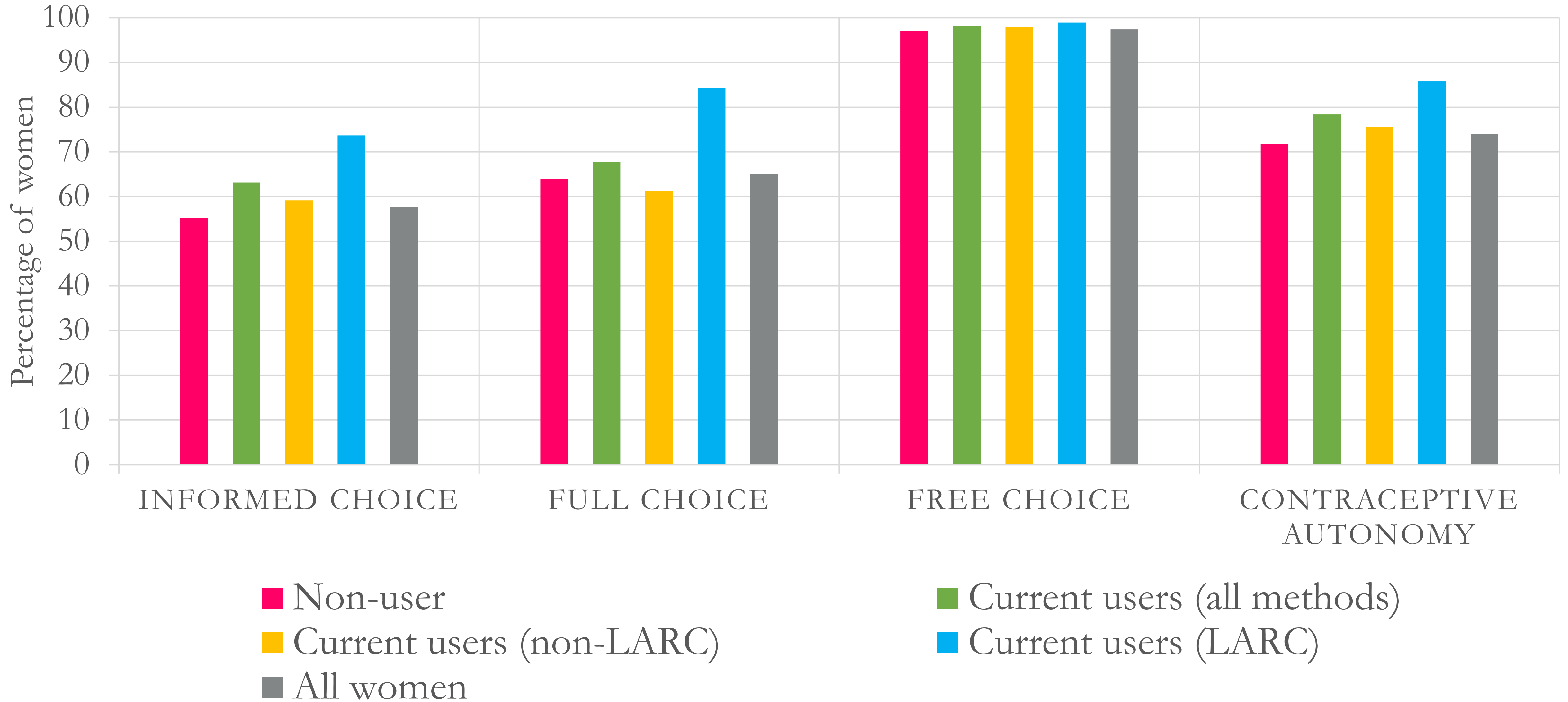
$$Autonomy\ score_j = \prod i_{ij}$$

Shades of gray:

$$Autonomy\ \ score_j = \frac{\sum_{i=1}^{n} (i_{ij})}{n}$$

where i_{ij} is the answer (0 for no, 1 for yes) the jth women gave to survey item i


CONTRACEPTIVE AUTONOMY BY CONTRACEPTIVE STATUS,
ALL OR NOTHING APPROACH
Percentage of women
100
90
80
70
60
50
40
30
20
10
0
INFORMED CHOICE
FULL CHOICE
FREE CHOICE
CONTRACEPTIVE AUTONOMY
Non-user
Current users (all methods)
Current users (non-LARC)
Current users (LARC)
All women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SHADES OF GRAY APPROACH
Percentage of women
100
90
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10
0
INFORMED CHOICE
FULL CHOICE
FREE CHOICE
CONTRACEPTIVE AUTONOMY
Non-user
Current users (all methods)
Current users (non-LARC)
Current users (LARC)
All women

NEW CONCEPTION OF UNMET NEED

		Has FP method	
		No	Yes
Wants FP method	No	A	B
	Yes	C	D

Radically revise the unmet need indicator to represent non-autonomous nonuse of contraception

Unmet need= C/(A+B+C+D)

LINGERING MEASUREMENT CHALLENGES

4

HOW TO MEASURE FREE CHOICE?

CONTRACEPTIVE AUTONOMY SCORES

Latent variable modeling approaches

- Multidimensional item response theory (MIRT)
- Multiple indicator multiple cause (MIMIC) models
- Formative vs. reflective indicator construction

CENTRAL QUESTIONS

WHAT PROPORTION OF UNMET NEED IS DUE TO LACK OF ACCESS TO VS. LACK OF DEMAND FOR CONTRACEPTION?

IS UNMET NEED A VALID PROXY MEASURE FOR LACK OF ACCESS TO CONTRACEPTION?

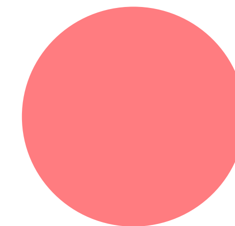
Study #1

DHS data from seven African countries

Study #2

Data from our dedicated survey in Burkina Faso

EXPLORING UNMET NEED USING DHS DATA



UNMET NEED COMES FROM BOTH A LACK OF ACCESS AND A LACK OF DEMAND

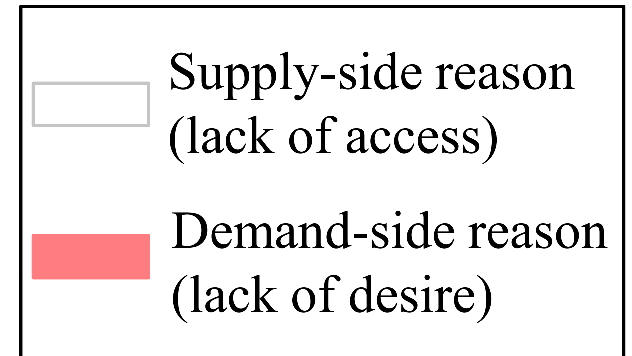
Women with inadequate access to contraception → Supply-side unmet need

Women who do not want contraception → Demand-side unmet need

Unmet need for contraception

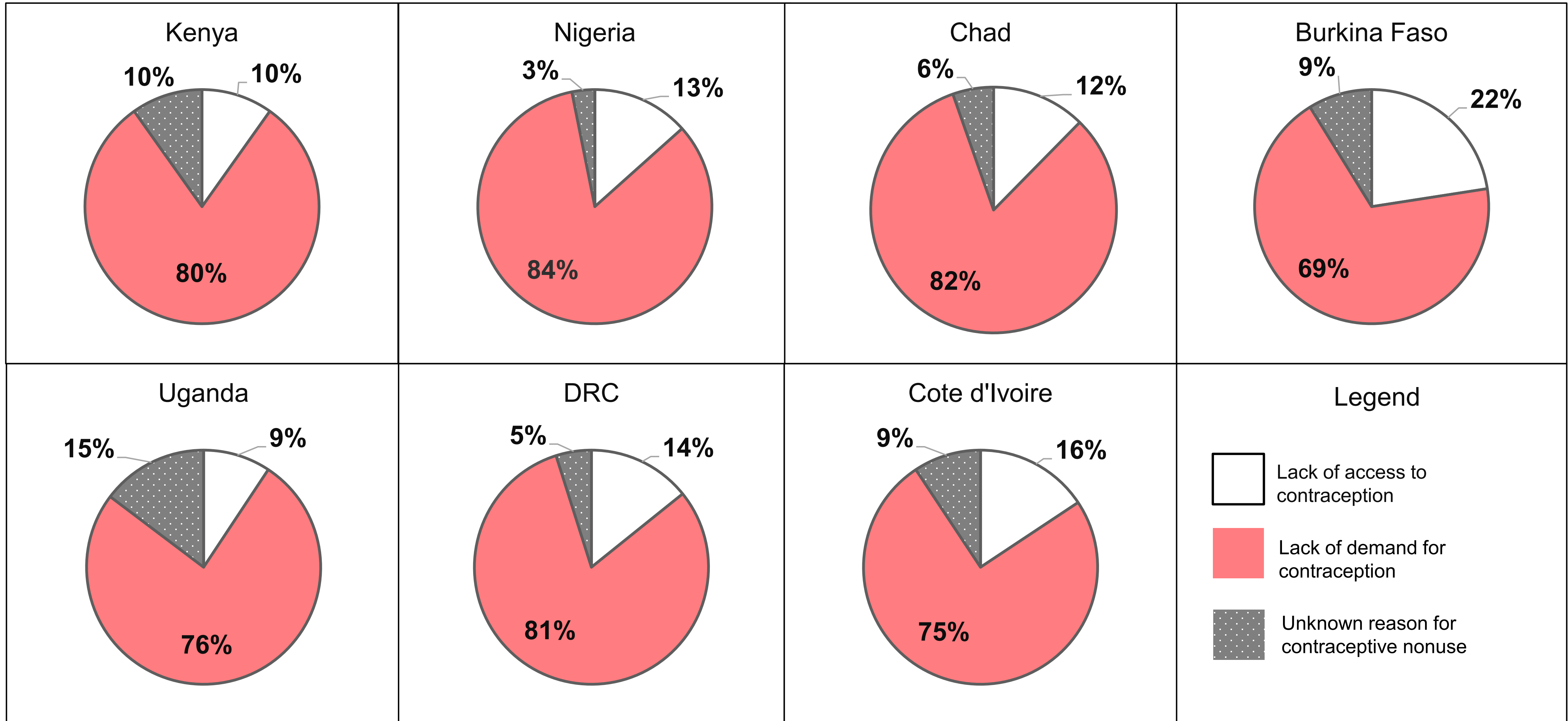
Reasons for contraceptive nonuse attributed to supply-side or demand-side unmet need, by version

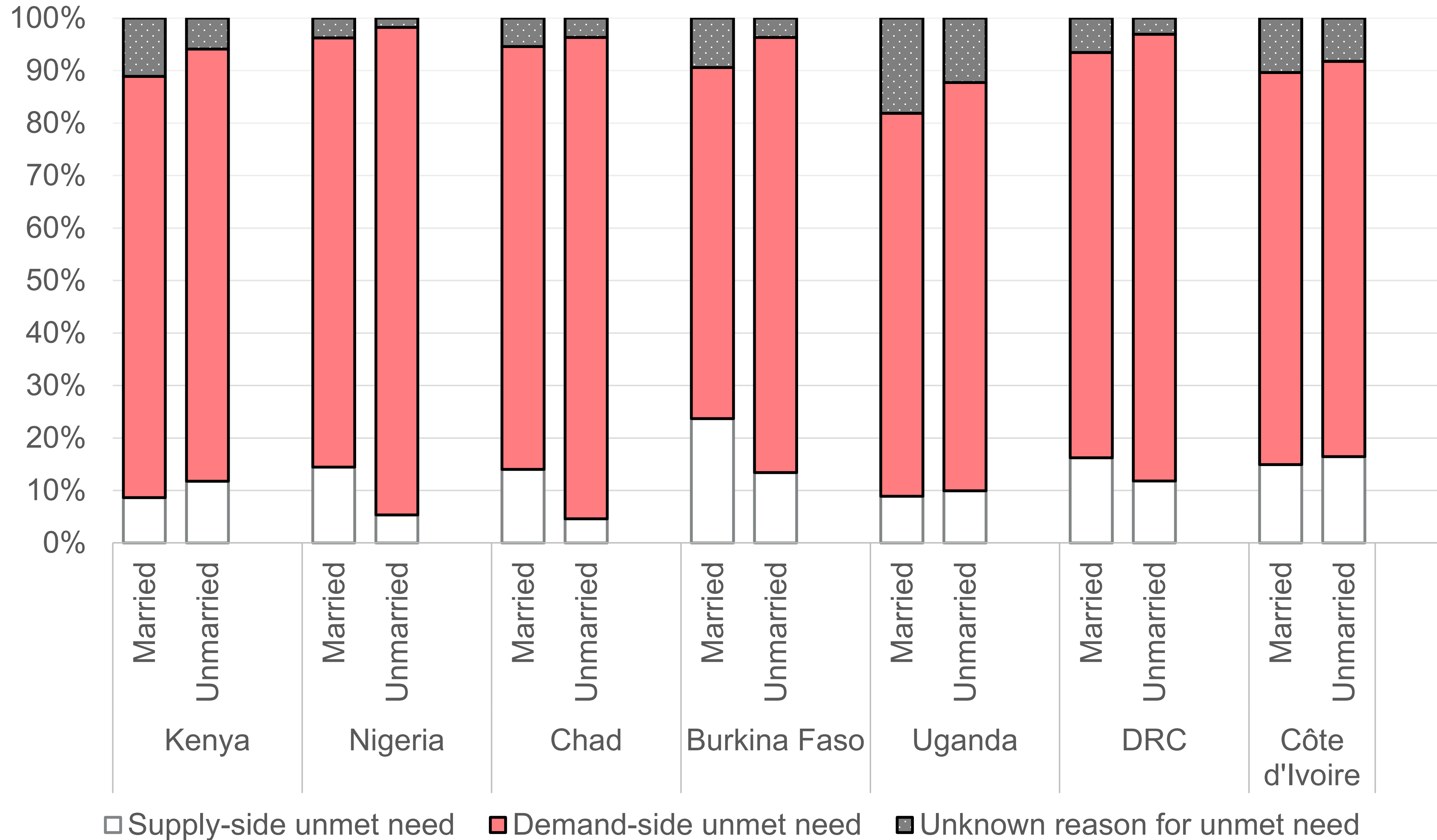
Reason for Contraceptive Nonuse	Strict	Moderate	Broad
Knows no method			
Knows no source			
Lack of access/too far			
Costs too much			
Preferred method not available			
No method available			
Religious prohibition			
Not married			
Husband opposed			
Others opposed			
Inconvenient to use			
Fear of side effects/health concerns			
Interferes with body’s normal processes			
Not having sex			
Infrequent sex			
Up to God/fatalistic			
Respondent opposed			
Breastfeeding			

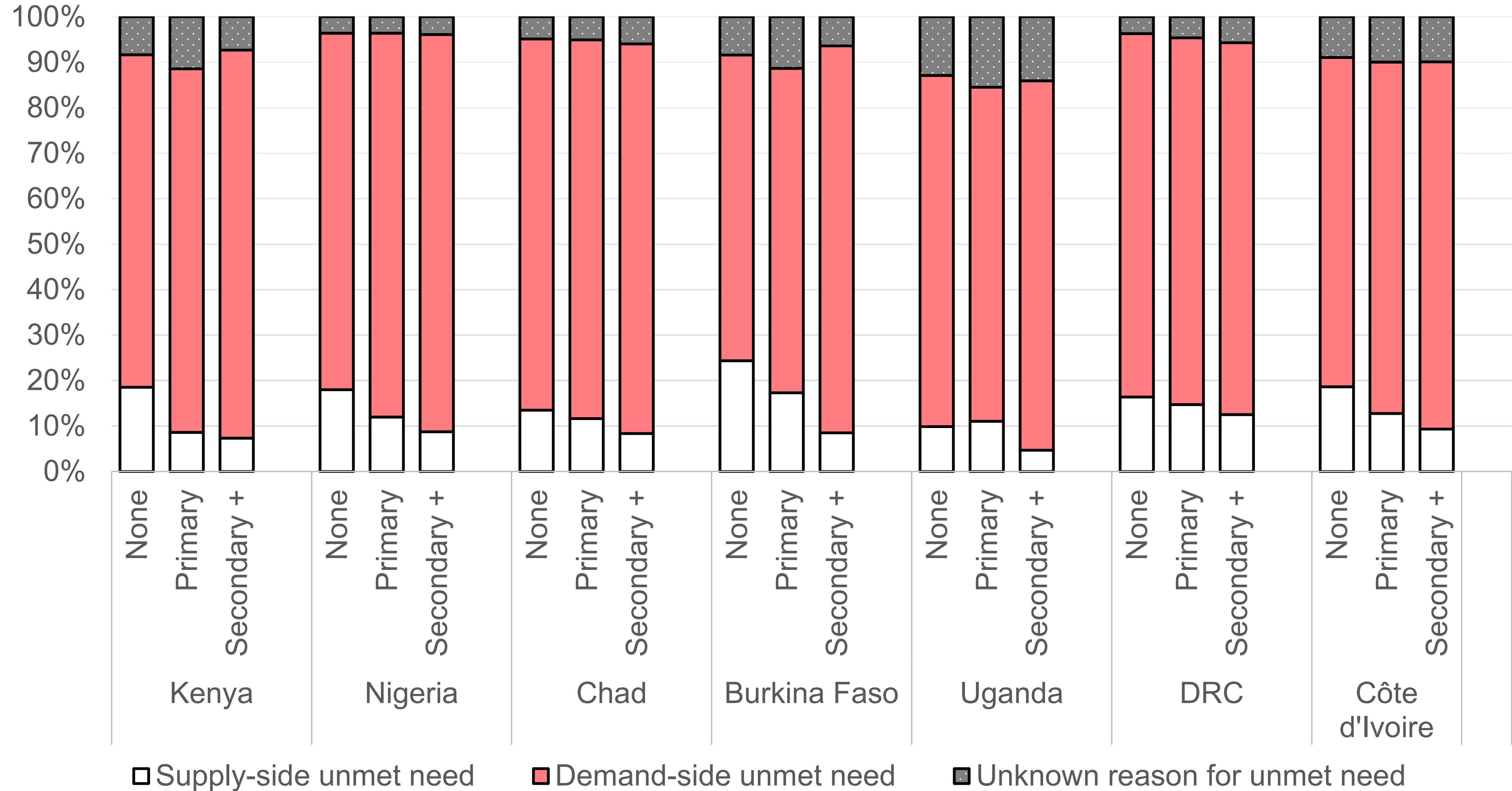


	Kenya, 2014	Nigeria, 2013	Chad, 2014-15	Burkina Faso, 2010	Uganda, 2016	DRC, 2012-14	Cote d'Ivoire 2011-12	7-country average
Total Unmet Need	6.0%	12.7%	18.6%	20.4%	20.4%	22.5%	23.5%	17.7%
Unknown reason for unmet need	0.6%	0.4%	1.0%	1.8%	3.0%	1.1%	2.2%	1.4%
Version 1- Strict conception of access								
Supply-side unmet need	0.1%	0.8%	1.2%	2.4%	0.3%	1.9%	2.2%	1.3%
Demand-side unmet need	5.3%	11.5%	16.4%	16.3%	17.1%	19.5%	19.2%	15.0%
Version 2- Moderate conception of access								
Supply-side unmet need	0.6%	1.7%	2.3%	4.6%	1.9%	3.2%	3.7%	2.6%
Demand-side unmet need	4.9%	10.6%	15.3%	14.0%	15.5%	18.2%	17.7%	13.7%
Version 3- Broad conception of access								
Supply-side unmet need	2.1%	2.9%	3.0%	6.8%	4.8%	4.8%	7.0%	4.5%
Demand-side unmet need	3.4%	9.4%	14.6%	11.8%	12.7%	16.5%	14.4%	11.8%

Proportion of unmet need by type (Version 2– Moderate)




Proportion of unmet need by type and marital status (Moderate)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Married
Unmarried
Kenya
Nigeria
Chad
Burkina Faso
Uganda
DRC
Côte d'Ivoire
Supply-side unmet need
Demand-side unmet need
Unknown reason for unmet need



Proportion of unmet need by type and educational attainment (Moderate)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
None
Primary
Secondary +
Kenya
Nigeria
Chad
Burkina Faso
Uganda
DRC
Côte d'Ivoire
Supply-side unmet need
Demand-side unmet need
Unknown reason for unmet need

CENTRAL QUESTION

WHAT PROPORTION OF UNMET NEED IS DUE TO LACK OF ACCESS TO CONTRACEPTION?

Not very much