

## REPORT

# Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator

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*Since the 1994 International Conference on Population and Development, there has been increased attention to high-quality and rights-based family planning, but these concepts have been difficult to measure. Perhaps due to an intellectual history intertwined with population control, contemporary family planning programs and researchers often use (modern) method use as a primary marker of success, with indicators focusing narrowly on contraceptive use and fertility. This results in a fundamental misalignment between existing metrics and the stated family planning goals of promoting reproductive health and rights. This report describes the rationale for a novel family planning indicator called “contraceptive autonomy” and proposes a methodology for measuring this concept at the population level. Defining contraceptive autonomy as the factors necessary for a person to decide for themselves what they want in relation to contraception and then to realize that decision, this indicator divides the contraceptive autonomy construct into subdomains of informed choice, full choice, and free choice. By acknowledging that autonomous nonuse is a positive outcome, aiming to maximize contraceptive autonomy rather than use could help shift incentives for family planning programs and reduce some common forms of contraceptive coercion, as our measurement approach is realigned with our focus on high-quality rights-based care.*

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## INTRODUCTION

**I**n the prevailing global health discourse, family planning is portrayed as an unambiguous good: a cost-effective intervention that can yield improvements in everything from

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HIV/AIDS to sanitation to marine resources, with virtually no downside (Starbird, Norton, and Marcus 2016; K. Cleland et al. 2011; Burkman and Sonnenberg 2000; Tsui, McDonald-Mosley, and Burke 2010). Arguments for the widespread promotion of family planning include benefits to the health of the user themselves (Ahmed et al. 2012; J. Cleland et al. 2012) and their offspring (J. Cleland et al. 2012; World Health Organization 2005), micro and macroeconomic gains (Schultz 2001; Bloom, Canning, and Sevilla 2003), environmental advantages (Guillebaud and Hayes 2008; Potts et al. 2011), as well as improvements to women's rights and empowerment (Crissman, Adanu, and Harlow 2012; Newman and Feldman-Jacobs 2015). Given these myriad benefits and few stated drawbacks, the family planning community has promoted contraception as something of a panacea to the multidimensional challenges of poverty, climate change, and women's subjugation (Starbird, Norton, and Marcus 2016). 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 people as possible to take up an effective method (Campbell, Sahin-Hodoglugil, and Potts 2006; Choi, Fabric, and Adetunji 2016; Sieverding et al. 2018; Bongaarts and Sinding 2009). In addition to the good that family planning can do, however, it is important to remember that fertility control can be (and has been) deployed toward nefarious ends. Rather than being an emancipatory project for all people 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 (Bashford and Levine 2010; Ziegler 2008; Rao 2004; Berelson and Lieberman 1979; Christiansen 1977; Lipworth et al. 1995).

The 1994 International Conference on Population and Development in Cairo was a well-known reckoning, where feminists and people from around the world organized and demanded an end to target-driven and coercive family planning programs geared toward population control. In their place, the Cairo Programme of Action calls for a broad understanding of sexual and reproductive health that emphasizes the pillars of health, rights, access, and quality within family planning programs (UNFPA 1994). In many ways, however, the post-Cairo shift toward these pillars has been more successful rhetorically than substantively. While the language used to describe family planning has shifted dramatically in the 25 years since ICPD, changes to how we conceptualize, implement, and evaluate family planning programs have been far less complete. The field has fully embraced the ICPD language of rights and empowerment to promote contraceptive programs, but many of the structures, institutions, and other systemic legacies of the population control movement have been only partially dismantled. This is due in large part to the fact that the ways that systems and structures perpetuate ideology can often be invisible and very difficult to change (Sturm 2010; Vaught and Castagno 2008).

The continued focus on fertility reduction and contraceptive uptake in global family planning is evident in the way that success is defined and goals are measured in the field. Family Planning 2020 set a worldwide goal of adding 120 million "additional users of modern methods of contraception" in the eight years between its 2012 founding and its end date in the year 2020 (Brown et al. 2014). More regionally focused numerical goals have also been set, such as the Ouagadougou Partnership, which established a goal of 2.2 million new users within its nine francophone West African member countries by 2020 (Partenariat de Ouagadougou 2016). Concerns that "uncontrolled population growth will hinder the attainment

of development” (Cleland, Ndugwa, and Zulu 2011) 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” (Potts et al. 2011) abound in the contemporary family planning literature.

A key difference between these arguments and their predecessors from the population control era is that these contemporary statements are careful to assert that the goals of fertility reduction be pursued only through voluntary, rights-based approaches to family planning (Hardee, Harris, et al. 2014). The FP2020 target of “120 in 20,” for example, is proposed only “in the context of voluntary family planning and quality of care” (Brown et al. 2014). Indeed, the 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 that explicitly espouse the provision of voluntary, rights-based family planning (Bruce 1990; Hardee, Kumar, et al. 2014). Despite this rhetorical shift, however, many of the arguments for improved quality of care in family planning themselves conclude that improved quality ultimately leads to increased contraceptive uptake and fertility reduction, which remain ultimate programmatic goals (Reichenbach, Hardee, and Harris 2016; Fruhauf et al. 2018).

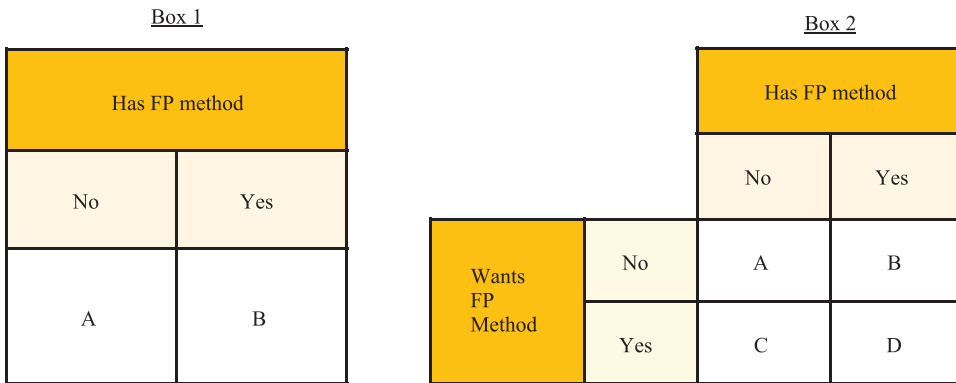
## THE ROLE OF MEASUREMENT

One of the key mechanisms through which the legacy of population control affects our contemporary approach to family planning research is through what we choose to measure and how. Although countless approaches to measuring the success of family planning programs exist and novel measures are being continuously introduced, the most widely measured indicators in global family planning continue to be: (1) the total fertility rate (TFR, a synthetic cohort measure of age-specific fertility rates); (2) the contraceptive prevalence rate (CPR, the proportion of contraceptive users among the population of reproductive aged women); and (3) unmet need for contraception (a proportion of fecund women who wish to delay or limit childbearing but do not use a contraceptive method).

These three population-based indicators have the advantage of being routinely measured within nationally representative surveys such as the Demographic and Health Surveys (DHS) around the world without the need for a dedicated study in any given context. In the absence of more nuanced data, we routinely summarize TFR, CPR, and unmet need to paint a picture of the overall family planning context. And yet, none of these indicators is a measure of health, quality, access, or rights (nor are they consistently measured among the unmarried). In fact, most 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 newly proposed indicators in family planning have tended to reflect tweaks to and reformulations of these concepts, rather than radical reconceptualizations (Fabic and Becker 2017; Cahill et al. 2018), a reality that is seldom, but sometimes, acknowledged in the family planning literature. A report from the Guttmacher Institute called for the creation of “[a]n indicator reflective of respectful care and human rights in provision of SRH

**FIGURE 1** Conceptions of family planning outcomes



[sexual and reproductive health] information and services” but called such an indicator “aspirational,” while the FP2020 team called this type of measurement part of an “unfinished agenda” (Brown et al. 2014; Barot et al. 2015). The lack of a person-centered population-based indicator for family planning is not just a question of academic concern. Rather, in a global health context dependent on quantitative indicators for everything from agenda setting to program evaluation, the absence of an indicator reflective of rights-based family planning can mean that other, more measurable outcomes are prioritized instead. Recent evidence has shown that varying degrees of contraceptive coercion can be found in mainstream global family planning programs as they pursue quantitative uptake targets (Senderowicz 2019).

**CONTRACEPTIVE AUTONOMY: A NEW DEFINITION OF SUCCESS FOR GLOBAL FAMILY PLANNING**

Heretofore, the primary outcome of interest to the family planning community has been contraceptive use (often modern method use), which has traditionally been measured and interpreted in a fairly straightforward way. Generally, a person using a (modern) method is considered a positive outcome, while someone not using a (modern) method is considered a negative outcome. This dichotomous measurement is, for example, the sole basis of CPR calculations, which are then interpreted as either bad (low CPR) or good (high CPR). This dichotomous measure, however, is problematized by the addition of a new criterion—the extent to which a person actually wants a given family planning method, depicted in Figure 1.

Box 1 is a conceptual model of how the field currently defines success in family planning. The left-hand column (cell A, representing nonusers) denotes negative outcomes, and the right-hand column (cell B, representing users) denotes successes. Box 2 adds the dimension of preference to the model, adding a new criterion for whether the respondent is in possession of a family planning method *they desire*. This added complexity effectively renders the current definition of success untenable, since it is now clear that the right-hand column may include both those who wish to use their method (cell D), as well as those using a method who do not wish to (cell B), a family planning failure that can result from adverse experiences such as coercion.

Likewise, the negative outcome in Box 1 (cell A, the contraceptive nonusers) is complicated in Box 2. Rather than viewing contraceptive nonuse as a universally negative outcome, Box 2 breaks this group into nonusers who do not wish to use a method (cell A), and nonusers who do wish to use a method (cell C). With this new dimension, it is now possible to distinguish between the nonusers who would benefit from improved access and programs (cell C), and those who are happy with their status as nonusers of contraception (cell A), which ought to be considered a family planning success.

With this conceptual grounding, the proposed model redefines success in family planning as concordance between what a person wants and what they have, regardless of contraceptive use status. Using Box 2, family planning success is redefined to include those in cells A and D (“contraceptive autonomy”), while those in cells B and C represent where family planning programs have not been successful (“contraceptive nonautonomy”).

## WHAT IS CONTRACEPTIVE AUTONOMY?

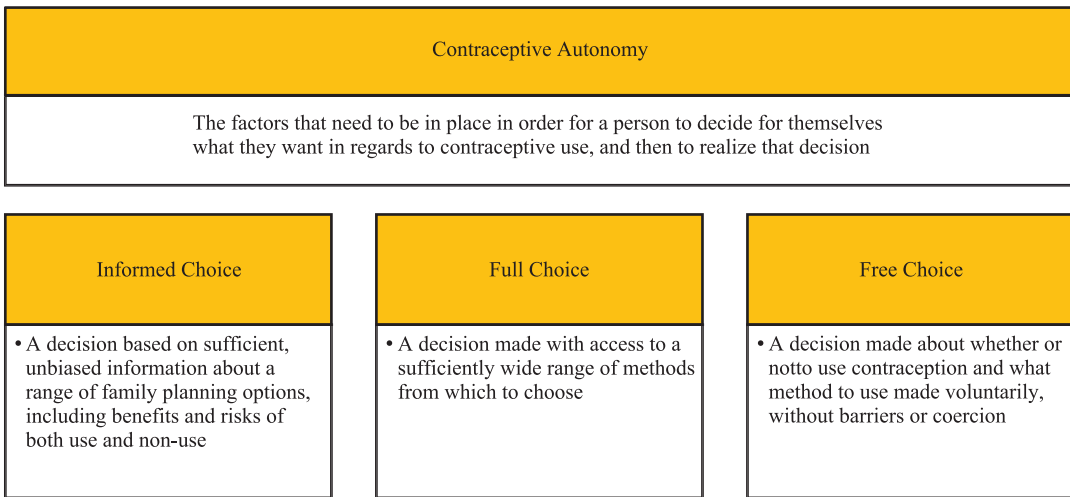
The extent to which a person is free to act of their own volition is one of the oldest questions in philosophy, with scholars from the ancient Greeks (Stent 2002) to contemporary feminist theorists (Veltman and Piper 2014) elaborating their own takes on the concepts of autonomy and free will. Hoping to avoid becoming mired in philosophical debates over the nature of free will, a concise definition of contraceptive autonomy was sought that is comprehensive yet straightforward to operationalize. Contraceptive autonomy is defined here as the factors that need to be in place in order for a person to decide for themselves what they want in regards to contraceptive use, and then to realize that decision. Drawing on the work of Newman and Feldman-Jacobs, the construct of contraceptive autonomy is divided into the three subdomains of informed choice, full choice, and free choice (Newman and Feldman-Jacobs 2015) (Figure 2).

There is a growing body of literature aimed at assessing coercion coming from within the intimate partnership or from other family members (Upadhyay et al. 2014; Grace and Anderson 2016). Similarly, there are a range of factors (such as cultural values or literacy) that can significantly affect contraceptive decision-making, but are outside of the direct control of the health system. Though these factors are extremely important and very much worthy of study, the approach to measuring contraceptive autonomy elaborated here focuses somewhat more narrowly on factors directly related to health systems and to family planning programming, as opposed to all of the possible factors that can constrain reproductive decision-making. It is also important to note that this measurement focuses specifically on contraception, and that other key aspects of reproductive freedom (such as access to comprehensive abortion care) are not included here.

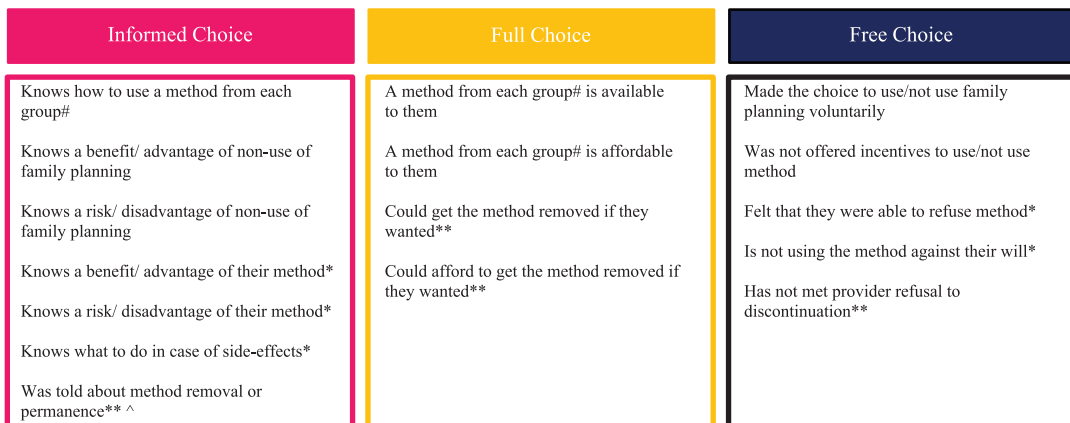
## OPERATIONALIZING INFORMED CHOICE, FREE CHOICE, AND FULL CHOICE

Figure 3 summarizes the proposed algorithm for the measurement of contraceptive autonomy, listing the criteria to measure the subdomains of informed, full, and free choice.

**FIGURE 2 Subdomains of contraceptive autonomy**



**FIGURE 3 Algorithm for operationalizing contraceptive autonomy**



# Contraceptive Attribute Groups

Duration of use	• Long-acting <u>and</u> short-acting
Presence of hormones	• Hormonal <u>and</u> non-hormonal
Coital dependence	• Coitally dependent <u>and</u> coitally independent
Provider dependence	• Provider dependent <u>and</u> provider independent
Control	• Male controlled <u>and</u> female controlled
Return to fertility	• Immediate return to fertility
Effectiveness	• Tier 1

NOTE: \*Current method user, \*\*Current LARC user, ^Permanent method user.

## Informed Choice

While a decision based on complete information may seem ideal, in practice it might be unreasonable to expect any health system, no matter how good, to be able to educate all people on *all possible* family planning options. Recognizing this, family planning researchers in the past have sought to find other ways to reasonably define adequate information in the context of family planning. The Method Information Index (MII), for example, defines sufficient information as: (1) being informed about other methods; (2) being informed about side-effects of the method chosen; and (3) being told what to do in the case of side-effects (MEASURE Evaluation n.d.). While these are indeed important questions, they fall short of the definition of informed choice. It may not be possible to be informed about all possible contraceptive methods, however it is certainly possible (and often desirable) to be informed about more than two. To address this, some researchers have developed other ways to define sufficient information (such as being informed about three methods, for example, or five), but choosing an arbitrary number cannot ensure that a person has knowledge of an array of methods with a variety of different attributes and characteristics that could meet their specific needs. A person might be told about condoms, pills, and emergency contraception and thus meet the threshold of three methods, but lack information about any long-acting methods when a LARC better suits their needs. Or they may know about sterilization, implants, and intrauterine devices, but not know of any methods that they can discontinue on their own. Using Festin et al.'s paper on various ways to classify contraceptives (Festin et al. 2016), some of the basic qualities of a well-rounded contraceptive method mix are enumerated into contraceptive attribute groups and used as a key feature of the proposed measure.

The major challenge to the definition of informed choice is that it is prescriptive about the type and amount of information that people *should* receive, rather than leaving people free to decide how much information, if any, they want and need. How to balance the needs of informed consent for a medical procedure with the sometimes conflicting imperatives of patient autonomy and high technical quality of care has been the subject of a great deal of research and debate from around the medical arena (Stanley, Walters, and Maddern 1998; O'Neill 2003; Nijhawan et al. 2013; Bester, Cole, and Kodish 2016; Brach 2019; Johansson et al. 2016; Moulton et al. 2013). Psychologists and behavioral economists, too, have explored the question of informed choice and described the "Paradox of Choice" or "overchoice" in which an overabundance of information actually constrains decision-making by paralyzing people with options (Shah and Wolford 2007; Kinjo and Ebina 2015; Ross and Cummings 2011). In the context of family planning then, many of these critics might argue that a person should not be subjected to a long counseling session filled with a lot of detailed information about the side effects of methods that do not interest them. As a patient-centered response to some of these challenges, Dehlendorf and others have advocated for a shared decision-making approach that is based on an elicitation of client preferences, followed by the provision of a "scaffolding" for decision-making by the health provider based on unbiased information that aligns with patient preferences (Dehlendorf et al. 2017). However, the shared decision-making framework's very strength—that it is a client-centered approach to information provision

narrowly tailored to each person's needs—poses challenges to the type of standardization that is necessary for a population-based indicator.

For the purposes of this measurement of contraceptive autonomy, a balance is sought between the position that complete information about all methods is necessary and, on the other end of the spectrum, that there is no standard amount of information that a person would need in order to make an informed choice. The criteria for informed choice delineated here establish a sort of a floor for basic information that is somewhat flexible (based on the contraceptive attribute groups) and also includes symmetrical questions on the benefits and risks of family planning in an attempt to measure overall bias in the types of information people have acquired.

Informed choice is thus measured as (1) knowing how to use a method from each contraceptive attribute group; (2) knowing a benefit/advantage of family planning nonuse; (3) knowing a risk/disadvantage of family planning; (4) knowing a benefit/advantage of their current method; (5) knowing a risk/disadvantage of their current method; (6) knowing what to do in case of side-effects; and (7) being told about method removal or permanence. These criteria would be only applied to those for whom they are relevant, and so criteria 1, 2, and 3 would be applied to everyone (users and nonusers alike) while criteria 4, 5, and 6 would be applied to all contraceptive users, and criterion 7 would be applied only to users of a long-acting or permanent method. In this way, informed choice is based on a balanced understanding of both the advantages and disadvantages of family planning, as well as additional criteria for users who should possess additional information about the method they use.

This algorithm does not seek to distinguish between correct and incorrect beliefs or understandings. For example, if a current user replies that they know a benefit or advantage of their method, this measurement does not seek to determine whether the information they possess about this benefit is correct. Instead, the measurement assesses how the person themselves perceives their knowledge and information levels.

## Full Choice

The concept of access is fraught and complex throughout health research. In the field of family planning specifically, access has taken on additional complexity due to the field's desire not only to reduce supply-side barriers to access, but to increase demand for contraception. This has resulted in some definitions of access that incorporate lack of demand as a dimension of lack of access. A recent conceptual framework on family planning access, for example, classified respondent opposition to family planning as a lack of "psychosocial access" (Choi, Fabric, and Adetunji 2016). This complex conception of access has long presented a measurement challenge, and a series of increasingly complex access measures have been proposed over the years seeking to measure barriers to access not only on the supply-side of family planning, but on the demand-side as well. There is important richness in this topic, but what seems to be most relevant for the question of contraceptive autonomy is whether the person themselves perceives that they have access. This approach finds support in the World Health Organization's definition of access to health services—"the perceptions and experiences of people as to their ease in reaching health services or health facilities in terms of location, time, and ease



of approach” (World Health Organization 2011). This approach to measure access places trust in the person’s own assessment of their situation, and is congruent with the person-centered approach to healthcare and research that recognizes the respondent’s expertise in their own life and decision-making.

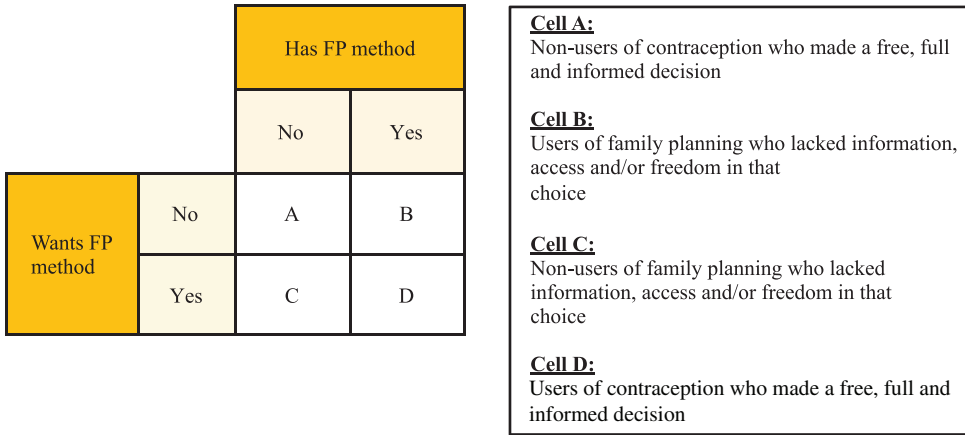
As such, full choice would be measured in a quite straightforward way: self-reported answers to whether: (8) a method from each group is available to them; and (9) a method from each group is affordable to them. Additionally, for users of provider-dependent methods, this will include whether (10) they think they could get the method removed if they wanted; and (11) could afford to get the method removed if they wanted.

## Free Choice

There is a widespread consensus in the family planning community that the adoption of a method should be completely voluntary, and that no degree of coercion in this process is acceptable, making the operationalization of free choice a bit more straightforward than informed choice and full choice. Free choice has been operationalized here into two simple criteria for all people: that they (12) made the choice to use or not use family planning voluntarily; and (13) were not offered incentives to use/not use a method. For current users of a method, that they (14) felt they were able to refuse their method; and (15) are not using their method against their will are added, while users of long-acting methods must have (16) not met provider refusal to discontinuation/removal.

A key feature of the algorithm for informed choice, full choice, and free choice is that each subdomain has differing criteria for different people based on their status as either a (1) noncurrent user of contraception; (2) current user of contraception; and (3) current user of a provider-dependent method (or, in the case of informed choice, a permanent method). Applying differential criteria to different groups of the population of interest is a somewhat unorthodox approach to measurement. Most social measurements seek to apply the same benchmarks to all, which facilitates interpretation of the measure, as well as creates a level playing field in which no one is held to a different (or higher) standard than anyone else. In the case of contraceptive autonomy, however, which seeks to measure such a broad concept across so many categories of people, it is important to tailor the criteria for contraceptive autonomy to the person’s current relationship with contraception. Since contraception (with the exception of fertility awareness-based methods and withdrawal) necessitates the use of either a medical device or a medication, codes of medical ethics require that users of those methods be held to a different standard of informed consent than nonusers who have not experienced medical intervention (American Medical Association 2001; American College of Obstetricians and Gynecologists Committee on Ethics 2009). Additionally, a growing body of evidence suggests that users of provider-dependent methods can face substantial barriers to discontinuation, creating the possibility for a type nonautonomy that simply does not exist for other people. Because the threats to autonomy vary differentially by contraceptive user status, the benchmark for measuring autonomy among these groups must do so as well. While these benchmarks may differ, however, it is important to note that none of them could be considered particularly lofty or aspirational. Rather, they reflect a sort of floor of established criteria for voluntary family planning.

**FIGURE 4** Contraceptive autonomy cells



## CONTRACEPTIVE AUTONOMY INDICATOR

Figure 4 shows a refined conceptual model on which a new suite of indicators can be developed.

These include an autonomy-adjustment to the CPR (based on the exclusion of cell B from the CPR numerator), a radical reconceptualization of the unmet need indicator based on cell C (the subject of planned future work), and a stand-alone indicator of contraceptive autonomy (explained here in depth), among many others.

For all of these indicators, it will be essential that they should be measured not only among married or in-union respondents, but among all those of reproductive age who are susceptible to pregnancy. For (often young) unmarried women, their exclusion from many of the most common contraceptive measures serves to erase their needs from the policymaking agenda, and provides no incentive for providers or programs to ensure that their needs are being met. Though there are certainly logistical and cultural justifications for this measurement approach, when a young unmarried person is turned away from family planning due to provider bias, for example, their exclusion from wanted reproductive health services appears nowhere using current metrics. With later marriage and changes in sexual mores rendering marriage an increasingly less reliable proxy for sexual activity (Fabric and Becker 2017), contraceptive autonomy should be calculated among all women of reproductive age.

This approach to measure contraceptive autonomy marks an advancement from existing indicators in several ways, but key among them is the recognition that autonomous nonuse of family planning is a perfectly valid outcome for a family planning program. Ensuring that a person has sufficient information and access, and then respecting their decision not to use contraception is something to be commended from a rights-based perspective, and so this indicator does not make a value-laden distinction between autonomous users and autonomous nonusers.

The autonomy score would be calculated based on the answers to the 16 components of the contraceptive autonomy items as follows:

$$\text{Autonomy score}_j = \prod i_{ij},$$

where  $i_i$  is the answer (0 for no, 1 for yes) the  $j$ th women gave to item  $i$ .

This approach to calculating contraceptive autonomy is based on a conception that is essentially “all or nothing”: a woman either has autonomy or she does not. The idea undergirding this approach is that the component parts of autonomy are mutually constitutive, and there can be no free choice without informed choice, no full choice without free choice, and so on. Thus, if any one component of autonomy is lacking, there can be no autonomy at all. If she is found to have all 16 of the constituent items of autonomy, she is not decremented at all, but if she is found not to have any of those items, her autonomy score is 0.

Reasonable people may disagree with this “all or nothing stance,” and argue that there should be partial credit in the calculation of the autonomy score. A score allowing for this type of partial credit could be calculated:

$$\text{Autonomy score}_j = \frac{\sum_{i=1}^n (i_{ij})}{n}.$$

There are arguments to be made in favor of both the “all or nothing” and “partial credit” approaches to calculating this indicator. The “all or nothing” approach is stricter in its adherence to the conceptual underpinnings of the indicator, and thus, perhaps a truer measurement of contraceptive autonomy than the partial credit model. However, this clarity comes at the cost of sensitivity, and this approach to the measurement may obscure important changes and distinctions. If, for example, a program previously both employed overt coercion and failed to provide information about a wide range of methods, and then ceased to use overt coercion but still failed to provide adequate information, the contraceptive autonomy scores in that area would not change to reflect the important but incomplete improvements in the program. Nor would the all or nothing approach effectively differentiate between two settings, one that used overt coercion and the second that failed to provide adequate information.

The partial credit approach would be able to reflect these types of improvements or differences, but the intuitive interpretation of the indicator would suffer. No longer would the contraceptive autonomy score be the proportion of women who were able to exercise contraceptive autonomy. Instead, it would become the average proportion of the 16 autonomy items that the aggregate population met. With the partial credit model, a strong argument could be made in favor of weighting the 16 items (e.g., weighting the importance of using a method against one’s will more heavily than not knowing a disadvantage of contraceptive nonuse), necessitating some consensus on the relative importance of each of the autonomy criteria. This process would indeed improve the ability of the measure to perceive changes in programs and policies, but would distance the measure from the original intent and allow programs that are not meeting basic standards of voluntarism to still score fairly highly.

As with other indicators, once calculated it will be important to disaggregate overall scores of contraceptive autonomy by sociodemographic and economic position, to explore potential disparities based on class, race/ethnicity, age, marital status, and a range of other variables and markers of social exclusion.

## CONCLUSION

It may be helpful to imagine what family planning would be like today if it had not emerged from the population control movement, but rather, if it were created today based wholly on reproductive rights and health. Goals and targets would likely be agnostic on questions of fertility growth or decline, of contraceptive uptake or nonuse, and instead might focus entirely on concerns of quality, rights, access, health, and autonomy.

In order for contraceptive autonomy to be measured widely and consistently, the questions for its calculation will need to be added to population-based surveys such as the DHS and the National Survey of Family Growth, among others. Future work on the road to this ultimate goal includes the piloting, adaptation and validation of the measure in diverse settings, as well as the use of factor analysis and other statistical techniques for item reduction (to reduce the data collection burden that so many new questions would pose). The institutionalization and scale up of this measurement would allow for its routine measurement around the world, as well as the ability to conduct comparative studies of contraceptive autonomy across time and place.

The absence of a measure for contraceptive autonomy has enabled the perception that nonautonomy in family planning is rare, and that isolated cases sometimes highlighted in anecdotes or the news are nothing more than the result of a few bad actors. It can be challenging to think more critically about the systems that undergird our work, how they may be doing harm, and how we can reimagine them to promote an agenda that is more centered on women and a holistic view of our well-being.

It is perhaps unsurprising that some hesitance or reluctance to name and measure nonautonomy and coercion exists within the family planning field itself. Fear that any such findings would be seized upon by the antichoice community and other forces that seek to limit access to essential reproductive health services are real. Indeed, antichoice groups have seized upon the infamous cases of forced sterilization in Peru under Fujimori and other examples of egregious rights violations to promote an agenda focused on limiting access to contraceptives (Population Research Institute 2002). Yet it would be a mistake to allow the desire to protect family planning from these types of attacks to override the fundamental commitment to promoting the health and rights of the people we serve. It has not been enough to change our rhetoric to match the post-Cairo agenda. Twenty-five years after that gathering, there is still a fundamental misalignment between the approach to measurement in family planning (focused on fertility and contraceptive use) and the stated goals of contemporary programs (to promote rights and health). The continued influence of population control in measurement is indicative of the broader ways that fertility reduction still motivates much family planning programming, research and advocacy. The family planning community must explicitly engage with the institutional and structural remnants of population control ideology

throughout contemporary research and programs. And 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.

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