Title: The family planning monitoring blind spot: how current family planning indicators miss coercion

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Extended Abstract for Submission

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Introduction

Family planning programs are rapidly scaling up services in many countries since the London Summit on Family Planning in 2012 (FP2020, 2013). These programs aim to expand family planning availability, accessibility and method choice to enable at least 120 million more women to use contraceptives by the year 2020. As part of the FP2020 commitment, the Family Planning 2020 movement has committed to ensuring "promotion of voluntary family planning and concrete measures to prevent coercion and discrimination, and ensure respect for human rights" (FamilyPlanning2020.org). This goal reiterates a long-standing commitment within FP programs to provide services that are voluntary and of high quality (Bruce/Jain 1990; ICPD, 1994).

During this time of increased funding and striving to achieve ambitious goals in family planning programs, multiple efforts have been taken to make sure that voluntarism and rights are respected in programs (Hardee et al, 2014a, WHO, 2013a; WHO 2013b; PMA2020, 2013). While these efforts promote quality, voluntary, rights-based family planning programs, they may not be sufficient to ensure accountability for voluntarism and coercion-free programs. Coercion has not, until recently, been defined operationally (Hardee et al, forthcoming 2014) and has suffered from subsequent a lack measurement tools.

Family planning has traditionally used measurement constructs that report positively framed results based on quality of care, voluntarism and informed choice e.g. how many women were told of other methods or counseled on side effects. These measures may inadvertently de-emphasize negative client experiences, including coercion. Drawing on the negatively framed disrespect and abuse framework developed by Bowser and Hill (2010), this paper describes where gaps in current family planning measurement indicators may render coercion and related client experiences invisible, making identification of coercion and the development of remedies difficult.

Methods:

The term "family planning" was searched for in combination with each type of D&A (non-consented care, non-dignified care, non-confidential care, physical abuse, detention in facilities, abandonment and discrimination) in SCOPUS, PubMed and CINAHL. The search was not bound by time or geographic location to capture widest range of tools possible. The search returned 7124 articles, 18 of which met the inclusion criteria. Tools and articles related to abortion services were eliminated from the search. For inclusion, articles had to include a quantitative measurement tool that captured elements of D&A or a related concept. Although the PMA2020 survey was not returned in the search it was included in the analysis because of its importance in current family planning monitoring efforts.

Specific indicators related to the seven D&A constructs were pulled from the measurement tools and linked with the specific D&A construct and gaps were identified. Abandonment, detention in facilities, and non-confidential care were eliminated from the analysis because they were considered either unlikely to occur in family planning or were not related to coercion.

Results:

Overall, only six tools were identified that included clear measures related to disrespect and abuse and coercion (Table 1). Gaps were identified in measurement tools relating to non-consented care and coercion, non-dignified care, and physical abuse. One tool assessed client perception of discrimination. The tools that have included indicators directly related to coercion, discrimination, and non-dignified care have been used only in the United States.

TABLE 1 GAPS IN MEASURING D&A IN FAMILY PLANNING

D&A Construct	Measure(s) exists in a validated assessment tool	Notes
Non-consented care		
• **Client receives procedure or method without her knowledge or consent**	No	
• **Clients are not given other options**	Yes	Indicator: Told of other methods (PMA2020 Indicators)
• **Clients are not given full or accurate information**	Yes	Indicators: Counseled on side effects (PMA2020 Indicators) Told of other methods (PMA2020)
• **Clients do not decide for themselves what method to use**	Yes	Indicator: Method chosen alone or jointly (PMA2020 Indicators)
• **Clients choose voluntarily (without barriers or coercion) whether and which FP method to use.**	Yes	Method chosen alone or jointly (PMA2020 Indicators) Have you ever felt pressured by someone at a clinic or doctor's office to use or continue to use a particular method of birth control when you would have rather used another method or no method at all? (Becker & Tsui, 2008) A doctor or nurse strongly encouraged you to use one method of birth control when you preferred another. (Bird and Bogart, 2003)
Non-dignified care		
• **Clients experience humiliating treatment such as yelling, name calling, threatening, scolding, or being insulted**	No	No tool identified in this review
• **Clients experience psychological abuse such as being shamed or ignored**	Yes	You felt like the doctor or nurse was not listening to what you were saying A doctor or nurse assumed you were on welfare A doctor or nurse assumed you had multiple sexual partners A doctor or nurse assumed you had a sexually transmitted disease such as chlamydia, gonorrhea, genital warts, herpes and HIV. (Bird and Bogart, 2003)
• **Clients are told inaccurate information to frighten, coerce or shame them**	No	No tool identified in this review
• **Clients are disempowered by the**	Yes	Have you ever felt pressured by someone at a clinic or

provider or staff		doctor's office to use or continue to use a particular method of birth control when you would have rather used another method or no method at all? (Becker & Tsui, 2008) Percent of women denied contraceptives by midwives. (Morrison, 2000) Number of midwives who would not provide contraceptives to particular women by characteristic and family planning method (Morrison, 2000) *Example indicators where negative responses may indicate disempowerment:* Feeling of being listened to by the health care provider Providers are willing to explain methods Providers are willing to answer questions Providers answer questions politely (Valdes, et al. 2013)
Physical abuse		
• **Clients experience intentional infliction of pain or injury**	No	No tool identified in this review
• **Clients are willfully deprived of services which are necessary to maintain physical and mental health**	No	No tool identified in this review
• **Clients experience injury caused by negligent acts or omissions, or sexual abuse**	No	No tool identified in this review
Discrimination		
• **Client experiences differential treatment on the basis of a personal characteristic that disadvantages the client**	Yes	You were treated with less courtesy than other people You were treated with less respect than other people You received poorer service than other people (Bird & Bogart, 2003)

Discussion

There are many indicators that relate to good client-provider interaction (CPI) and tools that measure whether patients have positive experiences. Current family planning assessment tools play an important role in promoting the highest standard of quality in CPI and these measures are valuable. Many of the tools not only protect against negative interactions, but they also help to empower clients in health decisions. The OPTIONS scale walks providers through a decision making process with clients,

considering clients preferences for making decisions solely or jointly (Elwyn, 2003). Other assessment tools demonstrate commitment to treating clients with dignity and respect.

However, when things go wrong the family planning field has very few tools to use to identify specific negative experiences or harmful actions by providers. Of the 18 tools reviewed, only three tools measured negative client experiences explicitly and all three of them had been used in developed countries (Becker and Tsui, 2008; Bird and Bogart, 2003, and Downing, LaVeist and Bullock, 2007). Simmons and Elias (1994) identified the need for additional tools to be developed to measure client provider interaction, including difficult to measure aspects of the interaction. The field remains in need of these tools especially as services are scaled up in the next six years and, with the additional investment in monitoring, issues around coercion, disrespect, and abuse are likely to arise.

Current family planning measurement tools fall short in measuring coercion and other negative client experiences. The recently developed definition of coercion, "*Coercion in family planning consists of actions or factors that compromise individual autonomy, agency or liberty in relation to contraceptive use or reproductive decision making through force, violence, intimidation or manipulation,"* (Hardee et al, forthcoming 2014) will assist in developing measurement tools that capture incidence of coercion. However, the mechanisms by which coercion occurs (intimidation, shame, humiliation, manipulation, etc.) still need to be described and may be informed by the constructs included in the disrespect and abuse framework.

There are limitations to applying the D&A framework to family planning. Many of the D&A constructs are more likely to happen when women are in a facility for an extended period of time, however, it also provides a wider lens by which client experience can be evaluated. Negative experiences that aren't necessarily coercion may also have important impact on FP program success (Blanc, et al, 2002).

Recommendations

Although focusing on the negative for routine monitoring may not be recommended, it is important to have tools to identify and describe negative experiences so that appropriate interventions can be developed. Tools that capture negative experiences should be designed so that they lead to program improvement, not punishment. Current accountability mechanisms to guard against coercion, such as the Tiahrt amendment used by USAID, may be viewed as being too punitive so that problems are more likely to be deemphasized rather than investigated and proactively addressed.

The political sensitivity to measures related to coercion cannot be overlooked. Too often, data and instances of coercion and abuse have been used to smear and defund programs rather than to invest more in ensuring better quality and more respectful treatment. With the current positive global climate for family planning, now is the right time for a paradigm shift by using increased monitoring to learn how negative experiences impact programs and develop interventions accordingly. By doing so, programs demonstrate their commitment to providing services without coercion and that respect the rights of women and girls.