

Is There an ‘Unmet Need’ for Family Planning?

Rebecca Oas

Visitors to New York’s Times Square in September 2014 encountered a massive electronic billboard that said, “Over 200 million women want access to contraception but can’t get it.” Although brightly lit, the billboard was far from illuminating. The assertion that there is a vast, global “unmet need” for contraception is promoted by family planning advocates and is commonplace in international-development circles. But the claim is not supported by the facts, and it rests on shaky assumptions.

The figure of 200 million likely came from a 2012 report, co-produced by the United Nations Population Fund and the Guttmacher Institute, saying that there are 222 million women around the world with an “unmet need for modern contraception.” The 2014 edition of the report has the number at 225 million. But the very concept of “unmet need” is deeply flawed and routinely mischaracterized, both by development organizations and the popular press, which has propagated these numbers over the years. This is especially troubling because the concept plays an important role in directing vast sums of money to projects seeking to meet a need that is wildly exaggerated—and thus away from other projects meeting real needs for food, water, shelter, health, and education.

In September 2015, the United Nations adopted the long-awaited “2030 Agenda” centered on seventeen Sustainable Development Goals intended to replace the expired Millennium Development Goals (MDGs) adopted in 2000. The new framework describes its goals as both “aspirational and global,” as is evident in its first proposed goal to “End poverty in all its forms everywhere.” The third goal is to “Ensure healthy lives and promote well-being for all at all ages,” which includes “universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.” In order to achieve these goals, the agenda proposes to use a complex mechanism of targets and indicators. Despite criticism, the flawed notion of an unmet need has for years been one of the indicators in the old MDGs. So if policymakers wish to avoid the misuse of funds in the new agenda, they would do well to examine the errors of the past—to consider the flaws of the unmet need

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indicator, to reject the concept when considering funding strategies, and to demand a better alternative.

A Concept Catches On

Before examining the origins of the “unmet need” concept, it is worth briefly remarking on the context in which it is used. There exists a vast web of entities concerned with reproduction and contraception in the developing world. Some of these are intergovernmental organizations, while others are nongovernmental organizations (NGOs), but they are almost entirely undemocratic institutions—which is to say, they involve activists, experts, and bureaucrats who wield money, power, and influence without the accountability that comes from electoral politics. The United Nations, with its byzantine structure, is home to a host of such initiatives, including the United Nations Population Fund (UNFPA). Among the NGOs are such groups as the International Planned Parenthood Federation, Marie Stopes International, and the Gates Foundation-led FP2020. Numerous academic centers, think tanks, and journals provide intellectual heft. Although these institutions and organizations are often secretive, many of their activities are hidden in plain sight—in tedious meetings of and pronouncements from the U.N. bureaucracy; in international conferences where activists, staffers from technocratic foundations, and scientists rub shoulders with world leaders; in reports and press releases that almost no one reads; in short articles relegated to the back pages of newspapers; in countless buzzwords and slogans that make their way into public-service announcements.

Of course, these institutions and organizations do not always agree with one another. There is, for example, a history of distrust between feminist groups who see birth control as an issue of women’s advancement and other groups with Malthusian concerns about overpopulation. But one thing that unites these many entities, with their disparate agendas and modes of operation, is the belief that there is a great global unmet need for contraception. As demographer John Cleland and coauthors note in a 2014 article in *Studies in Family Planning*, “Unmet need has proved to be an invaluable bridge between a human rights and feminist approach to fertility control and a demographic-economic rationale.” Writing elsewhere, Cleland and a coauthor point out that “unmet need has become a central rationale for donor support and advocacy and a crucial guide for interventions.”

In 1974, the United Nations published a World Population Plan of Action. It urged countries considering population policies to keep human

rights in mind—a noteworthy emphasis, since this was roughly the peak period of aggressive and coercive family planning programs, focused on limiting population growth and involving forced contraception, sterilization, and abortion. Among the document's principles: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

A few years later, in 1978, the language of an "unmet need" for contraception appeared in the social science literature for what seems to be the first time, in a Guttmacher Institute article. The author, Charles Westoff, used the term to describe what was then called the "KAP-gap"—that is, the discrepancy between some women's professed preferences regarding reproduction and their use of contraception to realize those preferences, as indicated by surveys of knowledge, attitudes, and practices (KAP).

The unmet need concept has become more prominent in the last two decades, since the U.N. International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994. By then, the old coercive model of family planning programs had fallen into global disfavor (despite not being eradicated entirely), and the shift toward a rights-based approach to family planning, focused on reproductive health, was enshrined in the "Programme of Action" document of the ICPD. This document repeated verbatim the 1974 language about "the basic right" both to make decisions about having children and to have the means to act on those decisions.

In 2008, the unmet need concept received a boost when a new target for reproductive health was added to the Millennium Development Goal for maternal health. The MDGs approved by U.N. member states were implemented to run from 2000 to 2015, but after what one academic recounted as "a period of protracted technical and political wrangling," an addition was made to the goal of improving maternal health: "Achieve, by 2015, universal access to reproductive health." Many member states had previously rejected inclusion of reproductive health language in the MDGs, out of concern that such vague language could imply a right to abortion (as indeed some abortion-rights advocates believed it did). But the change was adopted in 2008, along with four new indicators for determining whether the goal of universal access was being met—one of which reads simply "unmet need for family planning."

The idea that unmet need could be used as an indicator—a way of measuring whether a goal is being met—is itself somewhat strange. Unmet need is not a clearly defined indicator. It is not a simple measurement of behavior (such as contraceptive prevalence) or personal intent

(such as the desire to become pregnant or not within a specified length of time); rather, it is a policy construct that combines aspects of both. The MDG indicator defined women with an “unmet need” as those who are married, of reproductive age, sexually active, wishing to avoid becoming pregnant in the next two years, and who are not using a family planning method. It has been criticized over the years, most prominently by Harvard economist Lant Pritchett, who in a 1994 article not only disputed the conceptual validity of unmet need but also questioned the effectiveness of increased contraceptive access alone in reducing fertility. As Pritchett pointed out, non-use of contraceptives often has nothing to do with lack of knowledge or lack of access, yet women who consciously choose to forgo contraceptives—for instance because they are not often sexually active, dislike the side effects of contraceptives, or have religious objections—are nonetheless characterized as having a “need” for them. “‘Unmet need’ does not reflect just women who want contraceptives (a supply need) but also those women who require motivation to want what they are presumed to need”—a usage Pritchett described as “consistent only with either a very broad, or very paternalistic, definition of ‘need.’”

In a 2011 blog post, World Bank economist Berk Özler asked scholars to weigh in on the question of whether there is an unmet need for birth control. Özler opined that the concept was invented and promoted by demographers but did not make sense in terms of the economic concepts of supply and demand. Dominic Montagu, a University of California San Francisco epidemiology and biostatistics professor, commented that “A need with no demand might make sense for political activism, but not for programs or policies.” Pritchett wrote that “the usual numbers bandied about for estimates of ‘unmet need’ do not correspond to any definition of ‘unmet need’ that any economist (or just common sense) could agree to” and that they are “an advocacy tool, not particularly relevant to conceptually or empirically informed discussions.” And Georgetown University economics professor Shareen Joshi agreed that the concept “does not correspond to what any economist would call demand.” Several of the participants in the discussion called for a better indicator, something perhaps like “unsatisfied demand,” that would restrict itself to a calculus of how many women actually lack access to contraceptives and would use them if they could.

Blurring Distinctions

According to the definition of “unmet need for family planning” used in the MDGs, the concept “points to the gap between women’s reproductive

intentions and their contraceptive behaviour.” The central problem with this definition is that it equates the desire to avoid pregnancy with the desire to use contraceptives. While these desires may be related, they are demonstrably distinct from each other.

Data on reproductive intentions and contraceptive prevalence among women in developing countries is collected using fertility surveys such as the Demographic and Health Survey (DHS) system, which distinguishes between women desiring to avoid childbearing for at least two years (spacing) or altogether (limiting). The complex algorithm used to calculate unmet need from DHS questionnaires has subtly evolved over time, with corresponding changes to the questions being asked. Prior to 2003, women were asked questions to determine the strength of their fertility intentions: How happy would they be, or how big a problem would it be, if they discovered they were pregnant in the near future? These questions, often referred to as the “happy” or “problem” questions, were dropped entirely from the most recent DHS questionnaires at the urging of a “Technical Expert Working Group” made up of leading family planning proponents from academic institutions as well as participants from the United States Agency for International Development (USAID) and UNFPA. The justification for the omission of the questions was to “exclude inconsistently collected data,” as the group’s 2012 report “Revising Unmet Need for Family Planning” explains. In other words, rather than harmonizing the questionnaires so that data on reproductive intentions could be uniformly collected and compared between countries and regions, they chose to drop the original questions entirely.

The working group members acknowledged that “Removing the ‘happy’ and ‘problem’ questions can increase estimated levels of unmet need by putting fewer women into the ‘no need’ category.” According to the 2012 Guttmacher Institute and UNFPA report mentioned above, the combined effect of implementing the working group’s proposed changes to the algorithm was “to slightly increase the number of women in developing countries in 2008 with unmet need: from 215 million, under the old definition, to 226 million using the new calculation specifications.”

The elimination of the “happy” and “problem” questions from the DHS did away with any nuance from the recording of women’s reproductive intentions, reducing their spectrum of responses to a “yes” or “no.” However, data collected prior to the revision reveals that women’s own perspectives do not conform to a simple binary. An analysis by reproductive-health researcher Ilene S. Speizer of data from 1998 and 2003, using surveys from three sub-Saharan African countries, found that

“a large proportion of women have ambivalent fertility desires.” In the 2003 survey, between a quarter and 43 percent of women who expressed a desire not to become pregnant in the next two years or longer reported that becoming pregnant in the next few weeks would be “no problem” or “a small problem”—an apparent inconsistency that suggests it would be a mistake to put too much stock in the respondents’ answers.

Other scholars have expressed concern about including women with ambivalent reproductive intentions in unmet need estimates and ignoring the distinct psychological determinants of reproductive desires and contraceptive use. The problem these scholars highlight is that women who are highly motivated to avoid becoming pregnant—and more likely to take concrete steps to prevent it—are rendered indistinguishable from women whose motivation is much weaker and may be counterbalanced by competing interests, such as the desire to avoid side effects and health risks of contraceptive use, or from women with a general attitude of openness to having a child even in the absence of an explicit wish to do so.

Despite the “need” imputed to them by oversimplified surveys, women in developing countries claim a wide range of compelling reasons for not using, or ceasing to use, contraceptives. According to data collected by the Guttmacher Institute’s Gilda Sedgh and Rubina Hussain from 51 country-level Demographic and Health Surveys between 2006 and 2013, in Africa, Asia, and Latin America and the Caribbean, only about 4 to 8 percent of married women aged 15 to 49 described as having “unmet need” actually cited lack of access to contraceptives (including inability to afford them) as a reason for not using them. That means that in Africa, where 24 percent of married women are said to have an “unmet need” (the highest rate of any region in the world), in fact just under 2 percent of surveyed married women actually have a self-reported lack of access to contraceptives.

The most frequently cited reasons for not using contraceptives are concerns about health risks, personal opposition, infrequent or no sex, and postpartum infecundity. While health concerns are sometimes downplayed as an effect of misinformation, they are, as the Sedgh and Hussain study shows, prevalent in areas with high as well as low contraceptive use, and as Cleland and coauthors note in their 2014 article on unmet need, “in high-use countries these concerns are more likely to be based on personal experience than on perceptions.” Additionally, some methods of contraception carry greater risks than others, and the methods most frequently used in developed countries are not always the same as in developing regions. Consider Depo Provera, an injectable contraceptive widely

distributed in the developing world by international health organizations and NGOs. In the United States, the Food and Drug Administration recently rejected a proposal to remove the “black box” warning from Depo Provera, calling a reduction in its long-term use “a public health benefit” due to the drug’s linkage with bone density loss. Some studies have linked Depo Provera use to increased risk of HIV transmission. Yet despite those concerns, a new self-injectable packaging for the same drug is being heavily promoted in developing countries, with support from the Gates Foundation and other NGOs, in collaboration with the drug manufacturer Pfizer.

Discontinuation of contraceptive use for reasons other than a desire to become pregnant is a serious issue, according to a report by Population Council scholar Anrudh Jain and colleagues. They found that 38 percent of total estimated unmet need in 34 surveys conducted in the DHS system between 2005 and 2010 is accounted for by women who discontinued use of modern contraceptives. Jain has labeled this phenomenon “the leaking bucket” in family planning, for instance in a 2014 blog post, while calling for action to achieve the ideal condition in which “the hole is plugged.”

And yet the “leaking bucket” metaphor—attempting to describe women who stopped using contraceptives and who, by doing so, fell into the category of women with “unmet need” for them—ignores the question at the heart of the issue: What does it mean for family planning to be truly voluntary, to “decide freely,” in the language of the U.N.? Furthermore, is it advisable to use measurements that drastically oversimplify reproductive intentions or characterize the rejection of drugs and devices that are far from universally acceptable to their intended users as a problem to be solved? Both the desire to bear children and the intention to use (or not use) contraceptives are complex matters that are governed by distinct, if sometimes overlapping, sets of factors. As “unmet need” is currently defined, however, important questions about ambivalence toward child-bearing and actual demand for or lack of access to contraceptives remain unasked or intentionally ignored. As demographers Sarah E. K. Bradley and John B. Casterline put it, the concept has been “misused and misunderstood” by those who characterize it as a simple lack of access to contraceptives by women who want them; in fact, “the standard algorithm does not include any direct measures of the desire to practice contraception or any direct measures of access to contraception.”

Further confusing the issue is the classification of contraceptive methods as “modern” or “traditional.” When a woman reports on a survey that she is using a family planning method that is not considered “modern,”

some analyses might include her among those with an “unmet need,” others as someone whose “need” is satisfied. Different agencies, even within the U.N. system, have different definitions of “modern,” and have different designations for methods such as lactational amenorrhea or fertility-awareness-based systems. (Meanwhile, most characterize condoms as modern, despite their having been used for centuries.) When “unmet need” is measured without the modern-method qualification, estimates are significantly lower than the UNFPA figure of 225 million; for example, a 2015 United Nations report that does not use the modern-method qualification gives a global figure of 142 million women.

The Price of Bad Policy

If “unmet need” is problematic from a scholarly and conceptual perspective, its flaws are only amplified when translated into advocacy and policy recommendations. In 2012, the London Summit on Family Planning featured twenty-three nongovernmental organizations as its civil society partners. In their advocacy materials, these NGOs often characterize the unmet need statistic as lack of access. For example, in a form letter to the U.S. Congress urging increased funding for family planning worldwide, Pathfinder International wrote that “222 million women still lack access to family planning around the world.” Population Action International claimed that “right now, 222 million women—more than the populations of Germany, Spain, France, Belgium, and The Netherlands combined—want modern contraception, but they can’t get it,” and called upon global leaders to stop “ignoring” these women. The Times Square billboard claiming that “Over 200 Million women want access to contraception but can’t get it” was placed by the International Planned Parenthood Federation to coincide with the meeting of the U.N. General Assembly in 2014.

The misrepresentation of unmet need carries an enormous price tag. According to the 2014 report co-produced by the Guttmacher Institute and UNFPA, “meeting all women’s needs for modern contraceptive services would cost \$9.4 billion annually.” The authors explain that “these estimates assume that all women with unmet need would use modern contraceptives.” This flies in the face of findings that a large proportion of women with purported unmet need have no intention to use contraception in the future, as reported, for instance, in a 2012 USAID report by Charles Westoff. It also contradicts the findings of the Guttmacher Institute’s own researchers Sedgh and Hussain in the 2014 article mentioned above, which shows that 11 to 27 percent of women surveyed cited opposition to

contraception as their reason for not using them despite their intention to avoid pregnancy. To meet these women's "unmet need" would first require changing their moral or religious views.

The misperception that unmet need is equivalent to lack of access or a frustrated intent to use contraceptives sometimes snowballs into even grander claims. In a March 2015 *Foreign Policy* article, Melinda Gates and former South African first lady Graça Machel wrote, "In fact, if the world extended contraceptive access to only a quarter of the women with an unmet need, it could save the lives of 25,000 women and 250,000 newborns each year." Since lack of access, according to the 2014 article on the reasons for non-use, accounts for less than a tenth of "unmet need" in the developing world (4 to 8 percent), the goal of extending contraception to a quarter of women with "unmet need" would seem to have already been achieved. But what of the lives that could be saved?

Gates and Machel's claims are dubious. The numbers they cite are based on data from the 2012 Guttmacher Institute and UNFPA report, which estimates that 80 million unintended pregnancies would occur in that year—a number that includes pregnancies of both women not using contraceptives and those who experienced contraceptive failure. By averting unintended pregnancies, the authors of the report reason, 104,000 women's deaths could be averted, commensurate with existing maternal mortality rates. Their solution, apparently, is to avoid pregnancy rather than to make childbirth safer. Gates and Machel's claim that newborn lives would be saved by contraceptives relies on a similar logic, although they are mistaken to describe this as saving lives; the only way newborns' deaths would be averted is by averting their very existence in the first place. Again, wider use of contraceptives might reduce rates of infant mortality in raw numbers, but it would not in itself make infancy any safer.

While the unmet need statistic is routinely misrepresented as lack of access to contraceptives, at times increasing access can result in increased "need." According to the UNFPA's "The State of World Population 2014" report, "the unmet need for contraception often rises in the early stages of fertility decline, as increasing numbers of women become more aware of the possibility of exercising control over their childbearing." The report attributes this observation—that more access means more knowledge about contraceptive choices, which in turn means more "need"—to demographer John Bongaarts, writing in 1997. Two years earlier, Bongaarts and a coauthor noted that based on Demographic and Health Surveys from 1986 to 1990, 25 percent of unmet need was due to lack of

knowledge regarding contraceptive methods—the most frequently mentioned reason for non-use in the surveys (although the authors note that what lack of knowledge means is not perfectly clear). Lack of knowledge about contraception seems to have dropped significantly since the mid-1990s. According to the analysis by Sedgh and Hussain of surveys from 2006 to 2013, lack of knowledge accounted for only 1 to 6 percent of the unmet need. (In contrast, lack of access remained relatively constant, with the earlier article reporting 4 percent and the more recent one 4 to 8 percent.) On one hand, this significant increase in contraceptive awareness illustrates what may be the success of sexual-education policies of the sort encouraged by the United Nations. On the other hand, it suggests that those not using contraceptives today are more likely to be making a conscious decision to reject them, and may be more resistant to having their purported needs met.

By virtue of its phrasing, an unmet need seeks to be met, and by virtue of its definition, the unmet need for family planning cannot be met unless all women who fall within its algorithm either adopt modern contraceptive use or decide they want to become pregnant within the next two years. Since neither of these things can be forced upon women in the absence of highly coercive policies that would clearly violate their human rights, family planning organizations frame their advocacy in terms of providing access and education, despite the fact that the unmet need algorithm does not measure contraceptive effectiveness in terms of providing either access or education. Therefore, even as self-reported lack of access shrinks to minuscule levels—estimates from Sedgh and Hussain range from under 1 percent in Latin America and the Caribbean to 2 percent in Africa, while estimated “need” ranges from 13 percent to 24 percent, respectively—policymakers must ask how the \$9.4 billion to meet “unmet need” annually will be spent.

One troubling indication of how it will be spent, and how else it will therefore *not* be spent, comes in the form of an infographic designed to promote the 2014 Guttmacher Institute–UNFPA report: “Why invest in reproductive health? Add it up.” Under an image of a syringe, a pill, an intrauterine device, and a condom, the graphic says that every additional dollar invested in contraceptives means \$1.47 that doesn’t need to be spent on pregnancy-related care for women and newborns, the latter illustrated by an image of a mother and child.

In the Millennium Development Goals, the reproductive health target was included as a subset of the overall maternal health goal. In the proposed new Sustainable Development Goals, maternal health appears once,

as a target of the overarching health goal, whereas reproductive health appears both under the health goal and the gender equality goal, giving it a more prominent place than in the MDGs.

If the Guttmacher Institute and the UNFPA continue to interpret reproductive health as the avoidance of childbirth, to be achieved by voluntary contraceptive use, not only will this do nothing to make reproduction safer for mother and child, but may well divert needed funds away from initiatives that could.

Different Words, Same Problem

Even if “unmet need” is replaced by another family planning indicator, it is likely that the central flaws will remain. That is because the flaws are the key to its effectiveness: the ability to equate increased contraceptive use with increased access, just as it equates non-use of contraceptives with lack of access.

As the United Nations launches the 2030 Agenda, statisticians have been hard at work to develop the indicators to measure its progress. In a move strongly encouraged by USAID, the World Health Organization, and UNFPA, the “unmet need” indicator has been replaced in the proposed framework by a new measurement: the “proportion of women of reproductive age with their need for family planning satisfied with modern methods.” Measurement of the indicator would incorporate both the existing unmet need figure and the contraceptive prevalence rate:

$$\text{percent "met need" for family planning by modern methods} = \frac{\text{percent modern contraceptive prevalence}}{\text{percent modern contraceptive prevalence} + \text{percent "unmet need" for modern methods}}$$

The new indicator was described as an improvement “because it is more easily understood and is linearly correlated with contraceptive prevalence,” and also because it expands the definition to include unmarried women and adolescents, whereas before it had been limited to women married or in a union. Yet it is questionable how this new indicator could be “more easily understood” than the current “unmet need” indicator, since “unmet need” is actually a component of the new indicator. As to the linear correlation with prevalence, this introduces a further troubling aspect: it becomes impossible to improve performance on this indicator without increasing levels of contraceptive use. Consequently, countries with low contraceptive prevalence due to high desired fertility will appear

worse than countries with much higher prevalence and comparable levels of “need.” Health advisors from USAID and UNFPA have even gone so far as to propose a benchmark of 75 percent need satisfied with modern methods for each country. (On the other hand, as a thought experiment, if the numbers of self-reported lack of access from the Guttmacher Institute’s 51-country analysis were substituted for the unmet need figure, each of those countries would far surpass that benchmark, with over 90 percent of need satisfied.)

The United Nations is not alone in setting targets for increased contraceptive use, often shrouded in the language of “increased access.” At the 2012 London Summit on Family Planning, the Bill and Melinda Gates Foundation and the U.K. Department for International Development joined forces with UNFPA and USAID in an effort to put family planning at the forefront of the global development funding agenda. There they launched the FP2020 initiative. The quantitative goal of FP2020, known as “120 by 20,” seeks “to enable 120 million more women and girls to use contraceptives by 2020.” Elsewhere on its website, the target is described as “extending contraceptive access.”

A closer look at the methodology behind “120 by 20,” as described in a 2014 report on the initiative, reveals that while its boosters deemed “the reduction of unmet need relatively unsuitable as an overall goal for tracking the progress of family planning programs,” their criticisms of the unmet need indicator were more at the level of implementation than overall concept. For instance, as we have already seen, in countries with low contraceptive prevalence—the main targets of the initiative—family planning programs may increase the desire to space or limit births, which could lead to short-term increases in reported “unmet need.” The authors of the report conclude that “unmet need is not necessarily a unidirectional indicator of success.” Giving a hint of its conceptual limits, they note that “the relationship between unmet need and actual demand... is not always straightforward.”

Instead of focusing on reducing “unmet need,” the FP2020 agenda more simply aims at expanding contraceptive access by a set number. The authors of the agenda’s 120 by 20 goal express concern that “an overemphasis on reaching an absolute number of new users could lead to the abuse of girls’ and women’s reproductive rights.” Ultimately, though, their goal of increasing contraceptive access to 120 million new users does translate directly into increasing contraceptive *use* by 120 million (or even 215 million new users, if their “high aspiration” were to be met). To assuage squeamishness about potential human rights violations, the

FP2020 Metrics Group expanded to include “a range of experts in human rights and family planning” and set out to develop further indicators “reflective of these dimensions.”

Choice Under Duress

History shows that concerns about coercion in family planning programs are not unfounded. As Columbia University historian Matthew Connelly writes in *The Fatal Misconception: The Struggle to Control World Population* (2008),

The great tragedy of population control, the fatal misconception, was to think that one could know other people's interests better than they knew it themselves. But if the idea of planning other people's families is now discredited, this very human tendency is still with us.

Reflecting on the troubled pedigree of family planning programs in light of the new FP2020 agenda, a 2014 article by the Population Council's Karen Hardee and coauthors states that “defining coercion or coercive actions too broadly could incriminate all family planning programs”—a troubling perspective considering the extensive and ongoing effort to ensure that family planning is voluntary. The authors note that offering incentive payments to family planning users “may not be intrinsically coercive. The only definitive way to determine if incentives have a coercive effect is to...ask clients whether they would have made the same decision in the absence of the incentive.” This, of course, is very silly. Presumably, the question would be asked after the incentive has already been given, since asking about its effectiveness to persuade the person while offering it will almost certainly not produce an honest answer. But if the question were asked later, then coercion would at least in some cases already have occurred. And if there was no coercion—if, in the best-case scenario, all “clients” would have made the same decision without the incentive as they did with it—then what is the point of the incentive?

Incentives were used to convince millions of people in India to undergo sterilization or intrauterine device insertions in the 1960s. The payment may have been relatively modest, Connelly writes, but they “were subtly coercive even in the best of times, since many Indians were always at risk of malnutrition.” Even as public opinion has since become more skeptical toward the use of incentives, the issue made headlines in 2014 when twelve Indian women died in mass sterilization camps from botched operations. In poverty-stricken areas, any incentive, whether in the form of cash or not, risks blurring the line between a potential demand

for contraceptives and the demand for food and other basic necessities. The acceptance of sterilization is not, as family planning advocates would describe it, a means of broadening one's options; instead, it is a symptom of the lack of options.

Unmet Need for Better Policy

Good indicators enable researchers and policymakers to measure both the scale of problems and the degree of progress toward solutions. Bad indicators can overstate (or understate) the size of the problem, which can lead to misdirected attention and funding, premature declarations of victory, and important human needs left unaddressed.

Implementing the U.N.'s 2030 Agenda will involve the direction of vast sums of money to organizations and partnerships—often with powerful lobbying divisions—claiming to speak on behalf of large constituencies. For family planning groups, the “unmet need” concept purports to serve as a measurement of what women and their families actually want. Instead, it is the product of a multi-decade effort to further the agenda of fertility reduction using selectively interpreted survey findings. At its best, this constitutes poor social science and leads to indicators with poor technical validity. At its worst, it diverts funding and attention from real needs that remain unmet and creates situations ripe for abuses and human rights violations, where the interests of people in developing countries are at odds with those of the organizations tasked with helping them achieve their goals.

There is also the problem of conflict of interest: the organizations that developed the measurement system that gave us “unmet need” were politically highly motivated and unapologetically placed the “dictates of mission” over the “demands of science,” as Donald P. Warwick has written in *Social Research in Developing Countries* (1993). It raises serious questions when the wording of the surveys being conducted, the analysis of their findings, the measurement of the purported problem, and the price tag for solving it are all determined by organizations and individuals who benefit politically and financially by increased spending on family planning. For instance, in 2010, USAID's Demographic and Health Surveys program convened a working group to modify the definition and measurement of unmet need. The group included representatives of UNFPA and the Population Council, both of which receive U.S. funding for family planning work.

National delegates to international organizations working on global development need to familiarize themselves with the operational definitions

of the terms in the proposed indicators, as well as their potential weaknesses and susceptibility to manipulation. At a minimum, they should be aware that “unmet need” implies neither demand for nor access to contraceptives.

Health ministers should assess the types of surveys being done in their countries, and how their findings are translated into policy priorities. Along with delegates to international bodies, they need to recognize the extent to which family planning lobbying groups already control the types of measurements contained in multi-country demographic surveys and be prepared to question or oppose the use of policy constructs that are misleading or lack sufficient nuance.

The World Health Organization and other U.N. agencies with an interest in population and global health policy need to prioritize good maternal health over the avoidance of motherhood, and provide greater oversight in cases where the effort to increase contraceptive prevalence in developing countries leads to the strong promotion of contraceptives deemed too unsafe for use by leaders in wealthier countries.

Donors—including governments, philanthropic foundations, and private sector stakeholders—need to invest their money where the true needs and demands are and recognize that a life prevented is not a life saved. Given the long history of presumably well-intentioned donors enabling and supporting coercive population control programs, special care must be taken to respect the wishes of those whose purported “need” for family planning rings louder in high-level meetings than their own voice saying “no” when such services are offered.

Researchers focusing on health and demography must resist the urge to allow policy missions to cover for—or even drive the proliferation of—bad social science. Intellectual honesty must exist at all levels, particularly in the area of definitions of terms. Additionally, researchers with an interest in policy need to be aware when their work is being widely misconstrued for political purposes and be willing to criticize this practice, even when done by those who share the same policy goals.

The more demographers and family planning advocates hint at a desire to move beyond “unmet need,” ostensibly for reasons of greater clarity, the more they perpetuate its conceptual flaws and, ironically, further obscure them. The current and proposed indicators for family planning within the global development agenda are based on assumptions that are inextricably wedded to an advocacy agenda, which in turn unabashedly misconstrues them in an effort to direct funds toward meeting a demand that barely exists. If family planning advocates truly want to ensure that families are able to “decide freely and responsibly the number and spacing of their

children,” any “need” or “demand” for specific products and services must be directly communicated by the end users themselves, not by family planning groups armed with incentives, pharmaceutical companies seeking new markets, or demographers with Malthusian tendencies aspiring to reduce global fertility.

Policymakers need indicators that offer a clear picture of people’s realities and aspirations, not ones that risk institutionalizing coercive practices. Above all, they need to direct resources toward safeguarding the lives of the most vulnerable women and children by ensuring that it is safe both to give birth and to be born, no matter where you are.