Achieving the London FP Summit Goal through Adhering to Voluntary, Rights-based Family Planning: What Can We Learn from Past Experiences with Coercion?

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Draft, not for citation

September 27, 2013

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Abstract

Recently family planning has received renewed attention, and while the response to initiatives such as the London Summit on Family Planning has been generally positive, reproductive health and rights advocates have expressed concern that the strong focus of FP, especially the large numerical target of the London Summit, may result in coercion in programs. This paper answers the questions: What constitutes coercion in policy and program management and how do we use lessons of the past to avoid coercion in programs? We use literature from the 1960's onward to define coercion and examine instances when it has occurred in family planning programs and instances where it has been alleged to have occurred. This analysis informs recommended actions to reduce the incidence of coercion, redeem and improve programs that are falsely accused of coercion, and ensure that programming provides voluntary family planning services that respect, protect and fulfill human rights.

Introduction

The 2012 Family Planning (FP) Summit refocused attention on family planning, garnering much-needed support to reenergize and expand programs to reach 120 million additional family planning users in 69 low and medium income countries by 2020. While the response to the FP Summit was generally positive, reproductive health and rights advocates expressed concern that the numeric goal was a retreat from the 1994 consensus of the International Conference on Population and Development (ICPD) that promoted rights and repudiated targets (Girard, 2012; Khosla, 2012; Krishnan, 2012; Hodgson and Watkins, 1997). Following the FP Summit, some advocates questioned the means of achieving the ambitious goal of the Summit. The specter of coercion was raised in at least one reaction to the FP Summit (Girard (2012: 1):

> "for those of us trying to discern whether the rights of women will truly be at the center of this Family Planning Initiative, as promised…. there were moments of disquiet. … For example, the representatives of Indonesia and Bangladesh spoke in terms of achieving certain ambitious contraceptive prevalence rates and total fertility rates – thus raising the very real possibility that coercion might result without safeguards".

The international family planning movement was built on the foundation of the "right of individuals and couples to decide freely and responsibly the number and spacing of their children and the information and services to do so" from the UN's Tehran Human Rights Conference in 1968, although several early family planning programs were oriented towards slowing population growth. While the vast majority of family planning has been provided through programs that adhere to principles of voluntarism (Bongaarts and Sinding, 2009), instances and

allegations of coercion over the last several decades have dogged international family planning, and have evoked strong reactions (Warwick, 1982; Mason, 1994; Bongaarts et al. 2012; Barot, 2012; Harkavy and Roy, 2007; Feng et al., 2013; Coe, 2004; Center for Reproductive Rights, 2010). Indeed, the family planning field has been wrestling with this issue for decades (Berelson, 1969).

The purpose of the paper is to answer the questions: What constitutes coercion in policy and program management and how do we use lessons of the past to avoid coercion in programming moving forward? We contend that defining coercion, examining instances when it has occurred in family planning programs, as well as instances where it has been alleged to have occurred, will help ensure that safeguards can be put in place moving forward to reduce the incidence of coercion protect or redeem programs that are falsely accused of coercion, and to ensure that programming following the London Summit on Family Planning Summit provide voluntary family planning services that respect, protect and fulfill human rights.

Methodology

This paper is based on a review of the literature on allegations and documented cases of coercion in family planning programming, augmented by the authors' direct experience with and research on family planning programs, demography, quality of care, and human rights, since the 1970s. The literature for this paper is supplemented by a wider review of literature conducted on voluntary, human rights-based family planning (see Rodriguez et al., 2013). While Rodriguez et al.'s literature review focused on the years 1995 to 2012, this paper includes literature from family planning programming dating back to the 1970s, since some instances and allegations of coercive practices included here occurred during that time period.

What constitutes coercion?

To inform this paper, we looked for existing definitions and descriptions of coercion in family planning. There is no commonly held definition, although instances of coercion are always linked to violations of human rights. The 1994 ICPD Programme of Action mentions coercion twice, including stating that "…reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents…[and include the] right to make decisions concerning reproduction free of discrimination, coercion and violence" (UNFPA, 1994, Programme of Action para 7.3). There is broad consensus that coercion is morally wrong and should not be part of family planning programs (Wheeler, 1999), but the concept remains loosely defined. References to coercion draw on concepts such as autonomy, choice and liberty (Shalev, 1998). The Open Society Foundation defines coercion to include force or use of undue incentives and intimidation tactics (OSF, 2011), which reiterates the emphasis on autonomy and liberty. The Center for Reproductive Rights, in its call to eliminate coercion, states that acceptance of family planning methods must be accompanied by full, free and informed consent (CRR, 2013).

To develop a more concise definition of coercion, we found it instructive to review the range of reproductive rights. Erdman and Cook (2008: 535) list three broad categories of reproductive rights, derived from human rights as defined in international treaties, which describe both obligations in family planning service provision as well as rights that are violated in instances of coercion:

1. Right to reproductive self-determination (right to bodily integrity and security of person and the rights of couples and individuals to decide freely and responsibly the number and spacing of their children)

2. Rights to sexual and reproductive health services, information, and education (including right to the highest attainable standard of health)

3. Rights to equality and nondiscrimination (right to make decisions concerning reproduction free of discrimination, coercion, and violence)

Human rights are indivisible – the fulfillment of one right often depends on other associated rights. The right to reproductive self-determination can be fulfilled only when the rights to reproductive health services, information and supplies are also fulfilled. Additionally, violations of the rights to equality and nondiscrimination may co-occur or contribute to violations of the right to self-determination due to interpersonal or cultural power imbalances.

A definition of coercion that is too broad could incriminate all family planning programs – becoming a catchall term for poorly implemented programs that neglect or are unable to reach quality of care standards. We contend that in order for the term coercion to be useful for advocacy and accountability purposes, it should not be conflated with broader issues of quality of care or equity, which deserve equal, if not more, attention and are also linked with human rights violations. Considering these factors, we propose the following 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.

Under this definition, coercion is directly linked to violations of the right to reproductive self-determination, including the right to bodily integrity. Clarifying coercion as a violation of the right to self-determination narrows the focus of the term in order to underline the gravity of coercion allegations. It is important to note that coercion is not the only way in which the right to reproductive self-determination can be violated.

To illustrate actions and factors that may fit under this definition, this paper focuses on policies and program management that explicitly foster practices that impinge on autonomy, agency or liberty when implemented. Coercion is related to, but distinct from, more subtle actions that implicitly undermine full, free, and informed decision making regarding family planning. Each component of full, free and informed choice is important to consider when designing quality, voluntary family planning programs. Full choice indicates that the potential family planning user has an array of contraceptive method choices available (Bruce, 1990), including the option not to use family planning. Free choice implies that there are no disproportionate external inducements to make a particular choice. Informed choice indicates that potential family planning users receive accurate information and "emphasizes that clients select the method that best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options." (Kim, Kols & Mucheke, 1998:4) A description of the extent to which programs have provided full, free and informed choice in family planning is outside the scope of this paper, although there are clear linkages between any one, or a combination, of these elements being compromised and potential or actual coercive practices.

Violations and Vulnerabilities related to Coercion in Policies and Practices

There is a spectrum of coercive practices that can emanate from policies and program management. We have identified five program elements that are either violations, meaning that coercion is clearly occurring or is very likely to occur, or red flags that have the potential to lead to coercion in family planning or population policies:

1. Enforcement of policies that limit the numbers of births allowed to individuals or couples (clear violation)
2. Enforcement of mandatory contraceptive use policies and family planning procedures undertaken without a client's knowledge or against her or his will (violation)
3. Use of social pressure to adopt family planning (red flag)
4. Use of family planning as a target or performance indicator (red flag)
5. Provision of financial or other incentives or disincentives (red flag)

The first two actions are certainly coercive and are thus labeled clear violations. When enforced, policies which limit the number of births allowed to individuals clearly violate human rights (UNHCR, 2005), as do mandatory contraceptive use policies that are enforced. Actions three, four and five have been alleged to be coercive in family planning programs. However, more benign versions of these actions (i.e. behavior change communication, working with local leaders to change family planning norms and acceptability, setting goals for program management purposes, reimbursing for travel and lost wages to allow increased access, etc.) are program activities intended to expand access to family planning and improve management of programs. Because these benign forms of these actions can be taken to an extreme or be misinterpreted during implementation they represent vulnerabilities in programs because, without safeguards, they can diminish agency and become coercive in practice. These program

elements are labeled red flags because their use should be monitored to ensure that they do not progress to clear violations through practices which have the effect of being coercive.

It is important to note that by focusing on policy and program management actions related to implementation of family planning programs, this paper does not cover other types of coercion, such as forced sterilization based on provider-based stigma and discrimination (Center for Reproductive Rights, 2010; OSF, 2011; Kirsch, 1999; Smith, 2012), or pronatalist policies and involuntary childbearing (Barot, 2012), though these are critically important from a human rights perspective. The paper also does not address involuntary pregnancy/childbirth that can result from lack of access to/stockouts of contraceptives or limited method choice, although this affects millions of women and is a critical focus of FP2020. Furthermore, the paper does not address abortion services, the lack of which many contend results in involuntary childbearing (Barot, 2012).

Findings

We have organized the findings into the five actions (imposition of policies limiting number of children; childbirth limitation policies, mandatory or imposed contraceptive use, social pressure, targets, and incentives) and provide examples of the where these practices have been used. A few countries with a long history of family planning are discussed under more than one of the five actions. It is clear through these examples that in the cases of strong social pressure, targets and incentives there are debates about whether these practices have constituted coercion and illustrate the complexity in determining whether coercion occurred. We also highlight situations where there is concern about the potential for different types of coercion in more recently implemented family planning programs.

Policies Limiting the Number of Births

In terms of policies that limit the number of births allowed to individuals or couples, the Office of the High Commissioner for Refugees (UNHCR), writing about refugee claims based on coercive family planning laws or policies, noted the legitimate role of governments to implement family planning policies for "legitimate socio-economic objectives" and they linked such policies with international human rights standards, noting that

> "coercive family planning laws or policies which prescribe the number of children parents can have and/or which provide for enforcement measures or sanctions to promote compliance with such laws or policies, or punish individuals for breaching them, are not in conformity with international human rights standards…. [and that] coercive forms of family planning constitute a violation of human rights" (UNHCR, 2005: 3).

While countries have legitimate reasons to consider and plan for demographic dynamics, policies that limit childbearing go against the 1968 International Conference on Human Rights, which gave individuals and couples the right to decide on the number and spacing of their children (UN, 1968: 4). Promoting a small family norm has a long history in family planning programs, with many family planning posters extolling the benefits of a small family compared to a large family. However, policies that explicitly limit the number of children individuals and couples can have should not be promoted as a norm.

The most notorious of these child-limitation policies is China's One-child policy, "the most extreme example of state intervention in human reproduction in the modern era" (Feng et al., 2013: 126). China's One Child Policy elicited strong international reaction when it was announced in 1979 and has continued to draw heavy criticism for violating human rights (Winkler, 2002). Calls to end the One Child Policy continue (Wong, 2012) but the policy stands, as do instances of coercion. In June 2012, graphic photographs spread globally through social

media of a woman who was required to have an abortion in her seventh month because she was not able to pay the fine for an out-of-plan birth, brought global attention to family planning practices long in place. What was different in 2012 is that Chinese officials agreed to compensate the woman and her husband for the late-term abortion that the Shaanxi Province Population and Family Planning said was a violation of national policy (MacLeod, 2012), although as Wang et al. (2012: 126) notes, "Politically, the Chinese leadership has come to realize that the country can no longer continue the old development model that sacrifices long-term benefits for short-term gains, that ignores individual rights and welfare, and that elevates economic development above everything else."

Demographic concerns also led Vietnam to implement in 1988 a One to Two Child policy, with three to five years of spacing between births, and other specifications such as age of childbearing (Hoa et al., 1996). Following the 1994 ICPD, Vietnam shifted to a comprehensive reproductive health approach (Giang & Huong, 2008) and in 2003 the government issued a Population Ordinance which supported the right of couples to freely choose the number of children they wanted (Giang and Huang, 2008; Hanh, 2009). , After a "population surge" occurred, the Political Bureau of Vietnamese Communist Party responded with a resolution strongly supporting a two-child limit for Vietnamese families (Giang and Huang, 2008). While the two-child policy was re-emphasized after the Population Ordinance was issued is a sign of regressive policies regarding reproductive health and rights, there are few indications that people are forced to comply with the policy. The family planning program promotes voluntary, quality services (CRR, 2011). However, having a policy that limits the number of children a woman can have goes against human rights principles and has the potential to lead to coercive practices.

The most recent example of imposition of a child limitation policy occurred in 2013 in Myanmar and may be the first modern child limit policy to target a religious group (Aljazeera, 2013). Recent reports have revealed that Myanmar is enforcing a selective child limit policy for Muslim Rohingyas in two townships (Aljazeera, 2013; Szep and Marshall, 2013; Associated Press, 2013). Human rights activists have strongly criticized the government's policy, as has the United Nations (Mullen, 2013).

Two countries in Africa that have raised the possibility of implementing specific child limitation policies include Rwanda and Nigeria. Rwanda has long been concerned with issues of land, agricultural production and the size and growth of its population. Rwanda's 2006-2010 Family Planning Policy and its Five-Year Strategies included "giving birth to a number of children that is within the capacity of each household to support, in such a way that every family and the entire population as a whole will be more productive and then be able to contribute to the sustainable development of our country" (Republic of Rwanda, 2006: 6). In 2007, the government of Rwanda announced that it was considering a three child policy (Ndaruhuye et al., 2009). The bill was never taken to parliament and the president later said that it was part of a family planning sensitization campaign (Ndaruhuye et al, 2009).

Less than a month prior to the 2012 FP Summit in London, Nigeria's President, Goodluck Jonathan, caused controversy by calling on the need to implement birth control measures, and possibly a three child limit, in the country (BBC News, 2012). His comments, a response to concerns about population size and growth (Rosenthal, 2012), were met with criticism (Look, 2012; Daily Trust, 2012). Nigeria has not imposed a child limitation policy and is working to improve access to family planning. Countries concerned about demographic dynamics, for example, those that want to achieve the "demographic dividend," (Bloom et al.,

2003; Gribble and Bremner, 2012: Sathar et al. 2013 here), can address population issues with voluntary family planning programs without resorting to policies that violate human rights. The motivation to invest in family planning may come from different directions; the key is to ensure that it manifests itself in increased investment in voluntary family planning programmes that respect and protect human rights.

Mandatory or Involuntary Imposition of Contraceptive Use

Mandatory or involuntary imposition of contraceptive use, like child limitation policies, is coercive. The sheer political will necessary to implement mandatory contraceptive use is rare and associated with authoritarian governments as seen in China over the past 30 years, India under the rule of Indira Gandhi in the 1970s, and in Peru under the leadership of Alberto Fujimori in the 1990s. Excluding China, involuntary imposition of contraceptives has tended to be targeted towards minorities and disadvantaged groups. In the United States, for example, eugenics laws in many states led to involuntary sterilization of poor people of color and people with disabilities (Stern, 2005) and in Europe Roma women have been sterilized without their consent (Open Society Foundation, 2011). As part of the enforcement of the One-Child Policy China mandates contraceptive use. Generally women receive an IUD after a first birth and sterilization after a second birth (if permitted), although the current Chinese family planning program's quality of care approach, established after the 1994 ICPD and the 1995 Fourth World Conference on Women, is expanding method choice (Xie, 2011).

One of the most infamous example of coercion is the forced sterilization that occurred during the Emergency period in India. The seeds for coercion were set from the beginning of the population program that was based on a strong demographic imperative (Vicziany, 1982b), with

targets built into programme management and performance assessment. Findings from the 1971 census showed continued rapid growth of India's population and caused the program to reach a "crisis point," (Panandiker and Umashankar, 1994: 89). In 1975, the Union Health Minister recommended to Prime Minister Indira Gandhi that the country "has no alternative to thinking in terms of introduction of some elements of compulsion in the larger national interest" (Shah Commission of Inquiry, 1978, cited in Pai Panandiker and Umashankar, 1994: 89).

During twelve months of the emergency period 8.3 million sterilizations were performed, which was more than the total number performed in the previous five years (Srinivasan, 2006). Although there are no data showing the proportion of the 8.3 million sterilizations that were coercive, there is evidence that some men were physically forced by police officials to undergo sterilization (Brown, 1984). Vasectomy was previously acceptable to Indian men but since the Emergency period it has not recovered any of its previous popularity, thus the abuses have had a long-standing chilling effect. The Emergency, including the coercive implementation of family planning, resulted in the downfall of Indira Gandhi's government and a lack of enthusiasm for widespread implementation of family planning for a number of years. The Family planning program in India no longer imposes mandatory contraceptive use, although it emphasizes female sterilization as a program method resulting in a skewed contraceptive method mix (Sullivan et al., 2006). By not ensuring a range of methods from which women can choose, full, free and informed choice is compromised.

In 1995, Peruvian President Alberto Fujimori appeared to be a champion for reproductive health and a leader in Latin America linking the rights and health of women to a larger social development agenda. However, Fujimori's perceived motivation for reproductive health programming in the country became controversial when cases of coercive sterilization aimed at

rural, indigenous women came to light (Coe, 2004; MSNBC, 1998; Sims, 1998; Wilson, 1998). Criticism of the government's sterilization program began to arise from civil society groups, NGOs and from the Catholic Church. Many health care providers spoke out, confirming that they were obliged to fulfill government targets and that they could be dismissed if they did not meet targets (Coe, 2004). As a result of the sterilization campaign that was conducted during Fujimori's administration, between 200,000 and 300,000 women were sterilized (Clarin, 2012; Cordero, 2011; El Comercio, 2003; Miranda & Yamin 2004). Approximately 2,000 cases of forced sterilization have been brought to the attention of the government and Inter-American Court and confirmed as violations of human rights (Romo, 2011).

In the early days of NORPLANT, the contraceptive implant, many providers were not willing to remove the implant before five year use, citing that side effects would lessen or could be treated or that the implant was too costly and therefore should not be removed early (Hardee et al., 1994; Balasubrahmanyan, 1993; Tolley and Nare, 2001). Reports of early removals not being granted to women seeking them, for whatever reason, violate women's right to make their own decisions about contraceptive use, and constitute coercion. With the current expansion of implant availability, and its popularity as a method, ensuring access to removal by trained providers is crucial. "Programs …need to ensure routine, regular, and reliable removal services for clients, beginning by planning for them at the outset of service expansion efforts. Failure to provide reliable and ready access to removal services could easily tarnish the method's image and undermine an entire family planning program" (Jacobstein and Stanley, 2013: 14).

Social Pressure to Adopt Family Planning

Although efforts to affect fertility rates using education and informational campaigns are commonplace in family planning, the use of social pressure tactics that apply direct pressure to use family planning community leaders or people who have authority or power over another interferes with autonomy and liberty and can be considered coercive. This type of social pressure may have the effect of intimidating or manipulating people to use family planning and differs from normative social change within communities related to fertility and family size. In many countries with voluntary family planning programs the desired number of children has decreased as the health, education and economic profile has changed. In a recent review of the proximate causes of fertility change in African countries, Johnson et al (2011) found that over a 10-14 year period the desired number of children decreased in ten of the thirteen countries included in the study. China, as described below, clearly used social pressure as part of its tactics to enforce family planning. Use of social pressure also occurred in Indonesia in the past, although the extent to which the program was or was not coercive has been debated. Social pressure seems to be part of some contemporary programs, including those in Rwanda and Ethiopia, echoing the strategy that gave rise to concerns in Indonesia.

Implementation of China's family planning policy starts with public pressure to comply with the policy, followed by legal sanctions and, in some cases, force. Early in the implementation of the One Child Policy, Hardee (1984: 147) observed the power of the "forms of persuasion or attitude correction work employed by the family planning workers to wear people down to the point of submitting to actions such as a birth planning operation [sterilization]." Kaufman et al., (2005: 2) describe the "intense pressure, psychological and sometimes physical, that was put on couples." Officials kept track of women's menstrual cycles and family planning use and subjected them to regular pregnancy tests. The information was

often posted publically. Rewards were withheld from entire work units if one couple failed to comply with the policy. Measures such as these are coercive since they have the effect of compelling individuals to comply with the policy.

Indonesia's family planning program has been touted as a family planning success story, but has also been accused of using heavy-handed (some said coercive) practices. Chauls (1994:28) noted that Indonesia's program was criticized mainly for its "management approaches and its use of Indonesian culture." The program was implemented with substantial political will that signaled to local leadership that family planning uptake was a national priority (Warwick, 1982). The Suharto regime was authoritarian and able to exert considerable pressure on government officials to promote family planning (Shiffman, 2004). In the 1970s the program used a community approach to promote family planning through collective action, for example, by using *banjar* in Bali, which is a unit for mutual aid and cooperative work. Community leaders were expected to promote family planning and assist with changing community attitudes about family planning; it was looked upon very unfavorably, for example, if the leader's wife was not a family planning user. By one account, when family planning was being scaled up, individuals received visits from community motivators. If they did not adopt family planning initially, the village head or other administrators would come to the house and apply pressure to adopt family planning (Warwick, 1986). Indonesia's family planning program has evolved substantially since the 1970's and no longer uses such tactics at the community level to implement family planning.

Rwanda and Ethiopia's leadership have demonstrated a high levels of commitment to improving health and lowering fertility rates through family planning services (Wadhams, 2010). In Rwanda, the Minister of Health noted reducing population growth as essential to

socioeconomic development as well as a significant issue related to land and resource allocation in the country, stating that "family planning is priority number one—not just talking about it, but implementing it" (Solo, 2008). In Rwanda, like Indonesia, "People have a high propensity to listen to authority. This may be good or bad. There is a high level of obeying what the government says" (Solo, 2008: 13). In both countries, strong central leadership has been supported by community mobilization to implement family planning. In Ethiopia, as a way to implement Ethiopia's Health Sector Development Programme, the "health development army" has encouraged citizens to adopt a host of health behaviors, family planning among them. This group consists of members in the communities who exert political leadership and help to improve the community's understanding and knowledge of health issues (Abebe, 2012). This community pressure emphasizes the adoption of healthy behaviors and improving health outcomes. Although coercion has not been reported, some have raised concerns about the practice of community pressure in both Rwanda and Ethiopia (Solo, 2008; Morrison and Brundage, 2012).

Changing norms in countries in which the concept of family planning is new or in which there is opposition to limiting fertility is challenging. In order for attitudes and behaviors to shift so that it is socially safe and desirable to use family planning it takes time and continuous involvement of community members. However, when social pressure is applied to individuals to make them comply with family planning expectations, individual's rights are violated and coercion has occurred.

Family Planning as a Target and Performance Indicator for Managers

The use of targets and other performance indicators has attracted criticism for potentially promoting coercion in family planning. Indeed, the ICPD Program of Action was heralded a success in part because it shifted the focus away from "demographic targets" (UNFPA, 1994). Numerical targets of numbers of users or acceptors of particular methods are considered a means of putting demographic or program goals ahead of individual agency and preferences and encourage quantity over the quality of services provided. They are also criticized because they may put excess pressure on managers, providers and community health workers to meet them by coercing individuals into accepting family planning or a particular method of contraception, as highlighted in the Peru example above. The use of targets has been a point of criticism about the Chinese, Indian, and Indonesian family planning programs, among others.

Management of the family planning program in China has been the responsibility of the central and state governments, and of managers down to local levels. Provincial and local officials are given birth quotas for their areas, with achievement evaluated in performance reviews and tied to bonuses and advancement (Burns and Zhou, 2010). Early in India's family planning programs (1966-67) the government implemented the Health Department-operated the "Incentive-based, Target-oriented, Time-bound, and Sterilization-focused" programme or the "HITTS model". The ambitious demographic targets became the responsibility of districts to achieve and led to intense pressure for managers to increase contraceptive use (Harkavy & Roy, 2007). Though the approach was relatively quickly found to be ineffective, some of the tactics continued to be used even as the program evolved. In the 1990s, including through the 1994 ICPD and the 1995 Beijing Women's Conference, there was a groundswell to abolish targets in the program and to focus on improving quality of care. With a successful pilot of implementing family planning without targets, in 1996 the Government of India announced a new Target-free

Approach, eliminating targets set at the national level. Local targets would still be set, but they would be decided upon at a local level in consultation with the community (Visaria, Jejeeboy & Merrick, 1999). However, the policy change was met with significant concern and confusion about how performance would be evaluated and progress sustained; therefore many local areas maintained targets similar to what had been set at the national level (Visaria, et al, 1999).

Indonesia's program, led by the Indonesian National Family Planning Board (BKKBN) was established based on a voluntary approach, with a target system instituted to motivate workers to recruit new users. The target system was developed as a management tool, but was criticized by some as authoritarian and coercive (Lubis, 2003). In Java, the program used the hierarchical system of Governors working down the system to village heads to promote family planning. "In fact, family planning became an important indicator for evaluating the performance of these officials" (Lubis, 2003: 40). In a paper titled "Is the Indonesian Family Planning Coercive?" Chauls explored the allegations in detail, and concluded that although some coercion had likely occurred, it was very rare. He noted the BKKBN fundamentally understood that coercion would be "detrimental to the achievement of the programs' goals" (1994:28).

In 1999, the orientation of the BKKBN shifted to align with ICPD principles, including protection of reproductive rights (Lubis, 2003), although the demographic and economic rationale for family planning remains in place in Indonesia. The target system was replaced by a Family Planning Demand Fulfillment Policy which focuses more on client needs by estimating demand rather than setting program targets, measures quality of care, and evaluates the underlying reasons for women's unmet need for family planning (Policy Project, 1996). The BKKBN continues to lead family planning in Indonesia, but the majority of services are provided by the private sector. When the country program shifted away from targets for

management purposes and shifted towards private sector provision it led to overall monitoring efforts being deemphasized. Hayes (2010) contends that program management has suffered because BKKBN has not been able to maintain a programmatic focus and innovate to reach the goal of universal access to family planning services.

Under Rwanda's National Family Planning Policy, all ministries are responsible for developing action plans (Say and Chou, 2011). Rwanda uses performance-based contracts, adapted from a traditional concept called *Imihigo*, that are signed between the president and district mayors in which local leaders take responsibility for achieving certain development targets in one year, including family planning. Introduced in 2006, the family planning performance indicator (the percentage of the population using modern contraceptives and family planning) is frequently highlighted as a priority for district managers to increase in *Imihigo* ceremonies. Although the *Imihigo* process is quantitatively oriented, the government emphasizes the need for high quality services to be delivered (Government of Rwanda, 2013, Basinga, 2010); an important element to ensure that the practice results in voluntary family planning use.

A new trend in health programming to implement performance-based financing has implications for family planning. Given problems that have arisen from the use of targets and incentives to increase contraceptive use in some programs in the past, there is understandable reluctance to consider performance-based financing as good for family planning—although if implemented appropriately with emphasis on quality of care and meeting reproductive intentions, this new focus may have a place in supporting the extension of voluntary, rights-based family planning if it focuses on quality of care rather than numbers of clients (Eichler et al., 2010). Efforts such as these may effectively allow for the management and accountability gains that can be received from goal setting while ensuring that quality or voluntarism is not sacrificed.

Programs can benefit from using quantitative indicators to track progress by showing managers that services are being provided effectively or ineffectively and who has and has not received services. This information can be crucial for effective management and ensuring equity in the program, but use of such indicators is nascent and their practical application should be monitored particularly with regard to the quality of care provided.

Use of Incentives and Disincentives

The issue of use of incentives and disincentives has been discussed for decades amid concerns that these might provide undue influence on family planning providers and clients (Berelson, 1971; Cleland and Mauldin, 1991; Bongaarts et al., 2012). Over the years, some programs have introduced incentive payments for providers and clients to accept contraception or a particular method of contraception (National Academy of Sciences, 1974; Palmore and Yap, 1987). Mason (1994) explains that while small-scale incentives can allow some individuals more choice by removing access barriers, specifically poor people who might not be able to afford transportation costs or missed work, larger incentives to individuals are controversial. The critical question is whether the incentive has the effect of promoting equity in family planning decision making by leveling the field, for example providing travel costs or compensation for working time lost, or distorting the choice because the attractiveness of the incentive becomes the key motivation for accepting family planning.

A number of countries have instituted incentive schemes, among them Nepal, Sri Lanka, Philippines and Cambodia, Bangladesh and India provide examples of incentive payments through which individuals are compensated for lost wages and travel to health facilities that offered sterilization. Providers also receive payments for providing some methods. These practices raised concerns, notably in Bangladesh, that clients were being coerced into using

family planning. As described below, extensive review of Bangladesh's family planning program found that payments to users were not influential in the decision to use family planning, and thus were not coercive (Pillsbury, 1990, Cleland and Mauldin, 1991). However, the per-case payments to providers and motivators or "referral agents" or "helpers" were considered problematic and resulted in a focus on sterilization to the exclusion of other methods and biased information which minimized disadvantages and exaggerated the attractions of sterilization, including the compensation payment (Cleland and Mauldin, 1991).

India's program has made use of incentives to motivate providers, recruiters, and users. From an early experiment to provide small sums of money to reimburse adopters for travel and lost wages from undergoing sterilization, incentives became an official part of the national program in 1965 (Harkavy & Roy, 2007). Providers and motivators were given incentives for each adopter they assisted through the process and adopters were also offered incentives. During the Emergency Period in India men were given graduated incentives for sterilization based on their age and the number of children they had (Brown, 1984). India's family planning program still provides small incentive payments, which clients have come to expect (Banerjee, 2012).

The term incentive implies that a certain choice or behavior is being incentivized. When family planning programs provide an amount of funds or goods that entice a person to make a choice that they would not have made otherwise, it is effectively distorting a person's decision making process. However, when a person faces financial barriers to access, a stipend that allows them to recover lost funds may increase equitable access to family planning services.

Looking Closely at Allegations of Coercion

While it is critical to identify and address legitimate cases of coercion, it is also important to use caution in describing programs as coercive. Unfounded allegations, often made for

ideological or political reasons, negatively affect individuals and programs. East Timor, now Timor Leste, is a case in point. As part of the independence movement in the 1980s, rumors started circulating in 1987 that Indonesia "had 'forced birth control' on a 'largely Catholic population'…. Indonesia was accused of forcing 57% of the women of East Timor to use Depo Provera" (Hull, 2003: 74). Hull (2003: 74) notes that "These serious accusations would have been disturbing from the viewpoint of human rights were it not for the fact that they were based on a misinterpretation and misrepresentation of a single report prepared by the Family Planning Association of Indonesia (PKBI) in July 1986." The data was misconstrued to claim that 57% of all women were using Depo Provera, despite the fact that the percentage referred only to women using contraception – which was only 7%. Thus, only 4% of women in Timor Leste were using Depo Provera, among the lowest in Southeast Asia at the time. Although the skewed method mix may indicate quality of care issues, including a lack of other options or provider bias towards Depo Provera, further investigation did not find evidence of coercion. Furthermore, most of the users of Depo Provera were Javanese rather than women from East Timor.

Unfortunately, the perception of Indonesia forcing birth control on residents of East Timor persists, decades later. For example, a Gender Assessment prepared for the Japanese International Cooperation Agency (JICA) in 2011 stated that, "The concept of reproductive health is not recognized enough due to the influence of religion and the forced family planning under Indonesian rule" (2011:i). This issue is still used as partial explanation for the slow spread of family planning under independent Timor Leste (Hardee, 2012). Donors have been hesitant to promote family planning, leaving the women of Timor Leste without sufficient access to contraception. This demonstrates the negative outcomes of inadequate investigation into allegations of coercion and the damage done by continued perpetuation of false allegations,

creating a situation where it is easier for donors to walk away from the issue rather than take steps to increase access to family planning services.

The case of incentives for sterilization in Bangladesh provides another example of allegations that mix ideological arguments with allegations of coercion. In 1985, allegations of coercive user payments for sterilization were leveled against the program in Bangladesh – both by the "new right" movement that wanted the United States to cut off all aid to family planning, other than natural family planning, and a group of feminist academics and activists who considered family planning to be foisted on the people of the Third World (O'Reilly, 1985; Hartmann and Standing, 1985; Pillsbury, 1990). Political appointees from the Reagan Administration in the United States made preposterous claims that women could "add a new wing to their house" or "get a new party dress" from incentive payments, when in actuality the amount of money exchanged was small and the clean sari provided after the operation was not considered a desired item of clothing (Pillsbury, 1990). By misconstruing the real issue – that some motivators were using coercive tactics to increase uptake of family planning – steps to resolve the abuses were misdirected. Compensation payments had started in 1965 and helped women with travel, food and child care during their operation, making the method more accessible to them. For some women the payment did not cover all the costs and for others there was surplus, but even then the amount was immaterial to their decision to accept sterilization (Cleland and Mauldin, 1991). Pillsbury's research found that the payment clients received was not an important influence on their adoption of the method. Summarizing all of the research, including an evaluation she had been involved in conducting, Pillsbury (1990: 190) concluded that

> "continued improvements in Bangladesh's family planning program, as in anything else, depend on well-reasoned criticism based on sound observations. Ideologies, however, tend to confuse belief with evidence and to substitute their own interests for those of people they claim to serve. Continued ill-informed attack might easily deny the Bangladeshis who are most in need of…knowledge, information, and services for family planning. This would deny many Bangladeshis what might be the most fundamental of all human rights—the right to exert some effective control over one's life."

However, after extensive investigations USAID withdrew funding for all incentives because they found incentives created a substantial vulnerability in programs; the Bangladesh government chose not to eliminate incentives because they determined that the improved access outweighed relatively infrequent voluntarism issues (G. Newman, 2013). With the elimination of incentives, much of the donor's efforts to monitor family planning programming in Bangladesh also ended (Pillsbury, 1992), taking away an important check and balance in the family planning program.

In some cases coercion is egregious and needs to be addressed swiftly by identifying the specific factors that contributed to it and providing redress to victims. These factors could include political pressure, personal interests and biases, poor training, or unintended consequences of a new programming technique. It is important not to condemn entire programs when issues are localized and to deal with the issue at the appropriate level – within the community, by improving service quality, training and supervision, or changing policy that promotes coercive practices. However, some allegations of coercion are unfounded. Therefore it is also important to actively refute allegations that are not substantiated so that women are not denied the ability to plan their families based on misunderstandings or political ideologies. Due diligence in investigating coercion can lead to more appropriate responses in addressing the

problem and can clarify whether the issue is coercion or quality of care. Family planning can be controversial and the specter of coercion has been used to discredit efforts to expand access to voluntary family planning.

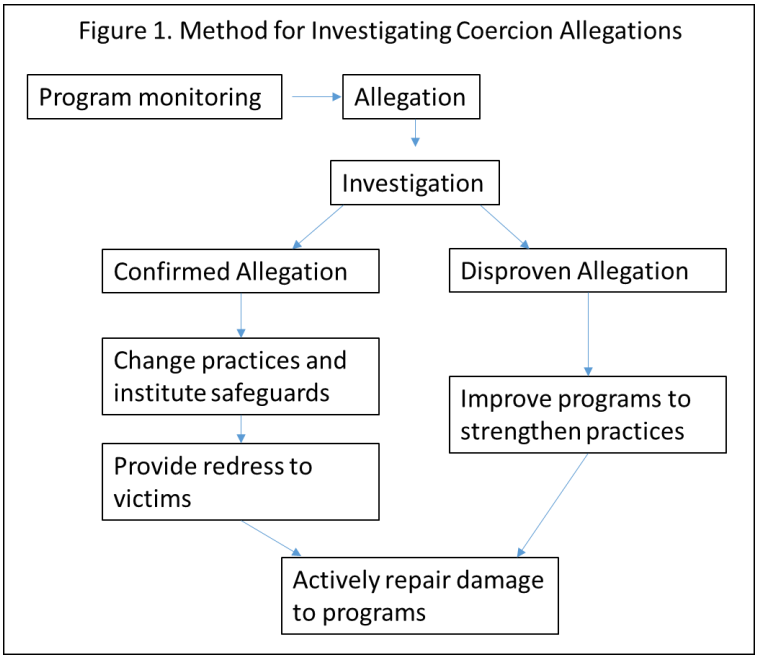
These examples also highlight how divisive arguments about programs can be detrimental to scaling up access to quality family planning services because, for some donors, it is simpler to withdraw funding for programs and avoid controversy. Governments can also take defensive postures regarding their family planning programs that can hamper program improvement initiatives. The vast majority of family planning is voluntary – to implicate all family planning when any issue or non-representative practice arises – and unfortunately issues will arise – or to continue to restate untrue allegations does a disservice to the millions of women and men, including youth, who need and want to have the means to control their fertility.

The Way Forward

While it may never be possible to prevent all instances of coercion, we are in a better position to set up programs to avoid coercion, to identify the instances quickly and to address them. Defining coercion in terms of both violations and vulnerabilities is a start. The human rights principles and programming and the monitoring and accountability mechanisms that need to be in place to avoid coercion are clear. Many tools exist to establish family planning programs that use a human rights approach (Hardee et al., 2013; Kumar et al., 2013; Erdman and Cook 2008; DFID 2004; WHO 2001; IPPF 1996; UNFPA 1994). A number of donors have adopted human rights-based approaches in their funding and governments have acknowledged human rights in their constitutions and national policies.

Monitoring and accountability mechanisms are crucial to ensuring that human rights are upheld. Policy and program safeguards must be put in place to prevent coercion and other rights abuses. When there is widespread coercion in policy or program implementation the remedy

requires action by donors, governments and civil society in order to make systematic change. With increased awareness of the vulnerabilities programs face, it may be easier to monitor family planning users' experience.. Routine program monitoring should be included as part of regular program activities, but useful monitoring data may also come from a variety of places – including from outside watchdogs, ad hoc reporting of cases, CSOs, individuals, or via reports to the press. A simple investigation algorithm is suggested (Figure 1) to show a complete investigation process including redress and reporting findings.



Accountability systems serve programs and individuals best when they are constructive rather than adversarial (Cabal, 2013). When donors, international governing bodies, and governments focus on program improvement rather than punitive processes that penalize programs when coercion is uncovered and addressed, they help programs respect, protect and fulfill people's right to family planning. USAID's use of Tiahrt is an example of a donor accountability system, although the provisions in Tiahrt have been noted to be necessary but not sufficient to guarantee full, free and informed choice in family planning programs (EngenderHealth, 2003). FP2020 as a global movement also has a role to play to ensuring voluntary, rights-based family planning. Its commitment is reinforced in the business plan (Family Planning 2020, 2012) and in the architecture of FP2020, which includes working groups

on Performance Monitoring and Accountability (PMA) and on Rights and Empowerment. This emphasis on monitoring is leading to the development of tools and indicators that can be used to identify potential issues with coercion and the funding of their use in routine data collection. The media, including social media, can also help to spread awareness rapidly regarding human rights violations and coercive practices. In contexts such as Myanmar, the child limitation policy for Muslim Rohingyas attracted media attention from media outlets such as Aljazeera and Reuters and the situation is being closely monitored. Furthermore, the spread of social media ensures that instances of coercion can be identified and called out more quickly and responses mobilized among stakeholders globally.

Legal mechanisms, national/regional human rights commissions, and linking to human rights treaty bodies, such as the Committee on the Elimination of Discrimination Against Women (CEDAW) and the Committee on Economic, Social and Cultural Rights (CESCR) can be important tools for addressing rights violations.

Regional human rights commissions are also important, as seen by the Kenyan National Commission on Human Rights which received an inquiry from the Federation of Women Lawyers–Kenya (FIDA Kenya) and the Center for Reproductive Rights (CRR) regarding the systemic problems with the reproductive health services in the country (Cottingham, Germain and Hunt, 2012). This inquiry resulted in recommendations to ensure expanded availability and accessibility of information, supplies and services through increased allocation of funds for family planning from government budgets and addressing sociocultural barriers to access, including gender dynamics (Kenya National Commission on Human Rights, 2012).

Civil society groups also play a significant role in the follow through and remediating of coercive family planning practices and human rights violations. For example, in Peru legal

organizations, the Public Ombudsman on Women's Rights, the media, and The Inter-American Commission on Human Rights (IACHR) were involved in identifying, publicizing, and prosecuting the cases of forced sterilization under the Fujimori regime (Center for Reproductive Rights, 2008; Coe, 2004). In Guatemala, efforts to hold the government accountable for the implementation of reproductive health policies (Merino 2010), led the government and the Multisectoral Monitoring Group to create the RH Policy Implementation Board (OSAR). OSAR not only serves as a monitoring and accountability mechanism in the country, but also offers the opportunity for participation by civil society groups, women's groups and researchers to contribute to the monitoring process (OSAR Guatemala, n.d.).

Conclusion

Through this review of allegations and confirmed instances of coercion, a definition of coercion in family planning has emerged. Some actions are clearly coercive and constitute vulnerabilities. Policies developed and implemented that limit the number of children or dictate mandatory contraceptive use violate the human rights of the individuals upon which the policies are imposed and are coercive. This review has also highlighted practices that raise red flags. These are practices that may inadvertently lead a program to coercive practices. Using excessive social pressure as a tactic to get individuals to conform to family planning, including by punishing wider groups or communities for noncompliance, constitutes coercion although the line between changing community norms to improve health and well-being and undue pressure on individual decision making can be blurred and should be assessed when evaluating whether or not a practice or program is coercive. While strong management systems that designate clear roles and responsibilities for family planning can have a positive effect on the efficiency and effectiveness of program implementation, management practices that include family planning targets as a performance measure can pressure managers and providers to "achieve numbers"

without respecting and protecting the rights of individuals to full, free and informed decision-making regarding family planning use can lead to coercion. This quantitative orientation in family planning programs often comes at the expense of high quality care and services for individuals, thus creating a space for coercion to occur as managers and providers are expected to reach certain quotas for contraceptive use or for use of a certain method. The case of incentives shows that payments to family planning users are not intrinsically coercive. While reimbursements can be positive components of a program if they "level the playing field" for individuals to access and use contraception, such payments or benefits may be considered inducements that have the power to distort decision making and compromise free and informed choice. Finally, monitoring and accountability systems are crucial to any family planning program and must include indicators that can identify coercive practices as well as redress for any confirmed instances of coercion.

It is important to remember that countries have legitimate concerns about demographic factors associated with economic, social wellbeing and environmental issues (UNHCR, 2005). Issues of population size, growth, structure and distribution warrant attention and planning. However, demographic concerns do not override individual liberties and rights (ICESCR, Article 4, 1966a; ICCPR; Article 4, 1966b) and thus cannot be used as justification for coercion.

Even one instance of coercion is unacceptable from a human rights perspective and requires a quick response. Evaluating the extent to which rights violations are systemic in a program assists in identifying the appropriate corrective actions and safeguards to stop the coercion and implement protective practices. Moving forward, using a human rights-based approach in the provision of voluntary family planning services can bring governments,

communities, civil society and donors together to work toward the common goal of preventing coercion and ensuring family planning programs respect, protect and fulfill human rights.

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