CONTRACEPTIVE AUTONOMY:

CONCEPTION AND MEASUREMENT OF A NOVEL FAMILY PLANNING INDICATOR

Leigh Senderowicz, MPH

Introduction

In the prevailing global health discourse, family planning is portrayed as an unambiguous good: a cost-effective intervention that can yield improvements in everything from HIV/AIDS to sanitation to marine resources, with virtually no downside[1,2]. Arguments for the widespread promotion of family planning include benefits to the health of the user herself[3,4] and her offspring[4,5], micro and macroeconomic gains[6,7], environmental advantages[8,9], as well as improvements to women's rights and empowerment[10,11]. Given these myriad benefits and few stated drawbacks, the family planning community has promoted contraception as something of a panacea to the multi-dimensional challenges of poverty, climate change, and women's subjugation. For family planning advocates, practitioners, providers, and researchers, then, the main challenge has been to reduce the barriers to care, and to encourage as many women as possible to take up an effective method. In addition to all of the good that family planning can do, however, it is worth remembering that fertility control can be deployed toward harmful ends, too. Rather than being an emancipatory project for all women since its inception, family planning has been intertwined with a range of efforts to limit population and to decide what kind of people should see their fertility restricted, from Eugenics to population control[12–17].

The 1994 International Conference on Population and Development in Cairo was the well-known reckoning, where feminists and women from around the world organized and demanded an end to target-driven and coercive family planning programs geared towards population control. In their place, the Cairo Programme of Action calls for a broad understanding of sexual and reproductive health that emphasizes the four pillars of health, rights, access and quality within family planning programs[18]. In many ways, however, the post-Cairo shift has been much more successful rhetorically than substantively. While the language we use to talk about family

planning has changed dramatically in the years since ICPD, changes to how we conceptualize, implement and evaluate family planning programs have been far less complete. The field has fully embraced ICPD's language of rights and empowerment to promote contraceptive programs, but it is harder to change systems than it is to change language. Many of the structures, institutions and other systemic legacies of the population control movement have been only partially dismantled. It is important to emphasize that this is not due to ill intent, but rather because the ways that systems and structures perpetuate ideology can often be invisible and very difficult to change.

The continued preoccupation with fertility reduction and contraceptive uptake in global family planning is evident tin the types of targets and measurements the field is using. Family Planning 2020 set a worldwide goal of 120 million new users of modern contraception in the eight years between its 2012 founding and its end date in the year 2020[19]. Smaller, regional goals have since also been set, like within the Ouagadougou Partnership, which set a goal of 2.2 million new users within its nine francophone West African member countries[20]. Concerns that "uncontrolled population growth will hinder the attainment of development"[21] and that "[P]opulation growth at the pace found in high-fertility African countries…undermines any plausible strategy to lift people out of poverty through economic development"[9] abound in the family planning literature.

A key difference between these arguments and their predecessors from the population control era is that these contemporary arguments are careful to assert that the goals of fertility reduction be pursued only through voluntary, rights-based approaches to family planning[22]. The FP2020 target of "120 in 20," for example, is proposed only "in the context of voluntary family planning and quality of care"[19]. Indeed, the contemporary family planning movement has devoted an

admirable amount of attention to the question of quality, from Judith Bruce's famous 1990 framework on quality of care, to more recent frameworks explicitly for the provision of voluntary, rights-based family planning[23,24]. Tellingly, however, many of the arguments for improving quality of care conclude that improved quality leads to increases in contraceptive uptake and fertility reduction, which still remain the ultimate goals of even an idealized, high-quality family planning program[25–27].

The Role of Measurement

One of the key mechanisms through which the intellectual history of population control still asserts itself on our contemporary approach to family planning is through measurement. Though there are countless approaches to measuring family planning, with novel measures being almost continuously introduced, the most widely measured indicators in global family planning are: 1) the total fertility rate (TFR); 2) the contraceptive prevalence rate (CPR); and 3) unmet need for contraception (unmet need). These three measures are population-based, and thus are ascertained from population-based, nationally representative surveys such as the Demographic and Health Surveys (DHS). These indicators have the advantage of being routinely measured without the need for a dedicated study to be mounted. In the absence of more in-depth information, we routinely summarize TFR, CPR and unmet need in a given setting to paint a picture of the overall family planning context. And yet, none of these indicators (nor any other population-based indicators for family planning) is a measure of health, quality, access, or rights. In fact, most (if not all) of the commonly measured indicators were created to monitor and promote fertility reduction during the population control era, and have been little changed in the intervening decades.

Even many of our novel indicators tend to be tweaks to and reformulations of these concepts, rather than radical reconceptualizations[28,29]. This is seldom, but sometimes, acknowledged in the family planning literature. For example, a recent reported from the Guttmacher Institute called for the creation of "[a]n indicator reflective of respectful care and human rights in provision of SRH information and services" but called such an indicator "aspirational," while the FP2020 team called this type of measurement part of an "unfinished agenda"[19,30].

This paper proposes a conceptual grounding and measurement strategy for a novel population-based indicator of contraceptive autonomy, that operationalizes a patient-centered approach to family planning outcomes. Dividing contraceptive autonomy into the subdomains of free choice, full choice and informed choice[11], this paper discusses some of the challenges and opportunities in this new approach to contraceptive measurement.

The lack of a women-centered population-based indicator for family planning is not just an academic question, of concern to researchers alone. Rather, these types of indicators have taken on an increasingly important role in priority setting and program evaluation in global health, and can be critically important to which types of programs get funded, renewed and promoted. . With measurement such an important part of priority setting, only by defining autonomy and continually monitoring it, can we affirm the values of rights-based and patient-centered care in our family planning programs.

Works Cited

1. Starbird E, Norton M, Marcus R. Investing in Family Planning: Key to Achieving the Sustainable Development Goals. *Glob Heal Sci Pract*. 2016;4(2):191-210. doi:10.9745/GHSP-D-15-00374
2. Cleland K, Peipert JF, Westhoff C, Spear S, Trussell J. Family Planning as a Cost-Saving Preventive Health Service. *N Engl J Med*. 2011;364(18):e37. doi:10.1056/NEJMp1104373
3. Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. *Lancet*. 2012;380(9837):111-125. doi:10.1016/S0140-6736(12)60478-4
4. Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. *Lancet*. 2012;380(9837):149-156. doi:10.1016/S0140-6736(12)60609-6
5. World Health Organization. *Report of a Technical Consultation on Birth Spacing*. Geneva; 2005. http://www.who.int/maternal_child_adolescent/documents/birth_spacing05/en/.
6. Schultz T. *The Fertility Transition: Economic Explanations*. New Haven; 2001. https://www.econstor.eu/bitstream/10419/98308/1/cdp833.pdf.
7. Bloom D, Canning D, Sevilla J. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change*. Rand Corporation; 2003. https://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1274.pdf. Accessed August 7, 2014.
8. Guillebaud J, Hayes P. Population growth and climate change. *BMJ*. 2008;337:a576. http://www.ncbi.nlm.nih.gov/pubmed/18653639. Accessed July 26, 2015.
9. Potts M, Gidi V, Campbell M, Zureick S. Niger: Too Little, Too Late. *Int Perspect Sex Reprod Health*. 2011;37(2).
10. Crissman HP, Adanu RM, Harlow SD. Women's sexual empowerment and contraceptive use in Ghana. *Stud Fam Plann*. 2012;43(3):201-212. http://www.ncbi.nlm.nih.gov/pubmed/23185863. Accessed December 22, 2013.
11. Newman K, Feldman-Jacobs C. *Family Planning and Humand Rights: What's the Connection and Why Is It so Important?*; 2015. http://www.prb.org/pdf15/family-planning-rights-brief.pdf. Accessed August 9, 2016.
12. Bashford A, Levine P. *The Oxford Handbook of the History of Eugenics*. Oxford: Oxford University Press; 2010.
13. Ziegler M. Eugenic feminism: mental hygiene, the women's movement, and the campaign for eugenic legal reform, 1900-1935. *Harvard J Law Gend*. 2008;31:211.
14. Rao M. *From Population Control To Reproductive Health: Malthusian Arithmetic*. SAGE Publications; 2004. https://books.google.com/books?id=lMqGAwAAQBAJ&pgis=1. Accessed December 11, 2014.

15. Berelson B, Lieberson J. Government Efforts to Influence Fertility: The Ethical Issues. *Popul Dev Rev*. 1979;5(4):581. doi:10.2307/1971973

16. Christiansen D. Ethics and compulsory population control. *Hastings Cent Rep*. 1977;7(1):30-33. http://www.ncbi.nlm.nih.gov/pubmed/845014. Accessed August 18, 2018.

17. Lipworth L, Katsouyanni K, Ekbom A, Michels KB, Trichopoulos D. Abortion and the risk of breast cancer: a case-control study in Greece. *Int J Cancer*. 1995;61(2):181-184. http://www.ncbi.nlm.nih.gov/pubmed/7705945. Accessed August 5, 2014.

18. UNFPA. *ICPD Programme of Action*. Cairo; 1994. http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web ENGLISH.pdf. Accessed August 9, 2016.

19. Brown W, Druce N, Bunting J, et al. Developing the "120 by 20" goal for the Global FP2020 Initiative. *Stud Fam Plann*. 2014;45(1):73-84. doi:10.1111/j.1728-4465.2014.00377.x

20. Partenariat de Ouagadougou. Qu'est-ce que le Partenariat de Ouagadougou? https://partenariatouaga.org/a-propos/le-partenariat/. Published 2016.

21. Cleland JG, Ndugwa RP, Zulu EM. Family planning in sub-Saharan Africa: progress or stagnation? *Bull World Health Organ*. 2011;89(2):137-143. doi:10.2471/BLT.10.077925

22. Hardee K, Harris S, Rodriguez M, et al. Achieving the Goal of the London Summit on Family Planning By Adhering to Voluntary, Rights-Based Family Planning: What Can We Learn from Past Experiences with Coercion? *Int Perspect Sex Reprod Health*. 2014;40(6):Pages 206-214.

23. Bruce J. Fundamental Elements of the Quality of Care: A Simple Framework. *Stud Fam Plann*. 1990;21(2):61-91. doi:10.2307/1966669

24. Hardee K, Kumar J, Newman K, et al. Voluntary, human rights-based family planning: a conceptual framework. *Stud Fam Plann*. 2014;45(1):1-18. doi:10.1111/j.1728-4465.2014.00373.x

25. Reichenbach L, Hardee K, Harris S. Measuring and monitoring quality of care in family planning: are we ignoring negative experiences? *Open Access J Contracept*. 2016;Volume 7:97. doi:10.2147/OAJC.S101281

26. Tumlinson K, Pence BW, Curtis SL, Marshall SW, Speizer IS. Quality of Care and Contraceptive Use in Urban Kenya. *Int Perspect Sex Reprod Health*. 2015;41(2):69. doi:10.1363/4106915

27. Singh S, García SG, Guillaume A, et al. Outcome of an intervention to improve the quality of private sector provision of postabortion care in northern Nigeria. *Int J Gynaecol Obstet*. 2012;118:S121-6. doi:10.1016/S0020-7292(12)60010-1

28. Fabic MS, Becker S. Measuring contraceptive prevalence among women who are at risk of pregnancy. *Contraception*. 2017;96(3):183-188. doi:10.1016/j.contraception.2017.06.007

29. Cahill N, Sonneveldt E, Stover J, et al. Modern contraceptive use, unmet need, and demand satisfied among women of reproductive age who are married or in a union in the focus countries of the Family Planning 2020 initiative: a systematic analysis using the Family Planning Estimation Tool. *Lancet*. 2018;391(10123):870-882. doi:10.1016/S0140-6736(17)33104-5

30. Barot S, S C, Darroch J, et al. *Sexual and Reproductive Health and Rights Indicators for the SDGs*.; 2015. https://www.guttmacher.org/pubs/SRHR-Indicators-Post-2015-Recommendations.pdf.