PONTIFÍCIA UNIVERSIDADE CATÓLICA
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Beatriz Nazareth de Souza Teixeira

CARING ABOUT WOMEN AND THE ROLE OF QUANTIFICATION IN FAMILY PLANNING

A critical analysis of the FP2020 programme

Dissertação de Mestrado

Dissertation presented to the Programa de Pós-graduação em Relações Internacionais of Instituto de Relações Internacionais of PUC-Rio in partial fulfillment of the requirements for the degree of Mestre em Relações Internacionais.

Advisor: Prof. Isabel Rocha de Siqueira

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Abstract

De Souza Teixeira, Beatriz Nazareth; Rocha de Siqueira, Isabel (Orientadora). **Caring about women and the role of quantification in family planning: a critical analysis of the FP2020 programme**. Rio de Janeiro, 202. 229 fls. Dissertação de Mestrado – Instituto de Relações Internacionais, Pontifícia Universidade Católica do Rio de Janeiro.

The intersection between population, conflict, climate change and migration is the cornerstone of contemporary population control debates and rekindles initiatives that target the bodies of women and girls, largely of colour and from the Global South. As a growing population becomes framed as a global problem, the fertility of those women turns into a threat and their bodies into a space for interventions by international organizations, development agencies, and governments. The purpose of this work is to investigate one of said interventions, the largest one when it comes to targets and financial investment - the Family Planning 2020.More specifically, the project will look to FP 2020 to analyse the role played by quantified data in substantiating interventions in the reproductive health of millions of women. The working hypothesis of this dissertation is that data is a crucial element to the "rebranding" of family planning policies as not racially oriented, but rather as objective and evidence-based and that, by adhering to an ethics of care, one might avoid the pitfalls of instrumentalizing women's fertility and overall health in order to address other pressing issues.

Keywords:

Family Planning; Development; Quantification; Care.

Resumo

De Souza Teixeira, Beatriz Nazareth; Rocha de Siqueira, Isabel (Orientadora). **Cuidado com as mulheres e o papel da quantificação no planejamento familiar: uma análise crítica do programa FP2020**. Rio de Janeiro, 202. 229 fls. Dissertação de Mestrado – Instituto de Relações Internacionais, Pontifícia Universidade Católica do Rio de Janeiro.

A interseção entre população, conflito, mudanças climáticas e migração é o ponto central dos debates contemporâneos sobre controle populacional e reacende iniciativas cujo alvo são os corpos de mulheres e meninas, majoritariamente não- brancas e do Sul Global. À medida que uma população crescente passa a ser enquadrada como um problema global, a fertilidade dessas mulheres se torna uma ameaça e os seus corpos um espaço para intervenções de organizações internacionais, agências de desenvolvimento e governos. O propósito do trabalho é investigar uma dessas intervenções, a maior em termos de recursos financeiros e de metas estabelecidas – Family Planning 2020. Mais especificamente, será focado no papel desempenhado por dados quantitativos para fundamentar intervenções na saúde reprodutiva de milhões de mulheres. A hipótese da dissertação é que esses dados desempenham um papel fundamental no posicionamento de políticas de planejamento familiar como objetivas e baseada em evidências, e não como fundadas em fatores raciais. Ademais, que a adesão a uma ética do cuidado pode orientar tais políticas de maneira que se evite instrumentalizar a fertilidade e a saúde de mulheres para enfrentar a questões atribuídos à 'superpopulação'

Palavras-chave:

Planejamento Familiar; Desenvolvimento; Quantificação; Cuidado.

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Introduction

Population control policy might at first glance seem like an outdated theme to analyse two decades into the twenty-first century, almost two hundred years after the death of Thomas Malthus, the economist who first and most notoriously wrote on the impending need to face population growth as a threat to humanity's very own survival. However, one should only look to some of the most debated issues in International Relations today, such as migration, conflict, and climate change to realize that population control concerns are seemingly everywhere and that far from a distant past, Malthusianism is alive and well.

In 2015, a report from the UK All-Party Parliamentary Group on Population Dynamics and the Sustainable Development Goals emphasised the interaction of population dynamics with climate change and conflict to highlight family planning policy as a pathway to address resource scarcity, migration, climate change and conflict (HUNTER, 2015).

This intersection between population, conflict, climate change and migration is the cornerstone of contemporary population control debates and the rekindling of population control initiatives that target the bodies of women and girls, largely of colour and from the Global South.

As a growing population becomes framed as a global problem, the fertility of these women turns into a threat and their bodies into a space for interventions by international organizations, development agencies, and governments.

The purpose of this work is to investigate one of said interventions, the largest one when it comes to targets and financial investment - the Family Planning 2020, created in 2012 in the auspices of the 2012 London Summit for Family Planning. More specifically, the project will look to FP 2020 to analyse the role played by quantified data in substantiating interventions in the reproductive health of millions of women.

In 2012, the United Kingdom Department for International Development (DFID) and the Bill and Melinda Gates Foundation (BGMF) convened the London Summit on Family Planning, which was described by the British Government as 'a groundbreaking effort to make affordable, lifesaving contraceptives, information, services, and supplies available to an additional 120 million women and girls in the world's poorest countries by 2020' (UK AID, 2013).

The Summit resulted in the largest family planning initiative with regards to targeted audience and financial investment. Sixty commitments to the realization of the summit's goal were formalized by governments from both developing/target countries and developed/donor countries, civil society and multilateral organizations, as well as by private foundations and companies. Donor countries and foundations, alongside private sector companies pledged over two billion dollars to what become known as 'FP2020'(UK AID, 2013).

Despite the problematic history of establishing population targets (BRIGGS, 2003, SOLINGER, NAKACHI, 2016), the FP2020 decided on the goal and slogan '120 by 20', indicating the objective of having 120 million additional users of modern contraceptive methods[1] by the year 2020. According to the London Summit Metrics Group, responsible for setting such target, the rationale behind stating it was the recent successes of health programs, namely UNICEF's 'child survival revolution' and the World Health Organization (WHO)'s '3 by 5'. Aware of the risks of target-oriented policies, the group pre-emptively responded to potential criticism by stating that '120 by 20' was to be interpreted as a 'global rallying cry' and not to be translated into national targets (BROWN, Win, DRUCE, *et al.*, 2014, p. 74–75).

Regardless of such disclaimer, the shadow of the horrific past of population control policy inevitably looms over the initiative. Many of the main donors, such as the World Bank, USAID and DFID have a well-known history of financing programs that were responsible to mass and coerced sterilization in places like India, Bangladesh and Puerto Rico, just to name some of the more prominent cases. The reality of family planning programs on the ground has been marked by violence to women's bodies and disregard for their wishes and will (BRIGGS,2003, CONNELLY, 2008, HARTMANN, 2016, WILSON, 2017b). India is perhaps the most notable example. The first country to develop nationwide family planning programs, India has been at the centre of the world's attention when it comes to population growth as it is set to soon surpass China as the country with the largest population in the world (RITCHIE, 2019).

[1] Defined as 'all hormonal methods (pills, injectables, implants), intrauterine devices, male and female sterilization, condoms, modern vaginal methods (e.g., spermicides), and the Standard Days Method' (BROWN, Win, DRUCE, *et al.*, 2014, p. 78)

India has also been the object of tragic notoriety in the topic of population control due to its facilities commonly referred to as ‘sterilization camps’, where dozens of women underwent tubectomy surgery, one after another, in a staggeringly fast manner, sometimes, reportedly, without the surgical instruments being even changed or sterilized from one procedure to the next (BURKE, 2014a, CHAMBERLAIN, 2012). On the village of Kaparfora, for instance, a single doctor performed surgery on fifty-three women in under two hours as part of a family planning program partially funded by the British Government, via UKAID (DOSHI, 2016). In 2014, at least thirteen women died after undergoing tubectomies at a sterilization camp in Chhattisgarh (BURKE, 2014b).

Whilst sterilization camps were only outlawed in India in 2017, the history of violent and controversial practices in the name of population control is, unfortunately, filled with examples. Some are old but many are new.

At the end of the 1980’s the World Bank financed a programme which provided cash payments in exchange to sterilization in Bangladesh (CLELAND, MAULDIN, 1991). In 2018, in the state of São Paulo, Brazil, a 36-year-old woman battling drug addiction who had given birth to eight children underwent an involuntary, court-ordered tubectomy (BERTOLINI, RODRIGUES, 2018). In the same year, a judge in the state of Oklahoma, in the United States, compelled a woman to get sterilized before her sentencing on a drug-related offense. Although there was no direct order from the court, the judge clearly signalled the inclination to lenience were the woman to present documentation proving that she was ‘no longer able to procreate’. The 34-year-old mother of seven ‘got the message’ and proceeded to have a tubectomy (JACKMAN, 2018). Both stories, although examples of individual cases rather than far-reaching policies, signal a trend that legitimises interventions on the reproductive health of women for the sake of addressing social problems.

Far from being an issue of the past, the reproductive freedom and general well-being of women remain in jeopardy as Malthusianism rhetoric resurges amid discussions regarding sustainable development, climate change and violent conflicts.

For instance, in late 2019, a declaration of warning signed by 11,000 scientists from 153 countries made headlines by describing the Earth’s current situation as one of climate crisis. They emphasized, among other urgent measures, the need for

the world's population to 'be stabilized—and, ideally, gradually reduced' (ROSTON, 2019).

In the very year of the London Summit, the Bill and Melinda Gates Foundation expressed what Hendrixson accurately describes as 'explicit neo-Malthusian language' on its family planning strategy by stating that the continued growth of the world's population would 'contribute significantly to the global burden of disease, environmental degradation, poverty, and conflict' (HENDRIXSON, 2019, p. 799).

Against the perils of a population bomb, the fertility of women, especially of those in the Global South, become targeted. Therefore, it is essential that large programs aimed at significantly affecting the reproductive health of these women do no go unchecked.

The idea behind this project stems from the desire to contribute to an approach to population policy that is ethically committed to the agency and well-being of women. It is important to note that it is not the intent of this project to demonize family planning programs, which to large extent can be lifesaving as well as crucial to the freedom of women and the fulfilment of their reproductive rights.

The complexity of the discussion cannot be overstated. Therefore, the analysis and constructions of this work will attempt to embrace said complexity and imagine a way forward in which the health and well-being of girls and women is the priority. For pursuing this goal, feminist thought, more specifically regarding the ethos of care (PUIG DE LA BELLACASA, 2017), presents itself as an adequate foundation upon which to build.

It is noteworthy that precisely the promotion of the health and well-being of girls and women is commonly mentioned as fundamental to the objectives of family planning programs. Health and well-being are often portrayed as aspects of the ubiquitous, nearly all-encompassing concept of 'female empowerment', core to many of such programmes, as demonstrated by the following example from the World Bank:

> Family planning along with other interventions like delayed marriages and access to education, empowers women and girls to have more control over their lives and well-being. It helps them achieve their potential – academically, professionally, and in their personal lives. And this has a cascade effect – children of educated mothers, for instance, are more likely to get an

> education themselves – further building the human capital of a country. (AL TUWAIJIRI, SAADAT, 2018).

This work hopes to scrutinize this affirmation of female empowerment vis-à-vis the environmental, economic, and security rationales presented for these initiatives. Part of the hypothesis that propels this investigation is that by adhering to an ethics of care, one might avoid some of the pitfalls that lead to the instrumentalizing women's fertility and overall health in order to address other pressing issues.

It is commonly referred to the International Conference on Population and Development (ICPD), held in Cairo in 1994, as a transformative moment in population policy. The conference would represent a pivotal moment, the end of a 'troubled history', as described by the United Nations (UN) in its 2014 Framework for Actions.

> In the decade prior to the International Conference, the escalation of incidents in which women's rights were transgressed by family planning programmes suggested a sector-wide subordination of women's health and human rights to population control imperatives (UNITED NATIONS, 2014, p. 79).

One of the major innovations of the ICPD was asserting a human rights-based approach to family planning. This human rights-based approach to health is founded on seven key principles: availability, accessibility, acceptability, quality of facilities and services, participation, equality and non-discrimination, and accountability (WORLD HEALTH ORGANIZATION, 2014). According to the FP2020, they are committed to such approach and their programs are based on voluntary adhesion to family planning (BROWN, Win, DRUCE, *et al.*, 2014, HARDEE, KUMAR, *et al.*, 2014).

Notwithstanding the novel rhetoric and nomenclature brought about by the ICPD, many of the historic shortcomings of population policy persist, as highlighted by the works of authors such as Kalpana Wilson (MADHOK, PHILLIPS, *et al.*, 2013, WILSON, 2015, 2017b, a, 2018), Diana Ojeda and Anne Hendrixson (BENDIX, FOLEY, *et al.*, 2020, BHATIA, SASSER, *et al.*, 2020, HENDRIXSON, HARTMANN, 2019, HENDRIXSON, OJEDA, *et al.*, 2020).

> (…) we argue that population control is part of a troubled present, and cannot be relegated to history as dated international development policy. Further, we suggest that population control is far more pervasive than anomalous abuses that run counter to global norms. Rather, population policies systematically shape

> nations and geopolitics and target particular bodies in both the global North and the global South (HENDRIXSON, OJEDA, *et al.*, 2020, p. 308–309).

This work's first objective is, thus, to contribute to these critical analyses of family planning programs, by exploring the role played by data in the decentering of gender and racial issues in contemporary family planning initiatives. The working hypothesis of this dissertation is that data is a crucial element to the 'rebranding' of family planning policies as not racially oriented, but rather as objective and evidence based.

FP2020 was chosen as a case study because it is the largest world's largest initiative on the field of family planning in scope (69 countries), financing (an average of approximately 3 billion dollars per year), and target (120 million women), with concrete repercussions to millions of women and girls in the Global South. It is also a prominent example of quantitative methods in development programmes, centred around a quantitative goal of 120 million additional users of contraception, a strategy of monitoring based on sixteen core indicators, and the digital tools which apply projection models to define priority interventions in family planning.

Both in the discourse and in the policies regarding population, quantified data plays a crucial role. Ever since the seminal writings of Malthus, projection models have been central to the alarmist claims regarding the impact of a growing population on the world's subsistence (DAVIS, Kingsley, 1945, KIRK, 1945, 1996, MALTHUS, 1998, NOTESTEIN, 1945).

Although it presents itself as a global initiative, as rightly highlighted by Hendrixson, the FP2020 so-called 'global' target of 120 million additional users of modern contraceptive methods is 'only global in the sense that it is intended to garner support from partners throughout the world', as it is very clear to establish 69 target countries, 41 of which are in Africa (HENDRIXSON, 2019, p. 789).

The target of the initiative, as well as its performance indicators, were defined by Monitoring and Evaluation (M&E) professionals, whose work was done, in their own words, 'with little external input, driven by the pressure to formulate a goal in time for the July 2012 London Summit' (BROWN, Win, DRUCE, *et al.*, 2014, p. 82). It therefore grants criticism that characterizes the target as a 'a top-down construct', considering that people from the target-countries did not have any say

in its development, neither did the professionals nor the women who would be directly affected by the programs.

The experts responsible for coming up with the target and the performance indicators for the FP2020 were professionals hired by large organizations from the developed North[2] (BROWN, Win, DRUCE, *et al.*, 2014). The data-driven approach of the work done is supposed to make that fact nearly irrelevant, as the faith in the objectivity and accuracy of quantitative data and methods is widely shared among development professionals and organizations.

As a way of advocating for the re-centering of concerns regarding race, gender and imperialist practices in population debates, programmes, and policies, the second goal of this work is to pursue an ethical pathway for quantitative data in population policy.

The works of three authors are fundamental to this effort. First, Betsy Hartman's reflections on the implications of scarcity-driven narratives of overpopulation (HARTMANN, 2016). Secondly, Kalpana Wilson's work on reproductive justice both make the case for the centering of race and gender in development and provide the ground on which to imagine a new approach to population policy (WILSON, 2015, 2017b, a, 2018). Finally, Maria Puig de la Bellacasa's book, 'Matters of Care', by framing care as an ethical and political intervention, lends theoretical footholds for reimagining the role of data in development (PUIG DE LA BELLACASA, 2017).

While there is vast literature to support criticism of the allegations of objectivity and neutrality often made regarding quantitative methods (EUBANKS, 2017, MERRY, 2016, O'NEIL, 2016, PASQUALE, 2015), this work intends to specifically reimagine the use of quantitative data in a manner that both forgoes aspirations of neutrality and objectivity and embraces an ethical commitment to contribute to the development of policies that address historical and systematic forms of oppression.

The effort of reimagining a role for quantitative data in a policy guided by an ethos of care is not to be underestimated. As Puig de la Bellacasa rightly points out, one must be cautious as not to fall on the traps of essentialization of women's experience or of idealization of care (PUIG DE LA BELLACASA, 2017, p. 7–8).

[2] See chapter 2 for complete table of members and their respective affiliations.

However, one cannot ignore the historical struggle to assure access to family planning and birth control by women, especially poor women from the South, who have faced numerous political, economic, cultural, and religion restrictions regarding their power of deciding if and when to have children. Therefore, it is imperative to thread carefully as not to undermine women's freedoms whilst criticizing population policies and family planning programs.

The first chapter will investigate the making of the so-called 'population problem'. This will be the starting point as it is the basis on which large-scale family planning programs such as FP 2020 are founded. Organizations and experts look to family planning as a solution to a very straightforward problem: the size of the population must be controlled (GAFFIN, O'NEILL, 1997, HICKEY, RIEDER, *et al.*, 2016, O'NEILL, DALTON, *et al.*, 2010, O'NEILL, LIDDLE, *et al.*, 2012, RIPPLE, WOLF, *et al.*, 2017, WYNES, NICHOLAS, 2017). The push to offer contraceptives, sterilizations and other forms of fertility control to the world's poorest countries starts on the largely unquestioned premise that humanity's survival is threatened by a scarcity-driven population time-bomb[3]. Therefore, the chapter aims to critically analyse the arguments applied in the framing of the topic of population as the **problem of overpopulation**, perceived as a triple threat: to development, to the environment and to security.

The second chapter will focus on setting a backdrop for the analysis of Family Planning 2020 (FP2020) initiative. It will provide an overview of the history of population policy in the international agenda up until the agenda of the Millennium Development Goals (MDGs), the framework in place at the time of the 2012 London Summit and the creation of the FP2020 programme.

Chapter three will focus on the role played by quantification in the Family Planning 2020 (FP 2020) programme. At first, it will briefly describe some of the main events that prefaced its launch at the 2012 London Summit on Family Planning, highlighting the main political forces that acted to bring focus in development back to the issue of overpopulation and family planning. It will also investigate further the role played by quantitative methods and quantified data in the programme. The effort will be divided in three parts. First, it will look to the

[3] Although it will not be an object of this particular study, it is noteworthy that such premise is not entirely uncontroversial, as demonstrated by the work of Bricker and Ibbitson (BRICKER, IBBITSON, 2019).

goal established for the initiative, namely, '120 by 20', meaning achieving a number of 120 million additional users of modern contraceptive methods by the year 2020, and reflect on the choice to establish a quantitative goal for the initiative despite the violent history of targets in family planning programmes. Second, it will look into the core indicators of the programme as they account for the advances made in the pursue of the initiative's goals and thus correspond to its very definition of success and illustrate how quantitative measures of achievement play a crucial role in the FP2020 and in the decentring of gender and race issues in family planning. And finally, it will look to the "FP Goals" application, developed by FP2020 to guide the development of public programs in family planning in developing countries. It will share the findings from a simulation performed with the digital applications as well as an example of how it was used in Lao PDR. With both the simulation and the case study, it expects to analyse how quantitative methods and digital technologies are shaping the production of reproductive health policy for millions of women. That last section will present the findings of a simulation performed on the FP Goals application.

Based on feminist politics of care, the final chapter will try to imagine how to challenge and hopefully transform the role played by quantification in the de-centering race and gender in family planning. It hopes to encourage more *caring* approaches to family planning programmes by arguing for an *ethos of care* in the production of the knowledge that substantiates initiatives such as FP2020 – chiefly among them, though not exclusively, quantification. To achieve that, it proposes an approach in three steps. More accurately, in offering answers for three questions. The first is 'what does it mean to care?'. It will be to explain what is meant by *care* when this work claims to aim by *encouraging an ethos of care* (MARTIN, MYERS, *et al.*, 2015, MURPHY, 2015, PUIG DE LA BELLACASA, 2011, 2017).

It will start by providing a brief overview of some of the main formulations of the ethics of care in feminist theory and will follow it by presenting the conception of ethics of care that inspires this work, the one proposed by Maria Puig de la Bellacasa (2011, 2017). Rather than offering an unequivocal meaning for care, her work embraces the multiplicities and complexities of *care* and defines it as as *an affective state,* as *a material vital doing* and as *an ethico-political obligation* (PUIG DE LA BELLACASA, 2011, p. 90). Next, it will address the question of 'how to care'. It will explore the notion of 'matters of care', Puig de la Bellacasa's

suggested approach to technoscientific agencies, things, and notions, based on Latour's 'matters of concern' (2004, 2005a) and feminist contributions on care and the situatedness of knowledge production (HARAWAY, 1988, HARAWAY, GOODEVE, 2018, TRONTO, 1993). The section will hopefully the foundation for the imaginative exercise of the last section, titled 'why care', which will contemplate what an ethos of care could mean to quantification and how it could help re-center race and gender in family planning programs (WILSON, 2017b) and thus contribute to more *caring* approaches in international development family planning programmes.

"A camera captures a bottle at three points in time. It is filled with *Drosophila,* also known as fruit flies, an organism that is born, reproduces, and dies in a flicker. In the first photo, the sparsely populated bottle, rich in food, finds generations of happy fruit flies reproducing and living long lives. In the second snapshot, the busy fruit flies multiply rapidly, sharply increasing their numbers until, in the third image of the bottle, the fruit flies are so numerous the container can no longer support them, a point in time when death rises, birth declines, and population growth stagnates. The bottle becomes a container of mass death.

Looking at images of this jar today, I want to reach back, pluck open the lid, and release the fruit flies to other fates. Or I could take responsibility for feeding the flies, bred as dependent laboratory creatures by the scientific practices I care so much about. Or better yet I could smash the bottle, breaking the illusion that it is the container that conditions how the flies live or die. **I want to imagine other ways of understanding aggregate life that do not demand a contained existence that ends in extermination. What would it take to smash the container?"** (Murphy, 2017, p. 1)

Chapter 1

Overpopulation': The Making of a Problem

Michelle Murphy opens her book on the 'Economization of life' with the powerful and distressing question reproduced in the opening of this chapter – 'What would it take to smash the container?'. She asks the question when faced with a well-known experiment that seeks to illustrate the threat of overpopulation. Notwithstanding the urgency of the question, if we are to investigate a form of moving forward on the goal of smashing the container, it might be worth starting by asking **'how the hell did we get in the container in the first place?'**.

The category 'population' can seem very straightforward at a first glance. One is unlikely to find anyone who would claim not to understand the meaning of the word or who would express some sort of confusion upon hearing it mentioned. However, the question of what it actually means and how, if so, is it different from simply 'people' might elicit a pause.

One person who famously tackled with that question was Foucault, most notably on his lectures at the Collège de France which were later compiled into the book 'Security, Territory, Population'. The author points to the eighteenth century as the moment when the 'biological destiny of the species' became a specific object of the mechanisms of power. That was when the fruit flies started being thought of within the confinement of a bottle.

> Population is undoubtedly an idea and a reality that is absolutely modern in relation to the functioning of political power, but also in relation to knowledge and political theory, prior to the eighteenth century (FOUCAULT, 2004, p. 11).

Situating the concept in time might help visualize its emergence as a political category. Mentioned more than thirty times by both Rousseau in his 'Social Contract' (1762) and by Adam Smith in 'Wealth of Nations' (1776), the word 'population' is not mentioned even once in More's 'Utopia' (1516), in Machiavelli's 'The Prince' (1532), in Hobbes' 'Leviathan' (1651), nor in Locke's 'Second Treatise of Government' (1690) (our own data).

Obviously, that does not mean that people were not a matter of concern for political theorists prior to the eighteenth century. A significant turn, however, comes about as the study of statistics and biology helps turn the generic 'people' into quantifiable, specific, and perhaps more importantly, manageable units. 'People' begins to be thought of as 'population' as it becomes an object of governmentality, a variable to be closely managed by a class of bureaucratic professionals (BANDARAGE, 1998, p. 28). In his writings on liberal economics, markedly in 'An Inquiry into the Nature and Causes of the Wealth of Nations', published in

1776, Adam Smith describes population as a fundamental element to the economy of a country, as individuals are understood as labourers, and, therefore, as instrumental to the prosperity of any given nation.

> If this demand [*for labour*] is continually increasing, the reward of labour must necessarily encourage in such a manner the marriage and multiplication of labourers, as may enable them to supply that continually increasing demand by a continually increasing population. (…) The liberal reward of labour, therefore, as it is the effect of increasing wealth, so it is the cause of increasing population. To complain of it, is to lament over the necessary cause and effect of the greatest public prosperity. (SMITH, Adam, 2007, p. 67).

Another development that helps us understand how the bottle of fruit flies became an adequate analogy for human population growth is the fact that the emergence of 'population' is contemporaneous to that of the concept of 'scarcity' (BREWER, FROMER, *et al.*, 2020). To define 'scarcity', Foucault turns to the definition offered by Abeille - 'the present insufficiency of the amount of grain necessary for a nation's subsistence' (Foucault 2004, 30).

It is the threat that scarcity presents for the stability of a government – a lesson learned after the European rebellions of the seventeenth century – that brings the subsistence of the people to the forefront of political matters, bringing about the phenomenon defined by Foucault as 'biopower':

> (…) the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power, or, in other words, how, starting from the eighteenth century, modern western societies took on board the fundamental biological fact that human beings are a species. This is roughly what I have called bio-power (FOUCAULT, 2004, p. 1).

The reason why this work turns to Foucault's writings is not only because he addresses the topic of population itself, including its origins. Foucault's notion of biopower offers a point of entry for understanding **the interweaved relation between population management, knowledge production, technologies, and the functioning of power**.

Foucault explains how **the phenomenon of population is at the same time a result and a condition of possibility of statistics and, ultimately, of the art of government**. Like other different forms of knowledge, by turning individuals into their objects of study, statistics allow for the functioning of power. This point is fundamental to understand the intrinsic relationship between the data that is produced on any given population and the dynamics of power that will come into play when said numbers become one of the tools for the management of that population. Describing this turning point, Barara Duden writes:

> Now the mathematical treatment of data became the basis of new theory and new concepts. In this transition a new language came into being, created to

> observe people in quantitative contexts. These new concepts made it possible to uncover general truths about mass phenomena even though the cause of each particular action was unknown and remained inaccessible. Population were attributed forms of 'behaviour', explained now by 'probability'. Statistics became the new 'Latin' of all modern sciences and **the term 'population' lost its tie to actual people** (Duden in Sachs et al. 2010, 163; emphasis added)

It is in this context of effervescence of knowledge production on population that the works of Thomas Malthus gain popularity. As statistics gain notoriety and the liberal political economy blooms, the attention to birth and death numbers allow for the identification of trends and for hypothetical exercises, the development of models and scenarios.

Malthus' theory was centred around the existence of two forces that created and sustained life – human sexuality and food production (SASSER, 2018, p. 52). According to him, human beings were reproducing in a pace faster than that of the production of food. This mismatch in pace would eventually doom humanity unless people urgently started delaying and further spacing pregnancies.

> The power of population is so superior to the power in the earth to produce subsistence for man, that premature death must in some shape or other visit the human race. The vices of mankind are active and able ministers of depopulation. They are the precursors in the great army of destruction; and often finish the dreadful work themselves. But should they fail in this war of extermination, sickly seasons, epidemics, pestilence, and plague, advance in terrific array, and sweep off their thousands and ten thousands. Should success be still incomplete, gigantic inevitable famine stalks in the rear, and with one mighty blow levels the population with the food of the world (MALTHUS, 1998, p. 44).

Quantification has been the form in which the 'population problem', understood as the threat a growing number of people represent to the very survival of the planet, has been expressed since Malthus first devised it. The mismatch at the root of the overpopulation problem was due, according to him, to the fact that population, when left unchecked, increased in a geometrical ratio whilst subsistence increased only in an arithmetical ratio (MALTHUS, 1998, p. 4).

As the capacity of producing food increased significantly in the following decades, it seemed fair to assume that Malthus' predictions would not become true. However, fast forward two hundred years and many present-day scientists would argue that the problem to which he pointed in his writings –overpopulation - still lingers (ROSTON, 2019)and that, at least in general terms, he was right on one aspect of his predictions: there simply are too many people!

Overpopulation is a theory, but feels like a fact

Whether one looks to news outlets, scientific publications or even popular culture, it becomes evident that Malthusian concerns have not gone anywhere. On its suitably named 'Big Questions' section, the BBC asks 'How many people can our planet really support?' (CUMMING, 2016). Similarly, its *Science Focus* Magazine published in early 2020 an article entitled 'Human overpopulation: can having fewer children really make a difference?' (TIMPERLEY, 2020). CNN's pessimism is made clear on its headline 'The world's population is nearing 8 billion. That's not great news' (DAVIS, Erin, GRIGGS, 2019). The same 8 billion figure prompted Robin McKie to issue an exasperated 'we can't go on like this' on the pages of *The Guardian* (MCKIE, 2019).

Different versions of humanity's dystopic future are featured in books, movies and plays. The book 'The Hunger Games', which originated a movie franchise that grossed close to three billion dollars worldwide was set in the fictional country of Panem, where the yearly fight-to-the-death reality show/competition between teenagers would always start by a brief retelling of the nation's recent apocalyptic history:

> He tells of the story of Panem, the country that rose up out of the ashes of a place that was once called North America. He lists disasters, the droughts, the storms, the fires, the encroaching seas that swallowed up so much of the land, the brutal war for what little sustenance remained (COLLINS, Suzanne, 2010, p. 15).

Less adventure-packed, but even more despairingly in its message, an unorthodox play called '10 billion' was presented on The Royal Court Theatre, in London, in 2012. The synopsis read as follows:

> By the end of this century, the human population is likely to be over ten billion. Just twenty five years ago, it was less than five billion. How are the choices we're making as a species impacting upon our environment? And how will the sheer force of numbers affect the way we live in the future? (THE ROYAL COURT THEATRE, 2012).

Inextricably intertwined to the overpopulation problem, quantification has retained – arguably even increased – its protagonism in the discourses regarding population. The looming threat of overpopulation is legitimized by models and projections, which are frequently prominently featured as evidence in the headlines previously mentioned. On the article published by the New York Times entitled 'Overpopulated and Underfed: Countries Near a Breaking Point', Bill Marsh presents 'a slowly unfolding catastrophe, told in five charts', turning to the visual representation of quantitative data to explore the issue that he

refers to as the 'population crisis', and arguing that the Malthusian predictions were not incorrect, but merely postponed by the Green Revolution and globalization (MARSH, 2017).

The following sections will look into how populationist approaches were developed. Often taken for granted as a self-evident mathematical fact, overpopulation is actually a theory – and a disputed one at that (BRICKER, IBBITSON, 2019). **Populationism** is the term used 'to refer to ideologies that attribute social and ecological ills to human numbers' (ANGUS, BUTLER, 2011). Hopefully, **the pages to follow will explain how technocratic populationist approaches reinforce colonialist sentiments and ideologies and legitimise interventions in the bodies of women, mostly women of colour from the Global South**.

Populationist theories

As it will be analysed in the upcoming topics, different theories will offer different perspectives on what can happen once we cross the metaphorical brink, the point where "population" becomes "overpopulation". Whether they are guided by economic principles, environmental or security concerns, they are all imbricated in systems of power that express normative standards and legitimize interventions which materialize on specific bodies and target specific groups.

> Malthusianism has not only shaped population control policies, but has influenced many theories and practices of development similarly based upon the assumption that poverty stems from the behaviour of the poor, which then becomes target for intervention (WILSON, 2017a, p. 52).

The goal of this work is to highlight the role played by quantified data in the production of discourses of true regarding population growth. The reason behind the choice for concentrating on this specific feature is the fact that those discourses of truth play an instrumental role in the targeting of particular bodies of - mostly racialized - women and, ultimately, determining which lives are reproducible and which are not (HENDRIXSON, OJEDA, *et al.*, 2019, p. 3).

Foucault provides a theoretical framework in which to visualise more clearly the inextricable relation between power and the forms of knowledge produced on population. This is especially relevant when one explores the construction of the discourse of *overpopulation*, meaning the framing of population growth as a problem that threatens the sustainability of life in the planet, that has fueled population control policies in the last century, a discourse that

'naturalizes and sustains discourses around sex and bodies, economics and security, sameness and difference' (HALFON, 1997, p. 122).

He describes how statistics allow for the pheonomena of population to be quantified and reduced to its smallest framework, the family. By making the family an element within the population, statistics turn population from a model of good government to an instrument. That means that **whenever one wants to obtain something from the population concerning sexual behavior, demography, the birth rate, or consumption, they have to utilise the family** (FOUCAULT, 2004, p. 104–105)**.**

The motivation behind this work is the desire to offer a political reading of overpopulation as a system of power (Halfon 1997, 121). It tackles the use of quantitative data in global family planning programs as an oppressive and often violent instrument of governmentality that mainly targets women of colour from the poorer corners of the developing – and sometimes even the developed – world.

> Whether population policies coerce or persuade or merely provide the resources with which people can make their own reproductive decisions, attempts to affect the rate of population growth converge on reproductive behaviour—on changing the social, cultural, and personal configurations around bodies. Importantly, the bodies of concern are rarely those of the primarily white, primarily male, primarily upper- and middle-class (elite) policymakers in the United States; they are rather the bodies of women, of Third World peoples, and of the poor. (HALFON, 1997, p. 133).

The next sections will explore the framing of the "population problem" as a triple threat and describe how the case for intervention on the lives and bodies of those women was first made. It will analyse how 'overpopulation' was framed as a development problem, responsible for the poverty and hunger in the so-called Third World; as an environmental menace to humanity itself; and finally, as a security concern, mainly linking a growing number of young men of colour from poorer countries to the threat of migration and terrorism. Rather than independent or consecutive narratives for the *problem* of population, as it will hopefully be made clear, these are three perspectives that are intertwined and that reinforce each other and the general perception of a *population bomb* that must be urgently diffused via programmes aimed at intervening in women's bodies, health, and behaviour.

Population and the global crisis model: making the case for population control

As previously described, the 'problem of population' first gained notoriety through the works of Thomas Malthus in the 18th century. Malthusian theory would remain relevant and inspire generations to come. Fletcher, Breiling and Puleo, highlighting Malthus' relevance in 19th century thought, describe its influence on Charles Darwin's and Alfred Wallace's theory of evolution by natural selection, as well as on Herbert Spencer and other 'social Darwinists'. They also mention how Tocqueville pointed to a 'too-numerous population' as the main cause of poverty in Ireland (FLETCHER, BREITLING, *et al.*, 2014, p. 1198).

> Malthusianism translates reproducing bodies and population into problems that can be solved through modernizing tools and technologies, including demographic and other scientific study, modernizing discourses, and interventions such as family planning and contraceptive use (SASSER, 2018, p. 59).

Despite opposing the English poor laws for fearing it would lead the poor to breed more and disturbing the natural course of balance between population and food production by the starvation of the poorest (MALTHUS, 1998), Malthus' writings were mostly focused in diagnosing the problem, rather than offering a pathway to a solution. To lay the groundwork for this dissertation, beyond understanding how the problem came to be, it is important to try to trace the steps to the point where 'population' became ripe for intervention, as a proxy for some of the main threats to humanity's well-being. **With Malthus, population became a problem, but when did population control become a strategy?**

To understand when and how the matter of population, which first emerged as object of governmentality in the 18th century, becomes a suitable object for the coordinated intervention of international organizations, development agencies, and the pharmaceutical industry, the work of Foley and Hendrixson (2011) offers the concept of the global crisis model. Drawing a parallel between population growth and AIDS, the authors delineate the approach that has been predominant in development since World War II.

The global crisis model describes the process in which a given development issue is classified as global in scope, highly urgent and unique, a threat to international stability, and addressable through a concerted global response consistent of immediate, definitive, and often technocratic interventions contrived by international experts (FOLEY, HENDRIXSON, 2011, p. 310). By framing of issue as a 'crisis', this process allows for the topic to be propelled to the centre of international development agenda thus mobilising attention and resources in its benefit.

> We pinpoint the debut of the global crisis model during the era of population control. Global crisis thinking informed the framing of rapid population growth as dangerous world 'overpopulation' and lent credence and

> momentum to the population control movement (FOLEY, HENDRIXSON, 2011, p. 311).

The notion of the 'overpopulation' problem is popularized in the decade following the end of the second World War. Even though the concern with the size of the world's population had been first raised by Malthus in the late 18th century and subsequently by the so-called Neo-Malthusians in the 19th century, it is in the context of what Escobar (1995) calls the 'creation of the third world' that the growing number of the global population starts to be presented as a threat to international stability, one that had been festering in the poorer countries and that demanded an urgent response from the developed world.

1.1. The threat of poverty: population and development

'As a rule, 'overpopulation' is simply
a way of talking about too many poor people'
("The Numbers Game", 1960)

The creation of the 'Third World'

The story of the rise of the development discourse is often told with Harry Truman's 1949 inaugural address as its first scene (ESCOBAR, 1995, SACHS, 1990), when the newly re- elected president announced 'a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas' ("Inaugural Address of Harry S. Truman", 1949). He describes the chronic poverty faced by more than half of the world's population, which represents 'a handicap and a threat both to them and to more prosperous areas'. Finally, he calls upon other developed nations to join the United States in the undertaking, pointing to the technical knowledge and skills of developed nations as the ideal instruments to promote development in poorer countries.

The reason why this moment is so often referred to is because it demonstrates how poverty became a central notion to understanding the post-war world. As poverty becomes an organizing concept, **developmentalism allows for the reorganizing of the colonial structure**. With independence struggles intensifying in Asia and Africa and nationalism gaining momentum in Latin America, the dichotomy empire-colony is substituted by developed-underdeveloped. As Escobar points out, 'that the essential trait of the Third World

was its poverty and that the solution was economic growth and development became self-evident, necessary, and universal truths' (ESCOBAR, 1995, p. 24).

In this context, the level of development of a given country is evidenced by its production. The social and economic status of Western countries becomes the standard against which all other countries are measured, and underdevelopment is thus defined by what other countries lack in comparison.

> No development thinking can scape a sort of retroactive teleology, since underdevelopment can only be recognized in looking back from a state of maturity. Development without predominance is like a race without a direction. Therefore, the hegemony of the West was logically included in the proclamation of development (SACHS, 1990, p. 4).

As the colonial rule eroded and the United States emerged after the war as the capitalist superpower, development became the concept around which the new world order would be structured. Economic interdependence replaced the political dominance of colonial times (SACHS, 1990). However, to assure the stability of this new founded hegemonic order, some issues would require the close attention of the developed world. One of these issues would be the growing population in the Third World.

In the 1950's and 60's, the population growth rate was almost twice that of the 30's and 40's (Table 1). This growth was largely due to improvements in health which led to lower child mortality rates (Figure 1) and higher life expectancy (Figure 2) rather than high fertility s (Figure 3).

Year	World Population (in billions of people)	Population Growth (in billions of people)	(%)
1900	1,65		
1910	1,75	0,10	6%
1920	1,86	0,11	6%
1930	2,07	0,21	11%
1940	2,3	0,23	11%
1950	2,54	0,24	10%
1960	3,03	0,49	19%
1970	3,7	0,67	22%
1980	4,46	0,76	21%
1990	5,33	0,87	20%
2000	6,14	0,81	15%
2010	6,96	0,82	13%
2019	7,71	0,75	11%

Table 1. World population and rate of population growth. Source: Ourworldindata.org

This growth observed in the poorer countries was similar to that previously experienced by developed nations and it was understood that, just as it had happened in the West, the population of the 'Third World' would soon stabilize and eventually even start decreasing (DRAPER JR., 1959, p. 96). Nonetheless, **the growing population in the 'underdeveloped' countries was presented as a challenge in an agenda geared toward economic growth and that had national annual income per capita as its yardstick** (ESCOBAR, 1995, p. 23).

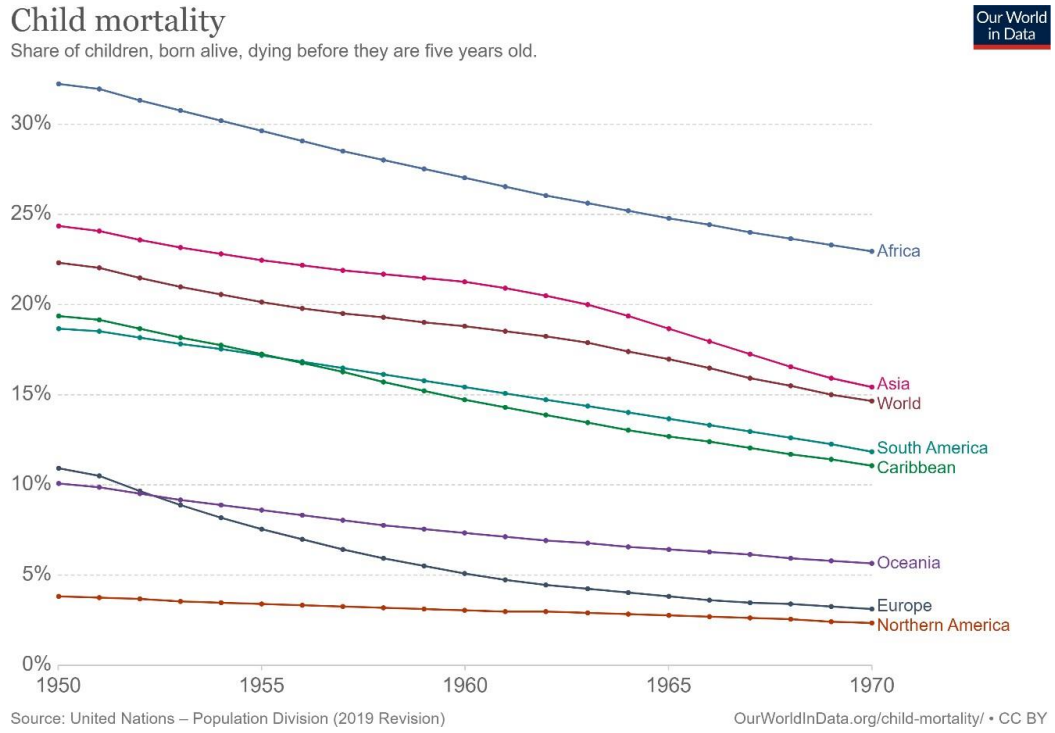

Figure 1. Child mortality (1950-1970)

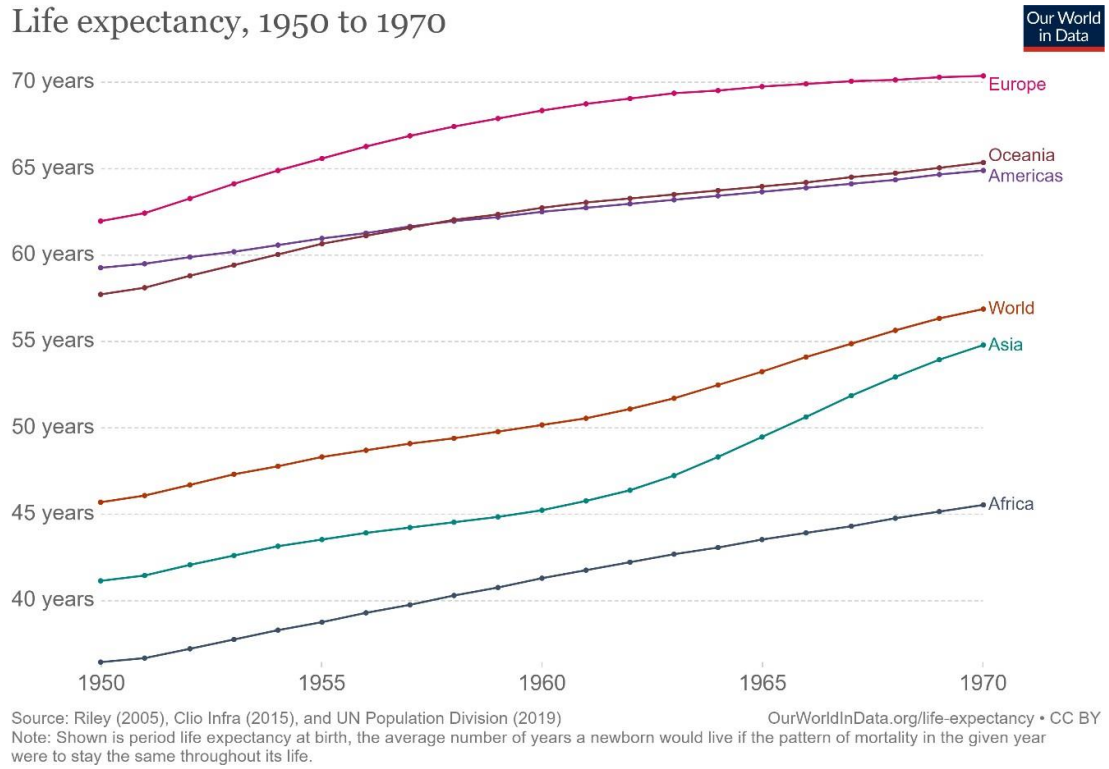

Figure 2. Life expectancy (1950-1970)

Therefore, the threat of 'overpopulation' was not simply a logical conclusion extracted from a certain demographic reality but a 'social construction charged with politics and ideology' (FOLEY, HENDRIXSON, 2011, p. 312). This is an important point to keep in mind as populationist approaches have become so widespread that one might easily neglect to observe how population has been socially constructed as a problem (SASSER, 2018, p. 51), losing sight of its dual epistemological incarnatios, as both real and relational (DESROSIÈRES, 2002).

In this agenda, quantitative data is used to legitimise the hegemonic developmentalist discourse. The assumptions that economic growth equals development and that maximising it should be the aspiration of every country in the world are taken for granted. Income per capita holds the measurement of the success of a nation. This measurement is expressed by a single equation: economic output dived by population. Two simple variables. **That means a straightforward blueprint to be followed by the so-called "Third World": maximise output and minimize the size of the population.**

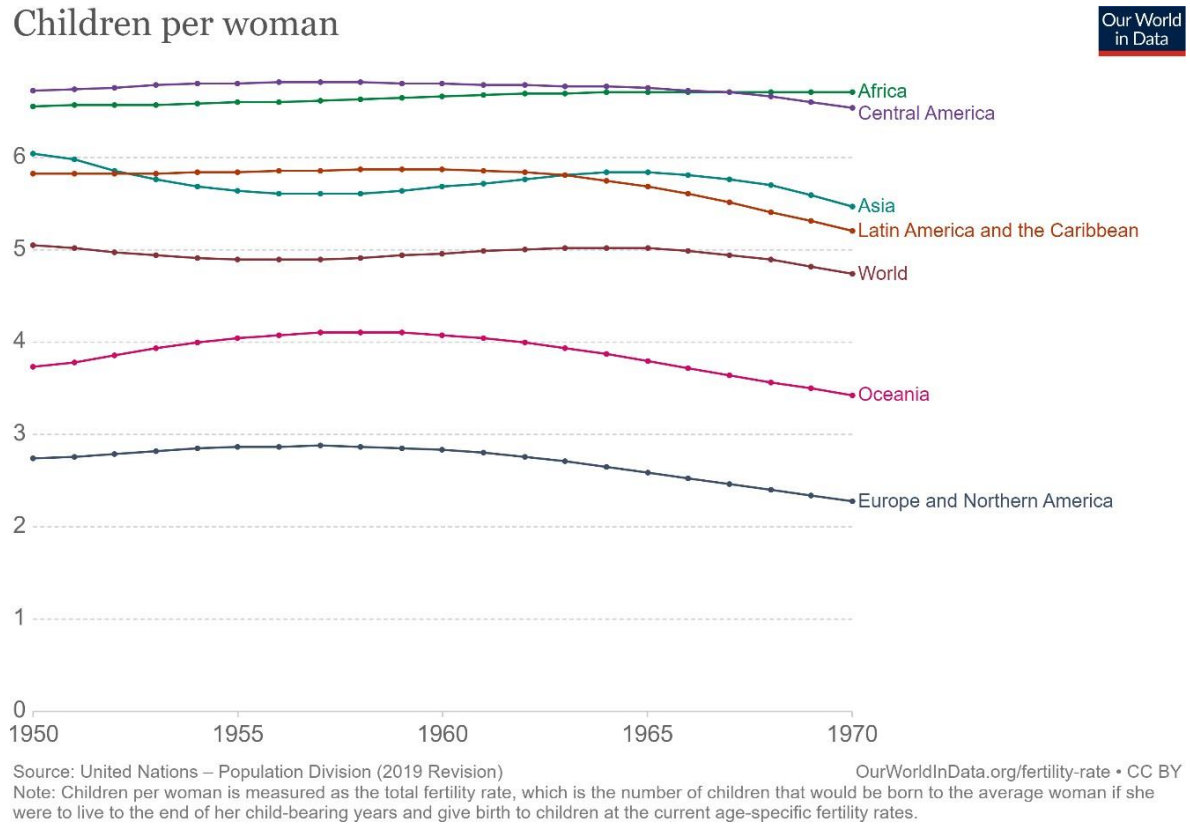

Figure 3. Children per woman (1950-1970)

The problematization of population brings forward a technocratic regime of truth that shapes the reality to which it refers (FOUCAULT, 2009) – 'overpopulation', rather than being perceived as a contentious hypothesis, begins to be stated as a mathematical fact. That is not an overnight occurrence, but the result of an argument reiterated and propagated for years by governments, academia, international organizations, foundations, and newly created aid agencies.

The birth of the population establishment

During the 40's and 50's, an alliance was forged among government economic planners, foreign policy experts, demographers, corporate leaders, and wealthy philanthropists with the purpose of influencing policy. According to Sasser (2018, 62), this took place through a three-pronged approach to the **dissemination of demographic knowledge** – data-collecting missions to the Global South, institutionalizing professional demography as academic and policy science, and influencing professional demographers. This would be the beginning of a trend that despite continuous criticism is yet to disappear – knowledge production on population

is still largely led by researchers, organizations and public entities based on the developed global North that look to the poorer South as ‘case studies’.

The Milbank Memorial Fund, which in the 30’s had funded the eugenics-oriented Office of Population Research, sponsored a roundtable discussion series for economist, federal and United Nations officials in 1947. In 1948, the International Planned Parenthood Federation was established in London, in a headquarters donated by the English Eugenics Society (Mass 1974, 657).

Also in 1948, Julius Huxley, then Director-General of UNESCO expressed concern with the growth of population. On his annual report to the United Nations, he stated that ‘Somehow or other, population must be balanced against resources, or civilization will perish. War is a less inevitable threat to civilization than is population increase’ (MASS, 1974, p. 657).

In 1952, John D. Rockefeller III convened a conference on population with the goal of establishing and international council for population planning. In November of that year the Population Council was created, largely funded by the Rockefeller family and guided by John D. Rockefeller III’s belief that ‘the relationship between population to material and cultural resources of the world represents one of the most crucial and urgent problems of the day’ (HARTMANN, 2016, p. 97).

In 1954, the United Nations hosted the World Population Conference in Rome. The Secretariat’s report on the meetings states that governments of countries with low income and productivity may find the need to adjust their populations ‘inescapable’ (UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, 1954, p. 167). In the same year, the founder of Dixie Cup, Hugh Moore, had a pamphlet entitled ‘The Population Bomb’ distributed to over 1.5 million people in the United States (SASSER, 2018, p. 33)

In 1958, Coale and Hoover introduce their theory that the high dependent ratios resultant from high fertility tend to depress per capita income and contribute to poverty (COALE, HOOVER, 1958). This theory would be widely accepted and reiterated by similarly influential works in the 60s and 70s as the case for overpopulation as a global crisis grew stronger (ENKE, 1970, MYRDAL, 1968).

In 1959, the famous Draper Report commissioned by the US Government on its international aid activities, contained a section devoted to the topic of population, where it stated that “No realistic discussion of economic development can fail to note that development efforts in many areas of the world are being offset by increasingly rapid population growth” (DRAPER JR., 1959, p. 94). Echoing Malthusian thought, it alerted to the mismatch rate between population and food production growth and recommended that the United States an

increased in assistance to programs relating to maternal and child welfare (DRAPER JR., 1959, p. 96). The report fulfilled its purpose and, in the coming years, population control would become a central feature of the America international development agenda (SASSER, 2018, p. 33).

Many critics would point that the relevance gained by population in international development would be animated by motives other than humanitarian concerns. Back in 1944, Dudley Kirk, from the Office of Population Research, had already argued for an international development agenda focused on slowing population growth in underdeveloped nations by highlighting its convergence with the promotion of American political interests.

> We will probably be serving our own ultimate political interests by speeding the social evolution that will bring about slower population growth. Most important of all, we shall have led all of humanity to new possibilities of life for the common man, freed from the degrading in- fluences of hunger and grinding poverty (Kirk 1944, 35).

There seems to be significant agreement among those who study population policy history that the fear of the spread of communism among poor 'Third World' nations was a crucial motivator for the United States to both make population part of its development agenda and push for the issue to be embraced by the international community as indispensable for the promotion of development (BANDARAGE, 1998, CONNELLY, 2008, DONALDSON, 1990, HARTMANN, 2016).2

Writing on the 'population establishment' that blossomed in the 40's and 50's, Grimes describes two significant vest interests in the promotion of population control: the paternalistic humanitarianism of population control enthusiasts, many of whom were linked to foundations whose goal was the diffusion of Western ideological views, and the state bureaucracy whose foreign policy was largely concerned with controlling the Third World (GRIMES, 1998, p. 375–376).

The population crisis goes mainstream

Less than five months after the Draper Report was presented, there was evidence of the progress made on the framing of population growth in underdeveloped countries as a crisis. 'Time' magazine's cover for January 11, 1960 was illustrated by the image of a multitude of women and their children, all but one women of colour –the white exception is also the only one portrayed buying food for her children (Figure 4). On the top right corner, a banner reads 'That population explosion' ("The Numbers Game", 1960).

The cover piece, named ‘The Numbers Game’, begins by mentioning the stories of a Chinese woman in Singapore, who is expecting her sixth child, a Palestinian refugee who has just welcomed her ninth, and a Brazilian rancher who has had 36 children and claims to be able to raise his offspring ‘as God raises potatoes’. The article then goes on portraying childbearing in underdeveloped countries as something exotic and borderline animalistic, rather than as a shared human experience.

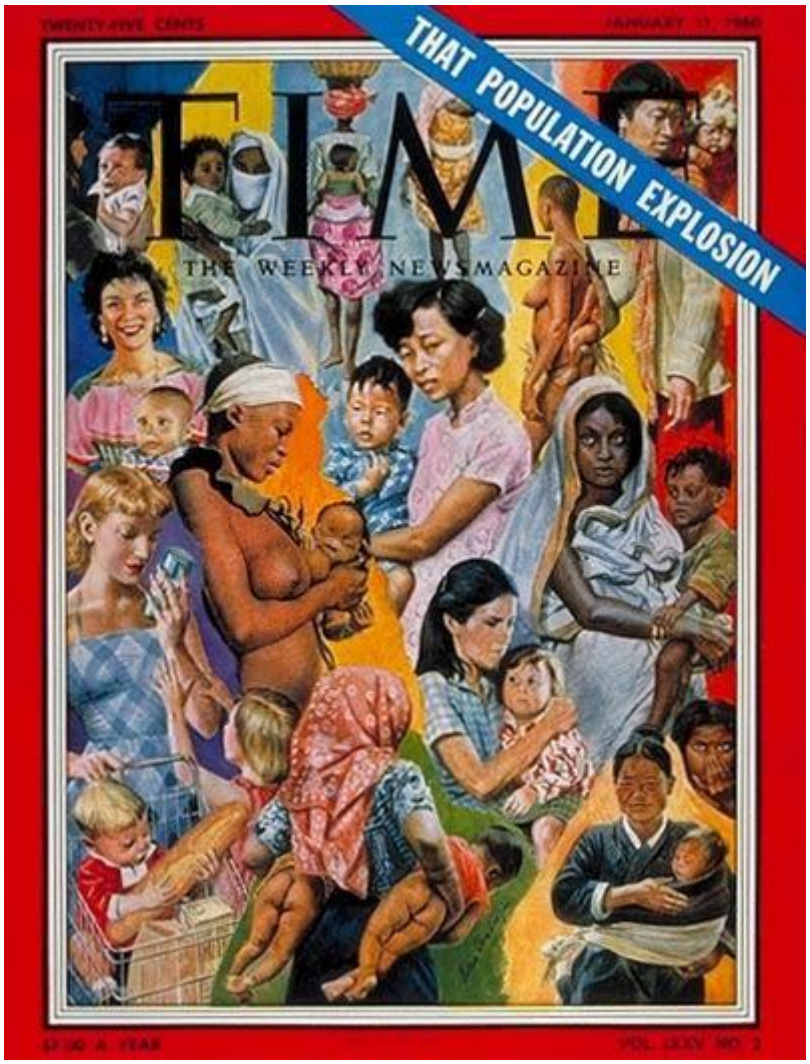

Figure 4. Cover of 'Time' magazine from January 11 1960

Moreover, despite acknowledging that ‘population experts still have no real idea what makes people decide to have more or fewer babies’, the text emphasises how cultural and religious pressures play an important role in the lack of success of birth control campaigns in the ‘Third World’. It highlights the role of the Roman Catholic Church’s prohibition of

contraception in places like Latin America and the Philippines; how children are considered a 'gift from Allah' in Muslim countries, and how political influence may also be a reason for having large families. On that last point, the author looks to Ghana's Kwame Nkrumah as an example – an interesting choice to say the least, considering he was probably a much less familiar name to the average American reader than JFK, the eldest of nine children and member of one of the country's most influential political families, who had just recently announced his candidacy for president.

Overall, the magazine paints a scary picture for the white West. It compares the population growth to the H-bomb, mentions projections where Asians and Latin Americans would soon outnumber North Americans and Europeans by two, three, fourfold, and where there would ultimately be one human being per square meter in the world. An Italian economist who remains nameless is quoted as saying 'Europe will soon be between black and yellow pincers, and that will be the end of us'.

On the political front, it presents the theory that Afro-Asian nations already outweigh the West in the United Nations (UN) and they could 'turn more violent against the West' unless they were 'pacified with rapid economic help', echoing the suggestions of the Draper.

The article helps to show how the overpopulation argument that had been cultivated in academic, political, and philanthropical circles since the 1940s started gaining momentum and gradually became mainstream. It delineates the population problem in the terms of the global crisis model – an unprecedent catastrophe loomed and it could only be averted by immediate and decisive action from the wealthier nations. This argument would be repeated countless times for decades to come, making populationist approaches accepted as common sense (SASSER, 2018).

In the 1960s, as the work done by private foundations thrived, the US government embraced population control as an important part of its foreign policy, notably in two fronts: through the United States Agency for International Development (USAID) and exerting pressure on the United Nations to embrace the cause of population control (BARCLAY, ENRIGHT, *et al.*, 1970).

In his speech before the United Nations on 25 June 1965, then US President Lyndon B. Johnson 'called upon the member nations to rededicate themselves to wager together an international war on poverty' and, as a proposed strategy, made an economic case for investing in population control, claiming that 'less than $5 invested in population control is worth $100 invested in economic growth' (JOHNSON, 1965).

At home, the strategic value attributed to population control meant an increasingly larger investment through the USAID. For the fiscal year of 1965, when LBJ delivered his speech, the USAID budget for population control was USD 2.1 million. In 1969, when the United Nations Population Fund was created, mainly funded by USAID, the latter's population control budget skyrocketed to USD 45.4 million in 1969 and 100 million in 1970 (BARCLAY, ENRIGHT, *et al.*, 1970, p. 14). As Grimes points out, the UNFPA would play an important part by providing legitimacy to fertility control policies conceived by the United States (GRIMES, 1998, p. 383).

As it will be examined in chapter 2, population remained a central point of population policy and programmes through the 60s and 70s, animated by the discourses of war on poverty.

1.2. The threat of degradation: population and the environment

'The causal chain of the deterioration is easily followed to its source. Too many cars, too many factories, too much detergent, too much pesticide, multiplying contrails, inadequate sewage treatment plants, too little water, too much. carbon dioxide-all can be traced easily to too many people.'
(Ehrlich 1968, 44)

In the 1960s, the release of the widely debated book 'The Population Bomb' by Paul Ehrlich heated even more the debate around the magnitude of the world's population and the need to engage in coordinated action in order to curb what was perceived as a growing threat.

On its 1968 cover, right under its title, it reads 'while you are reading these words, three children are dying of starvation – and twenty-four more babies are being born' (EHRLICH, 1968). The tone remains the same throughout the whole book. The author seems to believe the severity of the crisis leaves no space for subtlety.

According to the book, the world was fast approaching a breaking point at which humanity would face unbearable levels of pollution, hunger, sickness, and disasters, culminating in an explosion of social and ecological collapse. Urgent population control, according to Ehrlich, was the main tool for diffusing the population bomb (EHRLICH, 1968). The book reintroduces the Malthusian rationale, relating the world's population to it capacity of food production, and it also foresees a grim future for humanity despite potential developments in science and technology. The author does not believe human ingenuity will be

enough to counterbalance the so-called ‘population bomb’ because of the degradation to the environment that would inevitably accompany such increase in population.

One of the central concepts of this particular book and of the ‘population as environmental threat’ argument is that of ‘carrying capacity’. Simply put, as described by Sayre, ‘at its origins, it referred to a *fixed quantity* of X that some encompassing Y should carry in abstraction of time or history’ (SAYRE, 2008, p. 120). The term was used in reference to a never-specified threshold which would indicate the number of human beings that Earth could sustain.

Also in 1968, Garrett Hardin published an article in ‘Science’ magazine entitled ‘The tragedy of the commons’. Using the metaphor of a pasture open to all, ‘the commons’, where one could keep as many cattle as one wants, he explains that such an arrangement could work for a long time, as long as the number of cattle was below the capacity of the land to feed them. After that point, the story of the commons would become a tragedy (HARDIN, 1968, p. 1244).

The author uses this metaphor to oppose Adam Smith’s theory that if each person acts in a way as to maximize their individual well-being, society as a whole would benefit. According to Hardin, that would not be the case in the context where there is a pasture to be shared by all, as the benefit of adding cattle would be enjoyed exclusively by the owner of the cattle and the negative component of overgrazing would be shared by all. People would thus be in a system that compelled them to increase their herd without limit in a world that is limited in its resources (HARDIN, 1968, p. 1244). Similarly, despite the planet only being capable of feeding a limited number of people, people were free to breed as much as they wanted and the burden of these individual choices would be equally shared by all, including those who were ‘responsible’ enough to limit their offspring.

(Mis)Calculating carrying capacity: the racialized human surplus

Popularized by Ehrlich and Hardin, the neo-Malthusian use of ‘carrying capacity’ dates back to 1948 when William Vogt published ‘Road to Survival’ (SAYRE, 2008, p. 130). The author came up with a ‘bio-equation’ to mathematically express the world’s carrying capacity and, despite not being able to properly quantify his proposition (VOGT, 2007), the notion that such quantification was possible proved to be a lasting one. The term would sometimes describe a maximum limit and more often and optimal or normative one, but it always aspired to idealism and numerical expression (SAYRE, 2008, p. 121).

A crucial aspect of the concept of carrying capacity is the objectivity it seeks to evoke – Earth as a limited container that can only fit so many people. Much like any other container, the planet could only hold a given number of items in it. By this logic, the limit would be a determination of nature, rather than a social or political construction. **The limit was a given, the only thing up for debate was *how many* meant *too many*.**

> The history of carrying capacity and its application to the population problem is one of a search for numbers: a number, calculation or equation that can quantify the correct number of people to limit population to, in order to achieve balance with natural resources and prevent or reduce environmental degradation. Such a number has never been found; however, the quest to find it has never waned (SASSER, 2018).

This veneer of objectivity does not manage to obfuscate, however, the fact that the environmentalist challenge to population seems to implicate certain groups of people as responsible for the destruction route on which the planet found itself. Sasser (2013) points out how racialization is a central part of the interventions on population justified by environmental concerns, as historically, whether they were voluntary or coercive, said interventions have been based on identifying rapidly growing populations in the Global South as productive of environmental problems and resources shortages.

> Environmentalist population advocacy is centrally concerned with constructing narratives about the relationships between particular populations and natural resource use, and devising interventions to change those relationships by reducing the number of people in the population (SASSER, 2013, p. 1241).

Mirroring Malthus' point of view on the English Poor Laws, Hardin argues that the welfare system is to blame for hindering nature's course and forging a system where people were free to breed as much as they wanted, considering only their interest, and overlooking their impact on the planet. Because nature was not allowed to run its course and impose natural checks on overpopulation, it became necessary to intervene in people's freedom to breed.

> *If* each human family were dependent only on its own resources; *if* the children of improvident parents starved to death; *if*, thus, overbreeding brought its own 'punishment' to the germ line – *then* there would be no public interest in controlling the breeding of families. But our society is deeply committed to the welfare state, and hence is confronted with another aspect of the tragedy of the commons (HARDIN, 1968, p. 1246).

To put it bluntly – if those who cannot afford to feed their own were left to die instead of supported, an intervention would not be necessary. **But if society is keeping the poor from dying, it should also take upon itself to keep them from being born**. He criticizes the United Nations' approach to the issue and 'denies categorically the validity' of the right asserted by

the Secretary General that 'any choice and decision with regard to the size of the family must inevitably rest with the family itself, and cannot be made by anyone else' (U THANT, 1967).

Despite not expressing the same inclination towards coercive strategies as Hardin and pointing to the negative implications of the overconsumption taking place in the wealthy West, Ehrlich uses the description of a taxi ride in India to paint a scary image of overpopulation. He opens his book with an ahistorical snapshot ofoverpopulation that perfectly illustrates the role played by racialised anxieties in the problematization of populations.

> My wife and daughter and I were returning to our hotel in an ancient taxi. The seats were hopping with fleas. The only functional gear was third. As we crawled through the city, we entered a crowded slum area. The temperature was well over 100, and the air was a haze of dust and smoke. The streets seemed alive with people. People eating, people washing, people sleeping. People visiting, arguing, and screaming. People thrusting their hands through the taxi window, begging. People defecating and urinating. People clinging to buses. People herding animals. People, people, people, people. As we moved slowly through the mob, hand horn squawking, the dust, noise, heat, and cooking fires gave the scene a hellish aspect. Would we ever get to our hotel? All three of us were, frankly, frightened (EHRLICH, 1968, p. 1).

The author advocates for coercion in order to implement a limitation on the freedom to breed, as he believes that it was 'a mistake to think that we can control the breeding of mankind in the long run by an appeal to conscience' (HARDIN, 1968, p. 1246).

Looking back at the works of Ehrlich and Hardin, Amartya Sen points to the effect of the catastrophic scenarios described by these authors, how they 'encouraged a tendency to search for emergency solutions which treat the people involved not as reasonable beings, allies facing a common problem, but as impulsive and uncontrolled sources of great social harm, in need of strong discipline' (SEN, Amartya, 1994).

It is clear how the global crisis model is also the framework in which the environmental discourse on population is built and can elicit a 'the ends justify the means' mentality. Infringing on a personal freedom such as the right to determine the size of one's own family under *regular* circumstances would seem an unconceivable violation. However, **the extraordinary circumstances of imminent environmental disaster legitimise the discourse advocating for these extreme measures.**

Moreover, an 'us versus them' mentality is discernible in the argument, as the fertility of the people in the so-called Third World is portrayed as out of control and jeopardizing the well-being of all of humanity, including the wealthy 'First World'.

That last point is laid out in even clearer terms by Hardin in 1974, when he writes about 'lifeboat ethics' building on yet another metaphor.

> Metaphorically, each rich nation amounts to a lifeboat full of comparatively rich people. The poor of the world are in other, much more crowded, lifeboats. Continuously, so to speak, the poor fall out of their lifeboats and swim for a while in the water outside, hoping to be admitted to a rich lifeboat, or in some other way to benefit from the 'goodies' on board. What should the passengers on a rich lifeboat do? This is the central problem of 'the ethics of a lifeboat' (HARDIN, 1974).

The author advises against well-meaning impulses to in any way assist those stranded at sea. He alerts to the risk of self-destruction inherent to any sort of solidary action in this context. Providing assistance to any people whose sovereign was not committed to curbing their population growth in order to avoid nature's check on overpopulation such as pestilence, famine, and conflict was considered not only fruitless, but dangerous (HARDIN, 1974, p. 40–41).

Among those 'well-meaning' initiatives, he points to the funding provided by the Rockefeller and the Ford Foundation for the programmes that led to the 'Green Revolution', which through significant technological advancements, managed to improve agriculture in 'hungry nations'. By allowing the numerous poor to survive, such initiatives ultimately had a negative impact on the access to environmental goods such as 'clean beaches and unspoiled forests'. He mentions India as an example of a population whose environmental load had become too great, causing issues such as soil erosion and floods, and concludes with a simple, callous statement: 'Every life saved this year in a poor country diminishes the quality of life for subsequent generations' (HARDIN, 1974, p. 42–43).

That last statement might stand out for its unapologetically uncaring nature, but Hardin was hardly alone in the underlying sentiment. The people from the 'Third World' were portrayed as both a burden and a threat to the environment (HENDRIXSON, OJEDA, *et al.*, 2020, SASSER, 2018). This depiction carried special weight in the 1960's, in a context of growing popular concern with the environment, especially with regards to pollution.

The popularisation of environmentalism

In 1962, the book "Silent Spring", by Rachel Carson is published. The book became a best-seller and kickstarted the modern environmental movement in the United States. Carson alerts to the increase in the use of pesticides and their inherent risk to the environment and warns against technological solutions to dominate nature. On the introduction written to the 1994 edition of the book, then Vice-President Al Gore credits the book with having 'planted

the seeds of a new activism that has grown into one of the great popular forces of all time' (CARSON, 1994).

In 1963, 'The Quiet Crisis', by Secretary of Interior Stewart Udall was published with an introduction by President John Kennedy and alerted to the risks of environmental pollution. Later that year, the country approved the 'Clear Air Act', which was followed by the 'Water Quality Act' two years later.

Highly publicized environmental disasters took place in the following years, including the explosion of the Santa Barbara oil well that spilled over 200.000 gallons of oil into the ocean for eleven days, and the Cuyahoga River in Ohio burst into flames that reached five-stories high due to the oil and chemicals on its surface, both in 1969 (PBS, [S.d.]).

These events built the momentum that culminated on the first Earth Day, on 22 April 1970, when an estimated 20 million people took to the streets in the United States to protest against environmental destruction (YEO, 2020).

The growing concern with the environment added weight to the claims of urgency regarding the population problem, as a causal chain was established linking population growth to the deterioration of the environment (EHRLICH, 1968, p. 44). With the notion of carrying capacity, the case for intervening on the fertility of people from the so-called 'Third World' to contain the growth in their population grew stronger. This is because the concept provided a framework in which to conduct a cold calculus to determine the relative value of lives, especially of those deemed environmentally destructive (SASSER, 2018, p. 65).

The relevance of the concept of carrying capacity, the tragedy of the commons and their repercussions on development programmes can be exemplified by the work conducted by the UN and USAID with the technical support of the Massachusetts Institute of Technology (MIT) on the Sahel region of West Africa in 1973. Taylor (2005) describes how MIT experts worked on the assumption that the drought had been caused by pastoralists and farmers who had exceeded the carrying capacity of their land and who were bound to continue to do so unless a technical intervention was put in place to save them from themselves:

> Projected into the models was the theme that pastoralists, like mortals in a Greek tragedy, unwittingly acted to bring about their own ruin. They needed guidance from an outside agency—specifically, USAID, in turn guided by outsiders at MIT capable of understanding the system as a whole (TAYLOR, 2005, p. 114).

Decades later, the concept of carrying capacity is substituted by that of environmental or carbon footprint, but without much change to the underlying logic of calculating the number of human beings the planet is able to sustain, avoiding structural causes of environmental degradation, and, more importantly, without any change on the perception on who are the 'surplus bodies' (SASSER, 2013, p. 1244). The concern with the population boom of the Global South would go further, and, as degradation narratives became gradually and largely accepted as a fact, so would their alleged implications to security and international stability, with threats of overwhelming waves of migration and wars driven by resource shortage (SASSER, 2013, p. 1244).

1.3. The threat of immigration and conflict: population and security

'It is time to understand the environment for what it is: the national-security issue of the early twenty-first century.'
(KAPLAN, 1994)

A loss of momentum?

The World Population Conference in Bucharest in 1974 would mark an important point in the international debate on population. In preparation for the event, a draft of a World Population Action Plan had been created with significant input from the United States. The draft established 'specific targets for world population 'stabilization' and concentrated on population growth as the main obstacle to social and economic development' (HARTMANN, 2016, p. 103).

The pushback in Bucharest was the result of growing resistance in the Global South to the imperialistic family planning policies imposed by international multilateral organizations, development agencies, and financial institutions like the World Bank, which were under pressure from the United States to give loan preferences to countries with national family planning programmes or even to have family planning as a conditionality in structural adjustment programmes (BISHOP, 1969, p. 465–466).

The growing criticism on family planning programmes led the discourse on the threat of population to briefly dwindle during the 1980s, until it gained momentum again in the early 1990s, when the young populations if the Global South, especially young men of colour, started to be broadly portrayed as violent and menacing to the world's peace and stability.

The coming anarchy: an African dystopia

In 1994, Robert Kaplan published an article called 'The Coming Anarchy' in 'The Atlantic' magazine. His apocalyptic description of West Africa, filled with racial stereotypes and with an overall tone of imperialist nostalgia, would prove itself immensely influential, and reportedly became standard reading material in the Clinton administration, faxed to US embassies around the world (DALBY, 2002).

Kaplan describes a region that descended into chaos after independence. He starts by quoting an unnamed Minister as saying 'We did not manage ourselves well after the British departed. But what we have now is something worse—the revenge of the poor, of the social failures, of the people least able to bring up children in a modern society' (KAPLAN, 1994).

Ignoring the lasting and festering effects of colonization, the author blames West Africans for deforestation and land degradation, which would be responsible for soil erosion, floods, and the spread of diseases. He points to the reduction in rainforest area in countries like Sierra Leone and Côte d'Ivoire following the end of French rule. The sentiment expressed in the Minister's quote sets the tone of the whole piece, a narrative in which, left to their own devices, Africans are quickly bringing destruction upon themselves. Permeated by cautionary tales, the piece thus makes a case for Western interventions. Otherwise, the African nightmare might come knocking.

> In Abidjan, effectively the capital of the Cote d'Ivoire, or Ivory Coast, restaurants have stick- and gun-wielding guards who walk you the fifteen feet or so between your car and the entrance, giving you an eerie taste of what American cities might be like in the future (KAPLAN, 1994).

Moreover, whatever small positive development observed is credited to efforts of former colonizers. The message, in plain terms, is simple: self-destructing Africans need to be saved from themselves. For instance, Abidjan is described as an exceptional success story built on the high price of cocoa and 'the talents of a French expatriate community', in a Sierra Leone 'widely regarded as beyond salvage'. In Côte d'Ivoire, the threat of generalized conflict caused by the implosion of criminal violence is describe as increasingly more likely 'though the French are working assiduously to preserve stability'.

> Sierra Leone is a microcosm of what is occurring, albeit in a more tempered and gradual manner, throughout West Africa and much of the underdeveloped world: the withering away of central governments, the rise of tribal and regional domains, the unchecked spread of disease, and the growing pervasiveness of war (KAPLAN, 1994).

Regarding a possible explanation to what may be at the root of this apparent self-destructive route of West Africa, an abundance of stereotypes is offered, with the portrayal of religion and cultural practices as bizarre and dangerous, such as acts of violence during the Liberian civil war being attributed to juju spirits and the characterization of polygamous relationships as 'loose family structures largely responsible for the world's highest birth rates and the explosion of the HIV virus in the continent' (KAPLAN, 1994).

Population and climate wars

The article is credited with bringing attention to the connection between climate change caused by environmental degradation in developing countries and the risk of crime and war, which, in turn, allows for population growth to be reintroduced as threat, now in the form of migration, urban violence, tribal conflict, and war.

It introduces Thomas Homer-Dixon to the public. A Canadian political scientist, Dixon is one of the most identifiable proponents of the articulation of military-conflict studies and the environment. He links population growth to degradation, predicts a future of wars and civil violence caused by social disruptions rooted in scarcities of resources like water, cropland, forests, and fish.

The potential dismal scenario described by Homer-Dixon is the backdrop to one of the newest formulations of the population problem, now directly linked to climate change.

One of the main organisations that have in numerous occasions ratified that link is the Intergovernmental Panel on Climate Change (IPCC), the United Nations body for 'assessing the science related to climate change'. Its self-declared goal is to 'provide policymakers with

regular scientific assessments on climate change, its implications and potential future risks, as well as to put forward adaptations and mitigation options' (IPCC, [S.d.]).

In October 2018, the IPCC published a report focused on the actions required in order to meet the target of 1.5 degrees Celsius of global warming relative to pre-industrial levels, the threshold over which long-term changes to Earth's climate system, such extreme temperatures in many regions, increases in frequency, intensity, and/or amount of heavy precipitation in several regions, and an increase in intensity or frequency of droughts in some regions. The report pointed to population growth as a potential 'key impediment' to reaching climate targets (IPCC, 2018).

Similarly to what was previously described regarding the threat of poverty and pollution in previous decades, the threat of climate change has been widely publicised and became largely accepted as a very concrete risk by governments and people all over the planet, despite the existence of some very notorious "climate change deniers". Countless stories make the news warning of the dangerous effects of changes in climate system, most notably those related to rising sea levels.

A clear example of the reach of the threat of climate change made the news in 2018, with a drawing made by a 10-year-old Vietnamese girl (Figure 5). The primary school student drew an image of "people on their houses screaming for help" as part of a project from the University of Hull on people's attitude on climate change (SHUKMAN, 2018)

Figure 5 - Drawing made by 10-year-old on project regarding climate change.

However, if the idea of an environmental menace is not new, developments in technology have led to an escalation not only in the reach of information, but also in the accurateness of attributed models and projections based on quantified data. News stories featuring the latest figures from studies on the effect of climate change are ubiquitous, be it the 300 million people whose homes are projected to be at risk from rising sea levels, the one trillion per year economic loss (WATTS, 2019) or the 26 to 77 centimetres by which oceans are expected to rise (NUNEZ, [S.d.]). There is authority in such specificity, power in those numbers, as they are wielded to legitimise interventions on the reproductive health of millions. These dynamics will be explored in chapter 3.

Among the various impacts of climate change, one in particular merits additional attention, considering its relevance in the discourse of the securitization of climate: the flow of so-called 'climate refugees'.

Climate refugees: the threat of migration

The increase in migration and displacement is one of the effects attributed to the devastating effects of climate change on the poorer regions of the world (IPCC, 2018). Like other consequences of climate change, this projected movement of peoples would be object of categorisation and quantification.

Defined as 'people who can no longer gain a secure livelihood in their homelands because of drought, soil erosion, desertification, deforestation and other environmental problems, together with the associated problems of population pressures and profound poverty' (MYERS, 2001, p. 609), the category 'climate refugee' started being mobilized in the turn of the twenty-first century in an ambiguous manner – it represented both the victims and the threat of climate change.

On 'The Coming Anarchy', Kaplan (1994) portrays these refugees as a sectarian force that threatens to weaken Europe and the United States by cultural disputes, in a 'clash of civilizations'.

> As refugee flows increase and as peasants continue migrating to cities around the world—turning them into sprawling villages—national borders will mean less, even as more power will fall into the hands of less educated, less sophisticated groups. In the eyes of these uneducated but newly empowered millions, the real borders are the most tangible and intractable ones: those of culture and tribe (KAPLAN, 1994).

As expected, many models were built and quantified projections of the size of these "human tides". The most popular estimation was featured on the United Nations Environment Program's (UNEP) website in 2005 and pointed to "as many as 50 million people escaping the effects of creeping environmental deterioration" by the year 2010. However, that prediction never materialised and the UNEP later removed the information from its official page, explaining that "it was causing confusion and making some journalists think UNEP was the source of such forecasts" (BOJANOWSKI, 2011).

The point of bringing this frustrated prediction is not to discredit the work of numerous scientists who devote their careers to climate science and understanding the possible implications of climate change. The idea is to provide an example of how quickly and fullheartedly quantification has been embraced in the framing of the problem of climate. Moreover, how commonplace it has become for human stories to be translated into numbers for public consumption, in a process of depersonalisation that de-historicises, decontextualises experiences, and reinforce discriminatory discourses.

Hordes of 'juju warriors': the threat of the youth bulge

In the intersection of climate, population and security, the threat of violence is often embodied by young men of colour, often portrayed under colonialist lenses. In 'The Coming Anarchy', Kaplan describes young African men as 'juju warriors, influenced by the worst refuse of Western pop culture and ancient tribal hatreds'. These men are portrayed as numerous, idle, susceptible to vices and prone to criminal behaviour.

> Young unemployed men spend their time drinking beer, palm wine, and gin while gambling on pinball games constructed out of rotting wood and rusty nails. These are the same youths who rob houses in more prosperous Ivorian neighbourhoods at night (KAPLAN, 1994).

Kaplan's characterization of 'hordes of young men' as a threat to security is the expression of a demographic theory that would reinvigorate the debate on the need to curtail the population growth in Global South through family planning programmes – the *youth bulge* theory.

> Personified as a discontented, angry young man, almost always a person of colour, the 'youth bulge' is seen as an unpredictable, out-of-control force in the South generally, with Africa, the Middle East, and parts of Asia and Latin America all considered hot spots. 'Youth bulge' conflicts, it is implied, are capable of spilling over into neighbouring countries and even other areas of the world, including the US, and are an immediate threat that must be stopped (HENDRIXSON, 2004, p. 8).

Originally formulated in 1985 by the geographer Gary Fuller during his time as a visiting scholar at the Central Intelligence Agency of the Unites States (CIA), the youth bulge theory was aimed at providing analysts with a tool to predict political unrest and identify potential national security threats. According to the theory, a proportion of more than 20 per cent of young people in a population implies an increased possibility of violence, especially in the Global South (HENDRIXSON, 2004, p. 2).

Despite dating back to the 1980s, the youth bulge theory would gain prominence in international security discourse in the turn of the twenty first century, when, linked to social tensions attributed to climate change, it was evoked in to explain violent conflicts in Sub-Saharan Africa and the threat of Islamic extremism.

The deterministic idea of 'violence in numbers' (HENDRIXSON, 2004) added to long lasting colonialist perceptions of the Global South, especially Africa and the Middle-East, contributes to the dehumanisation of young men of colour from the Global South, as well as for a portrayal of young women of colour as vulnerable, lacking agency and in need of rescuing. In its twenty first century version, the population problem converges with narratives of climate change and points to family planning programmes as a strategy to minimize the security those men embody.

The youth bulge theory is another example of quantification as the basis to ahistorical analysis that are ultimately employed in racialized arguments under the disguise of objectivity. A clear example of this can be found on a briefing paper entitled 'Why population matters to security', by the non-governmental organization Population Action International (PAI). The document points to a research conducted by the NGO that showed that between 1970 and 2007, 80 percent of all outbreaks of civil conflict occurred in countries with very young and youthful age structures and that six of the nine outbreaks of new civil conflict between 2000 and 2007 occurred in countries where at least two-thirds of the population is younger than age 30. Apparently ignoring the aphorism on the correlation fallacy – *correlation does not imply causation* -, the text goes on the extrapolate from the numbers that 'reproductive health and family planning services need to be a priority in conflict or post-conflict countries (POPULATION ACTION INTERNATIONAL, 2011).

In this context, the main focus of international efforts to control population growth has become Sub-Saharan Africa, singled out for having the highest fertility level in the world. A report published by the United Nations in 2020 claims that the achievement of the Sustainable Development Goals (SDGs) will require 'intensified support for family planning' in the region, as progress towards the goal is being stifled by the relative slower decline of fertility (UNITED

NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, 2020). Therefore, it is not surprising that much of the FP2020 efforts are devoted to the African continent. The following chapter will describe the history of family planning as part of international development policy.

Chapter 2

History of Population Policy: The Road to London 2012

This chapter will focus on setting a backdrop for the analysis of Family Planning 2020 (FP2020) initiative. It will provide an overview of the history of population policy in the international agenda up until the agenda of the Millennium Development Goals (MDGs), the framework in place at the time of the 2012 London Summit and the creation of the Family Planning 2020 (FP2020) programme. With a yearly budget of over 3 billion dollars and a target of having 120 million girls and women using modern forms of contraception by 2020 in 69 target countries, FP2020 was the largest international family planning initiative in the history of international development.

This foundation will be important when this work subsequently describes the FP2020 initiative itself, so that continuities can be traced back and ruptures identified. The chapter will look to the emergence of an international population establishment and to how population policies became a fundamental element of foreign policy and was turned into an indispensable means to development.

The goal is to pick up from where chapter one left off on the problematization of population. It will be a closer look at how policies formulated based on the many – and simultaneous – incarnations of the population problem have been implemented and what were some of the consequences to the health and lives of millions of women in developing countries. Hopefully, this brief historical excursion will allow for the identification of some of the most problematic patterns in population policy, many of which are still present in the FP2020 programme.

The examples presented in the chapter were chosen taking into consideration some different factors, such as geographical distribution; how they illustrated the different forms abuse took place in family planning programs – notably, using poor women as guinea pigs for experimenting new contraceptives, incentives schemes, and coercion.

As one looks back at the controversial history of international development interventions focused on controlling the fertility of women in the Global South, it is important to note the role played by technical knowledge production in substantiating and legitimising said interventions. Accordingly, special attention will be granted to the field's tradition of heavily relying on quantitative data and methods in making the case for action. This will support the work's effort of investigating the role played by quantification in decentralizing race and

gender issues in family planning programmes, by ‘rebranding’ them as ‘evidence-based’ and objective.

2.1. Post-World War II and the Theory of Demographic Transition

As mentioned in the previous chapter, despite neo-Malthusian and eugenist thought dating back to the 19th century, it was in the aftermath of World War II that the case for a coordinated international effort to control the world’s population began to gain momentum, with the emergence of an interconnected network of foundations and government organisations that funded conferences and research projects on fertility control, and that would eventually become important players in the field of development. Scholars of population policies refer to this network as *the population establishment* (CONNELLY, 2008, GRIMES, 1998).

The first step in understanding how this establishment came to be and to wield significant control over the bodies of millions of women in the Global South will be to look at the theoretical foundation that elicited the implementation of programmes focused on fertility control. More specifically, the theory of demographic transition.

In 1945, Dudley Kirk, Frank W. Notestein and Kigsley Davis published works developing the argument of what came to be known as the demographic transition theory. Their works would set the terms in which the case for intervention in the population of the newly ‘discovered’ third world (ESCOBAR, 1995, p. 21) would be made.

The authors highlight how the European continent had been through a great increase in its own population. At the time of publishing, the population of Europe was estimated to be three times that of 1800 (KIRK, 1945, p. 45) and gone from being 18% of the world’s population to 35% (DAVIS, Kingsley, 1945, p. 6). This transformation is attributed to the industrialization that Europe had experienced in the previous century.

Two variables are considered when the growth in population is analysed: fertility and mortality. As no relevant increase in fertility was recorded during this period of unprecedented population growth, according to the authors, it was the modernization brought about by the Industrial Revolution that led to a major decline in mortality, with life expectancy practically at double of what it was in the seventeenth century (DAVIS, Kingsley, 1945, p. 4). This decline in mortality was due to improvement in agricultural techniques, and to better transportation, which allowed for the expansion of commercial agriculture and ultimately, reduced famine, undernourishment, and susceptibility to diseases (DAVIS, Kingsley, 1945, p. 4).

However, as the mid-twentieth century approached, the time of European population expansion was by all indications coming to an end. By the authors' projections, by the 1960s or 1970s at the latest the European population would peak and then remain unchanged or even decrease. This would be due to another transformation caused by modernization - decrease in fertility.

This movement of rapid population growth due to decline in mortality followed by stabilization resulting from decrease in fertility was named 'demographic transition' and described as a by-product of modernization. The term would come to represent a journey through which all countries were expected eventually go.

The journey described by the demographic transition model was composed of four stages. The first, corresponding to the pre-industrial era, was a time of high death and birth rates, with a stable population. The second was the moment of population explosion, when, due to the technological e social advancements brough about by industrialization, death rates declined significantly whilst birth rates were still high. The third one was marked by a decline in birth rates, a deferred effect of the social-economic improvements which would gradually reduce the rate of population growth. Finally, on the fourth and final stage, with both mortality and birth rates low, population would reach replacement level (BANDARAGE, 1998, p. 64).

At that moment in time, Europe was at the third stage, also referred to as 'transitional growth' (NOTESTEIN, 1945, p. 41), poised to reach its population peak soon. However, in the poorer – and unmodernized – parts of the world, population was also gradually growing, but this growth had no end in sight, at a stage characterized as that of 'high growth potential' (NOTESTEIN, 1945, p. 42). This was a cause for concern.

> In areas where the native population was more abundant, and especially where the transplanted European culture was not of northwestern Europe, the transition was not so rapid (DAVIS, Kingsley, 1945, p. 6).

All three authors present graphs and tables representing past and current population trends and, most importantly, their projections. They were unanimous in pointing to a major shift in population weight from West to East (DAVIS, Kingsley, 1945, p. 7, KIRK, 1945, p. 42, NOTESTEIN, 1945, p. 46). Expressing special concern for the projected growth in population in the URSS, Kirk alerted that such change in population weight would possibly bring about the collateral effect of also shifting political and economic power eastward (1945, 54). Although not a believer of the theory that such a growth in population weight in the East could 'sink' civilization, K. Davis (1945) warned that if the population kept growing, it would

inevitably be ‘adjusted’ close to subsistence level, possibly interrupting the cultural progress that had been achieved so far.

The difference in pace was attributed to the fact that while the techniques for reducing death rates (medical science, sanitary engineering, agricultural improvement, and better transport) had been shared with poorer countries for both humanitarian and economic reasons, the fertility rate had not been reduced because ‘reduction proved a less acceptable feature of Western culture’ and because the majority of the population was ‘part of a rural proletariat’, whose life style changed very little (NOTESTEIN, 1945, p. 50), which meant that birth rates would remain high (DAVIS, Kingsley, 1945, p. 6–7).

The trend of high fertility and growing population was likely to continue in those parts of the world unless they went through a process of modernization, similarly to what had happened in Europe and in North America and parts of Oceania. The demographic transition theory thus presented modernization as a single track moving in a specific direction, where some countries were further ahead and some lagged behind. Asian countries, for instance, were described at that point as being in a historical stage that resembled medieval Europe. That stage, however, could be left behind once they were modernised and became more like the Europeans (DAVIS, Kingsley, 1945, p. 7).

Therefore, it was only logical, according to the demographic transition theory, that those countries which were not yet modernized should go through this process sooner rather than later. Modernization would bring about reduction in fertility and inevitably cause the pace of population growth to slow down. Thus, the case for population control as an international agenda was made and the direct link between the size of population and development would gradually become understood more as a fact than a theory.

According to the demographic transition theory, the changes observed in the growth of population were due to the changes to the way of life caused by modernization. As economies became less dependent on agriculture and more on industries, urbanization took place. To urban life, larger families were not only unnecessary but also became a difficult and expensive undertaking (NOTESTEIN, 1945, p. 40).

Given the implications of continuous population growth, the proponents of demographic transition theory made a case for ‘scientifically grounded population policy throughout the world’ (DAVIS, Kingsley, 1945, p. 11), **making evident a change to a much more prescriptive and policy-oriented tone in the field of demography** (RAO, 1994, p. 47). If the poorer countries did not follow in Europe’s modernization footsteps, they would be destined to generations of poverty and standards of living little above subsistence at best. That

was the reason *why the poorer countries* should engage themselves in this process. Additionally, their population growth poised a threat to the social, economic, and cultural process of the West. *That* was the reason *why richer countries* should step up and intervene rather than stand idly by.

The demographic transition theory is perhaps the first major expression of the political implications of quantification in population policy. The work of its proponents was substantiated in the past trends of population growth and presented exercises in prediction, projecting forward trends to come up with hypothetical scenarios. As it will be further explored in chapter 3, the reliance of demography in quantified data and methods is part of the reason why the subject came to be regarded as scientifically rigorous – mathematics has long been almost synonymous with rigor and universality (PORTER, Theodore M., 1995, p. IX). These characteristics were appealing to philanthropists who financed the spread of the theory and its methods (SASSER, 2018, p. 63).

Considering the concept of the 'global crisis model', the demographic transition theory characterised the issue as global in scope, highly urgent and unique, and a threat to international stability, as overpopulation in poorer countries was described as about to jeopardise the progress achieved by the modernized Global North. The final element of the global crisis model is that the issue be addressable through a concerted global response consistent of immediate, definitive, and often technocratic interventions contrived by international experts. The experiments led by the population establishment in the island of Puerto Rico will demonstrate how those responses began to be concocted.

2.2. Piloting Development Population Programmes: The case of Puerto Rico

There was a joke that circulated about this time that asked:
Who are the members of the Puerto Rican family?
The answer: Mom, Dad, the kids, and the sociologist
(BRIGGS, 2003, p. 117)

The 1950s witnessed the issue of population control ascend to the central stage of international policy discussion. In 1954, the first World Population Conference was held in Rome, convened by the United Nations. Described by the UN (1999) as an 'eminently academic' event, it was a testimony of the role played by demography and quantitative methods to the formulation of population growth as a problem – a problem with serious economical and sociological implications, but mathematically framed.

In this context, demographic transition becomes the theoretical framework in which the 'population problem' turns into a 'development problem'. As previously mentioned, in 1949, during his inaugural address, the U.S. President Truman announces the plans for the country to 'embark on a bold new program for making the benefits of (…) scientific advances and industrial progress available for the improvement and growth of underdeveloped areas'. That came to be known as 'Point Four', because development was the fourth issue listed as a priority in Truman's speech. **As speech turned into action, the United States commenced an abrupt expansion of their social, political, economic, and military roles in the third world, replacing colonialism with development (BRIGGS, 2003, p. 110), population control would be a key aspect of that development agenda**. And Puerto Rico would be the laboratory in which development was tested as a global policy.

> From the economic point of view the overwhelming problem of Puerto Rico is the relation of population to the land (…) Puerto Rico's poverty is caused first and overwhelmingly by overpopulation, which is in turn caused by several factors – natural fecundity for one thing, the influence of the Catholic Church, and the efficiency of the United States Health Service (GUNTHER, 1941, p. 425).

On her book, 'Reproducing Empire', Laura Briggs (2003) writes about US imperialism in the island of Puerto Rico. She describes how Puerto Rico became a laboratory for development experiments and its inhabitants, especially the women, guinea pigs in clinical trials and endeavours in social engineering. As the author points out, **overpopulation became a sociological explanation for the poverty of the Third World, an explanation that denied a role for international capitalism or colonialism in the production of said poverty** (BRIGGS, 2003, p. 141).

The reason for the choice of the Puerto Rican case to illustrate how population policies were rolled out in the 40s and 50s is precisely because it functioned as a laboratory for development programmes that were supposed to be exportable to the rest of the Third World. The geographical and political proximity to the United States made experimenting in Puerto Rico easier. And its insularity made it an ideal petri dish for clinical and sociological tests.

The development experiment that took place in Puerto Rico had two main elements: **industrialization and population control.** The ingenuity of the United States scientific establishment would be employed in searching for explanations and, most importantly, solutions to the population problem. **In this process, the fecundity of the Puerto Rican woman became a matter of concern and their sexual behaviour a topic of interest in international development.** Researchers would consider the sexual behaviour of Third World

women ‘dangerous and unreasonable, the cause of poverty and hence of communism, and needed to be made known, managed, and regulated’ (BRIGGS, 2003, p. 117).

Medical knowledge would also play a crucial role in the experiment. Puerto Rican women would be the guinea pigs for the development of the hormonal birth control pill, which would be one of the main tools for population control for decades to come.

The idea of hormonal contraception had been around since the beginning of the twentieth century, with some studies in the 20s and 30s finding efficacy in the use of certain hormones to inhibit ovulation. However, studies had stagnated because there seem to be no way to predict its side effects – there was simply no way of knowing if the pill would be safe for human use, as the evidence collected from experiments with animals proofed unconclusive regarding the safety for human experimentation. (BRIGGS, 2003, p. 131–132).

In the 1950s, as the discourse regarding overpopulation was consolidated, an analysis of risk led researchers to resume efforts to develop a hormonal contraceptive, disregarding those previous ethical considerations. If before there was no justification for possibly endangering the lives of subjects in order to test the contraceptives, now overpopulation had shifted the equation – considering the dangerous consequences attributed to excess population, it seemed like now researchers could not afford *not* to move forward with the tests. (DOWIE, 1979)And Puerto Rico was the place to do it.

The year of 1952 was especially eventful in the field of population. In the non-governmental sector, the funding available from private foundations led to the creation of some of the most important international family planning organizations. In the United States, with funding provided by John D. Rockefeller III, the Population Council was established.Margaret Sanger, who had founded the American Birth Control League in 1921 and established the first birth control clinics in the country, changed the name of the organization to Planned Parenthood Federation of America (PPFA). One of the main reasons behind the name change was the fact that in the decades that followed the foundation of the American Birth Control League, Sanger became a renowned supporter of eugenics and the name of her organisation became closely associated with the movement in the USA. In the same year, Sanger would create with Lady Rama Rau the International Planned Parenthood Federation (IPPF) in India, where the first national family planning programme was launched, also in 1952.

During the 40s and 50s, many clinical trials and sociological experiments took place in Puerto Rico. They fed off each other. On one hand, sociological studies made the case for urgent intervention to contain population growth and characterized the Puerto Rican woman as either a victim of her circumstances, oppressed by *machismo* and lacking basic information or as

behaving irrationally, pathological due to poverty. This framing of the population problem and the Puerto Rican woman would justify the ends and means of the clinical trials that would take place in the island.

The risk presented by overpopulation outweighed the potential individual risks of experimenting a drug whose side effects were complete unknown. Also, the characterization of the Puerto Rican woman as pathological would serve as motive to justify lack of consent or not informing them of the risks involved. In one of the experiments, when a significant number of women presented side effects to the medication, the doctor in charge of treating the patients wrote repeatedly to Gregory Pincus, the lead researcher, expressing concern with the fact that the drug seemed to cause 'too many side effects to be generally acceptable' and with the changes she had noted in the cervices of the women who had been taking the pill. The manner which Pincus decided to deal with the issue was to assure funding to research a possible connection between the pill and cancer. In the press conference where he announced that the research would take place, however, he justified need for the research by claiming that he believed the pill could have *protective* effects against cancer. To address the issue of the side effects, he conducted a placebo trial in which he concluded that the cause of the complaints was 'the emotional super-activity of Puerto Rican women'. From then on, to avoid similar issues, he decided that participants should simply not be warned of any potential risks (BRIGGS, 2003, p. 139).

Notably among the drugs tested on the women in Puerto Rico was Enovid, which would eventually become a form of hormonal birth control adopted by many women in mainland United States and in other developed countries. This later fact obscured much of the pill's origin story. The expectation was that the pill could have an impact on population equivalent to that of the Green Revolution[4]. The marketability of the pill was a welcome development to medical experts and pharmaceutical companies involved in the trials in Puerto Rico – a narrative of promoting women's freedom was much more palatable and avoided potential

[4] The expression "Green Revolution" was coined by William S. Gaud of United States Agency for International Development (USAID) in 1968, for the introduction of new technology and policies implemented in the developing nations with aids from industrialized nations between the 1940s and the 1960s to increase the production and yield of food crops. Many high-yielding varieties (HYVs) were introduced as part of the Green Revolution to increase agricultural productivity. (…) The HYVs had 20% more grain than its earlier cultivars and were more responsive to the nitrogen fertilizers. The yield potential doubled due to the incorporation of several traits and specific genes for short stature in HYVs. The incorporation of the gene responsible for photo-insensitivity in rice and wheat enabled cultivation possible throughout the year; regardless of day length of the region, it was cultivated. Furthermore, the reduced cropping period increased the cropping intensity to 2–3 crops per year. The period between 1960 and 1985 saw the doubling of yield per hectare, total productivity, and total food production in developing countries. (ELIAZER NELSON, RAVICHANDRAN, *et al.*, 2019)

accusations of racist and genocidal tendencies. However, it is important to highlight that the development of the birth control pill involved the exposure of many non-consenting working-class Puerto Rican women to unknown health risks. And that it was the threat of overpopulation that pushed the research forward and justified its numerous abuses.

The choice for presenting the demographic transition theory followed by the Puerto Rican case is to highlight how theory and practice came together in the field of development and population control. Knowledge production does not happen in a vacuum and it brings about concrete consequences. Since its inception, family planning programmes have heavily relied on a quantified framing of 'population as a development problem' whilst disregarding the role played by imperialism, international capitalism, and race and gender relations.

2.3. 1960s and the Emergence of Population Control as Foreign Policy

During most of the 1950s, research on the topic of population was mostly funded by private foundations whose leaders expressed concern over the threat posed by overpopulation (GREENHALGH, 1996, GRIMES, 1998). In the 1960s, another major funder comes into the scene, as USAID is created, in 1961. The promotion of family planning in the Third World was the primary focus of the agency's Population Office, followed by the focus on improving the efficiency of said programmes through 'operations research' (GREENHALGH, 1996, p. 43). The funding model of the agency prioritized research products that could be quantified, standardized, and replicated in countries around the world (DEMENY, 1988).

Understanding where the funding for population studies came from is relevant because it can help understand why the field of demography became so reliant on quantitative methods and at the same time so focused on providing programmatic responses to the 'population problem'. Susan Greenhalgh's work on Population Policy (1996) provides important elements for pondering the matter. She points out how the fact that funding for population research came mostly from non-academic organizations with agendas for applied science, which meant that criticism of larger power structures to which these donors belonged was not welcome, nor were claims that family planning was an approach that diverted attention from larger social structures at play.

Despite acknowledging the quantitative bias that comes with the desire to estimate levels and trends of fertility, mortality, and other properties of social aggregates (p.4), she claims that the reliance of the field of demography on quantitative methods and mathematics derives from a desire to affirm legitimacy despite operating as a highly policy-oriented field:

> (…) while operating largely as a policy-oriented field to ensure its legitimacy, it has had to practice science making with a vengeance, declaring itself an intellectual activity with no connection to policy and politics and developing its identity as a highly quantitative and mathematical field.(GREENHALGH, 1996, p. 31)

The beginning of the 1960s was marked by the emergence of population control as a central issue in foreign policy. At the United Nations level, it started in 1961, when Sweden and Denmark pushed for population growth to be included in the General Assembly agenda. The move faced resistance, notably from the Vatican and catholic countries, such as Argentina. However, the momentum that was forming for the subject became clear, as the topic started to be raised in different stances. The Population Commission reported hearing that more governments requested advice for national plans and signaled interest in the type of technical assistance for population policies that countries like India and Egypt had received. Therefore, the commission requested the Secretary General to extend and diversify existing internationally sponsored facilities for demographic training and research; to develop such facilities in regions where they did not yet exist, especially in Africa; to make available for the government of underdeveloped countries the services of experts consultants in demography, and to assist these governments in establishing programmes of demographic research ("Report of the Population Commission.", 1961). At the Economic and Social Council the topic also came up, when the president of the World Bank contended that population growth was an obstacle for economic progress (CONNELLY, 2008).

Meanwhile, private foundations had already been playing a significant role in pushing population control in countries of rapid demographic growth. In India, for instance, the Ford Foundation funded consultants to work side by side with professionals from the Health Ministry. Connelly describes a growing tension between the Ministry and the Foundation, as their approaches to the role to be played by contraception in health care differed. Said tension is very much still at the centre of family planning programmes and is one of the contentious points which this work intends to highlight – rather than being considered within a broader context of provision of health care services, family planning programmes are often developed as stand-alone initiatives that operate as a vehicle for population control.

> The problem was that health ministries and health professionals operated according to a medical model centered on the doctor-patient relationship. Population control required looking past the individual in pursuit of a greater good: rapidly reducing fertility before it overwhelmed economic and social development (CONNELLY, 2008).

By then, the hormonal birth control pill had already been developed but it was still too expensive for mass distribution through population control programmes and there were growing concerns with some of its serious side effects. This limitation led to the rehabilitation of a low-tech and, thus far, discredited contraceptive method, the intrauterine device (IUD). There was significant risk of complications with the IUD, mostly involving pelvic inflammatory disease and infections that could lead to the need for a hysterectomy (REED, 2014, TIETZE, 1965). These issues did not deter the president of the PPFA, Alan Guttmacher, whose callous words seem to express the prevailing mentality within the population control establishment: 'perhaps the individual patient is expendable in the general scheme of things, particularly if the infection she acquires is sterilizing but not lethal' (CONNELLY, 2008).

The Population Council sponsored in 1964 a conference in which the results of recent research on the use of IUD were presented. There were varying and unconclusive results – they ignored patients who did not show up for follow-up exams, considered unimportant the bleeding caused by the device, and disregarded the risk of a snowball effect in the demand for medical care if mass insertion of IUDs were to take place. Nonetheless, following the event, the International Planned Parenthood Federation issued a press release announcing that the effectiveness, acceptability, and safety of the IUD had been demonstrated and recommending its use by member organizations. With allegedly promising results and a seemingly effective tool at hand, programmes for population control multiplied all over the Third World.

By the late 60s, despite more and more initiatives popping up across the world, there was still concern that the pace of population growth might not be slowing down as expected. Perhaps simply making birth control available and funding 'motivators' was not enough. At this point, the population establishment started considering more seriously other forms of influencing uptake of family planning. In his famous 'Population Bomb', Paul Ehrlich offers a glimpse into the possibilities being entertained at the time, claiming that many of his colleagues felt the need for compulsory regulation to be implemented, perhaps through adding sterilizers to water supplies or food staples – a possibility he regrets to inform was not viable due to the unavailability of technology to produce such sterilizer (EHRLICH, 1968, p. 130–131).

The economic case for population control grew stronger and experiences where individuals received incentive payments for undergoing sterilizations began to gain notoriety. A notable example of the economisation of life was how the economist Stephen Enke chose to make the case for USAID on the urgency of controlling population for the sake of development: he argued that fifteen years of consumption during childhood would outweigh a

lifetime of adult employment[5], assigning thus a negative value to life. His rationale was embraced by US President Johnson, who created a policy that came to be known as 'short leash', in which he started to personally approve every new food shipment for poorer countries deemed overpopulated, such as India.

> (…) there is evidence that the U.S. line on population control is becoming not only clearer, but harder. "There can no longer be any doubt in the administration of the country that this Congress was determined to defuse the population bomb", announced Senator Tydings last year (STYCOS, 1967, p. 77–78).

The idea that lives from poor, overpopulated countries weigh down their economies is still very much alive in the international discourse regarding population. As it will be examined in the following chapters, by pointing to excess population as a phenomenon partially to blame for the hardships faced in the Global South, mainstream discourse on population reinforces an idea that the there are people the world would be better off without. It creates a category of those who should not have been born, whose lives are simply not worth the burden to the lives of their mothers or the drain to the economy of their countries.

In 1966, US President Johnson had announced that 'the hungry world cannot be fed until and unless the growth in its resources and the growth in its population come into balance'. Alongside his advisors, he started to emphasize the idea of 'self-help', compelling the Indian government to develop an economic programme that included population control and ultimately reduced the need for aid from the US (CONNELLY, 2008, p. 213–214). An echo of this type of approach can still be found on FP2020. As it will be shown later, a key element of the programme's strategy is the idea of the 'commitments', in which the developed countries that take part in the initiative commit to financial support (e.g., FP2020 2012a; 2012b) while developing countries commit to adopt national strategies for family planning (e.g., FP2020 2019; Ministry of Health of Burkina Faso 2012; FP2020 2017).

In Latin America, what followed was a withdrawal of aid from the United States for health programs in general in favour of the emphasis in controlling population. The Peruvian minister of health denounced the measure on a national magazine, stating that 'the U.S. is willing to help in a campaign for the control of births, but not in one to reduce the rates of

[5] He claimed that any increase in GNP was the product of either more workers, increased capital stock, or innovations that boosted productivity. He assumed less from new manpower. These countries were also distinguished by the absence of innovation. With these assumptions it was easy to show how, in a hypothetical case, a 12 percent increase in labour would result in only a 6 percent increase in output, and hence lower per capita GNP (CONNELLY, 2008, p. 210).that every country that simply added workers to the labour force would reap diminishing returns. But he believed that already 'overpopulated' countries would gain even.

death' (STYCOS, 1967, p. 78). Health programs were not the only targets of the U.S. reshuffling of aid resources. At the Second World Population Conference that took place in Belgrade in 1965, an American envoy proposed that resources should be directed to population control *instead of* to accelerate economic growth ("World Population Conference, 1965. Vol 1: summary report", 1966).

Meanwhile, India was being flooded with IUDs and its government was being pressured into boosting the numbers of participants in family planning programs. In 1966, Indira Gandhi was elected Prime Minister. She was an enthusiast of population control and was among those who supported the idea of paying women to accept IUD insertion. The day after she was sworn into office, the Ministry of Health was renamed Ministry of Health and Family Planning and the country embarked on a coordinated effort to boost the number of vasectomies and IUD insertions. Doctors were paid bonuses and had to meet certain targets, as did the members of local administration. The promise of bonuses and the threat of punishment in case targets were not met led health professionals, the so-called 'motivators', and the administrative personnel involved in family planning to push harder and harder, often neglecting health, safety and ethical considerations (CONNELLY, 2006, SAMUEL, 1966)

At first, the 'carrots and sticks' approach caused adherence to the programme to skyrocket. However, after a while, the number of complications began piling up and the number of insertions eventually plummeted. The solution found to pick up the pace of the population programme was to follow the suggestion that had been pushed by the Ford Foundation, the UN, the IPPF and the World Bank – offer cash payments to everyone who agreed to be sterilized or have an IUD inserted. The federal government would provide states with 11 rupees for every IUD insertion, 30 per vasectomy, and 40 per tubectomy. States should use this money to pay the amount of incentive deemed necessary. At a time when millions of people faced the threat of famine (BRASS, 1986, DYSON, MAHARATNA, 1992), the cash incentives found hundreds of thousands of takers. Desperation seemed to be the strongest 'motivator' of all. Several Indian states were facing terrible droughts that pushed their population into famine and misery. Unsurprisingly, those states were the main responsible for the increase in national numbers (CONNELLY, 2008, p. 221–227).

Family planning officials, health professionals, and motivators kept being pressured to meet their quotas. The government went as far as demand that disciplinary action be taken against doctors who did not meet their targets. All of this led to a series of abuses and neglect. Connely (2008) reports that 80-year-old men and people with impairing mental problems were among those sterilized. He quotes studies which put in numbers the extent to the government-

sponsored violence against its citizens in the name of population control – 'in Maharashtra, 52 percent of men complained of pain, and 16 percent had sepsis or unhealed wounds. Over 40 percent were unable to see a doctor. Almost 58 percent of women surveyed experienced pain after IUD insertion' (CONNELLY, 2008, p. 227).

As population growth continued to be framed as a major developmental, environmental, and security threat, the population establishment grew stronger and wealthier, with money pouring in from development agencies and foundations. Population experts such as Notestein – one of the exponents of the demographic transition theory – travelled the world to consult on population programmes for countries all over the Third World. His work provides a glimpse into how the population establishment operated in providing 'solutions' to face population growth in the Third World. A single sentence was the difference in the reports he produced from Iran and Kenya[6]. Very little was done in terms of adapting plans to local scenarios. The translated versions of the same surveys were applied by field-workers in every country with the aim of delivering uniform datasets for ever more sophisticated statistical analysis (CONNELLY, 2008, p. 231–236).

As it will be explored further on the following chapters, for close to a century, 'overpopulation' has been framed as a developmental failing endemic to the developing world. Although much debate has taken place within the international population establishment and its many international fora on whether poverty is the cause of overpopulation or vice-versa, the interconnectedness of the two was never challenged in mainstream discourse. Neither was the assumption that all poor countries presented 'symptoms' of the same ailment. Being a Third World country was a chronic condition for which the population establishment believed to possess a single cure.

However, despite the momentum population control policies and organizations found in the 1960s, experts and donors began experiencing frustration with the rate at which population growth was (or was not) slowing down. If the threat of a population explosion was to be averted, the growing consensus within the population establishment was that more needed to be done.

In 1967, Davis, who had decades before pioneered the demographic transition theory alongside Kirk and Notestein, published an article on Science Magazine in which he expressed

[6] The only significant difference was to explain to the Iranian health ministry that 'the basic purpose of a family planning program is to improve the health and welfare of mothers and children.' Kenya's Ministry of Economic Planning and Development, on the other hand, was promised 'savings to Government in reduced maternity care expenditures.'

skepticism regarding the potential of the family planning programmes of the time to effectively manage population growth. In his article, he criticizes that the only efforts being made on the international arena to face the challenge of a growing global population was the provision of contraceptives. He described allowing families rather than societies to decide their ideal number of children as an 'ostrich-like approach' and called for family planning programmes to be supplemented with research and experimentation to determine socioeconomic measures best suited to address the issue of overpopulation (DAVIS, Kingsley, 1967).

> The things that make family planning acceptable are the very things that make it ineffective for population control. By stressing the right of parents to have the number of children they want, it evades the basic question of population policy, which is how to give societies the number of children they need. By offering only the means for couples to control fertility, it neglects the means for societies to do so. (DAVIS, Kingsley, 1967, p. 738)

Davis was not alone in his dissatisfaction, and his call for not having population control reliant on individual choices would echo with other scholars, governments, and organisations. At the dawn of the 1970s, a call for going 'beyond family planning' grew stronger.

2.4. Going 'beyond family planning' in the 1970s: the Third World fights back in Bucharest

As results of population programmes were not meeting donors' expectations, frustration built, and more aggressive measures started to be ventilated. The assumption that distributing contraceptives would eventually bring population numbers down was being proven inaccurate. With the availability of contraceptives, the issue of unmet need could be addressed, and parents would have the chance to limit the number of children they have. The 'problem' was that surveys showed that, for instance, in places like South Korea, Tunisia, India, and Indonesia, the average respondent still wanted four children (CONNELLY, 2008, p. 237–239). That finding points to a tension that had been boiling up in the debates about population, a tension that this work contends has not died out – what is it the true goal of population programmes: giving individuals (especially women) the chance to safely plan their family sizes or slowing down population growth in certain parts of the world? For those concerned with a population explosion, the latter should take precedent. Bernard Berelson was one of the scholars who decided to take upon themselves the task of imagining *how* that could be done and famously set out to explore possibilities 'beyond family planning' (BERELSON, 1969).

His article presented an extensive list of proposed paths for grappling with population growth, which included both voluntary and unvoluntary measures. As possible voluntary measures, he considered the possibility of extensions in voluntary fertility control, which could take the form of institutionalization of maternal care in rural areas of developing countries and the liberalization of induced abortion. As forms of involuntary fertility control, he contemplates adding a 'fertility control agent' to water or food; commercializing licences to have children; termporary sterilization of all girls; and compulsory sterilization of men with three or more living children. Among other possible measures, he lists intensified educational and cash-incentive programmes; tax and welfare benefits and taxes; increase minimum age of marriage; and promotion or requirement of female participation in the work force (BERELSON, 1969, p. 1–3).

One strategy adopted by USAID came to be known as 'inundation' – an effort to actively create demand for contraceptives, flooding countries with condoms and birth control pills. Condoms were supplied to vendors below cost to maximise profit; motivators, nonmedical professionals were allowed to dispense pills without prescription, midwives were taught to insert IUDs, doctors learned to speed up sterilization and abortion procedures (CONNELLY, 2008, p. 242). At the time, the head of USAID, Reimert Ravenholt was quoted as saying 'ordering contraceptives is like ordering bullets for a war – you don't want to run out' (BANDARAGE, 1998, p. 65). During the tensest period of the Cold War, the dispute for power made women's bodies a battlefield, with their health and agency increasingly treated as an afterthought, or, even worse, as a nuisance.

An example of this growing pressure was the 'Campaign to check the population explosion'. In the late 1960s, the campaign, in which members of the Federal Administration, ambassadors, businesspersons, and Nobel Prize laureates participated (based on the list of names, none of them women), ran several full page ads on the New York Times, as the ones featured below (BARCLAY, ENRIGHT, *et al.*, 1970).


Document THE NEW YORK TIMES

IN THE NEXT FEW SECONDS...
A CHILD WILL DIE
FOR LACK OF FOOD!

CAMPAIGN TO CHECK THE POPULATION EXPLOSION
EMERSON FOOTE, CHAIRMAN

Figure 6 - Advert from the 'Campaign to check the population explosion'

Mobilizing the fears of war and Communism, the adverts made the case for US intervention in the ‘third world; for population control purposes. It read:

> A world with mass starvation in underdeveloped countries will be a world of chaos, riots and war. And a perfect breeding ground for Communism. We cannot afford a half a dozen Vietnams or even one more. Our own national interest demands that we go out and help underdeveloped countries control their population.

With thousands of young American men losing their lives daily on the Vietnam War, the image of fast-reproducing multitudes of people from the third world (especially Asians) as an imminent threat became ever more resonant with the American audience, conveying the idea of urgency and gravity, indispensable characteristics to the framing of an issue as a global crisis (FOLEY, HENDRIXSON, 2011).

THE NEW YORK TIMES

THE POPULATION BOMB THREATENS THE PEACE OF THE WORLD

POPULATION CONTROL

SO WHAT ARE WE DOING ABOUT IT?

Fifteen years ago there were 2.5 billion people on earth. Today there are 3.5 billion—and newcomers are arriving on the scene at the net rate of more than one million a week! In another fifteen short years there will be a total of 4.5 billion people on this small planet of ours. Most of them hungry. And make no mistake about it, America cannot long remain an island of prosperity in a sea of poverty and hunger.

If corrective measures to check this human flood are not taken right here and now the resulting world-wide misery, strife, revolutions and wars will make our experience in Viet Nam appear minor by comparison.

President Johnson has said that the population crisis is the greatest problem humanity faces. And the National Academy of Sciences has said that "the Population Bomb can be successfully attacked by developing new methods of fertility regulation and implementing programs of family planning widely and rapidly throughout the world." Yet the accompanying chart reflects the scant amount of attention the population problem is currently receiving from our Government.

This is your problem and you can do something about it. Tear out this ad and send it to anyone in Washington you think might be helpful. Urge the Government to initiate a crash program for population stabilization. And write us for two things: (1) Measures the Government can take to implement such a program. (2) Additional things you can do to help.

We can't afford to wait much longer. Every day lost only compounds the problem. The time to act is now.

CURRENT GOVERNMENT PROGRAMS
(1968 Estimates from 1969 Budget)

Space Program	$5 billion
Grants to States for Welfare	$3 billion
Health and Death Control Programs	$2.5 billion
Food for Peace Exports	$1.2 billion
Supersonic Plane (Pilot Model)	$170 million
Air Pollution	$100 million
Crime Control	$100 million
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Figure 7 - Advert from the 'Campaign to check the population explosion'

Pressure for more cogent measures to assure population control was growing, despite the controversial results observed in India. As mentioned in chapter 1, 'The tragedy of the commons' (HARDIN, 1968) argued for more drastic measures, pushing forward what became known as 'lifeboat ethics'. And so, the idea of policies based on 'incentives' or even coercion grew popular.

It is worth noting that**, despite theoretically being two different types of strategies, in many cases, incentives and coercion became a distinction without a difference**. For instance, at that time, the Swedish International Development Authority (SIDA), the World Bank, the Food and Agriculture Organization (FAO), and UNFPA funded programs that distributed food as a way to increase use of contraception. The official policy was that sterilization or acceptance of contraception were not to be a condition for receiving aid. However, in Bangladesh, for

instance, field-workers under pressure to meet targets and fearing for loss of income, would deny food to women who did not accept sterilization (CONNELLY, 2008, p. 246, HARTMANN, 2016). Moreover, offering cash payments, however small, to starving populations as it was the case in India is the equivalent of coercion. **When starvation is the alternative, can you really call it an 'alternative'?**

The momentum gained by the population issue and the growing concern and investment from richer countries, especially the United States, led to the creation of the United Nations Population Fund in 1971. The Fund had been created in 1969 as the United Nations Fund for Population Activities (hence the acronym), under the administration of the United Nations Development Fund. Considering the increasing number of activities undertaken and resources managed in the field of population, it made sense for it to become an agency of its own, directly under the Secretariat.

By that time, it would seem like the link between population and development was taken as a fact and that the need to control the growth of population for the sake of economic and social prosperity was the only obvious pathway for countries to follow. At the UN level, the theme of population had become ubiquitous, as demonstrated by the resolutions approved during the previous decade, listed on the table below.

1962	General Assembly resolution calls for expansion of research on population and development and for increasing technical assistance to countries carrying out demographic studies
1963	Asian Population Conference – the first to call on the UN to expand technical assistance to countries carrying out 'family welfare planning programmes'
1965	World Population Conference in Belgrade helps legitimize fertility control as a theme of international concern
1966	General Assembly and World Health Assembly resolutions on technical assistance for family planning
1968	Tehran Conference on Human Rights affirming the rights of couples to decide the number and spacing of their children
1963	General Assembly resolution on social progress and development, calling on governments to provide families with the knowledge and means to control fertility
1970	General Assembly resolution on Second United Nations Development Decade, prescribing goals for growth in GDP implying reduction in average rate of population increase

1972	Economic and Social Council resolution deciding to produce a draft World Population Plan that urged member states to cooperate in exploring the possibility of setting targets for reducing population growth in countries where the present rate was deemed too high

Table 2 - UN Resolutions on population (1962-1972) (FINKLE, CRANE, 1975, p. 90–91).

With the goal of consolidating the policy gains regarding population in the international arena and pushing 'third world' countries to 'do more' to control the fertility of their population, the United States led the effort to organize the Bucharest World Population Conference of 1974, with the support of some Western European and Asian countries. In preparation for the event, a Draft World Population Plan of Action was prepared by the UN with significant input from American experts. The draft was ambitious. It declared the purpose 'to affect population variables' and emphasised the need to limit population growth through programmes that had direct effects on fertility (FINKLE, CRANE, 1975). Frustrating the organizers' expectations, however, the draft faced much resistance from developing countries and was only approved after more than 300 amendments were introduced and debated. The ambitious language of the draft was left behind and the result was a final document with much less 'teeth'[7].

One sentence became a symbol for the resistance of developing countries to the attempt of heightening the commitments to fighting population growth. Dr Karan Singh, a spokesperson for the Indian delegation, famously stated that **"development is the best contraceptive".** That assertion encapsulated the basis of the resistance from many third world countries. It was a challenge that turned on its head the agenda imposed by development agencies and endorsed by the UN – instead of taking family planning as a necessary means to achieve development, they proposed that if investments were made to develop their countries, population growth would slow down as a consequence. This sentiment was partially incorporated to the final version of the World Population Plan of Action where it reads, instead of the originally drafted goal of 'affecting population variables':

> The explicit aim of the World Population Plan of Action is to help co-ordinate population trends and the trends of economic and social development. The basis for an effective solution of population problems is, above all, socio-economic transformation. A population policy may have a certain success if it constitutes an integral part of socio-economic development; its contribution to the solution of world development problems is hence only partial, as is the case with the other sectoral strategies (UNITED NATIONS, 1974).

[7] The failure to achieve the original goal of organizers is commonly attributed to the fact that it was largely at the hands of population experts who did not have much involvement with other political sectors of the UN and member governments. Other factors such as the event's size, the type of country representation present, organization and procedures, openness to the public, duration, and location are also indicated as contributing to the result (FINKLE, CRANE, 1975).

In similar fashion, it stated that population policies must not be considered substitutes for socioeconomic development policies but rather as being integrated with these policies and that the analysis of population problems could not be reduced to population trends only.

It seems fair to say that compromise was the theme of the resulting Plan of Action. It declared that 'individual reproductive behaviour and the needs and aspirations of society should be reconciled', but it acknowledged the variety of national goals regarding fertility and **did 'not recommend any world family-size norm'**. On the one hand, it affirmed the sovereign right of each nation to formulate and implement its population policies without external interference, on the other, it highlighted the growing interdependence among nations and the importance of international action for the solution of development and population problems.

Despite the resistance of developing countries leading to some gains on the conference, little change in the reality of international population programme was noticeable. As a matter of fact, the period inaugurated on the second half of the 70s was marked by several examples of international population programmes that heavily relied on leveraging the needs of the poor, on uninformed consent, and even on violence.

2.5. Dumping Contraceptives in the third world

After functioning as a laboratory in the 40s and 50s, Puerto Rico was once again among those targeted by aggressive population policies spearheaded by the United States in the 1970s. The site of massive sterilization campaigns, it is estimated that one third of Puerto Rican women was sterilized by the end of that decade (DOWIE, 1979)

The island was also part of the third world dumping ground for contraceptives that could not be utilized in mainland US because they were deemed too dangerous by the American authorities. The first case was the Dalkon Shield IUD. Just after its release in 1971 in the United States, numerous cases of complications related to the use of the contraceptive started to be reported – pelvic inflammatory disease, septicaemia (blood poisoning), spontaneous abortions, ectopic (tubal) pregnancies, perforations of the uterus, and even cases of the IUD ripping its way through the walls of the uterus and being found floating free in the abdominal cavity. In February 1971, a doctor wrote to the manufacturer of the device about issues with its insertion: 'I have found the procedure to be the most traumatic manipulation ever perpetrated on womanhood, and I have inserted thousands of other varieties' (DOWIE, 1979). As the negative feedback and cases of complications amounted, the company reached out to USAID to offer

the device in bulk, unsterilized packages at a discount rate of 48 per cent. The deal was made, and the device was shipped for over 40 different countries by the agency. In 1974, the US Food and Drug Administration (FDA) held hearings following the outcry and backlash from the use of the device in the country. The process culminated with the sale of the product being suspended in the domestic market. That meant that USAID had to issue an international recall on the product. However, the recall came too late for thousands of women as there was no capacity for retrieving the IUDs that had already been sent to thousands of clinics, especially in rural areas. As late as 1979, there were reports of insertions in Pakistan, India, and South Africa.

During an interview, Ravenholt, head of USAID at the time, when questioned regarding the reports of infections received by the agency, claimed that the devices were not to blame for the infections, and implied that the fault was female promiscuity: 'Women who frequently change sexual partners have these intercurrent low-grade infections. The IUD can't cause an infection. The body tolerates anything that's sterile'. Regarding the fact that the Dalkon Shields were delivered unsterilized by USAID, he replied that at first so had another type of IUD. It is worth noting that, unlike the units provided to USAID, in the US, the Dalkon Shields had always been sold sterilized (DOWIE, 1979).

The IUD was not the only type of contraception 'dumped' by USAID in developing countries. In 1970, the FDA advised physicians to prescribe women only the lowest estrogen dose possible when prescribing birth control pills. That dose was 50 mg at the time. As the sale of high-dose pills plummeted, USAID, that at first had adhered to the FDA's recommendation, decided to take its business to the Syntex company, whose stock of 80 mg was sold at a discount for millions of dollars and distributed – exclusively – overseas.

The process of 'dumping' contraceptives in the Third World was not limited to any specific region or linked to particular strategies of 'persuasion'. As the next session will illustrate, during the period of 'inundation' promoted by USAID, family planning programmes grew closer to incentive schemes that became increasingly more difficult to distinguish from means of coercion.

2.6. Bangladesh: sterilization for clothing and food

Bangladesh was one of the main targets of the 'inundation' policy and one of the countries that committed to meeting fertility decline targets, encouraged by USAID and the World Bank. Betsy Hartmann writes about the population control efforts led by the government

in the 70s, 80s, and 90s. The Bangladeshi government was commended by its commitment to population control by donors when it set high fertility decline goals in its First (1973-1978) and Second (1980-1985) Five Year Plans.

The country failed at the first attempt to curtail fertility and, when the Second Five Year Plan began to signal it was headed to failure as well, pressure mounted from USAID, the World Bank and UNFPA. They circulated a position paper calling for a 'drastic reduction' in population growth, for the creation of an autonomous board for population control with 'emergency powers' and for frequent visits by 'high ranking government and Army personnel' to promote family planning in villages. The Bangladeshi government abided and, among other measures, introduced punitive actions for personnel who failed to meet their quotas (HARTMANN, 2016, p. 213).

In the 1980s, the family planning program in Bangladesh offered 175 taka (the equivalent of several weeks' wages) for each person – man or woman – who agreed to be sterilized, as well as a sari worth 100 taka for women and a lungi worth 50 taka for men. They also received a card stating that they had been sterilized – the presentation of that card was necessary if they wanted to receive food relief. The conditions in which these sterilizations took place were also distressing. A 1983 study raised many concerns as it found that in more than 40% of the centres observed, patients were not adequately informed of the permanent nature of the operation. The reviewers also found shocking standards of hygiene and felt compelled to prepare guidelines on procedures such as 'how to scrub the hands for operation'. They failed to find a significant number of complications, however, because no record of them was kept. If a patient died during a procedure or due to complications, their records were destroyed. As a result, according to the official numbers, Bangladesh had fewer deaths as a result of sterilization than the United States (HARTMANN, 2016, p. 214–216).

2.7. India: the emergency and the medal

By the early 1970s, India, the first country to have its own population control program in 1952, was still failing to significantly reduce its fertility rate, which had remained over 5 children per woman since the late 50s. The prime minister was still Indira Gandhi, who despite having demonstrated a serious commitment to the goal of controlling the country's fertility rate, was still facing international pressure from donors.

A challenge to her election to the Lok Sabha (Indian Parliament) caused political upheaval in the country, which was aggravated by the economic crisis caused by crop failures

and rising oil prices. Gandhi's reaction to the threat was to suspend the constitution, order the arrest of members of her opposition, and declare a State of Emergency that granted her the power to rule by decree. The State of Emergency lasted from 1975 to 1977 and became a mark of draconian and terrorizing rule in the history of independent India.

During 'the emergency', as the period came to be known, Gandhi's son, Sanjay, began wielding great power in the new police state. One of his main points of concern was making sure fertility was curbed. He did that through what became simply known as *nasbandi* (sterilization) – a policy of imposing sterilization by different means and channels, to both men and women. The policy of setting targets to be met by the Indian states' administration became more aggressive and local authorities were advised that targets should be met by any means necessary. In Delhi, the Lt. Governor decreed that medical treatments would only be provided for free in public hospitals to those that could provide proof of having been sterilized. Sterilization camps popped up throughout the country. An excerpt of a testimony transcribed in the book 'Reasons of State: Delhi under emergency' illustrates the terrible conditions in which the mass sterilizations took place in said camps:

> 'In the operation theatre, the doctors decided if it was to be a laparoscopy or an abdominal incision tubectomy. (…) During the operation, the only instruments needed were the scalpels, tube forceps and sufficient swabs and sponge forceps. These were cleaned and sterilized here in the morning. (…) The patient would be administered local anaesthesia. They would be taken to the post-operative ward and kept there for six hours. We had thirty beds in one ward. And we always had to put two women to each bed. One woman would have her head towards the wall. The other slept with her head on the other side. Sometimes, on days when there were more than 100 women, three women were put to each bed. The only criterion was that they had to be thin women. 'Each operation would take half an hour. After one surgery, the doctor would wash his hands and change his gloves. Most of the nurses did not change their dresses. The table would be wiped clean. That's all. (…) We had about 10 per cent of the women coming back with septic wounds. There were no deaths in the theatre. But some of the septic cases died. There were more than ten tubectomy deaths in this hospital during all the sterilization drives.' (DAYAL, BOSE, 2018)

The methods applied to pushing individuals into *nasbandi* and thus meeting sterilization targets were as various as they were cruel, including forcible sterilization of persons with no children, old persons, hospital patients, inmates, people at night-shelters, and pavement dwellers; catching hold of passers-by, passengers in buses and persons returning home after late night cinema shows; stopping the salaries of school teachers and administrative staff members; transfers as punishment (for non-procurement of sterilization cases); non-renewal of all manner of licences; rejection of applications of non-sterilized persons for loans, fertilizers, water and electric connection; cutting off water and electricity supplies; forcible

collection of money from shopkeepers by the so-called youth leaders on the pretext of organizing sterilization camps; threat of arrest; and, finally, police beating and firing (BOSE, 2014).

Gandhi's discourse had always been of energetically fighting poverty in India and an important part of that fight was sterilizing the poor. **It seems fair to say that poverty was expected to be eliminated largely by keeping poor people from ever being born.**

> They [the poor] submitted their own bodies for sterilization, not out of choice or, on the whole, for financial incentives, but rather in order to gain or retain access to basic civic amenities such as work, housing, hospital treatment and education. For many of those at the bottom end of the socio-economic heap, life in Delhi without a sterilization certificate became untenable, if not impossible (TARLO, 2003, p. 176).

In one year, it estimated that 8 million sterilizations were conducted in India, 6 million of them vasectomies. It is worth noting that such focus on the sterilization of men was unprecedented and remains unparalleled to this day, as population policies' history shows that women are normally the target. Despite the brutality of methods and the numerous violations to human rights committed in India in the name of controlling fertility, Indira Gandhi was one of the recipients of the first ever United Nations Population Award in 1983, granted by the UNFPA to both her and Qian Xinzhong, 'to pay tribute to the leadership of the world's two largest nations - China and India - for their vision and foresight in responding to the formidable challenge of controlling population growth', in the words of the Secretary General of the United Nations, Javier Pérez de Cuéllar (POPULATION COUNCIL, 1983, p. 751).

Figure 8 - Indira Gandhi is awarded the United Nations Population Award in 1983

The other recipient, Qian Xinzhong, was the Chinese Minister of Family Planning responsible for the country's one-child policy, launched in 1979 and tightened in 1982, when the Chinese state began to require that all women with at least one child be inserted an intrauterine device and that one member of every couple with two or more children be sterilized. To those who challenged the policy, the penalties were heavy fines, dismissal from their jobs, loss of farmland, housing and economic benefits.

Xinzhong was quoted as saying that **'the size of a family is too important to be left to the personal decision of a couple'** and that 'births are a matter of state planning, just like other economic and social activities, because they are a matter of strategic concern. **A couple cannot have a baby just because it wants to'** (WEISSKOPF, 1985).

An article by the Washington Post in 1985 described the lengths to which the Chinese government went to assure that the policy was observed by its citizens, as the shocking example of in Dongguan, a bucolic patch of Guangdong Province in southern China illustrates:

> Here, abortion posses[8] scoured the countryside in the spring of 1981, rounding up women in rice paddies and thatched-roof houses. Expectant mothers, including many in their last trimester, were trussed, handcuffed, herded into hog cages and delivered by the truckload to the operating tables of rural clinics, according to eyewitness accounts (…) In 50 days, 19,000 abortions were performed -- almost as many as the county's live births in all of 1981

[8] The journalist who authored the piece reported eyewitness accounts of "abortion posses" in Guangdong province that scoured the countryside for pregnant women, whom they proceeded to truss and handcuff for delivery to rural clinics.

> (…) Any mother who becomes pregnant again without receiving official authorization after having one child is required to have an abortion, and the incidence of such operations is stunning -- 53 million from 1979 to 1984, according to the Ministry of Public Health -- a five-year abortion count approximately equal to the population of France (WEISSKOPF, 1985).

The brutal examples of India and China and, most importantly, their celebration by the international population establishment as cases of success demonstrate what can happen when population is dealt with as a 'numbers problem' which requires, obviously, a solution also in numbers. Population policies have come a long way since its darkest days, which led some experts even to claim that population control was 'history' (CONNELLY, 2003). However, as many others do (HARTMANN, 2016, HENDRIXSON, 2019, WILSON, 2017b), this work argues that population control is still very much part of the present and that if numbers remain at the centre stage of allegedly 'family planning' policies it is likely that it will be at the expense of the reproductive health and liberty of women.

2.8. Population Policy and Loans

In the 1980s, a coordinated effort between USAID, the World Bank and UNFPA pushed African leaders to embrace population control. That was the case with Senegal, where those organizations sent finding missions to document the importance of population control, funded consultants to assist in drafting population policies, organized 'study tours' for Senegalese officials to learn from population programs in Zaire, among other initiatives. Finally, the World Bank established that the preparation of a population policy statement and an action plan on population were to be conditions for a structural adjustment loan with the West African country (HARTMANN, 2016, p. 119).

In South Africa, population policies were instrumental to the regime of apartheid, functioning as a tool to control black South Africans and foster the growth of the white population. South Africa started official population programs in the early 70s, following a crisis in the surplus of black labourers. Concerned with the fueling effect the crisis had on the sentiment of black indignation, the South African government started the implementation of several programmes, chief among them, population control. White political rhetoric at the time centred in *swart gevaar*, 'black peril' in Afrikaans. The argument of the international population establishment, which directed linked overpopulation and poverty, provided Pretoria with a globally ratified reasoning to implement policies that would ensure the maintenance of black-white inequality. Birth control clinics became a governmental priority to the point that,

by 1983, they outnumbered by 50% basic health clinics. Nurses were authorised to prescribe birth control that previously could only be prescribed by doctors – a policy that was most often implemented in black communities. Despite being 'officially' non-discriminatory, it was clear how the population control programmes targeted black South Africans. Education and outreach were concentrated in black communities, the services were mostly utilized by black South Africans, as most whites used private clinics, and perhaps mostly shockingly, whilst promoting the importance of limiting population growth, the government promoted white immigration to the country (BROWN, Barbara B., 1987).

In Nigeria, consultants funded by the World Bank to provide the local government with population policies concluded that 'the patriarchal family system in the country shall be recognized for stability of the home', to the outrage of Nigerian feminists. A national population policy was thus adopted in 1989, targeting women and reinforcing patriarchal norms. Women were told to reduce their number of children and even given a time-bound target – the average should drop from six to four children per woman by the year 2000. Meanwhile, men were encouraged to 'have a limited number of wives and optimum number of children they can foster within their resources' (HARTMANN, 2016). A similar conclusion was reached in a 1994 study, when the authors recommended acknowledging that in Nigerian society men were the ones who made reproductive decisions within families and thus, targeting persuasion efforts at them. The contraceptive use by women would be a consequence.

> Given the all-encompassing involvement of men in the family and society, we argue that men probably provide different and more realistic views than women do concerning fertility-related behavior and preferences. (…)
> The study underscores the need to include, within the framework of the National Policy on Population, specific population information and awareness programs targeted at men, with the aim of influencing their attitudes about reproductive matters and **motivating them, and thereby their wives,** to produce fewer children (UC, 1994).

The extent to which population control was prioritized can be assessed by the country's health budget. In 1991, a World Bank loan would give 'family planning' significantly more money per year than the Health Ministry had for its annual recurrent expenditure (HARTMANN, 2016, p. 120).

Aside from the questionable effectiveness of Structural Adjustment Programs (SAPs) in reducing population growth - and the even more questionable effect of the latter on development-, Grimes (1998) explains the detrimental effect of SAPs in African countries in other areas essential for development, such as health and education.

> Throughout Africa, SAPS are forcing families to reallocate diminishing resources, resulting in rising infant and child mortality in some areas, and in declining educational enrolment in others, where parents are too poor to send their children to school. In Zambia, for example, parents are adjusting their desired number of children to those they can afford to educate, as an adaptive strategy to SAPs. Similar harmful effects of such programmes have also been identified in Kenya (GRIMES, 1998, p. 387).

These cases help illustrate the role played by the international population establishment in forging the global crisis of population and leading developing countries to make controlling the size of its population an absolute priority, often in detriment of many other pressing challenges.

In 1984, one year after offering the first ever Population Awards to Gandhi and Xinzhong, UNFPA convened an International Conference on Population in Mexico City. The purpose of the event was to assess the progress made in the implementation of the World Population Plan of Action since Bucharest.

Within the agency, expectations for the event were high and preparations were in full swing. Among the latter, UNFPA produced a film called 'Tomorrow's World', depicting the risks of overpopulation and the need for modern family planning. In her book, Hartmann (2016) describes her interaction with agency officials at the time and offers a glimpse into both the tone of the message they expected to convey and the ideology that energised their activities:

> Among the more memorable scenes in the film were of a Thai hairdresser giving discounts to customers who buy pills from her and a closing shot of a woman flat on her back, giving birth in stirrups, as an example of what wonders modern medicine can bring. But the most vivid picture was of a poor, landless Mexican woman who had agreed to sterilization after the birth of her fourth child. "Life without land will never be an easy matter," the narrator tells us, "but at least this mother's problems will stop multiplying." At the UNFPA headquarters in New York, Dr. Joep van Arendonk, then director of the Program Division, discussed the upcoming conference. "The value of these conferences is that you can reach a number of opinion makers," he explained. "In Bucharest there was not as much awareness, particularly on the part of Africa and Latin America, that there is a population problem. Now there is an awareness, but what action to take? In Mexico, population targets will be a heated issue again, along with contraceptive approaches, the pros and cons of surgical contraception, and the redistribution of population." **What about redistribution of wealth? I asked him. "That," he answered, "is not our concern**." (HARTMANN, 2016, p. 121–122)

Despite discussions building upon the idea affirmed in Bucharest that equitable social and economic development were key to reducing poverty and hence slowing down population growth, the discussions in Mexico City concentrated on the problematization of population. The organizers also demonstrated having learned other important lessons from Bucharest, where the resistance of governments from developing

countries had caught them off-guard: in anticipation for the conference, a series of publications focused on a new 'consensus' in population (COHEN, RICHARDS, 1994, GERMAIN, KYTE, *et al.*, 1995)

Unlike what had happened in Bucharest, this was a conference of administrators from different countries but that, to a larger extent, were all immersed and well versed on the discourse of the population establishment, used to bypassing matters that underlie the 'population problem', such as inequality, imperialism, and racism. That is not to say all voices in population were unanimous, but dissenting sentiments were largely drowned out in Mexico City. That would lead to a reaction that would leave its mark in Cairo, ten years later.

During the lead up to the International Conference on Population and Development (ICPD) of Cairo in 1994, feminist pressure intensified and succeeded in broaden the population discourse to incorporate many women's health and empowerment concern.

By then, the population discourse had for decades been centred around the fertility of women. What became noticeable in the early 1990s was that girls and women started to be increasingly described as potential assets for economic development. Hartmann (2016) offers three main reasons for this. First, the growth of the feminist movement since the 1970s, not only in richer countries of the West, but also on developing countries. The latter's movement called attention to the experiences of neglected groups and managed to push the agenda into acknowledging said experiences in their formulation of policy, even if one still might wonder the extent to which the acknowledgement was translated into gains regarding rights, provision of services, and modifications to social and economic orders. The second factor was the growing number of women joining the global wealth chain (ENLOE, 2014, SEABROOKE, WIGAN, 2017) in low-wage works for multinational corporations meant that controlling their fertility was becoming increasingly more important to the globalized economy (ENLOE, 2014). And finally, demographic research had showed for decades now that enhancing women's status was an important factor for fertility decline. The combination of these factors led the issue of population to be integrated into income generation activities and micro-credit schemes.

2.9. International Conference on Population and Development – Cairo 1994

> The Cairo Conference moved population policy and programmes away from a focus on human numbers to a focus on human lives. It put the emphasis where it should be: on improving the lives of individuals and increasing respect for their human rights. Delegates from all regions and cultures agreed that reproductive health is a basic human right (UNFPA, 2004).

The excerpt was taken from the foreword of an UNFPA publication of the Action Plan resultant from the International Conference on Population and Development (ICPD) in Cairo and it summarises the main message that came out of the conference: less focus on the threat of overpopulation and numbers, in favour of an emphasis in reproductive health and the empowerment of women. How much of an impact that message had in transforming population policies in developing countries, however, is a debatable matter.

The Program of Action for Cairo was drafted in a more inclusive fashion than had ever been previously done, with an important role played by women's coalitions, including women from developing countries. The debates during the conference, however, were largely dominated by the topic of abortion (SIMONS, 1995), due largely to the efforts of an alliance formed between the Vatican and conservative Islamic forces. The focus on abortion ended up drawing attention from important critiques formulated by women's groups and representatives from governments of developing countries, such as the one from Eritrea, who spoke about the need for a 'much bolder and holistic approach that addresses and tackles the real causes of underdevelopment', pointed to imbalances in international trade, to the need for technological transfer and 'effectiveness and scale' of international assistance, and, finally, affirmed that population stabilization was more likely to be achieved as a by-product of development, rather than an antecedent to it (HARTMANN, 2016, p. 145–147).

The conference was overall considered positive by some of critics of the *status quo* of the population establishment (HARTMANN, 2016, KUUMBA, 1999). Despite not recommending the abolition of incentives and disincentives schemes, the final document discouraged them and condemned all forms of coercion in population programmes. It also adopted what became known as a **human rights-based approach to family planning**. FP 2020 points to Cairo and the rights-based approach that emerged from it as the basis of its programme, and defines the approach as follows.

> Rights-based family planning is an approach to developing and implementing programs that aims to fulfil the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence (FP2020, [S.d.]).

Others were less convinced by the message that came from Cairo. Women's reproductive health was indeed placed at the top of the agenda, but *what* did 'reproductive health' entail? Much like what had happened to the term 'family planning', the apparently

broad term 'reproductive health' was given a much narrower signifier, which again was focused on fertility and neglected the provision of primary health care (THE LANCET, 1995).

There was also criticism of the alleged 'feminist makeover' received by the population establishment in Cairo. Historically, mainstream Western feminism has neglected to incorporate the voices and struggles of non-white, non-Western women, and reproductive health was one of the main issues in which their voices were left unheard (DAVIS, Angela Y., 1981, KHADER, 2019). Despite making a significant contribution with their opposition to the more damaging and abusive aspects of population control policies, Western feminist groups often failed to understand the needs of poorer women in development countries.

Rozario (1999) writes about how the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE) had argued that village women in Bangladesh did not want or need access to any form of mechanical contraception. It is her contention that, despite formulating an eloquent criticism of how population policies were to blame for a series of abuses to which Bangladeshi women were subjected and how their traditional and religious values and customs were often ignored, there was ample evidence (including many first-hand accounts) to contradict the group's conclusion that there was not a demand for contraceptive among village women.

Additionally, the ICPD also did not end the securitisation of population debates. Following the end of the Cold War, the threat of communism was replaced by the renewed concerns with the impact of population on the environment (KAPLAN, 1994). That fear found its theoretical formulation on the works of Homer-Dixon on environmental conflict (see chapter 1, item 3). His work was largely responsible from bringing the US national security community into the ICPD coalition (HARTMANN, 2006).

It is true that the ICPD marked an important shift in the population discourse. Despite not being a legally binding document, a shared understanding of reproductive justice as intrinsic to human rights has had an effect in the formulation of population policy. **However, the underlying logic of acting upon fertility of women in the hopes of affecting economic performance has resisted**.

2.11. New framework, old problems: Sterilizations under Fujimori and the Millennium Development Goals

About a year after the Cairo ICPD, then Peruvian president, Alberto Fujimori, launched an initiative focused on lowering birth rates in his country. The 'Emergency Plan' was launched

in September 1995 and received 36 million dollars from USAID and about 5 million from UNFPA (BARTHÉLÉMY, 2004). The program was focused on sterilization. His plan had been announced on month prior in Beijing, at the Fourth Annual Conference on Women. That just one year after the ICPD the president of a country could openly present a population programme reliant on sterilization as a key element of his development policy is telling of the limits of the discourse change on population.

The program was largely aimed at rural women and minorities and it promoted **'ligation festivals'** in a strategy similar to what had been done in India in the 1970s. A congressional investigation into the matter concluded that the Peruvian government established targets which became mandatory quotas for health professionals and establishments and that rural, indigenous and poor women were especially targeted (SUBCOMISION INVESTIGADORA DEL CONGRESO DE LA REPÚBLICA DE PERU, 2003).

Figure 9 - Peruvian flag is displayed in a protest in Lima with the names of victims of forced sterilization conducted under the government of Alberto Fujimori (MILLER, 2019)

It is estimated that 350,000 women were sterilized due to the program. Over 2,000 of them have presented horrifying statements about being forcedly subjected to sterilization surgeries and at least 40 died as a result of the procedure.

> The first time nurses visited Gloria Basilio, she told them she wasn't interested in sterilization surgery. She already had three children but wanted more. The nurses kept returning to her home in the remote Peruvian countryside. They told her the president himself had ordered the procedure for women with large families — women who they said "reproduced like rabbits." With her husband away, Basilio finally conceded. She changed her

> mind in the operating room the next day, but nurses tied her arms and legs to a bed and blindfolded her (MILLER, 2019).
>
> In 1996, Esperanza Huayama was sterilized when she was three months pregnant. She had to fight so doctors would not perform an abortion then and there. 'You are not taking my little son, I told them. I would rather die than lose my little son. Afterwards, I woke up in a lot of pain. I could not see straight, I was weak. My son was born very little and sickly', she said. 'They did the same to many women that day. At least a hundred. We were treated like animals (…) Some women died, others were abandoned by their husbands' (Miranda 2015; our own translation).

Among the different methods employed to coerce women into sterilization were threatening mothers with refusal of the civil registry of their new-borns, threatening with abortion pregnant women who refused to be sterilized, psychological pressure, house visits by nurses who threatened to return with police escort if women refused to go to the health centres, money incentives for husbands to sign an 'authorization' to sterilize their wives, and forcefully bringing women to the health centres (MIRANDA, 2015).

The Government of Peru acknowledged that forced sterilizations had taken place and represented a violation of human rights in a settlement before the Inter-American Commission of Human Rights in 2003. However, as late as March 2021, the Peruvian courts were yet to grant reparation to the close to 1,700 plaintiffs who were victmised by the forced sterilizations (PAPALEO, 2021).

It is the contention of this work that, as evidenced by the results of the Congressional investigation, the centrality of quantitative targets in the Peruvian population policy was an important factor in the resulting violations faced by hundreds of thousands of women in the country. As long as numbers of women sterilized or using contraceptives continue to define success and to be interpreted as proxies for the fulfilment of female reproductive rights, family planning programmes risk functioning as catalysers of abuse and neglect.

The quantified definition of success in international development policy gained momentum in the late 1990s. In 1996, the Organisation for Economic Cooperation and Development (OECD) established the International Development Goals (OECD, 1996), setting time-bound targets to be pursued through cooperation for development. The success of the experience in terms of funds among its members inspired Michael Doyle, who would five years later lead the development of a blueprint for a similar framework for the United Nations: the Millennium Development Goals (MDGs). That blueprint was a 'roadmap' document which converted the Millennium Declaration of 2000 into MDGs. The original idea was for the MDGs to be used for reporting and communication. However, the MDGs ended up being used as

technical guidelines for allocating resources and developing policies (YAMIN, BOULANGER, 2013). Understanding this original 'modest' objective behind the development of the MDGs may help us make sense of **the reductionism of the MDGs vis-à-vis the state of the discourse of a human rights-based approach to development**. Specifically regarding reproductive health, the MDGs fell significantly short from embracing the spirit of the Plan of Action from Cairo, referencing exclusively maternal health and with the sole target of reducing by three-quarters the maternal mortality ration on its original version. After the 2007 revision, it also included the goal of achieving 'universal access to reproductive health' by 2015.

The criticism to the MDGs and the role it came to play in international development policy was ample. It is worth briefly going through some of the main points raised in order to better understand the limitations of the international framework for development in place at the time of the 2012 London Summit and the creation of FP 2020.

The first - and perhaps most obvious – criticism of the MDGs was the fact that many of them had targets formulated based on **proportional reduction**. For example, goal 1, eradicating extreme poverty and hunger was expressed by two targets that had as baseline numbers from 1990: 1.a. was to halve the number of people living under a dollar a day and 1.b was to halve the proportion of people living in hunger. By not taking into account population dynamics, the goals could be declared successfully met even if the absolute number of people living in poverty was higher at 2015 than it was in 1990 (CLEMENS, KENNY, *et al.*, 2007).

Gita Sen criticizes the segmentation of the goals and how that diminished their interconnectedness, which would be especially relevant to women as they make up the greatest proportion of marginalized individuals. She also pointed to the narrow definition of gender equality that left unaddressed reproductive, social, political, and economic rights.

> The consequence was the creation of a set of goals that became silos in themselves with critical interlinkages and synergies remaining untapped; this was especially true for how weakly the MDGs addressed the core problem of gender power relations and inequalities (SEN, Gita, 2013, p. 43).

Ashwani Saith (2006) credits the MDGs shortcomings to the adoption of the narrow focus on OECD's International Development Goals in detriment of the broader approaches of the ICPD document and the Beijing Declaration. Saith also brings attention to the fact that the targets brought forward by the MDGs tended to lead to poor governmental practices because it made return on investment (ROI) a central criterion for allocation of results. So, for instance, it would be more effective for achieving the targets focusing on people just below the poverty line rather than the very poorest, as the latter group was less likely to be 'counted' as lifted out

of poverty (SAITH, 2006). As it will be shown in the following chapters, the strategy adopted for FP 2020 similarly leaves a door open for distorted incentives due to its focus on ROI.

The MDGs were also criticized for defining development in terms of increase in GDP, neglecting human-centred issues. Carol Barton argues that the MDGs operated on the assumption that neoliberal politics were the best means to reduce poverty when in reality it inhibits access to services necessary for development (BARTON, 2005). That commitment to neoliberalism, as explained by Wilson (2015), has outlived the MDGs and is at the basis of the development of FP 2020.

2.12. Is it really 'history'?

Familiarising oneself with the violent and abusive history of population policy can perhaps make one wiser for critically analysing a programme, allowing for the identification of continuities and ruptures. The chapter analysed several examples of population programmes implemented in the developing world throughout the decades and the role played by technocracy and, more specifically, by a discourse that has long relied on quantitative methods in order to self-declare as objective and evidence based.

Connelly (2003) was criticized for announcing that 'population control was history' (HENDRIXSON, 2019). Despite never having shared his optimism, in the original blueprint of this work, the history of population policies was supposed to make up a few pages, a brief introduction to help contextualize FP2020. However, during the process of reviewing the literature, parallels began to present themselves. Too many to be ignored. Targets, experimental drugs, the health of poorer women being put in jeopardy for the sake of economic progress, the economization of lives (MURPHY, 2017), the global crisis model (FOLEY, HENDRIXSON, 2011) – it was all there. It feels like it has always been there. On the next chapter, as the FP2020 programme is presented, these parallels and the pitfalls they may represent will be explored further and hopefully will provide some building blocks for exploring methodological alternatives inspired by feminist thought and the ethics of care.

Chapter 3

Family Planning 2020 and Quantification

This chapter will focus on the role played by quantification in the Family Planning 2020 (FP 2020) programme. At first, it will briefly describe some of the main events that prefaced its launch at the 2012 London Summit on Family Planning, highlighting the main political forces that acted to bring focus in development back to the issue of overpopulation and family planning. That section will be followed by considerations on the summit itself and how the FP2020 initiative was presented, including its strategy and main elements. That will include the justification for the need of an initiative of this nature, a justification that assembles phraseology of female empowerment, climate change, sustainable economic development, and security into a case for intervention on the bodies of millions of women from the Global South.

The following step will be investigating further the role played by quantitative methods and quantified data in the programme. The effort will be divided in three parts. First, it will look to the goal established for the initiative, namely, '120 by 20', meaning achieving a number of 120 million additional users of modern contraceptive methods by the year 2020. This section will reflect on the choice to **establish a quantitative goal** for the initiative despite the violent history of targets in family planning programmes. Second, it will look into the core indicators of the programme as they account for the advances made in the pursue of the initiative's goals and thus correspond to its very definition of success. **They also illustrate how quantitative measures of achievement play a crucial role in the FP2020 and how they play an important role on the decentring of gender and race issues in family planning.** And finally, it will look to the "FP Goals" application, developed by FP2020 to guide the development of public programs in family planning in developing countries. Based on an example of how the application was used in Lao PDR, the section will critically analyse **how quantitative methods and digital technologies are shaping the production of reproductive health policy for millions of women.** That last section will present the findings of a simulation performed on the FP Goals application.

The goal of this chapter is to scrutinize the reliance of FP2020 on quantification and the role it plays in the de-politicizing of reproductive rights, and ultimately sustaining the systemic pattern of abuse in international development policies focused on the 'population problem'.

3.1. Welcome Back to Family Planning

In the early 21st century, following the many advances in the field of family planning, target-based programmes were gradually dropped by most governments, a result of decades of outcry about the violence and coercion so common to these types of programmes as well as of the instrumentalization of women's bodies for the sake of population control. It seemed, however, that a rights-based approach to family planning was less appealing to donors and the issue of population lost prominence in the field of development.

> Governments began to change their official attitudes toward population and reproductive health and rights. Many countries that had established demographic targets dropped them in favor of rights-based programs, emphasizing improved quality of care and attention to reproductive health problems (…) The new focus brought with it a decline in attention to and resources for family planning (CENTRE FOR PUBLIC HEALTH ADVOCACY, 2017, p. 3).

As results of the focus shifting away from family planning, funding for contraceptives began to fall, contraceptive supplies for developing countries by donor agencies became limited and contraceptive prevalence rates began to decline in some countries (Sinding in Centre for Public Health Advocacy 2017, 22–23).

To better understand how family planning regained a momentum that culminated with the 2012 London Summit on Family Planning and the creation of Family Planning 2020 (FP2020), it is important to look back on a succession of events, including the entry of a new actor with deep pockets and the desire to change the landscape of the field.

In 2009, marking the 15-year anniversary of the ICPD in Cairo, the First International Conference on Family Planning took place in Uganda, organized by more than 50 organizations, among which were USAID, UNFPA, the World Bank, the World Health Organization (WHO), and the Bill and Melinda Gates Foundation (BMGF).

The Gates couple had been important names in philanthropy since the mid-1990s, leading both the William H. Gates Foundation and the Gates Learning Foundation. In 2000, the William H. Gates Foundation pledged a 750 million dollars for the formation of Gavi, the Vaccine Alliance, focused on the immunization of children in the development world (BILL AND MELINDA GATES FOUNDATION, [S.d.]). That pledge marked the transition of the couples philanthropic endeavours to the field of health, a transition that would be consolidated when, months later, the two existing foundations were merged and the BMGF created.

By the time of the Uganda conference, BMGF had become one of the largest private foundations in the world, with close to 30 billion dollars in assets (KPMG, 2009). Having

awarded over 450 million dollars in grants for researches involving diseases that disproportionately affect developing countries with its 'Grand Challenges in Global Health', and launched the Alliance for a Green Revolution in Africa (AGRA), led by Kofi Annan and supported by the Rockefeller Foundation (BILL AND MELINDA GATES FOUNDATION, [S.d.]), BMGF had also established itself as an innovation-focused organisation.

With such credentials, BMGF made waves when it arrived in Kampala. The tone of the event was set from the start, when Amy Tsui, then Director of the Bill and Melinda Gates Institute for Population and Reproductive Health presented a 'Welcome Back to Family Planning Speech'. By the time the event was over, a thousand participants had attended the more than 400 presentation and workshops; USAID, Bill and Melinda Gates Foundation, The World Bank, UNFPA, WHO and the UK Department for International Development (DFID) committed to work in partnership for funding in family planning. More importantly, the development establishment had been reenergised for discussing and working on the issue. Funding was secured after USAID announced an increase of close to 60% in its family planning budget for the coming year (from USD 450 million to USD 715 million) and a USD 12 million, three-year project was announced by the Johns Hopkins Bloomberg School of Public Health, David and Lucile Packard Foundation, USAID, and the Bill and Melinda Gates Foundation (OBER, 2010, UNFPA, 2009).

In September 2010, the UN Secretary General announced the 'Every Woman, Every Child' Global Strategy for Women's and Children's Health. The strategy picked up on the MDG 5 of improving maternal health and went further, including family planning among the necessary interventions for maternal, new-born and child health. It also highlighted the transversality of the issue within the MDGs and issued calls to action for governments, donors, the UN and multilateral organizations, civil society, businesses, health care workers, and academic and research institutions. The 2010-2015 strategy was scheduled to be in place up until the advent of the Sustainable Development Goals (SDG). After being ignored by the MDGs, the inclusion of family planning in the 2010-2015 strategy signaled that the theme was likely to be soon reintegrated into the main framework of the development agenda.

In both the United States and the United Kingdom, political will seemed to also favour a resumption in the focus on family planning. In the United States, the Secretary of State, Hilary Clinton, declared in early 2010 that the Obama administration would invest in women and girls and stated that 'there is a direct line between a woman's reproductive health and her ability to lead a productive, fulfilling life' (GUTTMACHER INSTITUTE, 2010). The speech was

followed by allocation of more funds in family planning and an increase in the US contribution by UFPA.

In the United Kingdom, Andrew Mitchell became the Secretary of State for International Development in 2010. He had a special interest in 'making his mark' in the issues of reproductive health and family planning (CENTRE FOR PUBLIC HEALTH ADVOCACY, 2017, p. 4). In 2011, Mitchell wrote an opinion piece on HuffPost[9] in which he argued for a renewed focus on population. Despite mentioning very noble and humane reasons for investing in family planning, such as providing women with control over their own fertility and making sure fewer adolescent girls drop out of school after becoming pregnant, it is noticeable that some of the most problematic aspects of international development policy regarding population had not gone anywhere, chief among them the lack of concern with the structural causes of poverty and inequality. It seemed like the main strategy once more consisted in reducing poverty by reducing the number of poor people. At an especially cringeworthy passage, Mitchell touts the need for 130,000 *less* teachers as one of the benefits of family planning. Finally, he says that access to family planning will mean that 'the poorest families can make what little they have go further' (MITCHELL, 2011).

It was the DFID under Mitchell's leadership that partnered with the Bill and Melinda Gates Foundation to convene a Summit in London in 2012, with the support of USAID and UNFPA. The event was to take place on July 11, World Population Day. Top of the planning checklist for the event was to come up with a baseline and a target number of women to be reached by the initiative. As it was later revealed by the expert group in charge of the task, coming up with this figure was crucial because organisers agreed that a clear numerical target would have the effect of galvanizing efforts for the global initiative they were about to kickstart (BROWN, Win, DRUCE, *et al.*, 2014).

3.2. The 2012 London Summit on Family Planning and the FP 2020

When announcing the London upcoming Summit on Family Planning, the organisers described it as 'a ground-breaking effort to make affordable, lifesaving contraceptives, information, services and supplies available to an additional 120 million girls and women in the world's poorest countries by 2020' (UK AID, BILL AND MELINDA GATES FOUNDATION, 2012b). The main target, '120 by 20' was to become a rallying cry that would

[9] At the time still called Huffington Post. The outlet was renamed in 2017.

mobilise governments from both developing and developed countries, multilateral organizations, businesses, and academia on the most ambitious initiative to date in the field of family planning.

The summit convened four main groups of stakeholders: donors, developing countries, private sector, and civil society. The idea was for each group of stakeholders to make pledges during the event. These pledges were named ‘commitments’ and constituted an enrolment to the global partnership.

Donors’ commitments were to sustain current investments and provide additional funds for contraceptive information, services, and supplies; improve coordination for effective fund use; and support advocacy. Developing countries committed to making additional domestic resources available and tackling policy, demand, and service delivery barriers for increased access to family planning information, services, and supplies. The private sector, represented by manufacturers of contraceptives, were engaged to make more products available. And finally, commitments made by members of civil society were related to expanding advocacy, building community support, monitoring services, holding other stakeholders accountable for their commitments, and implementing behaviour change and service delivery interventions (CENTRE FOR PUBLIC HEALTH ADVOCACY, 2017).

A case study was conducted by the Centre for Public Health Advocacy (CPHA) of the Bloomberg School of Public Health on the 2012 London Summit as an example of successful garnering of support for an initiative related to public policy, as organizers seemed to have accomplished the goal of bringing attention back to the issue and finding various willing parties to rally around the subject.

> The willingness of DFID and BMGF to lead this initiative represented a key turning point and opportunity for revitalizing family planning. Together they put resources, political commitment and voices behind this issue – components that had been missing for decades (CENTRE FOR PUBLIC HEALTH ADVOCACY, 2017).

The event had extensive media coverage and had among its attendees the UK Prime Minister, the Heads of State of Malawi, Rwanda, Tanzania and Uganda, as a dozen ministers of health and development from developing and developed countries, as well as high-level representation from the UN. All those factors contributed to bringing a strong spotlight back to the issue of population and family planning.

Some of the main outcomes from the event were:

- A commitment by many participant organizations and governments to the goal of providing 120 million more women and girls with contraceptives by 2020:

    - USD 2.6 billion pledged by donors (surpassing the original goal by USD 300 million), most notable among them were the pledges by:
        - UNFPA to increase expenditure on family planning from 20% to 40%;
        - The Bill and Melinda Gates Foundation to double its annual budget for family planning to USD 140 million;
        - Bloomberg Philantropy to USD 50 million;
        - IPPF to triple sexual and reproductive health services provided.
- Pledges from 20 different countries to address national policy on family planning.
- Launch of FP 2020.

By the end of the event, the partnership had sixty formally committed parties: twenty-one civil society organizations, nineteen developing countries, ten developed countries, seven foundations and three multilateral organizations (Appendix 1 – Summary of Commitments).

That aforementioned case study, however, listed some issues as having been 'trade-offs along the way'. One of these so-called 'trade-offs' deserve special attention: 'compromising on the broader Sexual and Reproductive Health and Rights (SRHR) agenda'.

Compromising on SRHR for the sake of population control

> 'The thing with the development sector is that everybody bangs their own drum; everyone's issue is a neglected issue. To some extent it's impossible to please everybody' (Leo Bryant, Marie Stopes International in interview for Centre for Public Health Advocacy 2017)

The fact that the seemingly unconcerned quote above came from on the of the main representatives of civil society involved in the event might by itself shed some light on to the matter of why a broader SRHR approach was rejected in favour of focusing solely on 'family planning'. Considering the track record of the international development establishment with family planning programmes, the fact that from the outset a focus on women's overall reproductive health and rights was not the central point of the agenda was, at the very least, disheartening.

It is unfortunately unsurprising that an initiative, despite claiming to be based on Cairo's agenda for a human-rights based approach to family planning zoomed in on contraceptives and ended up with such narrow a focus. Narrower than its title suggests, in fact. Framing the matter on whether the focus should be on SRHR or on family planning is already misleading, as the

term ‘family planning’ is used in the narrowest possible sense, meaning, simply, the provision of contraceptives.

The history of trying to manage populations through intervening in the fertility of women is responsible for the fact that those who belong to the population establishment apparently do not bat an eye at the fact that ‘family planning’ is in fact a mere euphemism for supplying contraceptives. It is like an unspoken agreement. ‘Family planning’ is not for those who want to become pregnant and have a child. **‘Family planning’ is not for those who face fertility difficulties. ‘Family planning’ is not for same sex couples. ‘Family planning’ is not for elderly women. ‘Family planning’ is not for those planning on adopting. ‘Family planning’ is not for those who will need to be main caregivers for an elderly parent. ‘Family planning’ is for avoiding pregnancies. Only for that.**

Organisations that were contacted to offer input on the lead up to the event had already complained months prior about the focus of the initiative being concentrated on provision of contraception rather than fulfilling women’s rights.

> Women’s organisations feel they have not been strongly engaged in the Summit preparation. Francoise Girard, President of the International Women’s Health Coalition, regrets the lack of transparency in the run-up to the Summit. The first draft of the business plan civil society members were given in April had less to do with women rights than with buying contraceptives (PICQ, 2012).

Hosting the event on population day is also telling. Despite the rhetoric of providing women and girls the ability to control their own fertilities, a closer reading of the ‘strategy overview’ of FP 2020 shows that may not indeed be the main motivator of the initiative[10]. Or, at the very least, the organization of FP 2020 did not believe that to be a strong enough reason for governments and other organizations to come onboard. On the document, the Bill and Melinda Gates Foundation call on the threat of poverty, environmental degradation and conflict in order to make the case for investing in family planning.

> By 2050, the global population is expected to grow to over 9 billion people, an increase of more than 50 percent over 2005 levels. This growth will only exacerbate the current health inequities for women and children, put pressure on social services and resources, and contribute significantly to the global burden of disease, environmental degradation, poverty, and conflict. Family planning is one of the best investments a country can make in its future (BILL AND MELINDA GATES FOUNDATION, 2012).

Once more, women and their bodies are treated as means to an end. And that end is population control. Population continues to be framed as a problem which legitimises

[10] Strategy Overview can be found in Appendix 3.

making the bodies of women sites of intervention for development initiatives. It is because the goal is controlling fertility of women and, through them, ultimately, the growth of population, that other aspects of sexual and reproductive health and rights become susceptible to compromise.

The documents of FP 2020 highlight how 'investing' in family planning is a 'good deal'. Several documents from the initiative claim that 'every US $1 invested in family planning services yields up to $6 in savings on health, housing, water and other public services' (UK AID, BILL AND MELINDA GATES FOUNDATION, 2012b, a). Other documents add that the returns can be of up to $13 in Asia (FP2020, 2012c). A publication specifically on Return on Investment (ROI) presents different models and their respective results. Two of them refer specifically to the savings that could be made from investing in unmet contraceptive need. According to the 'Adding it up' model, the short-term outcome would be of $2.20 savings in pregnancy-related care for every $1 invested in unmet need for contraceptives and the 'Family Planning and MDGs' model indicated savings varying between $2-$6 for every $1(FP2020, [S.d.]).

This type of cost-effectiveness formulation attributes a negative value to life, similar to the thinking that guided USAID in the 1960s. Despite now using 'unmet need' instead of 'averted births' as an indicator, the logic behind the calculations remains essentially unchanged. As Murphy eloquently puts it: it refers to 'the better-not-born, a naming and counting of a better-to-have-never-lived' (MURPHY, 2017, p. 48).

This economic case for family planning is one of the main arguments mentioned by proponents of this type of programme. They frequently highlight with very specific figures how paying for contraceptives can allow for much money to be saved or better invested. There is a reason why these figures are believed to be persuasive. There is an evocation in these figures. **They conjure 'what ifs' of less scarcity, where there is more to share among fewer.** In these scenarios, contraceptives are presented as the key to make it all happen. There are no other variables, a direct correlation is established and certain aspects such as history, culture, class, gender, and race are rendered invisible or worse, irrelevant.

To call the 'evocation' promoted by this type of reasoning with numbers an oversimplification is an understatement that neglects the functioning of power at play. This is a feature, not a bug. It is an example of how quantification can create the world it purposes to explain and why it is important to resist the temptation to attribute factuality to arguments simply because they rely on quantified data and to remember that no choice of method precludes examination of matters of ethics and politics.

To state that quantification creates the world it purposes to explain does not negate numbers their descriptive capacities. In that sense, Derosières teaches how numbers are both real and conventional, objective and subjective, as he points to the constant epistemological tension between taking them as representatives of the real and seeing them as arbitrary political decisions (DESROSIÈRES, 2002, ROCHA DE SIQUEIRA, 2017).

In the following sections, specific elements of FP 2020 will be analysed with an emphasis on their reliance on quantified data and quantitative methods. Hopefully, the analysis of these specific elements of the programme will provide some building blocks on which to draw a larger critique of **how quantification as a technocratic practice can have a de-politicizing effect that obfuscates complex racial and gender struggles and allows for the perpetuation of women's bodies as sites for intervention in the name of the environment, development or security.**

3.3. FP 2020: the goal (or target?)

For decades now, numerical indicators have been central to not only monitoring programmes, but also for their planning and communication. One of the main reasons for the popularity of numbers among development programmes and experts is their ability of making complex social issues more easily understandable without waiving scientific credentials. If anything, numbers lend apparent 'scientific objectivity' decisions made based on them (HANSEN, PORTER, 2012, PORTER, Theodore M., 1995, PORTER, Tony, SERVICE), 2012).

> Throughout modernity, numbers and quantification have come to epitomize objectivity and true knowledge, reflecting distrust in knowledge generated from bonds of personal mutuality and qualitative accounts (Porter 1995). This is reinforced by the inaccessibility of higher mathematics to the average person. (HANSEN, PORTER, 2012, p. 415)

On the day of its launch, the leaders of FP2020 presented the initiative alongside its slogan '120 by 20', which expressed the goal of having an additional 120 million women using contraceptives by the year 2020. As it is often the case when dealing with large-scale programmes, a commitment to monitoring results and gathering data for guiding decision-making was also made public (BILL AND MELINDA GATES FOUNDATION, 2012).

Unsurprisingly, FP2020 does not use the term 'targets' to describe the goals it intends to achieve. As seen on previous chapters, 'target' is a loaded word when it comes to family planning, as many acts of violence and abuse have been, for decades, perpetrated against

millions of women for the sake of meeting targets. Therefore, it is important to examine if there is in fact a substantial difference to the programme or if the goals FP 2020 aims to achieve are simply rebranded targets.

The programme defines its main goal as follows:

> OUR GOAL
> To bring access to high-quality contraceptive information, services, and supplies to an additional 120 million women and girls in the poorest countries by 2020 without coercion or discrimination, with the longer-term goal of universal access to voluntary family planning (FP2020, [S.d.]).

What does the goal mean?

The statement makes clear the aim of providing 120 million additional women and girls with high-quality contraceptive information, services, and supplies. Despite the apparent simplicity of this statement, two considerations are in order.

First, despite mentioning 'information, services, and supplies', an analysis of the initiative as whole shows that its ultimate objective is to have 120 million more women and girls *effectively using contraceptives*. To a casual observer, this might seem like a small matter, but to those aware of the history of population control programmes and the lengths governments and other providers have gone to make sure targets were met, it is not difficult to imagine some possible implications. **Is information being made widely available to largest number of girls and women or are efforts geared towards those believed to be more likely to adhere to the use of contraceptives?** As it will be covered on the next section, FP2020 does not monitor the number of women who are 'just' adequately informed on contraceptives. **When it comes the tracking the progress of the programme, only those who effectively choose to use 'modern forms of contraception' get counted.**

That and many other complications follow when there is a compromise on broader SRHR approach in favour of a focus on contraception: 'women' become reduced to wombs. Are lesbians provided services? Elderly women? Trans women? **Does the initiative's emphasis in long acting reversable contraceptives (LARCs) influences or worse, restricts women's choices? Does that same emphasis lead health providers to neglect to emphasize methods which also offer protection against sexually transmissible infections (STIs)?**

Second, the programme targets specific countries described simply as the 'poorest'. At the time of the launch those countries were counted and named. The purpose of FP2020 would be to reach a number of 120 million additional users of contraceptives in the '69 poorest

countries' in the world[11]. Perhaps the first question worth asking is **how these 69 target countries were defined.** As explained by a press release, those were the 69 countries with the Gross National Income (GNI) of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method) at the time of the launch (UK AID, BILL AND MELINDA GATES FOUNDATION, 2012b).

Regarding that criterion, some considerations are in order. First, the fact that the explanation that by 'poorest', they meant **'with the lowest GNI' was at an endnote on the press release (Appendix 2) and is not visible on the programme page where the goal is featured prominently**[12]. This omission can make it seem like 'poor country' is a self-explanatory term, which is far from the truth. Plus, **the choice of an indicator of income in order to define on where efforts for distributing contraceptives should be focused is nothing if not neo-Malthusian.**

The combination of the arguments which relied on the framing of population as an environmental, economic and security problem and **the deliberate choice to target countries where the population has the lowest level of income indicates that curbing the global number of poor people might take precedent over assuring that access to contraceptives goes to where women need it the most.**

Aiming for the poorest and trusting numbers

Aside from the questionable decision to select a single income indicator as yardstick for poverty, a pressing question comes to mind**: if the goal is to reach women who lack access to contraceptives, why is FP2020 targeting poverty? Is there a necessary relation between those two factors? An extensive review of dozens of documents and reports from the programme did not locate any claim to that effect.**

[11] The 69 countries, by region, are as follows. Eastern and Southern Africa (16): Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Rwanda, Somalia, Tanzania, Uganda, Zambia, and Zimbabwe. Central Africa (6): Cameroon, Central African Republic, Chad, Congo, DR Congo, and Sao Tome and Principe. Western Africa (15): Benin, Burkina Faso, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo. Middle East and Northern Africa (7): Egypt, Iraq, South Sudan, State of Palestine, Sudan, Western Sahara, and Yemen. Eastern and Central Asia (5): Kyrgyz Republic, Mongolia, DPR Korea, Tajikistan, and Uzbekistan. South Asia (7): Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka. Southeast Asia and Oceania (9): Cambodia, Indonesia, Lao PDR, Myanmar, Papua New Guinea, Philippines, Solomon Islands, Timor-Leste, and Viet Nam. Latin America and Caribbean (4): Bolivia, Haiti, Honduras, and Nicaragua.

[12] https://www.gatesfoundation.org/our-work/programs/global-development/family-planning . Accessed on 27 May 2021.

Even if one were decided to rely on quantitative data in order to select the countries in which to concentrate efforts for making contraceptives more accessible to women, there are several other indicators that, considering what they propose to measure, could be best suited to guide that decision – for instance, the Global Gender Gap, calculated by the World Economic Forum, both its overall ranking or the one specific on health and survival. Another possibility could be the Adolescent Birth Rate, one of the indicators used for monitoring the progress of the SDG 5 (Gender Equality).

Considering the year of 2012, half of the countries which occupied the last twenty positions of the gender gap ranking were not targeted by FP 2020[13]. Specifically relating to health and survival, more than half of the 25 countries with the lowest scores were not targets of the initiative[14]. The results are even more surprising when looking to the adolescent birth rate (per 1,000 women aged 15-19) - for the year of 2011, 16 out of the 20 countries which had the largest percentage of teenage pregnancies are not on FP2020's target list[15].

The extensive media coverage of the initiative did not question the inconsistency between the proposed goal and the indicator used to decide the scope of the intervention and that seems understandable. **There is something about choosing the 'poorest' countries for receiving this type of aid that *feels* right, even fair.** When we see a claim that aid is being directed to the poorest places on the world, we do not often ask: 'what do you mean by poorest?'. And that is because we *believe* there is a poorest country in the world. Just like *there is* a richest. We simply might not know which one is it. We assume that the 'poorest country' is something *knowable*, even if not unequivocally so.

Quantification can have the effect of making an assertion *feel* reasonable, substantiated. That points to two important aspects of quantification – the authority of numbers and to how they relate to socially shared understandings.

First, the authority of numbers is largely attributed to their capacity of lending scientific objectivity to political decisions, as explained by many who have taken up the issue of

[13] Those countries were: Syria (#132), Saudi Arabia (#131), Morocco (#129), Iran (#127), Oman (#125), Turkey (#124), Lebanon (#122), Jordan (#121), Algeria (#120), and Guatemala (#116).
[14] Those countries were: Azerbaijan (#135), Albania (#133), China (#132), Armenia (#130), Georgia (#129), Trinidad and Tobago (#128), Qatar (#127), North Macedonia (#126), Botswana (#125), Bahrain (#111), Kuwait (#111), United Arab Emirates (#111), and Maldives (#111). The complete ranking is in
[15] Those countries and their respective rates are: Venezuela (95.2), Guatemala (89.4), Panama (88.7), Marshall Islands (84.5), Burundi (84.5), Colombia (72.6), South Africa (70.6), Seychelles (69.7), El Salvador (67.1), Argentina (66.9), Costa Rica (65.4), Peru (64.2), St. Vincent and the Grenadines (64.1), Brazil (63.1), United States (59.3), and Cuba (56.8). The data is available by consultation at https://unstats.un.org/sdgs/indicators/database/.

quantification and the role played by numbers in governance (DAVIS, Kevin E, FISHER, *et al.*, 2015, HANSEN, PORTER, 2012, MERRY, 2016, PORTER, Theodore M., 1995).

Despite the accuracy often perceived in the exactness of numbers, their credibility does not necessarily stem from a shared belief that they are capable of mirroring their social phenomena with exactness. Rocha de Siqueira points out when analysing quantification and fragile states, authority also lies in 'good enough' numbers (ROCHA DE SIQUEIRA, 2017). She argues how their ever-perfectability rather than their stability can provide them with authority as acceptance of errors is taken as 'part of the game', especially when dealing with countries about which there is limited availability of official quantitative data, such as it is the case with most of the FP2020 targeted countries.

That ever-perfectability can help understand how the existence of limited data can lead to 'doubling down' on quantitative methods, rather than their abandonment. It helps answering the question asked by Hansen and Mühlen-Schulte: 'Why is it that the criticism launched against numbers usually leads to the creation of purportedly 'better' or 'improved' numbers rather than to their abandonment?' (HANSEN, MÜHLEN-SCHULTE, 2012).

By consulting FP2020's data dashboard, for example, one can see indicators for unmet contraceptive need and modern contraceptive prevalence rate for all target countries. **Numbers from countries with different levels of data transparency such as India and North Korea are displayed side-by-side in graphs and tables. Decisions are made based on these numbers not because they are believed to be exact representations of reality, but because they express a type of thinking and doing that enables ordering amid heterogeneity** (HANSEN, PORTER, 2012, p. 412).

That ordering ability of numbers leads to the second point – how numbers relate to socially shared understandings. Writing about technical classifications, Bowker and Star argue that they 'grow out of and answer to our common sense, socially comfortable classification' (BOWKER, STAR, 2008, p. 67). It is worth asking, however, what makes any given classification 'socially comfortable'?

The idea of developed countries providing financial aid for developing countries, as previously stated, is one that *feels right, reasonable*. The many examinations of the colonial legacy present in international development may help shed a light on *why* it feels right (BENDIX, 2016, DUFFIELD, HEWITT, 2009, KAPOOR, 2008, WILSON, 2013).
Sometimes, comfort is a feeling worth challenging.

If one is to attempt challenging the instrumentalization of women's bodies and health for the sake of population control, one must investigate the systems of knowledge/power that

sustain the discourse of the problematization of population and the case for intervention on fertility. As part of this effort, it is prudent to take a closer look at how the goal '120 by 20' came to be.

Why '120 by 20'?

At the time of the London Summit, the MDGs were the main framework of the international development agenda and it had measurability as a defining characteristic, with an agenda structured in targets the members of the United Nations aspired to achieve by the year 2000 (see item 2.11). The MDGs were originally silent on the matter of family planning, but a target for 'universal access to reproductive health' was added in 2007, with indicators for contraceptive prevalence rate and unmet need for family planning. Neither indicator, however, was associated with quantitative goals, which made sense considering the experiences the field had had with targets.

However, defining a numerical target to be pursued by 2020 was a key part of the FP2020 strategy and that task was fulfilled by the London Summit on Family Planning Metrics Group. According to the group, the need for a single, quantified target for the initiative had the purpose of 'allow[ing] the Summit to stand out amid the 100-plus global health partnerships, initiatives and campaigns' that had been created be since 2000 (BROWN, Win, DRUCE, *et al.*, 2014, p. 74). They also hoped the goal would capture global attention the same way UNICEF's 'child survival revolution'[16] and the WHO's '3 by 5'[17] had.

Despite claiming to have proceeded with 'sensitivity to the prospect of in-country interpretation of the quantitative goals as mandated targets, which in [the field] raises the specter of population control policies and coercive family planning practice' (BROWN, Win, DRUCE, *et al.*, 2014, p. 75), the group justifies the setting of a global numerical target due to their capacity to mobilize and guide efforts by emphasizing outcomes and providing benchmarks for program advocacy. There are several points of this reasoning worthy of objection.

[16]'UNICEF spearheaded what would later become known as the "child survival revolution": a blend of goal setting, campaigning, and global summitry that was successful in driving rapid global diffusion of child health interventions. Considered by many at the time to be foolishly unrealistic, the achievements were extraordinary; the efforts were credited with saving millions of children's lives' (BROWN, Win, DRUCE, *et al.*, 2014, p. 74).

[17] The "3 by 5" initiative, launched by UNAIDS and WHO in 2003, was a global TARGET to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005 (WORLD HEALTH ORGANIZATION, [S.d.]).

First, it must be mentioned that '*coercive* family *planning*' is an oxymoron that only makes explicit how that the term 'family planning' has been hollowed out in international development discourse and turned into jargon for contraception.

Second, it is clear that there was no lack of awareness regarding the possible implications of having a numerical target for new users of contraceptive. If a numerical target is deemed necessary for its mobilization capacity, how should one expect that such mobilization does not turn into pressure for meeting that very target? Insisting on setting numeric targets for women whose fertility are successfully checked by the programme means gambling with the health and lives of millions of women.

And a final point regarding the concern that the goal should not be translated into national targets. The participation in the FP2020 partnership is formalised through commitments, and, as the table below shows, participating development countries were indeed led to commit to reaching a target number of additional women using contraceptives. The table below illustrates how the overall goal of the initiative ended up translated into national targets of overall modern contraceptive prevalence rate (mCPR) and number of additional users.

Country	Increase in mCPR	Additional users
Chad	from 5% to 8% by 2020	115,000 additional users between 2017 and 2020
Haiti*	by 10%	---
South Sudan	among married women from 5% (2016 FPET estimate) to 10% by 2020	---
Bangladesh*	---	---
Benin	by 20% by 2018	---
Burkina Faso	15% in 2010 to 22.5% in 2015	---
Burundi	22% in 2012 to 40% by 2015, reaching 50% by 2020	322,316 (~100% increase) between 2012 and 2015
Côte D'Ivoire	---	---
DRC	from 6,5% to 19% by 2020	1.4 million additional women (15-49) by 2020
Ethiopia	---	---
Ghana*	---	470,000 between 2015 and 2020
Guinea*	from 9% to 22% by 2020	188,000 from 2017 to 2020
India	from 53.1% to 54.3%	---
Indonesia	120 million more	at least 2.8 million
Kenya	---	---
Liberia	---	---
Madagascar	to 50%	---
Malawi	---	---
Mali	to 20% by 2020	about 208,988
Mauritania	---	---
Mozambique	married/in union adolescents (15-19 years old) from 14.1% (2015) to 19.3% in 2020; unmarried sexually active adolescents from	---
Myanmar*	---	---
Nepal*	---	estimated 1 million additional users by 2020, provided the proportion of demand satisfied increases to 71% by then
Niger*	from 12% in 2012 to 25% in 2015 and to 50% in 2020	---
Nigeria*	to 27% by 2020	---
Pakistan	---	---
Philippines	---	---
Rwanda	---	---
Senegal	to 45%	
Sierra Leone	to 33.7% in 2022	to over 755,939 by 2022
Somalia*	---	---
Tanzania	---	---
Togo	to 35.5% by 2022	---
Uganda	to 50% by 2020	---
Zambia	among married women to 58% by 2020	---
Zimbabwe	to 68% of married women by 2020	---

Table 3. Commitments made by targeted countries regarding mCPR and additional users.

The goal of additional users predictably cascaded into national goals. The table illustrates how the '120 by 20' goal was translated into the national contexts of the developing countries involved in the programme. It shows how limited was the change when it came to how family planning programmes are operationalised.

Insisting on targets means once more putting women's aspirations and freedoms second to the desire to control population. It reinforces a culture that reduces poor women to wombs and dehumanises them as excessively reproductive, putting their bodies to the service of economic goals, security and environmental concerns. As governments, agencies, NGOs, and the media keep their eyes on targets and indicators of progress, women get lost, which often leads to abuses, violence and even death.

In 2014, the death of more than a dozen women in a sterilization camp in India made headlines worldwide. More than eighty women underwent tubectomies at a government-operated camp in the state of Chhattisgarh. Reports inform that all operations were performed by a single doctor and one assistant in the space of only five hours. The women underwent no pre-operatory examination and were discharged immediately after surgery, with no follow up care. The Indian population control programme was partially funded by DFID and offered 1,400 rupees for each woman who agreed to be sterilized (BURKE, 2014a).

Despite claiming a human-rights based approach to family planning, the way in which the FP2020 was structured favours a focus on numbers and reaching targets instead of and, often, in detriment of the health, safety and self-determination of women.

Who gets to decide? And how?

The case study on the London Summit on Family Planning lists, alongside compromising on SRHR, one other important 'trade-off' made along the way: failure to include the Global South sufficiently (CENTRE FOR PUBLIC HEALTH ADVOCACY, 2017). As evidence of the failings in including the Global South in Summit, the study points to the number of pledges made by developing countries – only 19 out of 69 targeted countries formalized a commitment at the event, and, notably, there were no pledgers from Latin America. The absence of the Global South, however, is much bigger than the study makes it sound.

First, there is no arguing that the initiative is donor-led. As mentioned before, the organisation of the event was led by the DFID and the Bill and Melinda Gates Foundation, with the support of UNFPA and USAID. There is nothing on the reports and documents of the programme that suggest any sort of involvement of the governments from the target countries in the planning of the initiative.

There was a clear distinction of roles between developed and developing countries within the partnership. **Developed countries were donors. Developing countries were targets.** The type of participation expected from developing countries was to propose how they would

adhere to the initiative by specifying the changes in national policy and budget they were committed to promoting.

Regarding the '120 by 20' goal, there were no representatives of developing countries taking part in the London Summit Metrics Group. The list of the ten members of the group, accompanied by their respective affiliation at the time of the Summit can be found on the table below.

Professional	Title	Affiliation	Programme/Division
Win Brown	Senior Program Officer	Bill & Melinda Gates Foundation	Family Planning Program
Monica Kerrigan	Deputy Director	Bill & Melinda Gates Foundation	Family Planning Program
Brian Siems	Program Manager	Bill & Melinda Gates Foundation	Global Development Division
Gary L. Darmstadt	Senior Felow	Bill & Melinda Gates Foundation	Global Development Division
Dan Kress	Deputy Director	Bill & Melinda Gates Foundation	Global Policy and Advocacy Division
Nel Druce	Senior Health Advisor	Department for International Development (DFID)	-
Julia Bunting	Director, Programmes & Technical	International Planned Parenthood Federation (IPPF)	-
Scott Radloff	Senior Scholar and Director PM/2020	Johns Hopkins University	Bloomberg School of Public Health
Desmond Koroma	Technical Specialist	UNFPA	Planning, Monitoring & Reporting
Srishti Gupta	Senior Expert	McKinsey & Company	-

Table 4 - Members of the London Summit Metrics Group

As the table shows, all ten members of the Metrics Group were affiliated with organizations based in the Global North, more specifically in the United States, United Kingdom and Switzerland. Aside from not having in the group any representatives from the Global South, **they do not report having consulted with any of the target countries when developing the goal.**

> Beneath the "truth" of quantified knowledge, indicators are part of a regime of power based on the collection and analysis of data and their representation. It is important to see who is creating the indicators, where these people come from, and what forms of expertise they have (MERRY, 2016, p. 5).

In an article from 2014 written by the ten members, they describe how they decided on the 120 million target and on the indicator best suited to measure the progress of the program (BROWN, Win, DRUCE, *et al.*, 2014). There are no mentions of consultations with the targeted countries or interviews of potential users. The authors concentrate their efforts mostly in explaining the choice for the indicator of modern contraceptive prevalence rate instead of the indicator of unmet need for contraceptives. It is as if the quantitative methodology behind the goal is the extent to which said goal needs explaining.

The lack of participation from the Global South is not restricted to the organisation of the initiative, though. Something similar can be noticed when examining the list of organizations from the civil society that took part on the Summit: they were almost exclusively based either on the United States or in Europe. Despite many of them operating on countries from the global South, the lack of voice of the people from these countries is one of the problematic aspects that quantification allows to be glossed over. The myth of the objectivity and the contention of the universality of quantification renders that lack of voice irrelevant**. If one's work is based entirely on numbers, what difference does it make who does the math?** That is one of the ways quantification can operate to render issues invisible and voices unheard. The following section will expand on that matter whilst analysing the indicators monitored by the FP2020 programme.

3.4. FP 2020: Indicators

Once the goal for the initiative was set, FP 2020 needed a strategy for monitoring the pace of the progress towards said goal. And, as it is the case with virtually every international development programme, the chosen form of doing so was by selecting a set of quantitative indicators to be tracked periodically throughout the duration of the initiative.

The programme decided on a set of twenty core indicators, classified into two categories:

1. Indicators that are reported annually for 69 countries.
2. Indicators that are reported annually in a subset of countries in years that they have a Demographic and Health Survey (DHS) and/or data from the Performance Monitoring and Accountability 2020 (PMA2020) project[18].

[18] The Performance Monitoring and Accountability 2020 (PMA2020) is now called Performance Monitoring for Action. It is a project that trains and engages training women in nine different countries to use smartphones to administer rapid-turnaround surveys on a regular basis in their communities. The

The list of indicators can be found on the tables below[19].

Indicators that are reported annually for 69 countries	
1	Number of additional users of modern methods of contraception
2	Contraceptive Prevalence Rate, Modern Methods (mCPR)
3	Percentage of women with an unmet need for modern methods of contraception
4	Percentage of women whose demand is satisfied with a modern method of contraception
5	Number of unintended pregnancies
6	Number of unintended pregnancies averted due to modern contraceptive use
7	Number of unsafe abortions averted due to modern contraceptive use
8	Number of maternal deaths averted due to modern contraceptive use
9	Percentage of women using each modern method of contraception
10	Percentage of facilities stocked out, by method offered on the day of assessment
11a	Percentage of primary Service Delivery Points (SDPs) that have at least 3 modern methods of contraception available on day of assessment
11b	Percentage of secondary/tertiary Service Delivery Points (SDPs) with at least 5 modern methods of contraception available on day of assessment
12	Annual expenditure on family planning from government domestic budget
13	Couple-Years of Protection

Table 5. FP2020's set of indicators that are reported annually for 69 countries

Indicators that are reported annually in a subset of countries in years that they have a DHS and/or data from the PMA2020 project	
14	Method Information Index
15	Percentage of women who were provided with information on family planning during their last contact with a health service provider

project was created as an effort to fill ‘data gaps’ in family planning and has since been expanded to water and sanitation as well.

[19] The definition of each indicator as well as their respective data source and availability can be found in Appendix 4.

16	Percentage of women who decided to use family planning alone or jointly with their husband/partners
17	Adolescent birth rate
18a	Contraceptive Discontinuation Rate
18b	Contraceptive Method Switching

Table 6. FP2020's set of indicators that are reported annually in a subset of countries in years that they have a DHS and/or data from the PMA2020 project

This section will focus on the role played by indicators in the FP2020 programme and how they encapsulate both the initiative's reliance on quantification for defining and measuring its goals and how the choice for a results-centred approach was made in detriment of an approach that prioritizes women's overall health, agency and reproductive rights.

Deciding on a key indicator

When the London Summit Metrics Group was entrusted with the definition of a numerical goal for the FP2020 initiative, their original thought was predictably directed towards the idea of unmet need for family planning. After all, the problem the whole initiative was set on addressing was the lack of access to modern methods of contraception for women in the poorest countries in the world. They agreed that 'unmet need' was an indicator that had the advantage of reflecting 'both the respondent's fertility intentions and her current practice of contraception' (BROWN, Win, DRUCE, *et al.*, 2014, p. 76).

However, after some consideration, they concluded that unmet need for contraception would not be an ideal indicator to measure and communicate the results of the initiative. One reason was the fact that raising awareness of the subject and making family planning more available could have a short-term effect of increasing the proportion of women with an unmet need for contraception. A phenomenon such as this was to be expected, especially in countries with a low prevalence of modern contraception use, which was the case of many of the 69 target countries.

Additionally, assuring the accuracy of the indicator would imply making sure that women's intentions towards family planning were properly captured in data collection, which is an information not as easily collectible as the information of whether or not women were

using a method of modern contraceptive[20]. Thus, the group concluded it was best not to use unmet need as their yardstick of success:

> Therefore, unmet need is not necessarily a unidirectional indicator of success. Measurement of unmet need also requires that a lengthy set of survey items be administered to ensure accuracy. Finally, the relationship between unmet need and actual demand for family planning, as measured by available surveys, is not always straightforward (BROWN, Win, DRUCE, *et al.*, 2014, p. 76).

What the group describes as the challenges in using unmet need for family planning are examples of a common methodological issue: sometimes, practical restraints can make some strategies too costly, too complex, or too arduous for implementation. Acknowledging the limitations of any given method is often a signal of sound work.

Limitations such as this are rarely object of communication to the general public. Understanding what indicators mean and what they *do not* mean can require lengthy and complex explications, as well as not rarely a statistical background, so it is far from surprising that such limitations are often debated almost exclusively among experts or within academia. However, indicators themselves go way beyond that, increasingly reaching more members of the general public and swaying public opinion and policy.

One need only to look at the press coverage of the 2012 London Summit on Family Planning to see how the issue of access to contraceptives got replicated in the numerical terms presented by the organizers:

> The summit's organisers say commitments made at the summit will result in 200,000 fewer women dying in pregnancy and childbirth, more than 110m fewer unintended pregnancies, over 50m fewer abortions and nearly 3 million fewer babies dying in their first year of life (…) The aim of the London summit on family planning is to raise $4bn to expand access to contraception for 120 million women in the global south by 2020. According to the UN, about 220 million women in the south who do not want to get pregnant cannot get reliable access to contraception (TRAN[21], 2012).

> A new study by researchers at Johns Hopkins University shows that fulfilling unmet contraception demand by women in developing countries could reduce global maternal mortality by nearly a third, a potentially great improvement for one of the world's most vulnerable populations (…) They also found that an additional 29 percent of the deaths could have been prevented if women who wanted birth control would have received it, a concept called unmet need

[20] As Table 5 shows, however, those limitations of 'unmet need' did not keep it from being used as one of the initiative's core indicators.
[21] Writing for 'The Guardian'

> that is estimated using surveys of mothers in developing countries (TAVERNISE[22], 2012).

On CNN.com, Melinda Gates herself was the one providing the information on access to family planning on developing countries.

> Nearly 13 million adolescent girls give birth each year in developing countries, typically before they are physically, emotionally or economically prepared. (…) Simply giving women the means to space the births of their children three years apart would decrease deaths of children 4 and younger by 25% (GATES, 2012).

On one hand, the use of indicators often facilitates the necessary dialogue among experts and non-experts. Moreover, their ability to call attention to a given subject is a welcome feature for awareness-raising. The fact that the issue of lack of access to contraceptive by women received such extensive news coverage is one of the positive outcomes of the summit. This happens because quantification makes complex information more palatable. They propose to bridge a gap between social science knowledge and the general understanding. When they do so, they strip away complexities and omit the limitations and assumptions, presenting a simple, comprehensible descriptor accompanied by a number. As an example, the news articles mentioned before offer numbers of abortions and maternal deaths averted. These excerpts show the unambiguous and objective manner in which indicators are presented. That is how they act to produce a truth about the world despite all the pragmatic compromises that inevitably arise in their creation.

> Rather than revealing truth, indicators create it. However, the result is not simply a fiction but a particular way of dividing up and making known one reality among many possibilities. As indicators cross the gap from social science knowledge to that used by policy makers and the public, the drawbacks and complexities recognized by their creators, such as limited data, the use of proxies, and the uncertainty of flawed or missing data, are typically stripped away. (..) Data are never complete and may not measure exactly what the author of the indicator seeks to assess. Thus the truth of indicators can be quite misleading (MERRY, 2016).

Of course, this predilection for making a case by relying on quantification and quantitative methods is far from a peculiarity of FP2020 nor does it represent a new phenomenon in development. Merry (2016) uses the term ‘indicator culture’ to express the set of cultural practices, techniques and assumptions embedded in institutional and bureaucratic

[22] Writing for ‘The New York Times’. The article does mention that the study was funded by the Bill and Melinda Gates Foundation and that researchers acknowledged that maternal mortality record keeping is often weak in developing countries, which represented a limitation to the study.

settings that place a high value on numerical data as a form of knowledge and basis for decision making (p.9).

Some of the characteristics of **'indicator culture'** are the trust in technical rationality, in the legibility of the social through measurement and statistics and the capacity of numbers to render different social worlds commensurable. Terms such as 'results-based monitoring' and 'evidence making decision making' are ubiquitous and are often used as shorthand for 'based on numerical data' and imply neutrality and objectivity, and to suggest depoliticisation of matters when used to substantiate decisions regarding policy and management. Decision making is shifted to systems of measurement established by experts.

Additional users and false specificity

As a result of the work conducted by the London Summit Metrics Group, the number of additional users was chosen as the key indicator of FP2020. The indicator refers to the additional number of modern contraceptive users in each country, taking 2012 as a baseline. In the 2013-2014 Progress Report, the calculation of the indicator was described as such:

> Number of additional users of modern methods of contraception. To calculate its value, we subtract the estimated number of women and girls using modern contraceptive methods in the current year from the number in 2012, the year of the London Summit on Family Planning. The difference represents change during FP2020's first year (FP2020, 2015).

First, indicators create false specificity by appearing more accurate than they actually are. At the time of the launch of the FP2020 initiative, there was one clear message and goal: there were over 200 million women in developing countries who want to prevent or space pregnancies and they lacked access to modern contraceptives and FP2020 would provide 120 million of these women with contraceptives by the year 2020.

As the programme started its implementation, however, keeping track of additional users turned out to be more complicated than anticipated. The term generated confusion about the meaning of several other related metrics, such as 'new users', 'acceptors', 'first-time users', and 'adopters' (DASGUPTA, WEINBERGER, *et al.*, 2017). Was a woman who had used modern contraceptive before, stopped, and was now back on contraceptives an additional user? Some services providers would use the term 'adopter' to describe both women who were receiving contraceptive for the first time and for those who were not on any contraceptive at the time of her visit but may have used contraceptives before.

On the exasperatedly titled article 'New Users are Confusing our Counting' (DASGUPTA, WEINBERGER, *et al.*, 2017) experts from FP2020 acknowledged the

confusion the term ‘additional users’ had caused. At the root of the problem was the fact that different countries would use similar names for different things and different names for similar things, and that caused FP2020 to have trouble keeping track of its main goal.

Homogeneity is key for comparability. Indicators used for monitoring programmes are based on categories that are supposed to be universal. Since that is rarely the case across different countries, cultures, classes, religions, etc., that universality must be forged. To address the problem, FP2020 called on governments, ministries, services providers, and donors to align their definition to the nomenclature of the programme. Therefore, for the sake of keeping cohesion within the initiative and making sure its goal is properly tracked, countries and services providers might have had to abdicate the internal coherence of their own historical data by adopting a new classification.

Results-based rather than human rights-based

On virtually all its documents and reports, FP2020 stresses that the initiative relies on a human-rights based approach to reproductive rights, aligned to the learnings from ICPD in Cairo (FP2020, [S.d.], UK AID, BILL AND MELINDA GATES FOUNDATION, 2012b). However, skepticism was to be expected after a decision was made to focus the initiative on a numerical goal rather than choose an approach centred on the health and reproductive rights of women, especially those who belong to groups historically victimised by state-sponsored violence and violations.

A correspondent for Amnesty International present at the summit expressed concern with the little attention given to the commitment made in Cairo of putting women’s human, sexual and reproductive rights at centre of family planning initiatives. Considering the risks involved in fomenting interventions on the fertility of women**, accountability** was an issue of obvious relevance and one she was looking forward to learning how FP2020 would approach. The tone of the presentations on the issue did very little to alleviate preoccupation, as her account of the event shows:

> As I listened to discussions through the day I kept on thinking “What about accountability?” The issue was the focus of discussion in a parallel session in the afternoon. While the panelists spoke about indicators, data and drivers for progress, **accountability for human rights was mentioned as an optional feature**. While quantitative evaluations and hard data are necessary to measure progress, **they fail to address the barriers and challenges faced by women and girls in their attempts to realise their sexual and reproductive rights** (KHOSIA, 2012, emphasis added).

It is important to highlight that, as the article by the London Metrics Group demonstrated, the choice for an initiative geared towards achieving a numerical goal was made *despite* the organisers' full awareness of the systemic violation of women's rights that had been endemic to family planning programmes for almost 70 years.

Moreover, prior to launch of the initiative, feminists from organizations from 75 different countries signed a declaration calling on the leaders that would attend the London Summit 'to ensure that sexual and reproductive health and rights are at the centre of all efforts to meet reproductive health needs, including family planning'[23] (CENTER FOR REPRODUCTIVE RIGHTS, AMNESTY INTERNATIONAL, *et al.*, 2012). They warned precisely that history had shown that failure to guide actions by women's rights could have devastating consequences, resulting in policies that condoned coercion and denial of services to young, poor and marginalized women.

The letter concluded by urging governments, donors and other actors supporting the Summit to take action regarding some of the threats that loomed as the field of family planning regained attention in a context of problematization of population and once more planned to intervene on women's bodies in order to address economic, environmental and security issues. To avoid that coercive measures were introduced in the provision of contraceptives, make sure services were responsive to women's, and that human rights violations were prevented, they urged for organisers to take all measures to ensure the initiative was designed with quality of care and human rights at its core, with the meaningful participation of women in all stages of design and implementation. They highlighted the need for contraceptives to be integrated into reproductive health services and that a full range of contraceptives was offered. Regarding monitoring and evaluation, they called for the design and implementation of a system that tracked and measured impact on the human rights of women and allowed for corrections to be urgently made following any information on violation coming to mind. And finally, they asked for a commitment for tackling legal and policy barriers to the access of information and services.

It is fair to say the concerns voiced fell largely on deaf years. As the initiative was announced and the original list of core indicators presented, it became clear that FP2020's would have well defined, mathematical parameters for success, but those did not necessarily reflect a prioritisation of women and their reproductive rights.

[23] The complete declaration with the full list of organizations and countries can be found in Appendix 1.

None of the fifteen core indicators of FP2020's original list were aimed at tracking whether any violations of human rights were taking place as millions of women were being targeted to adhere to contraceptive methods. As the FP2020 Progress Report for the cycle 2012-2013 shows, there were no indicators in place nor any data that could be used for tracking accordance to human rights was being collected:

> An important area of contribution of the FP2020 partnership is and will continue to be the identification of new indicators that better measure concepts of informed choice, autonomy, and the extent to which family planning programs are implemented in accordance with human rights principles. **Currently, data that are routinely collected through existing mechanisms arguably do not adequately measure these concepts** (FP2020, 2014, emphasis added).

Despite the claiming that FP2020 would work on indicators that measured informed choice, autonomy and overall accordance to human rights, the only indicator that minimally attempts to capture whether women's rights were not violated on the process of adhering to contraceptive, core indicator 16 (Percentage of women who decided to use family planning alone or jointly with their husband/partners), would not be introduced until 2015, following mounting criticism and pressure from women's rights movements.

Moreover, as the table on the beginning of the sections showed, indicator 16 was not collected among all 69 targeted countries. The indicator's scope was of only 24 countries when it started being published in 2015, and by the deadline year of 2020, had expanded to 45. Even so, by the FP2020's own account, the scores of indicator 16 were unusually high and showed very little variation from country to country, which suggested that it was 'likely not capturing many of the challenges related to decision making that contraceptive users face'(FP2020, 2018, 2019b, 2020). That same observation about the unreliability of the indicator was repeated on every progress report from 2016 to 2019. On the 2020 report, nothing was written regarding the indicator.

Despite the rhetoric employed by FP2020, it would seem that the protection of women against violations of their reproductive rights was not made into a priority in the design of the programme. Not only the narrow focus on contraceptive was dissonant from the human right based approach which located family planning within a broader framework of reproductive health care ratified in Cairo, no reliable instrument for tracking potential violations to human rights was incorporated into the programme's monitoring strategy.

A central claim this work wishes to bring forward is **how the reliance on quantification can ultimately function as an instrument of depoliticization which decentres issues such as gender and race within the discourse of population, development and family planning.** By doing so, it allows for the same systems of power to perpetuate violence.

> In a society such as ours – or in any society come to that – multiple relations of power travers, characterize, and constitute the social body; they are indissociable from a discourse of truth and they can neither be established nor function unless a true discourse is produced, accumulated, put into circulation, and set to work. Power cannot be exercised unless a certain economy of discourses of truth functions in, on the basis of, and thanks to, that power (FOUCAULT, 1997, p. 24).

The use of the word 'exercised' in Foucault's account of the intrinsic relation between knowledge and power may lead to an interpretation of power as something that is deliberately yielded by those who have it 'against' those who do not. In the case of family planning programmes, for instance, rich organizations and governments from powerful countries exercising their power through numbers and thus victimizing poor nations and women. Such interpretation, however, would be naïve and oversimplistic. It could also lead to a demonization of organizations and professionals.

Here, it is the emphasis on the circulation of regimes of truth that is the focus of the argument. As analysed in chapter one, overpopulation has long been framed as problem and taken as an environmental, economic and security liability. Population growth is a phenomenon that has been statistically framed as the direct result of two simple variables: numbers of births and deaths, and family planning programmes have historically been aimed at grappling with the latter.

The critique this works brings forward refers to the fact that FP202's choice of the number of women using modern forms of contraception as its main metric is an evidence of how the initiative does not succeed in breaking away with the longstanding tradition in international development of treating family planning as means to an end. This instrumentalization of family planning implies the instrumentalization of women's health and can ultimately materialise in the form of abuses and violence.

The fact that the issue of human rights was no prioritised for monitoring is telling but perhaps even more so is the fact that the pressure from feminist activists and academics among other relevant groups, and scandals of forced sterilization such as the one in Chhattisgarh were not enough to force FP2020 to review its strategy. And despite being one of the most publicised cases in the media, India was not the only country where systematic violations of women's reproductive rights were enacted in the name of 'family planning'. In South Africa, for example, HIV-positive women were forcibly sterilised.

> Doctors and nurses told some of the HIV-positive women that they should not be having children and that they would die if they didn't get sterilized following delivery. Many agreed to the procedure by signing forms they didn't understand.
> When one of the women asked what the forms were for, her concerns were dismissed by a nurse, according to an affidavit.
> "You HIV people don't ask questions when you make babies. Why are you asking questions now?" the report quoted a nurse as saying. "You must be closed up because you HIV people like making babies and it just annoys us. Just sign the forms, so you can go to theater." (SGUAZZIN, 2020)

Similar cases of forced sterilization of HIV-positive women were also reported in Namibia, Chile (BI, KLUTSY, 2015) and Uganda (KAKANDE, 2016). Although these cases were not directly linked to the work promoted by FP2020, they are hardly surprising considering that governments of developing countries are pressured into committing to targets for increasing the use of modern contraceptive methods[24] and reducing unmet need for family planning.

The implications of target-setting cannot be thought of as separate from the targets that function as yardstick for determining courses of action. The way numbers and indicators are suited for governing at a distance, across heterogeneity and rely on socially comfortable categories is precisely why they can de-politicize the debate regarding how family planning programmes have operated as to perpetuate historical e systemic forms of violence and abuse.

3.5. 'FP Goals' and how data is shaping policy

Another evidence of the reliance of FP2020 on quantification is the work performed by the **Track20 project.** The project is dedicated to monitoring the progress of the initiative towards achieving the '120 by 20' goal. According to its website, the project works directly with governments that participate in FP2020 to collect, analyse and use data to monitor annual progress in family planning and, more importantly for the scope of this analysis, 'to actively use data to improve family planning strategies and plans' (TRACK20, [S.d.]).

[24] For the purpose of monitoring in FP2020, sterilization figures among the modern forms of contraception, as the definition offered by the project Track20, responsible for monitoring FP2020 is the following: 'A product or medical procedure that interferes with reproduction from acts of sexual intercourse' (HUBACHER, TRUSSELL, 2015, p. 240). The same reference article also warns that the definition 'does not address concepts of contraceptive effectiveness or efficacy. Specifically, the word modern should not be equated with higher efficacy. Indeed, in terms of effectiveness, some modern methods are demonstrably inferior to some of the non-modern methods' (idem).

Aside from monitoring the indicators of FP2020, Track20 also develops tools to assist FP2020 partners in using quantitative data for the formulation of their strategies and policies. This section will look to one of these tools specifically, selected for analysis for the role it has played - and can potentially play to an even larger extent - in shaping family planning policies in developing countries: 'FP Goals'. The section is divided in three parts. The first will provide a brief description of the tool as well as an account of a simulation in order to better illustrate its functioning. Second, it will look to one example of how the FP Goals application was used in one of the FP2020 target countries for decision-making regarding implementation of family planning policy. Based on these two experiences, the final part will present an analysis of the tool and reflect on its potential implications for reproductive health policy and ultimately, to the women who are reached (or not) by said policies.

Understanding the tool

Track20 describes FP Goals tool as follows:

> FP Goals is an innovative model designed to improve strategic planning. FP Goals combines demographic data, family planning program information, and evidence of the effectiveness of diverse interventions to help decision-makers set realistic goals and prioritize investments across different family planning interventions (TRACK20, [S.d.]).

The tool is a web application that promises to provide users with the necessary information to formulate their family planning policies. The application garners the available data from different sources and combine it with studies on the potential effectiveness of a range of interventions aimed at enhancing *modern contraceptive prevalence rate* (mCPR). Based on this information, the user chooses their country and sets on the application the scale of the impact desired on up to ten different issues, such as policy environment, stockout reductions, mobile outreach, youth interventions, and postpartum family planning. With these inputs, the application provides interventions scenarios, calculating the projected mCPR growth.

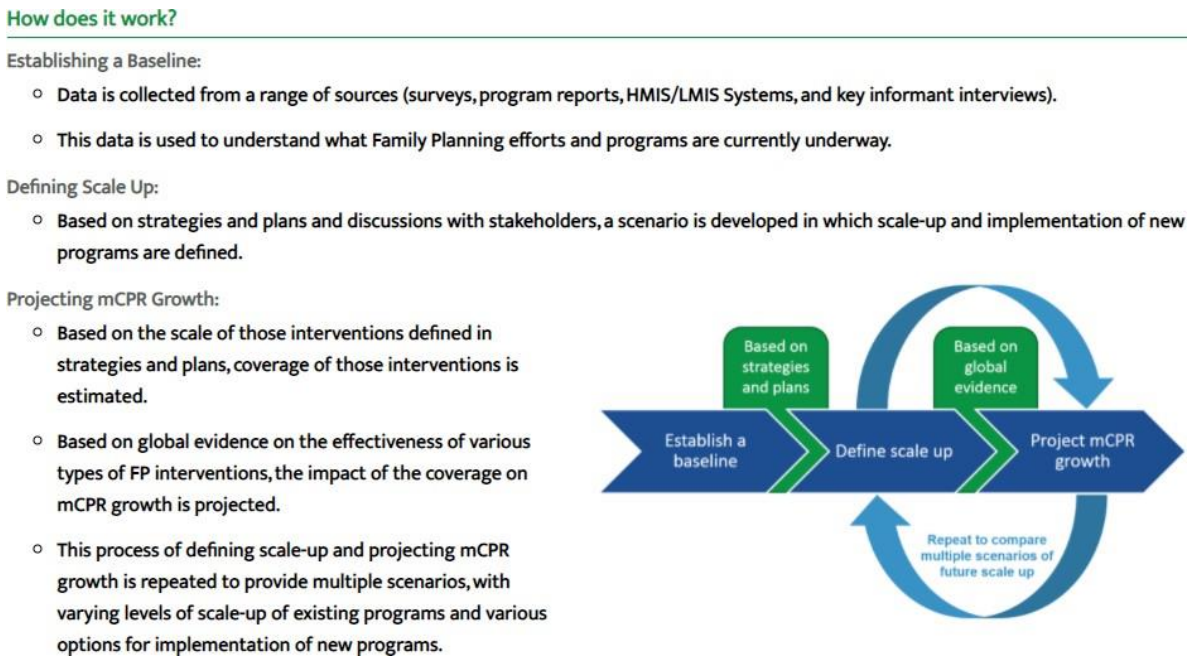

Figure 10. 'FP Goals': How does it work?

The application has a 'lite' version online which allows for simulations. The following experiments were conducted in order to **observe the functioning of the tool and the outputs regarding intervention from a user's perspective.**

The first step was to choose a country. In this exercise, Cambodia was chosen. The following step was indicating the aim of the planned interventions. Let us imagine that the Cambodian authorities are planning on prioritizing expanding access to contraceptive methods and community engagement. Accordingly, the following choices were made:

- Expand access to methods: a goal was set for increasing the extent to which the entire population has access to Long-Acting Reversible Contraception from the 49% baseline to an endline of 75%.
- Social Behaviour Change (SBC) Community: a goal was set for raising the percentage of women reached by comprehensive community engagement from the 22% baseline to an endline of 50%.

As outputs, the application provides two graphs: one with the projected growth in mCPR during the 5-year period and one with the contribution of each intervention for the project growth. The 'FP Goals' application informed that the chosen interventions would yield a 2.5% growth in mCPR within 5 years. Not only that, but it also showed the projected contribution of each of the two interventions to that growth: community engagement would lead to a 1.5% growth in mCPR and the expansion of access to methods to the remaining 1%. The pictures below show how the application worked:

Figure 11. FP Goals Lite's interface

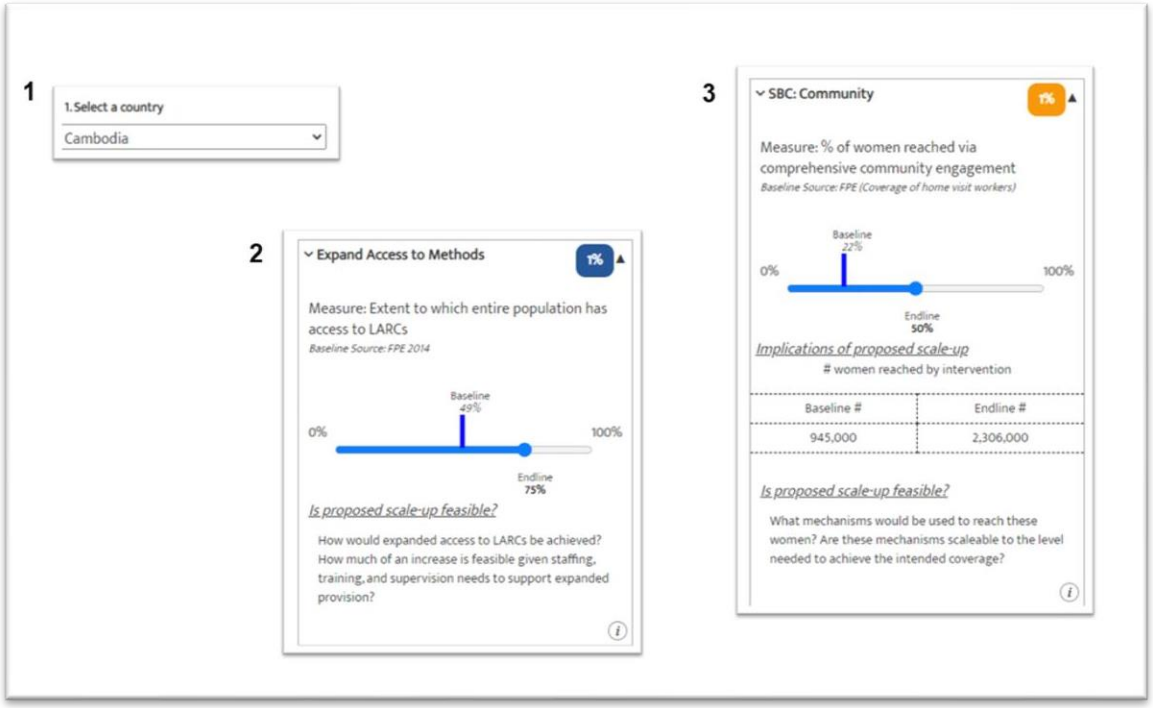

Figure 12. Simulation: inputs to FP Goals Lite

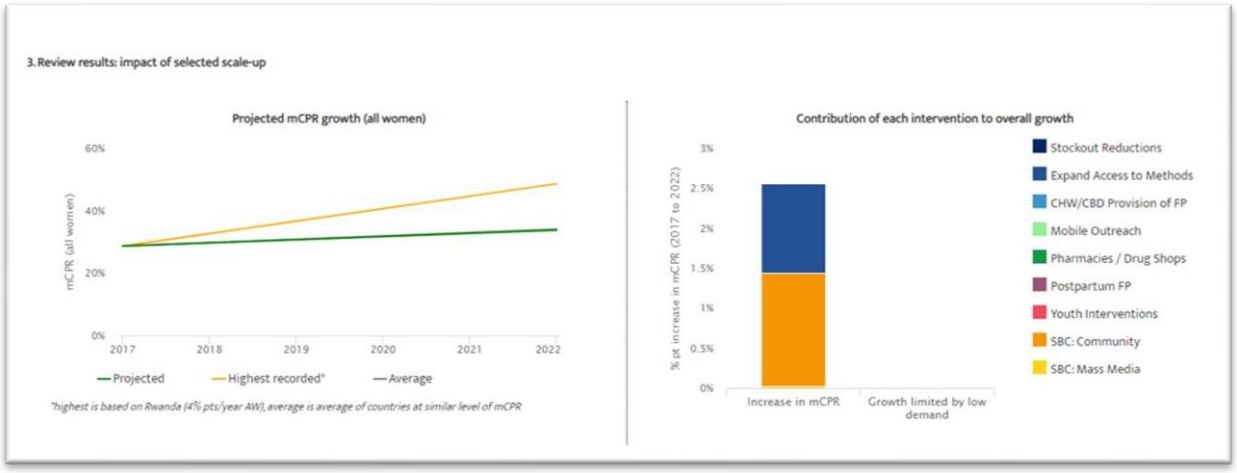

Figure 13. Simulation: outputs from FP Goals Lite

In a second simulation, still using Cambodia, instead of expanding access to methods and community engagement, the interventions chosen were youth interventions, provision of contraceptives by community health workers (CHW) and postpartum family planning. Below the description of the changes in outputs as each input was added to the 'intervention scale-up' fields.

- Scenario 1. Scale up youth interventions, raising the percentage of women aged 15-24 reached by comprehensive intervention from 0% baseline to 25% endline. That generated an output that pointed to an increase in mCPR of 0,06%.
- Scenario 2. Added to Scenario 1 an intervention that would rise the percentage of women covered by CHW offering family planning methods from the 0% baseline to a 10% endline. The output was an overall projected mCPR increase of 1%, almost solely attributed to provision of FP by CHW. However, it also showed a 1,5% of mCPR growth limited by low demand.
- Scenario 3. Added to the interventions from previous scenarios intervention focused on postpartum family planning and projected raising the percentage of women using family planning at 6 months postpartum from the 23% baseline to an endline of 40%. That yielded the same 1% growth in mCPR, with about two thirds attributed to CHW work and a third to postpartum family planning and virtually zero to youth intervention. However, it also showed a percentage of mCPR growth limited by low demand of 3%.
- Considering how that scenario 3 resulted in the same level of mCPR increase as scenario 2 with double the percentage of growth limited by low demand, a fourth scenario was considered, in which CHW offering FP methods was the only form

of intervention. The result was that, by itself, an intervention focused on having FP methods offered by CHW would yield an increase of 0.5%, with a growth limited by low demand of 2%.

The table below describes the four scenarios with their respective inputs and outputs.

	INPUT TO FP GOALS		OUTPUT	
	Type of intervention	Target of intervention	Increase in mCPR	Growth limited by low demand
Scenario 1	Young intervention	From 0% to 25%	0,06%	0%
		Total of Scenario 1	**0,06%**	**0%**
Scenario 2	Young intervention	From 0% to 25%	Approx. 0%	1,5%
	CHW offering FP methods	From 0% to 10%	1%	
		Total of Scenario 2	**1%**	**1,5%**
Scenario 3	Young intervention	From 0% to 25%	Approx. 0%	3%
	CHW offering FP methods	From 0% to 10%	0,66%	
	Post-partum FP	From 23% to 40%	0,33%	
		Total of Scenario 3	**1%**	**3%**
Scenario 4	CHW offering FP methods	From 0% to 10%	0,5%	2%
		Total of Scenario 4	**0,5%**	**2%**

Table 7. Results from simulation with FP Goals Lite

At this point, it is possible to notice how some of the strategies implemented for 'making a case for family planning' can lead to decision-making that ultimately could end up operating in detriment of women's reproductive rights. FP2020, like many other initiatives that preceded it, argue for investment in family planning by highlighting, among other aspects, the potential economic return a country can reap from an investment of this nature.

> Family planning is a smart, sensible, and vital component of global health and development (…) Voluntary family planning is one of the most cost-effective investments a country can make in its future. Every dollar spent on family planning can save governments up to 6 dollars that can be spent on improving health, housing, water, sanitation, and other public services. (FP2020, [S.d.])

On a factsheet dedicated to the topic of 'Return on Investment' and aimed at advocates if family planning, FP2020 mentions 'comparing different approaches to measuring family planning's return on investment' (FP2020, [S.d.]). One of the implications of emphasizing family planning as a 'good deal' rather than as a necessary investment in health services is that

it generates a rationale in which the investment needs to always be perceived as 'worth the cost'.

In the case of the simulation, one might reach the conclusion that some types of intervention are simply not worth it, unless combined with an effort for actively generating demand (and thus tapping into the growth limited by low demand). Obviously, one should seek effectiveness in public spending. However, what should be the variables that determine that effectiveness? What should a government choose as priority to be pursued with its policies?

By establishing mCPR as its only output, FP Goals ends up defining that in any of the countries targeted by the initiative, the prevalence of contraceptive use should be the defining measure of effectiveness.

This is an example of how quantification can function in the instrumentalization of women's reproductive health. Despite claiming to adhere to a human-rights based approach for family planning in the terms of the Cairo Declaration, by developing a tool that conditions the advisability of an intervention to its impact on mCPR, FP2020 fails to center women's health and reproductive rights. Providing contraceptives continues to be an end in itself, and adequate sexual and reproductive health care continues to be treated almost as an afterthought.

This type of reasoning shows how, despite the adoption of a discourse of human-rights based approaches and female empowerment (BILL AND MELINDA GATES FOUNDATION, 2012), FP2020 still fails to prioritize women.

The 'FP Goals' application have been used in the development of plans for family planning in at least four different countries: Malawi, Tanzania, Lao PDR, and Sierra Leone.

The development of the 2017-2020 Costed Implementation Plan (CIP) for family planning in Lao PDR offers an overview of how the tool was incorporated into the decision-making process ("Lao PDR National Family Planning Costed Implementation Plan 2017 – 2020", 2017). The CIP development process was divided into four steps:

- Step 1. Landscape analysis:

  The landscape analysis had the purpose of understanding the context for developing the CIP. The process included a revision of the Reproductive, Maternal, Newborn and Child Health (RMNCH) Strategy, which in its strategic objective 1 contemplated family planning targets; review of data on service provision and logistics (DHIS2 and LMIS); and interviews with stakeholders on

priorities, existing and expected funding and resources[25]. Based on the landscape analysis, scenarios were developed, including implementation of the RMNCH plan (fully and partially), prioritization of provinces based on opportunity, and prioritization of high impact interventions.

- Step 2. Baseline review: data sets and creating scenarios:
  Data sets collected included demographic data, total number of facilities, number of facilities that provided FP services by methods, average number of FP clients per facilities, community-based distribution, stock-out, youth-focused interventions, FP integration with other services and health education, training. The table below shows the interventions inputted in GP Goals for scenario building.

What is in the RMNCH strategy and plan?	Interventions included in FP Goals
Policies, Strategies and Guidelines	Not included in model - no direct impact on mCPR (but indirect by allowing more access interventions)
Management, Monitoring and Supervision	Not included in model - no direct impact on mCPR (but indirect by ensuring quality services)
Reduce stock outs	Reduce stock outs (98% addressed by 2020)
Increase access to LARCs via the public sector	Retraining providers + midwife trainings → higher availability of LARC in public facilities (aim = all health centres offer LARC via midwives)
Increase provision of LARC via the private sector	Policy shifts (IUD in private sector) and training of providers → higher availability of LARC in private facilities
Scale up community-based interventions (CBD, VHW, VHV) and outreach	Scale up of FP provision via CBD/VHV/VHW, and scale up of FP through integrated outreach (aim: visit each village once every 3 months)
Demand generation activities	Roll out group discussions + community FP days in all districts
Youth-focused interventions: in school curriculum, YFS, BCC	Scale up comprehensive youth programming with YFS (youth room at all district hospitals), and scale up in-school RH education

Table 8. Inputs to GP Goals for CIP in LAO PDR

[25] The interviewees were the Ministry of Health, mass organizations, public health service provides, international non-government organisation, the World Bank and UNFPA.

With the baseline data, it was then possible to represent the FP landscape for Lao PDR and establish selected scenarios (containing FP interventions and activities) that could be entered into FP Goals to determine the estimated increase in mCPR. The consultations evaluated the impact on mCPR from the different scenarios to identify opportunities to maximize impact by using geographical targeting and selective interventions. The results showed that *selection of targeted locations for implementation with prioritisation, could achieve comparable increases in mCPR with efforts that are within feasible parameters to the full implementation of the RMNCH strategy.*

- Step 3. Results and impact review process:

  Once the base scenario was established, a set of conditions was established to inform the construction of the next scenarios to compare against the base scenario. There were two key rationale used to select the next scenarios. The first was to improve the mCPR in low prevalence provinces and the second was to include only the interventions that provided the most impact on mCPR growth. The analysis demonstrated that a substantial increase in mCPR can be achieved with a lower level of effort than through full implementation of the existing RMNCH strategy or the base scenario.

- Step 4. Decision making

  The base scenario and impact on mCPR provided a basis for comparison of the investments required. With the target of reaching 65% of mCPR among married women in mind, different efforts and their respective expected returns were contemplated through on four different scenarios, as shown in the table below:

Intervention	Effort	mCPR in 2020 55.6%	mCPR in 2020 57.8%	mCPR in 2020 58.8%	mCPR in 2020 61.7%
		A: prioritize 5 province per intervention	B: prioritize 10 province per intervention	C: Prioritize additional interventions (above A, B)	Full RMNCH Implemented
Stock out reductions	# facilities with stock outs to be eliminated	333	461	485	547
LARC via public sector	Min # midwives to be trained at Health Center	483	713	838	956
LARC via private sector	# private facilities to be trained on LARC provision	219	309	369	394
Integrated Outreach	# integrated visits to take place	0	0	0	28,434
CBD/ VHW/ VHV	# CBD/VHW/VHV trained to provide FP services	0	0	0	1,854
Youth-focused	# providers trained on YFS	1,408	1,717	1,872	2,010
Demand generation	# group discussions held	468	1,116	1,224	1,776

Table 9. Scenario comparison for CIP in LAO PDR

> Based on the comparison above, a decision was made to focus on five high need provinces, as this scenario was 'expected to achieve a mCPR of 56 percent, only 6 percentage points below the full implementation of the actions in for SO1 of the RMNCH strategy and plan, but with much lower overall efforts' ("Lao PDR National Family Planning Costed Implementation Plan 2017 – 2020", 2017).

The family planning CIP uses modelling to address these issues by proposing that a limited number of high impact interventions are implemented in selected provinces.

Policies and black boxes

Both the simulations on FP Goals Lite and the analysis of how the tool was implemented in Lao PDR offer important elements to comprehend the role played by quantified data/ knowledge in the FP2020 programme. Based on them as well as on the previous' sections comments on the role played by indicators on the initiative, this work expects to raise questions which hopefully can contribute to a critical perspective on the role quantification has played in

de-centering issues such as race and gender in family planning, and, by doing so, obfuscating how women's health and reproductive rights become vulnerable in the context of target-driven policies. All of this while instrumentalizing their bodies for the sake of confronting population growth, framed as a threat to the environment, the economy and security.

The simulation and the employment of FP Goals for the development of the CIP for Lao PDR illustrate the promises of quantification for simplifying and automatize decision-making processes.

One of the reasons why quantification has become so widespread and sought after in policy decision-making is largely because of its two important claims: of objectivity and truth. With regards to objectivity, as mentioned in the previous sections, the exactness of numbers is often understood as implying a capability for reflecting reality superior to that of words[26]. However, in the words of the eloquently entitled book by Lisa Gitelman, '"Raw data" is an oxymoron' (2013). Numbers are materially productive signifiers and, as a form of language, they do not simply represent but indeed constitute reality (HACKING, 2006).

> In the end, those who create indicators aspire to measure the world but, in practice, create the world they are measuring. In other words, indicators do not stand outside regimes of power and governance but exist within them, both in their creation and in their ongoing functioning. They are a blending of science and politics, of technical expertise and political influence(MERRY, 2016, p. 21).

Considering the magnitude of the initiative, by leading developing countries to conform their national policies to its own parameters and priorities, FP2020 in redefining the boundaries of family planning in developing, imposing its own categories, excluding local meanings and practices.

The examples of abuse coming from India, South Africa, Chile, Namibia and Uganda show that the violent approaches of population control are far from being 'history' (CONNELLY, 2003) and are very much still a part of our 'troubled present' (HENDRIXSON, 2019). Quantification and the implementation of digital technologies that automatize its modeling have removed issues of concern such as gender and race from the sphere of political debate on reproductive health, reframing family planning as expert knowledge and thus, silencing the voices of women who for decades have fought for the fulfillment of their reproductive rights.

[26] Such ardent faith in the objectivity of not only numbers, but any form of scientific knowledge production, however, has long been disputed (MERRY, 2016, PORTER, Theodore M., 1995), with important contribution of feminist thought (SMITH, Linda Tuhiwai, 2012), notably regarding the situatedness of knowledge (HARAWAY, 1988)

Tools such as FP Goals are the perfect example of a 'black box', meaning 'a system whose workings are mysterious; we can observe its inputs and outputs, but we cannot tell how one becomes the other' (PASQUALE, 2015, p. 3). This black box highjacks the formulation of policies from democratic debate. And the women affected by the policies are not the only ones excluded from the debate. A tool with such opacity can make even experts in family planning policies find themselves lacking the necessary information to scrutinize choices made.

Even though local stakeholders may be heard in the process of developing a landscape analysis, it is ultimately representatives of FP2020 who decide from the outset which aspects will be analysed, which sources should or not be included, the weight of each of those sources and the methods of defining and measuring categories (LÖWENHEIM, 2008).

How quantification is closing the horizon

In the case of FP2020, given the magnitude of its reach, their selected indicators have been re-shaping family planning policies in the developing world. In this process, it has pushed a target-driven agenda that has compromised the pursuit of policies that are centered on the health and rights of women, especially those who belong to historically marginalized groups.

There is nothing particularly new about numbers playing an important role in policy. As the first chapters showed, the population problem has always been a 'numbers problem'. Not only that but it was precisely the advent of statistical techniques that allowed for population to be governed (FOUCAULT, 2004). So, what makes tools such as FP Goals worth investigating?

The advances in computational and communication technology have allowed a much larger amount of information to be collected, stored, processed and analyzed, with gradually less human intervention (HANSEN, 2015). This lack of human intervention is one of the reasons that contribute to a belief on the 'neutrality' of the knowledge produced with the support of technology that allows for much more complex statistical models to be automated. The outputs of these automated calculations, however, still stem from models which translate the assumptions, interpretations, and biases of the human beings responsible for them.

However, as the process becomes ever more reliant on quantitative methods and digital technologies, the field of family planning is reframed as one of expert knowledge (ERKKILÄ, PIIRONEN, 2014) and thus, grows impervious to the political debate regarding the instrumentalization of women's health and the violence inflicted upon their bodies for the sake of population control.

The demographic transition theory proposed by Kirk, Notestein and Davis in 1945 illustrates how, since its inception, the population establishment has relied on the interpretation

of quantitative data by experts and has been guided by their elaborate models and projections. Today, however, given the availability of data and sophistication of estimation models, the digital technology available allows for the population establishment to have unprecedented capillarity and specificity on its claims of knowledge, significantly restricting the space for decision-making. The use of the FP Goals shows how these claims are made and these restrictions imposed.

The application has a limited set of possible interventions in the family planning, according to Track20, selected 'using evidence from more than 70 studies'. There are ten different types of intervention possible, selected on the basis of their potential contribution to increasing mCPR. That means that if the tool were to be implemented in all developing countries targeted by initiative, there would **be almost 70 entirely different countries implementing essentially variations of the same family planning policy**. Countries as different as Bolivia, Indonesia, Fiji, and South Sudan would have their local practices and needs homogenized by the same categories and translated into data points to be interpreted by a model that will come up with a 'recipe' of family planning from the same limited set of ingredients.

Narrowing meanings and nefarious incentives

Another way in which FP2020 is reshaping family planning is by transforming signifiers, narrowing meanings to fit their correspondents in the initiative's contraceptive-driven frameworks.

The narrowing of the meaning of 'family planning' was already mentioned in this work. Truth be said, family planning as shorthand for contraceptive was one correspondence already established in population vernacular. If the initiative succeeds in imposing its frameworks on most of the developing world as it intends to, their restrictive effect on family planning will be extensive and will potentially turn back the clock on many of the progress made by the fight for reproductive justice.

For instance, one of the ten possible interventions in family planning within the FP Goals terms is the employment of Community Health Workers (CHW). CHWs can be an important asset for successfully implementing policies and services in contexts with restricted access to health facilities, for example. They can also play an important role in the dissemination of sexual and reproductive education. **However, in the framework set by the FP Goals, this specific intervention can take only one of two possible forms of execution: CHW for the provision of pills and condoms or for the provision of pills, condoms and injectables.** It is only natural that, if the interventions are developed with the sole focus of incrementing levels

of contraceptive use, distributing contraception is the only admissible purpose for engaging CHW. Not only that but, according to the document that details the possible interventions in FP Goals, providing contraceptives is a *requirement* for a given worker to be classified as CHW (FP2020, [S.d.]).

Another example is the intervention **'expand access to methods'. This type of intervention has only one indicator accounting for its measurement: the extent to which the entire population has access to long-acting reversible contraception.**

Past experiences with population control programmes taught the risk of nefarious incentives in the implementation of policies, especially those which are target-driven. According to Human Rights Watch, health workers continue to be pressured to meeting their targets for contraception (WATCH, 2012). As late as 2020, the Indian state of Madhya Pradesh made the news when it was leaked that a circular had been issued directing officials to identify staff members in its Health Mission who had failed to get any man sterilized in the fiscal year ending March 31 (MUKHOPADHYAY, 2020).

Regarding equivalating 'expanding methods' to the making LARCs more widely available, it is not too difficult to imagine the potential injurious effects. Focusing on such measurement will inevitably lead to a disproportionate focus on the provision of LARCs, perhaps even to the detriment of other contraceptive methods that, unlike LARCS, do offer protection against STIs. Moreover, there have been numerous reports of the already damaging effects the focus on injectables have had on the health of women in Asia and Africa, where contraceptives deemed unsafe for the European markets were still used; devices that require medical expertise for insertion have been implanted by non-medical workers; and devices that require a medical professional for removal were implanted in women who live in areas where no medical service is available (BENDIX, FOLEY, *et al.*, 2020, WILSON, 2017b, 2018).

By promoting the use of a tool such as FP Goals, with its limiting categories and narrowly focused indicators, FP2020 is enhancing the exposure of women in developing countries to abuses in the provision of family planning services as it sets up a target-driven system susceptible to pernicious incentives.

Quantification and family planning: can it be done differently?

This chapter was focused on exploring the role played by quantification in the FP2020 initiative. It discussed how it reignited not only the interest of the international development establishment on the issue of population but also the implementation of target-driven policies.

The FP2020 has reshaped the international landscape of family planning and has relied heavily on the use of quantification to consolidate discourses of truth on the subject that enable circulation of power. This power, as Foucault alerts, is not to be understood as a mass and homogeneous phenomenon of domination, as something dived between those who have and those who do have not. In order to understand the relevance of the indicators that define the terms of family planning to the botched tubectomy taking place at a sterilization camp, one must think of power as something that functions only when it is part of a chain (FOUCAULT, 1997).

In that sense, thinking of indicators as instruments may be misleading. They are not tools employed by something or someone in the pursuit of programmatic goals (BHUTA, 2012, HANSEN, PORTER, 2012, ROCHA DE SIQUEIRA, 2017). They are not yielded guns. But that does not mean they cannot harm.

The main characteristics that made quantitative methods appealing and contribute to make quantification a widespread practice, are the reasons why their *doings* and *becomings* need to be investigated and cannot be thought of as separated from them. The distance must be reshuffled, the comfortable categorizing, chanllenged.

FP2020's choice of goal, indicators and tools point to a conformance with practices in family planning that have historically led to abuse and violence against – mostly – poor women from the Global South. Thus, it is unfortunate unsurprising to learn that mass sterilizations, cash incentives, targeting of minority communities, neglect for women's needs and wishes, and formulating policies that reach for the lowest-hanging fruits are still part of family planning programmes (BURKE, 2014b, KAKANDE, 2016, PAPALEO, 2021, SGUAZZIN, 2020).

The past and present show that family planning programmes must do better. However, as it was said before, there is no intrinsic characteristic of quantification that makes it by definition unsuitable for challenging violent, patriarchal and racist practices. The following chapter will be an attempt to imagine how that could be done. It will explore how an ethos of care could contribute to re-centering race and gender in the reproductive rights agenda.

Chapter 4

Caring about women and quantification in family planning

There is a space for care in knowledge production. Or, more adequately put, *there is care in knowledge production*. Of course, such affirmation leads to a series of inevitable questions. *Who is doing the caring? What kind of care? Care for what? For whom? How?*

This final chapter will try to address some of these questions. But fair warning – it might perhaps leave just as many unanswered. Ironically, despite being the final chapter, far from a destination, it proposes to be a point of departure. The first three chapters were an effort to convince the reader that the journey is necessary.

International development programmes in family planning have a racist and patriarchal past and present that must be exposed and challenged. Relying in quantification to make a case for action to control population growth, as well as to design strategies based on intervening on the bodies of poor women from developing countries is a way of avoiding that difficult and much overdue reckoning. The perpetuation of abuse and violence is a consequence of that avoidance.

That being said, where to go from now? How to challenge and hopefully transform the role played by quantification in the de-centering race and gender in family planning? This work's suggestion is to look for a way *in care*. For a way *to care*.

Based on feminist politics of care, this final chapter will try to imagine how to do that. It hopes to encourage more *caring* approaches to family planning programmes by arguing for an *ethos of care* in the production of the knowledge that substantiates initiatives such as FP2020 – chiefly among them, though not exclusively, quantification. To achieve that, it proposes an approach in three steps. More accurately, in offering answers for three questions.

The first section asks, 'what does it mean to care?'. Historically associated with feminist thought, care is a multivocal term that has long been criticized for its essentialized interpretations and thus warrants clarification. Therefore, the first step will be to explain what is meant by *care* when this work claims to aim at *encouraging an ethos of care* (MARTIN, MYERS, *et al.*, 2015, MURPHY, 2015, PUIG DE LA BELLACASA, 2011, 2017).

It will start by providing a brief overview of some of the main formulations of the ethics of care in feminist theory and will follow it by presenting the conception of ethics of care that inspires this work, the one proposed by Maria Puig de la Bellacasa (2011, 2017). Rather than offering an unequivocal meaning for care, her work embraces the multiplicities and

complexities of *care* and defines it as as *an affective state*, as *a material vital doing* and as *an ethico-political obligation* (PUIG DE LA BELLACASA, 2011, p. 90).

The second section will address the question of 'how to care'. It will explore the notion of 'matters of care', Puig de la Bellacasa's suggested approach to technoscientific agencies, things, and notions, based on Latour's 'matters of concern' (2004, 2005a) and feminist contributions on care and the situatedness of knowledge production (HARAWAY, 1988, HARAWAY, GOODEVE, 2018, TRONTO, 1993). The section will hopefully the foundation for the imaginative exercise of the last section.

Titled 'why to care', the final section will contemplate what an ethos of care could mean to quantification and how it could help re-center race and gender in family planning programs (WILSON, 2017b) and thus contribute to more *caring* approaches in international development family planning programmes.

4.1. What does it mean to care?

The focus of this first section is to explain the understanding of care that supports this work's hypothesis that an ethic of care can play an important role in resisting the depoliticizing tendencies of quantification, help re-centre race and gender and thus, contribute for imagining ways to make family planning more *caring*.

However, before delving into what *this work* means by *care*, it will provide a brief overview of the history of the concept in feminist theory as well as some of the main criticisms it has received.

A voice for care

Care, in its many senses, has historically been associated with women and the role they play and are assigned in society[27]. It has also been for decades an important part of feminist thought.

The feminist movement of the 1970s brought the term to the foreground of political theory, highlighting both how the 'care work' performed by women had traditionally been

[27] Puig de la Bellacasa highlights how caring is a doing most often assigned and performed by the more marginalized, not necessarily women (PUIG DE LA BELLACASA, 2017, p. 56), an assertion with which I agree wholeheartedly. However, as it has been the case throughout this work, a deliberate choice was made to highlight the position of girls and women because they are the main – almost exclusive – target of family planning programmes.

taken for granted and made invisible, and how it played a crucial role in capitalist production by (re)producing labour-power (FEDERICI, 1975).

However, it would be in the 1980s, with Carol Gilligan's 'In a different voice' (1982), that care would gain prominence in the realm of ethics. Gilligan's proposition was to listen to the 'different voice' of girls and women, in whom she identified a specific sensitivity to the needs of others. She referred to that sensitivity as care and contrasted it with the notion of 'justice', typically associated with rule-following and masculinity.

> Women's construction of the moral problem as a problem of care and responsibility in relationships rather than as one of rights and rules ties the development of their moral thinking to changes in their understanding of responsibility and relationships, just as the conception of morality as justice ties development to the logic of equality and reciprocity. Thus the logic underlying an ethic of care is a psychological logic of relationships, which contrasts with the formal logic of fairness that informs the justice approach. (GILLIGAN, 1982, p. 73)

Praised for bringing feminist analysis into the field of developmental psychology and for 'showing how various models of "human" moral psychological development were actually premised on only one paradigmatic perspective, closely associated with masculine psychology' (HEYES, 1997, p. 145), Gilligan's work was also vehemently criticised. Among the criticisms received, the most notable was perhaps for the essentialisation of womanhood and the experience of women.

Whose voice? The anti-essentialist critique

Criticised for 'falling into the trap' of false generalisation, Gilligan's work was challenged for its reliance on the experience of a limited number of white and overall privileged North American girls and women. Authors such as Hester Eisenstein (EISENSTEIN, 1984) pointed to the tendency not of Gilligan's work exclusively, but of feminist theory in general, of presenting as universal to women the experiences of privileged groups, ignoring the differences and inequalities that exist within women, markedly those of race and class.

> By using in her original research women who are mainly white, mainly heterosexual, and mainly middle-class, her critics claim, Gilligan constructs an avowedly gendered model of moral development based only on a small group of dominant women. To the extent that the ethic of care is coextensive with "women's moral voice," that voice is most typical of a white, heterosexual, middle-class woman in the United States of the 1980s, and furthermore is perhaps heard only in certain limited moral situations. (HEYES, 1997, p. 148)

Writing specifically about Gilligan's work, Nancy Fraser and Linda Nicholson (1989) described it as essentialist for not specifying the women about whose 'voices' she was writing nor the historical circumstances in which they spoke (p. 33).

In that sense, the homogeneity of Gilligan's supposedly different voice indeed reinforced academia's racist tradition of leaving unheard the voices of women of colour. In her book 'Ain't I a woman? Black Women and Feminism', bell hooks (1981) calls attention to how the failure of acknowledging the racial identity of white women, who are referred to simply as 'women', renders black women in the status of a 'non-person' (p. 140).

> Throughout American history, the racial imperialism of whites has supported the custom of scholars using the term "women" even if they are referring solely to the experience of white women. Yet such a custom, whether practiced consciously or unconsciously, perpetuates racism in that it denies the existence of non-white women in America. It also perpetuates sexism in that it assumes that sexuality is the sole self-defining trait of white women and denies their racial identity. (HOOKS, 1981, p. 8)

Her reliance on biological binarism and determinism was also deserving of criticism. Linda K. Kerber writes to that effect in her anti-essentialist critique, arguing that 'Gilligan permits her readers to conclude that women's alleged affinity for "relationships of care" is both biologically natural and a good thing' (1986, p. 309).

Despite the criticism directed at Gilligan's work, 'In a different Voice' did manage to create an important space for care in ethics discussions. The idea of 'care ethics' continued to be taken up and developed by other theorists, who seem to have built precisely on much of that criticism. So, in the following years, care became part of the vocabulary and toolbox of a range of feminist theories (MARTIN, MYERS, *et al.*, 2015, p. 628).

'Caring' is relational

> Caring involves stepping out of one's own personal frame of reference into the other's. When we care, we consider the other's point of view, his objective needs, and what he expects of us. Our attention, our mental engrossment is on the cared-for, not on ourselves. Our reasons for acting, then, have to do both with the other's wants and desires and with the objective elements of his problematic situation. (NODDINGS, 2013, p. 24)

The excerpt above is from the book 'Caring', by Nel Noddings, published only two years after 'In a different voice', in which she draws from a maternal perspective to apply an ethical notion of care to moral education.

Despite devising what she called a 'feminine ethic' (1984, p.90), she builds on experiences that she describes as 'natural and accessible to all human beings' (p.28), placing the origin of ethical action on a natural human affective response (p.3). In fact, she highlights

that her ‘description of an ethic of caring as a feminine ethic does not imply a claim to speak for all women nor to exclude men’ (p.97). She also underscores the fact that she did not argue for any universal principles prescribing action and judgement and states that care must always be considered in context (p.28).

> As we have seen, caring is not in itself a virtue. The genuine ethical commitment to maintain oneself as caring gives rise to the development and exercise of virtues, but these must be assessed in the context of caring situations. (NODDINGS, 2013, p. 96)

Emphasizing the relational nature of care, she points to the two parties she visualises as involved in a caring relation, the ‘one-caring’ and the ‘cared-for’. Albeit not necessarily balanced, a caring relation was always reciprocal as it ‘requires the engrossment and motivational displacement of the one-caring, and it requires the recognition and spontaneous response of the cared-for’ (2013, p. 78).

Similarly inspired by mothering, Virginia Held conceptualizes care as ‘both a practice, or cluster of practices, and a value, or cluster of values’ (HELD, 2006, p. 4). Refusing the distinction between justice and care as respectively normative and non-normative (p.37), she argues that care offers standards for evaluating practices and recommending better ones (p.4).

> Care is a practice involving the work of care-giving and the standards by which the practices of care can be evaluated. Care must concern itself with the effectiveness of its efforts to meet needs, but also with the motives with which care is provided. It seeks good caring relations. (HELD, 2006, p. 36)

Held argues for the transformative potential of care and looked to the concept to move beyond the standards of liberal justice. According to her, a society guided by care is one that attends to the health of social relations instead of focusing primarily on promoting the pursuit of an individual self-interest that is only subjectable to legal restraints (2006, p.136).

In her 2006 book, she expands to the global level her proposal from a decade earlier of looking to society in terms of family, and finding in mother-children relations the adequate model to substitute the logic of rational contracting (HELD, 1993, p. 202). To a potential criticism of idealizing mothering, she responds that her theory is indeed based on an ideal picture of a mother but argues that such picture is just as idealized as the picture of rational contracting that guides notions of liberal justice (idem).

Both Noddings (1984) and Held (1993, 2006) employ the notion of care to argue for an ethical theory that is relational, committed to nurturing and that is centered around human relations. However, to contend with how the politics of knowledge production in general and of quantification specifically can and often do operate in a manner as to sustain systemic

oppressions, this work requires an approach that extends the notion of care in two important senses: beyond relations that are strictly among humans, and beyond the realm of morality. Such need to expand both the scope and the meaning of care would be addressed by other feminist theories.

Redrawing boundaries and making care political

In the same year Held published her 'Feminist Morality', Joan Tronto published her 'Moral boundaries: a political argument for an ethic of care' which invited feminist thought to endeavour beyond the boundaries of 'women's morality' and bring care into the realm of the political (1993).

Her argument is structured around three moral boundaries that she proposes redrawing. The first is the boundary that separates morality and politics. She argues that as long as those two concepts are thought of as pertinent to two different aspects of human life, the possibility of moral arguments promoting any political change will be extremely limited. Therefore, that care should function as both a moral value *and* a basis for the political achievement of a good society.

The second boundary is that of the Kantian 'moral point of view', which requires that moral judgement be made from a distant and disinterested perspective, stripped of emotions and feelings, as well as of local customs, in favour of depersonalized rational thought.

The third is the boundary that separates public and private life, a boundary that, if not challenged, threatens to exclude women from the public sphere even if they indeed manage to demonstrate possessing a unique set of moral values (TRONTO, 1993, p. 8–10).

Tronto approaches 'caring' as a process and presents it in four analytically separate but interconnected phases: caring about, taking care, caregiving and care-receiving.

'Caring about' means recognizing care as a necessity and it is culturally and individually shaped. 'Taking care' implies assuming some responsibility for an identified need and for determining how to respond to it. It is a phase that involves not only the notion of responsibility, but also that of agency. 'Care-giving' refers to the work of meeting needs for care. 'Work' is stressed as a crucial element of caregiving because it impedes the purchasing of caring services from being equated to care-giving – Tronto explains that although money allows for the provision of resources, it does not, by itself, satisfy human needs. And finally, 'care-receiving' is the phase in which the object of care responds to the care received, signaling that the need for care has been met (1993, 106-108).

Regarding the question of *what it means to care*, Tronto offers a definition she devised with Berenice Fisher:

> On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves [sic], and our environment, all of which we seek to interweave in a complex, life-sustaining web. (TRONTO, 1993, p. 103)

Subsequently, she highlights four important aspects of their definition of care. First, it is not restricted to human interaction with others, and it includes the possibility that caring occurs for objects and for the environment, as well as for others. Second, it does not assume caring to be dyadic, that is, limited to the relationship between two individuals. She warns that such a perception of care dismisses from the outset how care can function socially and politically. Third, she highlights how the activity of caring is largely defined culturally. And fourth, she conceives caring as ongoing: it can characterize a single activity, or it can describe a process. To that last point, she warns that 'caring is not simply a cerebral concern, or a character trait, but the concern of living, active humans engaged in the processes of everyday living. Care is both a practice and a disposition' (TRONTO, 1993, p. 103–104).

Tronto and Fisher's definition of and considerations regarding care offer an entryway to the understanding of care and of its multiple dimensions that this works borrows from Puig de la Bellacasa (2011, 2017).

Embracing the complexities of care

Puig de la Bellacasa (2011, 2017) embraces three important elements offered in Tronto and Fisher's definition of care when building her definition of care: (a) the extended notions of agency encompassed by care in 'everything that we do'; (b) the incorporation of both the materiality of care in the form of care work (the 'maintenance' aspect of care) and the ethics and politics of care (the affectively charged 'as well as possible'); and (c) the highlighting of care as vital in interweaving a web of life, which expresses a key theme in feminist ethics, the emphasis on interconnection and interdependency (2017, p.4).

Tronto's contribution is not the only one valued in the understanding of care advanced by this work. The concept of care borrowed by this work inherits important notions from the works that preceded it, including, but not limited to, the ones covered in this chapter.

Faced with the multiple incarnations and meanings of care in feminist theory, one might feel tempted to either 'give up' of the term in favour of one that is less fraught, or neatly define

it in a way as to specify its content and boundaries and make it more 'manageable'. Puig de la Bellacasa, however, offers a definition that embraces the complexities of care.

> Care as a concrete work of maintenance, with ethical and affective implications, and as a vital politics in interdependent worlds is an important conception that this book inherits from. These three dimensions of care—labor/work, affect/affections, ethics/politics—are not necessarily equally distributed in all relational situations, nor do they sit together without tensions and contradictions, but they are held together and sometimes challenge each other. (PUIG DE LA BELLACASA, 2017, p. 5)

An important first step in working to elaborate on this definition of care might be to address some of the assumptions usually made about the term. Such assumptions come with the territory when dealing with a concept as filled with meanings as care. Therefore, to better express what this work *means* by care, it is probably advisable to preemptively address *what it does not mean* by it.

Not always 'good': a note on the non-innocence of care

It is not surprising that associations with an alleged superior women's morality and inspiration in loving mothering relations have led to a common understanding of care as something necessarily positive.

The definition of care proposed here, however, does not imply 'good feelings'. The interdependency expressed in the idea of the world as a complex, interweaved life-sustaining web borrowed from Tronto (1993) means that care is not something for feminists to 'bring' with them to the debates in which they engage. *Care is an already circulating force in the world*. It is a *condition*. Care sustains the worlds we inhabit, however precariously or problematically.

Concerned with the common misconception of care for 'innocent', Murphy sets out to investigate transnational feminist health practices by 'unsettling care'. Her first step in that effort is to 'caution against the conflation of care with affection, happiness, attachment and positive feelings as political goods' (MURPHY, 2015, p. 719). By understanding care as *circulating force* with no intrinsic superior moral value, one can understand how care is often *circulating within systemic and often violent relations of power*. She reminds readers that among the several meanings of care is 'to be troubled, worried, sorrowed, uneasy, and unsettled' (p. 721).

This work's goal of proposing engaging with an ethos of care in family planning programmes does not mean that care is not already part of these initiatives. It is not claiming that *there is no care in family planning.* Quite the contrary. Caring about the future of women

and girls is central to the message of family planning programmes, as the following excerpt from the FP2020 website illustrates.

> Our vision: a future where women and girls everywhere have the freedom and ability to lead healthy lives, make their own informed decisions about using contraception and having children, and participate as equals in society and its development (FP2020, [S.d.]).

In the delivery of family planning, in the formulation of family planning policies, in the development of tools for guiding decision-making in family planning. Care is everywhere. That is all the more reason not into fall into the trap of taking care as intrinsically good and thus blinding oneself to the ways in which care is entangled in racist, patriarchal and capitalist structures.

> Care is a selective mode of attention: it circumscribes and cherishes some things, lives, or phenomena as its objects. In the process, it excludes others. Practices of care are always shot through with asymmetrical power relations: who has the power to care? Who has the power to define what counts as care and how it should be administered? Care can render a receiver powerless or otherwise limit their power (MARTIN, MYERS, *et al.*, 2015, p. 627)

The proposed approach of thinking about care in quantification is not inspired by an idealized notion of care. It is not a way of saying 'if only we cared…'. Care is a given. It is a force. That does not mean it is equally or 'fairly' distributed. The selectiveness of caring and the unescapable situatedness of knowledge production will always imply that some things are in the forefront while others might fade into the background.

Adhering to an ethic of care does not mean 'start to care'. It means critically thinking about *how* care is circulating, *whom and what are being cared for*. But not only that. Perhaps more importantly, as it will be explored in the second section when discussing the idea of approaching objects of study as matters of care, by adhering to an ethic of care, one commits oneself to critically think about how care is redistributing distances, to look for what is being neglected, silenced or obscured.

Therefore, the call for an investigation of family planning, its methods and tools that is guided by an ethic of care implies a commitment to be *critical and attentive to the situated workings of care* (MARTIN, MYERS, *et al.*, 2015).

It is important to highlight that the skepticism regarding care that this brief note on the non-innocence of care addressed is not unjustified. As stressed before, it comes with the territory. It is an unavoidable consequence of dealing with such a multivocal and, yes, fraught term such as care. Hopefully, though, this preemptive clarification will make it easier to, now, look at what this work *does mean* by care.

The multiple dimensions of care

On her definition, Puig de la Bellacasa mentions three dimensions of - labor/work, affect/affections, and ethics/politics (2017, p. 5). These three dimensions of care warrant an explication, albeit a succinct one.

The successive manner in which they will be presented, however, should not be mistaken for a sign that they are divisible or neatly distinguishable, nor that in any given situation they will necessarily present themselves in a balanced or even cohesive manner.

First, understanding care as *labour/work* implies thinking of caring as a *doing.* As mentioned before, care is a word that points to the types of work that have been historically devalued and associated with women. Despite the history of care being modelled after mothering relations (GILLIGAN, 1982, NODDINGS, 2013), this particular dimension of care is related to the need for labours of mundane maintenance and repair of the world. It is a *practice*. Including within knowledge production.

Therefore, what does care as *doing* mean to quantification?

It was underscored several times throughout the chapters how expressions of quantification such as indicators and digital applications have world-altering consequences. If that is the case, it is reasonable to ask, 'what kind of world is being built through quantification?'.

To think of a technology of knowledge such as quantification in terms of care as labour/work implies examining *the role they play* in the sustaining of the world.

Here, one more distinction from previous meanings attributed to care is important. Sustaining is not synonymous with nurturing. Of course, that sustaining of the world *can* be nurturing. Hopefully, it will. But there is no necessary relation between the two. To the contrary. In a world of unequal, racist and patriarchal relations, there is a strong possibility that the labour/caring being done is contributing to the maintenance of the *status quo*.

In the case of FP2020, for example, the reliance of the programme on quantitative indicators means that they ultimately *shape what matters and what does not* in family planning programmes. Therefore, to think of indicators and applications such as FP Goals as *acting* serves both to the critical effort of questioning a de-politicization of family planning programs and to open space for the speculative imagining of *how* they could labour for the creation of *more caring* worlds.

The second dimension of care mentioned is that of *affect/affections*. It is not difficult to relate affect/affections to care. In fact, it might be more difficult not to. But what are the

implications for the politics of knowledge? Where does *caring* as affection fits into quantification?

Indicators and the quantitative data they offer are often presented as sound basis for decision-making (OECD, 2006, WALPOLE, MCGEOCH, *et al.*, 2017). As discussed in chapter 3, this is largely due to the objectivity and accuracy often associated with quantitative methods. An important consequence of that understanding of quantification is that it can allow for a decision-maker to *feel* like its use kept them from 'getting their hands dirty'.

One example is the use of FP Goals to decide on an approach to family planning policies. Making choices is normally anxiety-inducing. What to let go? Who to exclude? Who shall receive more resources? Moreover, that anxiety is not limited to the moment when a decision is being made. After a decision is made, there is often the need to justify them, especially to those that might *feel* like they were overlooked, and that their needs were ignored. In such a messy entanglements of feelings, it is not difficult to imagine how using an application such as this can make a user *feel* much more at ease with the decision made. 'Letting the numbers speak' might be an effective way of avoiding that anxiety. The anxiety that comes from *caring*.

That last point leads to the need of a very important clarification. It does not imply that those who rely on indicators and quantitative methods. Far from it. The belief that conclusions drawn from the application quantitative methods lead to better decisions is widely shared (OECD, 2006, WALPOLE, MCGEOCH, *et al.*, 2017) and is most often the reason why decision-makers rely on them.

However, as a technology of knowledge, quantification allows for a redistribution of distances that can end up pushing certain concerns to the background. This work contends that FP2020's employment of quantification does precisely that to the issues of racism and patriarchy in family planning. And that is where *caring* as ethics/politics comes in.

The politics of care challenge the bifurcation of consciousness that would keep knowledge untouched by anxiety. Involved knowledge is about being touched rather than observing from a distance (PUIG DE LA BELLACASA, 2017, p. 93).

Rather than proposing care as a moral obligation, the ethos of care requires occupying oneself with neglected things when approaching purported facts and objects. That means looking for neglected labours and marginalized experiences. In the context of technoscientific mobilizations, it implies thinking of the problems that might have been erased or silenced (PUIG DE LA BELLACASA, 2017, p. 108).

Writing about care and advocacy, Lorraine Code makes an eloquent case for epistemic responsibility arguing that knowing *requires caring* about *what and how on knows* (CODE, 2015).

> Statistical population analyses are not well attuned to the particularities and specificities that, for many concerned/caring inquirers— among them feminist epistemologists and others who depart from the positivistic norm— require special attention. Thus with respect to the assurance "statistics have shown," the question is more pressingly about what statistics do not show and have not shown, what they are selected or constrained to show, what picture of social beings they work from and generate, and why "we" should care (CODE, 2015, p. 12).

An ethic of care, therefore, is more than a simple moral disposition. Caring is at the same time a *doing* and an *ethico-political commitment* that *affects* the production of knowledge about things. Caring in knowledge production implies attentiveness to how distances get redistributed by technologies, acknowledging that there is no bird's eye view. A politics of care is concerned by which mediations, forms of sustaining life, and problems are neglected.

Having explained what is meant by care, it is time to deal with the question of *how* one adheres to an ethos of care when engaging with knowledge production. The approach suggested for that is one that deals with meaning-producing technologies, methods, and theories as matters of care.

4.2. How to care? An introduction to matters of care

To address the question of 'how to care' and thus attempt to offer some insights for approaching technologies of knowledge such as quantification in a way that adheres to an ethics of care, this section will explore the notion of 'matters of care'.

Matters of care is a term that expresses Puig de la Bellacasa's suggested approach to technoscientific agencies, things, and notions. It is based on Latour's 'matters of concern' (2004, 2005a) and on feminist contributions about care and the situatedness of knowledge production (HARAWAY, 1988, HARAWAY, GOODEVE, 2018, TRONTO, 1993).

Assuming that modes of thought and research ethos affect the politics attributed to objects of study, the notion of matters of care is one that is particularly aimed at encouraging the ethos of care in the field of scientific research and technological solutions (PUIG DE LA BELLACASA, 2017, p. 85).

It builds on the works of STS social studies that challenge the 'bifurcation of nature' that splits feelings and meanings from hard facts. And that science and technology are mere objects

susceptible to being ‘used’ and ‘misused’ (COLLINS, H M, PINCH, 2010, LATOUR, 2015, SHAPIN, SCHAFFER, 2011).

> The discussion begins to shift for good when one introduces not matters of fact, but what I now call matters of concern. While highly uncertain and loudly disputed, these real, objective, atypical and, above all, interesting agencies are taken not exactly as object but rather as gatherings. You cannot do with Monte Carlo calculations what you do with mugs; you cannot do with genetically modified organisms what you do with mats; you cannot do with quaternions what you do with black swans.(LATOUR, 2005a, p. 114)

In order to imagine how care can fit into the politics of knowledge, it is necessary broaden the constructivist understanding of scientific and technological assemblages to encompass not only social and political interest but also affectively animated forces. For that, Puig de la Bellacasa looks to Latour’s notion of ‘matters of concern’ (MoC) comes in.

Latour’s ‘matters of concern’ allows one to overcome binary classification of human – nonhumans and provides an entryway into considering human-nonhuman meditations. These mediations, rather than mastered by human/social subjects who control nonhuman agents, are understood within the context of entanglements of interests and animated forces (such as concern and care) that take part in the material remaking of the world (BARAD, 2007).

Thinking in terms of ‘matters of concern’ allows for formulations to reject the objectification of the work and products of science and technology and make visible the mode of fabrication and the stabilizations mechanism at play. (PUIG DE LA BELLACASA, 2017, p. 31–33).

Another contribution of the notion of MoC is the fact that it not only enlivens *things*, but it also politicizes them.

> The target of this critique can be identified as a humanist morality, traditionally oblivious to how scientific matters of fact and technical things “gather,” to how they can transform the composition of a world. Instead, Latour argued, thing-oriented politics give them a political “voice.” (PUIG DE LA BELLACASA, 2017, p. 34)

On chapter 3, this work emphasized how quantification does not operate as a mere descriptor, but it indeed *plays a role* in the world and the lives it claims to count and describe. De-objectifying and enlivening things such as projection models or a web application allow one to comprehend that they play a role within gatherings[28].

[28] Latour uses ‘gathering’ as described by Martin Heidegger(HEIDEGGER, 1977). ‘From earliest times until Plato the word techne is linked with the word episteme. Both words are names for knowing in the widest sense. They mean to be entirely at home in something, to understand and be expert in it. Such knowing provides an opening up. As an opening up it is a revealing. Aristotle, in a discussion of special

Latour criticizes the moderns for emptying the relevance of such 'quasi-objects' by taking them as mere intermediaries. As he explains, '[an] intermediary - although recognized as necessary - simply transports, transfers, transmits energy from one of the poles of the Constitution' (LATOUR, 1993, p. 77–78). He suggests, in turn, the notion of 'mediator', 'an original event and [which] creates what it translates as well as the entities between which it plays the mediating role' (p. 78).

That notion of mediation, however, is not new nor implied exclusively by MoC. What indeed is new is the element of *concern*. 'Concern' allows for the comprehension not only of the political aspect of *things*, but also for thinking about them as affectively charged.

> We could simply say that the notion of MoC translates the political life of things in a language compatible with the changing terminologies of contemporary majoritarian democracies, today dealing with "issues" of "public concern" (and I'll come back to this problem later). But it also goes beyond this. Emphasizing concern stresses the troubled and unsettled ways, the more or less subtle ethical, political, and affective tremors, by which a gathering/thing/issue is constructed and holds together. (PUIG DE LA BELLACASA, 2017, p. 35)

However, despite its affective charge being part of what made the notion of 'matters of concern' a compelling approach to deal with the political and material complexities of knowledge production, the idea of 'matters of concern' falls short from offering a sense of attachment or commitment and, most importantly, from expressing action. That is why a notion of 'matters of care' is needed. To be concerned expresses 'worry and thoughtfulness about an issue as well as, though not necessarily, the fact of belonging to the collective of those concerned, "affected" by it' (PUIG DE LA BELLACASA, 2011, p. 89).

> One can make oneself concerned, but "to care" contains a notion of doing that concern lacks. This is because understanding caring as something we do materializes it as an ethically and politically charged practice, and one that has been at the forefront of feminist concern with devalued agencies and exclusions. In this vision, to care joins together an affective state, a material vital doing, and an ethico-political obligation. (PUIG DE LA BELLACASA, 2017, p. 42)

importance (Nicomachean Ethics, Bk. VI, chaps. 3 and 4), distinguishes between episteme and techne and indeed with respect to what and how they reveal. Techne is a mode of aletheuein. It reveals whatever does not bring itself forth and does not yet lie here before us, whatever can look and turn out now one way and now another. Whoever builds a house or a ship or forges a sacrificial chalice reveals what is to be brought forth, according to the perspectives of the four modes of occasioning. This revealing gathers together in advance the aspect and the matter of ship or house, with a view to the finished thing envisioned as completed, and from this gathering determines the manner of its construction. Thus what is decisive in techne does not lie at all in making and manipulating nor in the using of means, but rather in the aforementioned revealing. It is as revealing, and not as manufacturing, that techne is a bringing-forth.'(HEIDEGGER, 1977, p. 13)

There is no escaping the politics of knowledge production nor a researcher's own situatedness (HARAWAY, 1988). Despite it being important, *caring* does not end at being affected, moved. It implies awareness of belonging to an interweaved web and a commitment to engage in an ongoing process of recreating 'as well as possible' relations.

Care adds layers to the notion of matters off concern that have nothing to do with introducing morality. The difference between matters of concern and matters of care is one that ultimately pertains to knowledge politics, to the ethos of knowledge production.

Arguing for the importance of incorporating care into researching knowledge production, Puig de la Bellacasa (2011, 2017) points to three additional layers that feminist knowledge politics adds when matters of concern are 'turned' into matters of care.

The first is how care evokes the often-devalued *labours of care*. To say that care is needed entails considering *who* will do the work of care, as well as *how* that work will be done, and *for whom.* Moreover, it makes one aware to what is being taken for granted and invites a curious eye for works and doings that perhaps are being made invisible. Secondly, care highlights the need of attention and worry for those who can be harmed by the assemblage but whose voices are less valued. Avoiding the pitfalls of demonizing tools, individuals and organizations should not imply abandoning a critical stance. The feminist vision of care points to the importance of occupying oneself with persistent forms of exclusion. And finally, care informs the staging of the assemblages by the STS scholar, who should aim stage them in a way as *to make others care as well* (PUIG DE LA BELLACASA, 2011, p. 90–92).

To help illustrate the potential contribution of these layers, let us look to the example of the 'smart economics' of investing in girls and women.

A World Bank policy research paper set out to calculate what the 'girl effect' could mean to the economy of developing countries. The findings were encouraging.

> If young women had inactivity rates similar to those of young men, annual GDP growth rates would be up to 4.4% higher. Annual GDP growth rates in India, Nigeria, and Paraguay would be 4.4, 3.5, and 3.3 percent higher if girls were as economically active as boys. This is equivalent to almost US$165 billion (PPP adjusted) in India, for example. In South Africa, where the gender differential in inactivity rates is small, the gains to greater economic activity of girls is much smaller, though it still exceeds US$3.7 billion. (CHAABAN, CUNNINGHAM, 2012, p. 19)

Importantly, the authors do not ignore that housework add economic value. They take data from countries such as India and Brazil to adjust the calculations of the cost of inactivity to these countries. They conclude, however, that including a proxy for the value of home-based production activities did not lead to a considerable decrease in the cost of inactivity

(CHAABAN, CUNNINGHAM, 2012). Therefore, it is not that housework performed by girls in developing countries does not add value to the economy, it is just that staying in school as and later being employed can add even more.

> Girls face specific adversities that make them even more vulnerable than women or than boys. For example household and community-wide perceptions that girls have limited economic value, compared to boys, can result in reduced family desire to keep their daughters in school. Given this, the recommendations presented in this paper highlight actions that countries can take to reap the benefit of investing in their girls (CHAABAN, CUNNINGHAM, 2012).

It is this work's contention that an approach based on care would lead one to wonder *'where did the care go'*? There seems to be an underlying assumption that the housework which often busies girls and keep them from attending school will simply disappear or be absorbed by someone else who is not specified. An example of to what this awareness can lead when scrutinizing family planning programs can be found in Wilson's critique of 'smart economics'.

> While using the language of gender equality, the Smart Economics approach, as should be evident, in fact relies heavily on the perpetuation of gendered ideologies and gendered material compulsions to produce its ideal altruistic entrepreneurial subject, who will continue to fulfil gendered reproductive duties while producing for global capital under ever more precarious conditions (Wilson, 2015). It is also embedded in a racialized postcolonial hierarchy in which economic policies can be built on the assumption that 'poor women in the global South' have a capacity for labour which is almost infinitely elastic. (WILSON, 2017b, p. 446)

The ethics of care allows for turning matters of concern into matters of care by applying lessons of feminist knowledge politics. Feminist knowledge politics incites transformation in habits of seeing and thinking. It invites one to worry about those who, despite finding themselves directly implicated by the object of study, do not have their voices heard.

Approaching objects as matters of care is effective to illustrate the potential of care for knowledge production. It is not, however, the extent of the ethos of care. The following section will seek to explain further what does the ethos of care entail and imagine how it could contribute for thinking about quantification in family planning.

4.3. Why care? A political imagination of the possible

The focus of this work was to challenge the way in which quantification has played a role in displacing race and gender concerns while foregrounding an economically inspired notion of effectiveness. This effort, however, was not aimed at discarding quantification nor negating its value as a method, but rather at inviting an engagement with quantification that is

committed to addressing the exclusions and inequalities historically present in family planning programmes.

Let us start by looking back to the target '120 by 20' (see chapter 3). When it was criticised for representing the risk of exposing women to violence and abuse for the sake of meeting targets as it had happened in the past, the group of experts responsible for coming up with the goal argued that '120 by 20' was not to be understood as parameter for target setting, but rather as a 'rallying crying' for galvanising efforts for the initiative (BROWN, Win, DRUCE, *et al.*, 2014).

However, as mentioned earlier, abuses against women continue to take place, as the 2014 deaths in a sterilization camp in Chhattisgarh, India sadly demonstrated. The Indian Health Minister at the time, denied that the country was engaging in target-driven policies. However, media outlets revealed soon after that the minister had ordered an increase in the compensation scheme for sterilization for the women who agreed to be submitted to the procedure, for the 'social health activists' (a.k.a., 'motivators'), as well as for the doctors who performed the sterilization. In the letter that ordered the increase, he focus on specific states with lower rates of contraceptive prevalence and specifically mentions the commitments made to FP2020 when explaining the need to increase the number of sterilizations (SINGH, 2014).

To call this type of outcome from the initiative unsurprising is an understatement. As shown by the criticisms of FP2020 (BENDIX, FOLEY, et al., 2020, HENDRIXSON, 2019, WILSON, 2017b, 2018), violence and abuse have not only marked the history of family planning policies (see chapter 2; BANDARAGE, 1998, BRIGGS, 2003, CONNELLY, 2008, HARTMANN, 2016, SASSER, 2018) but are is still very much part of its present (BI, KLUTSY, 2015, BURKE, 2014, CHAMBERLAIN, 2012, DOSHI, 2016a, KAKANDE, 2016, MATTHEWS, PINKERTON, 2019, SGUAZZIN, 2020). It is clear that more needs to be done in order to properly care for the rights of women in family planning programmes.

An ethos of care and epistemological responsibility

That leads to the question at the title of this section – *why care*. Meaning why does this work proposes that an ethos of care for quantification can be helpful in addressing the historic injustices of family planning programmes, especially those related to gender and race?

First, it is worth considering one important premise discussed earlier: that quantification, as a technology of knowledge production, has political and material effects. It should not be thought of as a neutral tool that is *employed*, and whose effects will depend on *how the user decides* to employ it (LATOUR, 2004).

Taking once more the example of the application FP Goals for the formulation of family planning policy. What are some of the effects of the tool? By having the potential impact of an intervention on mCPR as the sole output, the employment of the application has the *political* effect of defining 'increasing contraceptive prevalence rate' as the guiding purpose of a country's family planning program.

Priority setting is one of the most important aspects of democratic political deliberations. It is, in a sense, deciding on *what to care.* Evaluating possible interventions for family planning solely on the basis of what would be their respective impact on one indicator means displacing women's reproductive needs and rights to the background of political concerns[29].

Additionally, as it was seen on the example for expansion of methods – the application uses an indicator regarding the availability exclusively of LARCs to calculate the potential impact on mCPR of an 'expansion of methods' intervention. That has the *political* effect of determining the meaning of such intervention within family planning programmes. And it does so very narrowly, equating it to LARCs. That means that increasing the availability of other contraceptives such as condoms or birth control pills was made statistically irrelevant and thus, will likely not be the object of public investment. By staying with the *becomings* of the FP Goals application, one can notice its *material* effect of determining what type of contraceptives women will – and will not – have made available for them.

It is our contention that *those political and material effects cannot be thought of as separate* from the indicators and the application FP Goals.

By understanding these political and material effects as indissociable from the methods and tools which generate them, one can trouble the manner in which scientific methods in general and quantification in particular distribute distances. Those who develop technologies of knowledge production cannot be thought of (by themselves or others) as having split from the results of their work after its publication, launch, etc.

Latour (2005b) uses the example of Dr. Frankenstein to call attention to the duty creators should have to their creatures, the duty of not abandoning them. Puig de la Bellacasa (2011) picks up the example and frames it as the need to *care* for the technologies we create. By care she does not mean love. And it does not mean *simply* maintenance of a technology. She uses the example to highlight how *care implies responsibility.* To require that one care for the

[29] The choice of the term 'displace' is deliberate. At no point, this work claims that family planning programmes, and most importantly, the people involved with them, *do not care about the women*. Especially because, as previously underscored, care is a force that is always in action. As it operates, it organises priorities and distributes distances.

technologies they develop means requiring for them to have *responsibility for the becomings of these technologies*.

Considering how reliant the whole FP2020 initiative is on its quantitative data and digital tools, one thought comes to mind. Does calling for those who work with knowledge production to be responsible for the becomings of their technologies mean blaming the developers responsible for the FP Goals, or the Monitoring and Evaluation team responsible for the core indicators of FP2020 for any violent, anti-democratic, or abusive act committed within the initiative?

No.

The terms in which the ethos of care is proposed is not for it to function as a standard of evaluation (or worse, judgement) of knowledge practices, least of all of individuals. *It is not for accusing someone of not caring*. What it does is invite one to 'stay with the trouble' (HARAWAY, 2016) and engage in a speculative imagining of ways to generate more care through one's practice.

> Caring should not become an accusatory moral stance – if only you would care! – nor can its knowledge politics become a moralism in epistemological guise – show that you care and your knowledge will be better. (PUIG DE LA BELLACASA, 2011, p. 95)

For instance, as mentioned on chapter 3, despite claiming to employ a human-rights based approach for family planning, the original table of indicators for the initiative did not have any indicators aimed at monitoring if or how human rights were being observed on the practices taken up by the programme. Even after criticism, only one indicator was developed and data for it was never even gathered in all the targeted countries.

The ethos of care, inspired by feminist knowledge politics, requires that one occupies oneself with the neglected things. It requires awareness to the exclusions and power imbalances present in the context in which one will intervene. In the context of programmes that will seek to intervene in the fertility of women, in a field with such a violent past and present, the development of indicators *could be more into a more caring practice if it tackled with the issues that have led to the systematic abuse of women*.

It is impossible to tell in advance what that will look like. As it was said before, care is contextual. It could mean having specific indicators, different disaggregation, deciding for a more reliance in qualitative approaches, etc. There are no closed answers. It would not even imply giving up on looking to indicators for answers. Although it would likely imply starting by asking different questions and accepting that indicators might not answer all of them.

What influences how and for what we care

The feminist view of interconnectedness and the understanding of care as acts of maintenance of worlds, rather than as actions inspired by good feelings have important implications for when pondering the ethics of any type of knowledge production. When we think of our doings as acts of care that sustain the world, we are pushed into asking ourselves 'what are we sustaining?', 'how are we distributing our care?'.

Speaking once again specifically about family planning programs, much like the work of quantification cannot be separated from what comes of it, it also cannot be separated from its context. The problematization of population is crucial to understand how care is distributes distances within family planning programmes. Despite claiming to be focused on the health and reproductive rights of women, the rhetoric that surrounded the development of FP2020 was one that foregrounded the threats of overpopulation to the environment, to the economy, and to global security (FP2020, [S.d.], HENDRIXSON, 2019, HENDRIXSON, OJEDA, *et al.*, 2019, HUNTER, 2015, WILSON, 2017b).

This triple framing of the population problem leads to a second important premise. *Care is a selective mode of attention* (MARTIN, MYERS, *et al.*, 2015). One cannot care about everything that is relevant to a given situation at the same time. Least of all care for them equally. *The problem of population is undoubtedly a matter of concern that informed the development of the FP2020*. Therefore, it is no surprise that, when deciding on strategies for implementation and monitoring the programme, the potential impact of women's fertility on population was made into a priority. That prioritization implied a specific distribution of distances that did very little for addressing the historical injustices of the field of family planning.

What could be different if population were taken as a matter of care rather than one of concern? Although one cannot anticipate a final result, when dealing with matters of care, there is the crucial 'step' of looking for the neglected things, supporting the voices that are not normally heard, exploring oppositional standpoints.

The awareness of care to oppression and its commitment to neglected experiences allow for the creation of oppositional standpoints and produce visions that can 'cut' differently the shape of a thing (BARAD, 2007, SUCHMAN, 2009).

A famous example of the potential offered by the vision of an oppositional standpoint is Cynthia Enloe's feminist curiosity for asking 'where are the women?' (2014). By asking that

question in different contexts, Enloe 'cuts differently' military bases, the travel industry, factories, among others.

> Most of all, one has to become interested in the actual lives— and thoughts— of complicatedly diverse women. One need not necessarily admire every woman whose life one finds interesting. Feminist attentiveness to all sorts of women is not derived from hero worship. Some women, of course, will turn out to be insightful, innovative, and even courageous. Upon closer examination, other women will prove to be complicit, intolerant, or selfserving. The motivation to take all women's lives seriously lies deeper than admiration. Asking "Where are the women?" is motivated by a determination to discover exactly how this world works. One's feminist-informed digging is fueled by a desire to reveal the ideas, relationships, and policies those (usually unequal) gendered workings rely upon (ENLOE, 2014, p. 5–6)

Beyond providing an example of the critical and investigative potential of feminist attentiveness, Enloe shares on the excerpt below another insight that this work would like to extend to the reasoning on the ethos of care. Much like her feminist curiosity, the ethos of care does not come from an idealised version of women or of their sense of morality. It comes from the acknowledgement that feminist thought has long called upon the need for awareness of often neglected things, people, and concerns. And that such awareness has valuable critical potential.

Building on oppositional standpoints

The ethos of care suggests taking advantage of the critical standpoint enabled by the awareness of neglected things for *speculating how to contribute for the world to be as well as possible* (PUIG DE LA BELLACASA, 2017, TRONTO, 1993). Meaning, how can it contribute to reshuffle power imbalances, challenge oppressions, or, *at the very least*, do no further harm.

The way in which the ethics of care orients a concern with exclusions and injustices invites for a speculative exercise about what quantification *could* be like if the distances it establishes were troubled as to attempt to generate more *caring* policies.

> Standing by the vital necessity of care means standing for sustainable and flourishing relations, not merely survivalist or instrumental ones. Continuing to hold together a triptych vision of care doings-practice/ affectivity/ethics-politics helps to resist to ground care as an ethico-affective everyday doing that is vital to engage with the inescapable troubles of interdependent existences. (PUIG DE LA BELLACASA, 2017, p. 70)

The purpose of the critique of family planning in development and of FP2020 as well as of the speculative exercise is not to provide a closed answer. Nor it is to demonize family planning programs. It is important to acknowledge that caring is contextual. The same care that

can heal here can kill there (MARTIN, MYERS, *et al.*, 2015). In the case of family planning, that last affirmation can be taken literally.

There is no doubt that provision of contraceptives can be lifesaving and can provide women more control over their reproductive lives. As shown by qualitative research that proposed to listen to groups of women in Ghana regarding their use of contraceptives, LARCs were preferred by some because of how they allowed them to circumvent imbalanced power relations within their communities and relationships. Often pressured by partners not to use contraceptives, for some of the women interviewed, receiving an injection every few months or having a discreet and long-acting device implanted meant that they could make the decision to avoid pregnancy by themselves (MARSTON, RENEDO, *et al.*, 2017).

However, to assume that employing the same approach to understand and deal with the reproductive lives of hundreds of millions of women will necessarily lead to a political good is as naïve and as misguided as claiming that 'if we just care it will all be alright'.

Then, where to go from here? If one is willing to dedicate oneself to support more caring practices of quantification in family planning, acknowledging the serious failings of family planning programmes in general and of FP2020 specifically is an important part of that work. Thankfully, for a long time now, there has been extensive feminist critical work on discourses of overpopopulation and on family planning programmes. They can certainly help in the process of looking for neglected things, unheard voices and ignored experiences (BHATIA, SASSER, *et al.*, 2020, HARTMANN, 2014, 2016, HARTMANN, RAO, 2015, HENDRIXSON, OJEDA, *et al.*, 2019, ROBERTS, SMALL, 2020, SASSER, 2018, WILSON, 2015, 2017b).

> This way, the significance of standpoints committed to care is not limited to their critique of power, but also to creating a relationship through that critique. In the perspective proposed here, foregrounding care at the heart of critical constructivism reminds us that, in order to be liveable, a critical cut into a thing, a detachment of a part of the assemblage, involves a re-attachment. (PUIG DE LA BELLACASA, 2011, p. 97)

Adhering to an ethos of care involves a willingness to allow oneself to be affected, touched by their object of study. One way of trying to do that is exploring the visions provided by oppositional standpoints that enable different cuts for family planning. These cuts do not entail any specific method nor, therefore, imply abandoning quantitative data.

A brief look at two examples might illustrate how some researchers and activists are engaging with family planning and reproductive rights from a perspective that highlights neglected voices and experiences in family planning.

The first example challenges one of the main political effects of the narrow framing of family planning as provision of contraceptives. Dorcas Ofosu-Budu e Vilma Hänninen (2021) conducted a research on the views of infertility in Ghana. In their work, they interviewed married women who could not conceive as well as herbalists on the stigmas surrounding infertility in what they describe as a pronatalist culture.

The fertility of African women has historically been treated by family planning programmes and the international development in general as a threat and a problem. Additionally, the focus on provision of modern contraceptives has implied a rejection of traditional approaches to reproductive health. By listening to infertile women and herbalists the authors support voices of two groups that are often disregarded in family planning.

Annabel Sowemimo (2018) writes about how reproductive medicine has been used to oppress people of colour. She starts her article by telling how her mother had expressed concern when she informed her about having had a progesterone implant fitted to prevent pregnancy. As she goes on to explain, her mother shares with many other members of diaspora populations and colonised communities a widespread suspicion of contraceptives[30]. Such suspicion stem from decades of being used as guinea pigs for the development of contraceptives, submitted coerced sterilisation and contraceptive use.

Sowemimo is part of an NGO formed by black & people of colour (BPOC) working in sexual and reproductive health called 'Decolonising Contraception', focused on increasing awareness about the colonial influences in sexual and reproductive health practices. In their manifesto, it reads:

> We believe that SRH hasn't addressed its colonial origins - its practice is derived from racial hierarchies and continues to operate based on a desire for population control. This in part contributes to health inequalities experienced by those experiencing racism.(DECOLONISING CONTRACEPTION, [S.d.])

Committed to work that draws from decolonial methodologies and approaches that are derived from communities and grassroot organisations led by BPOC, the organisation centres the often-neglected colonial inheritance of family planning. As demonstrated by the example of Sowemimo's own mother, family planning interventions that seek to influence contraceptive uptake within communities that have been systematically and historically abused must address that legacy.

[30] Presumably to pre-emptively address certain assumptions on the causes of contraceptive hesitancy, the author highlights that her mother was born in Great Britain and has university level education (SOWEMIMO, 2018).

These were just two examples, but they help highlight the existence of different neglected voices, issues and experiences that need to be addressed in the field of family planning, by its different theories and methods.

If the first three chapters were an effort to convince the reader that a journey towards more caring practices of quantification in family planning was necessary, this very last section was an attempt to point to a few possible paths.

Hopefully, someone will find this a journey worth taking.

Conclusion

‘Handle with care’: politics and ethics for breaking jars

Murphy’s allegory of the jar of fruit flies opened chapter one of this work (MURPHY, 2017). She writes in reference to the experiment with fruit flies in a jar that illustrates the problematization of population, or more simply, of ‘overpopulation’. Originally put in a container rich in foods, the fruit flies live long lives and reproduce at a rate that eventually crowds the jar, leading to scarcity of resources. The scarcity of resources causes the number of fruit fly deaths to rise, of births to fall and thus, the population growth to stagnate. As the jar becomes ‘a container of mass death’, Murphy feels the urge to intervene:

> Looking at images of this jar today, I want to reach back, pluck open the lid, and release the fruit flies to other fates. Or I could take responsibility for feeding the flies, bred as dependent laboratory creatures by the scientific practices I care so much about. Or better yet I could smash the bottle, breaking the illusion that it is the container that conditions how the flies live or die. I want to imagine other ways of understanding aggregate life that do not demand a contained existence that ends in extermination. **What would it take to smash the container?** (Murphy, 2017, p. 1; emphasis added).

Despite opening with Murphy’s question, chapter one did not answer it. Instead, it proposed to investigate ‘how the hell we ended up in the jar in the first place’ as it explored how population was turned into a problem. However, as we close this work, it feels like an answer must be provided. *How to break the jar?*

Our suggestion? *Carefully.*

The choice of opening with Murphy’s text was due not only (nor even mainly) to the description of the fruit fly experiment itself. The experiment is well-known and a competent description of it could have been easily found elsewhere. The most appealing aspect of Murphy’s account is how she describes *being herself affected by the experiment.* How, faced with the fruit fly population experiment she cannot help but feel the need to *do something*. Her account expresses a connection, an attachment to the destiny of the fruit flies. In simple terms, the power of her text comes from the fact that *she clearly cares.*

There is a space for care in knowledge production. Or, more adequately put, *there is care in knowledge production*. Of course, such affirmation leads to a series of inevitable questions. *Who is doing the caring? What kind of care? Care for what? For whom? How?*

Care feels like an especially fraught concept in family planning. It is a place where so many different forms of care intersect, not only medical and maternal. This work was based on a broader notion of care, one that encompasses everything that is done to sustain the

interweaved web of life. In that sense, it is a *doing*, but it is not only that. It is an ethos. In our *doings*, to act ethically, one must aim at contributing to sustain our world *as well as possible*.

The history of family planning in development programmes is one of various abuses and violations of the rights of millions of mainly, though not exclusively, poor women from developing countries. It has been long based on the strategy of controlling the fertility of poor women as a misguided way of protecting the environment, fighting poverty, and making the world safer.

Numbers have always played an important role in population. Demographic studies expressed concerned with there being *too many people* – and sometimes and in some specific places, *too few*. Obviously, the conclusion of having *too many* or *too few* are only made possible by the belief in the existence of an *optimal number*. The pursuit of an optimal number of people was organized by the setting of other strategic numbers – *targets.*

The way in which these targets have always been – and still are – set are telling of something else in population: it is not *just* a numbers problem. The overpopulation problem is not simply a problem of there being too many people. It is a problem of there being *too many of a certain type of people*. That is the only way to understand how 'the population problem' could make sense of having all of the following things simultaneously be true:

- The global population is exploding.
- Some places have too many people and others have too few.
- Migration is a problem and can pose a threat.
- Climate change is a problem that must be urgently addressed through population.
- The birth rate of those who have the lowest carbon footprint is too high.
- The birth rate of those who have the highest carbon footprint is too low.
- Women must have control over their own fertility.
- The most effective solution for family planning is the use of contraceptives that, once inserted/applied, either cannot have their effects interrupted (injectables) or cannot be removed by the user herself, requiring the intervention of a health professional (implants).

Racism and sexism are some of the glues that hold all these arguments together. Otherwise, how could one make sense of how certain governments can invest significant amounts of money to *both* curb immigration *and* incentivize their citizens to have more children? Or of why women and girls are the main targets of population programmes even

though their number of reproductive years as well as the number of children they can biologically parent are considerably lower than those of men?

International development programmes in family planning have a racist and patriarchal past and present that must be exposed and challenged. Relying on quantification to make a case for action to control population growth, as well as to design strategies based on intervening on the bodies of poor women from developing countries has long been distributing distances in a way that avoids that difficult and much overdue reckoning. The perpetuation of abuse and violence is a consequence of that avoidance.

Desrosières (2002) describes numbers as 'useful fictions' as he points to the epistemological tension between their being taken as representations of *what is real* versus being taken for constructs originated by arbitrary political decisions.

That tension comes with the territory when dealing with numbers. It is a fine line on which one must tread when formulating a critique of quantification – a line this work may perhaps have missed on occasion. But the cost of not trying is perhaps too high. The path chosen here was one that led us through a critical analysis of the FP2020 programme to an invitation to adhere to an ethos of care in quantification.

The first chapter analysed the history of the problematization of population. It explored how the emergence of statistics turned *people* into *population*, a countable, devisable and manageable unit that would be key to the art of governing (FOUCAULT, 2004). Then, it accounted for the phenomenon that came to be known as *overpopulation*, meaning the framing of population as a *problem*, the problem of *too many people.* The first to ring an alarm on the threat of a growing population was Thomas Malthus, in the turn of the nineteenth century. However, it would only be after World War II that *overpopulation* would be framed as a problem that demanded coordinated international action. The threat of communism and environmental degradation fueled initiatives led by development experts who hit the ground running all over the recently 'discovered' Third World (ESCOBAR, 1995). Decades went by, the Cold War and the threat of communism were gone but that did not substantially change the way in which population was treated in development as an environmental, economic and security problem. Fear of migration, terrorism, and conflict continued to be associated with the growing populations of the Global South, where the fertility of women continued to be considered a liability to global stability.

Chapter two provided an overview of family planning programmes for most of the second half of the twentieth century, leading up to the launch of the FP2020 programme, contemplating the main international conferences that helped shape frameworks for international development

as well as family planning programmes. The purpose of revisiting this history was to allow for connections and ruptures to be identified, to understand the tradition of development intervention in which FP2020 emerged. It relied on examples of experiences from different developing countries and territories to demonstrate how target-driven policies have led to abuse and violence against poor people of colour in the Global South – the majority of them, women. It also illustrated how the fertility and sexuality of the women from these countries were construed as different and pathological, which ultimately concurred to justify the adoption of practices that violated their reproductive rights and that would normally be deemed unacceptable in developed countries.

Chapter three briefly placed FP2020 in the history of family planning interventions, describing the context of its launch in 2012 before focusing on the role played by quantification in the programme. It looked at the initiative's '120 by 20' goal, aimed at increasing in 120 million the number of women and girls using modern contraceptives by 2020; at its list of core indicators; and at one of the main tools developed for the elaboration of family planning policies within the target countries of FP2020, the FP Goals application. The chapter explored how the choice of indicators and targets failed to challenge long-standing assumptions and practices that have ultimately contributed to many of the abuses described on the previous chapter. The chapter prefaced the speculative exercise presented next.

The final chapter described a vision of what the adherence to an ethos of care could mean to family planning interventions. Focusing on the potential of care for imagining ethical engagements in knowledge production, it aimed at encouraging further exploration of care with – but not limited to – quantitative methods. It offered some groundwork by explaining the concept of matters of care developed by Puig de la Bellacasa (PUIG DE LA BELLACASA, 2011, 2017) and describing how feminist knowledge politics can support those who decide to engage with the ethos of care. Such support happens on two different fronts: in formulating critical analyses, and in building from oppositional practices, thanks to its long-standing tradition of exposing power imbalances and exclusionary practices.

Rather than a romanticized idea of care that conflates it with 'good feelings' (MURPHY, 2015) or that claims any moral superiority of women, the definition of care with which this work grapples is one that understands it as an existing force, which is already in motion operating in the distribution of distances. It is not about 'bringing' care to family planning – if anything, family planning is already characterized by the intersection of many different forms of care. Care is also not meant to be turned into an accusatory moral stance nor some form of moralism in epistemological guise (PUIG DE LA BELLACASA, 2011).

Adhering to an ethos of care and, thus, making a commitment to the neglected things, the unheard voices and overlooked experiences are to be understood as a call for epistemological responsibility, for engaging properly with the *becomings* of the things we create. It invites a speculative exercise to contemplate how one's *doings* could contribute to more caring practices. It allows for troubling the distance typical of scholarly work in general and quantification specifically, and for re-affecting objects of study.

Care is also situational; it allows for specific needs to be addressed in specific situations. There is no *one right way* to care – that is an important part of its potential. And it is also the reason why it is described as a form of speculative ethics. It is impossible to define in advance what a more caring quantification would look like. However, considering the past and present of family planning, imagining different practices and *becomings* feels urgent.

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APPENDIX 1
SUMMARY OF COMMITMENTS FROM 2012 LONDON SUMMIT ON FAMILY PLANNING

London Summit on
FAMILY PLANNING

Summaries of Commitments

2 December 2013

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**This document will be updated as additional commitments are approved.*

Civil Society Organizations

ActionAid

ActionAid commits to promoting a transformative understanding of the sexual and reproductive health of women as central to development and poverty reduction. ActionAid will promote a discourse that reflects the importance of women's sexual health, sexuality and control over their bodies, to eradicating violence against women and women's social, economic and political exclusion. With the goal of fulfilling its commitments by 2017, ActionAid pledges to organize women and girls in rural areas to challenge and reject gender-based violence that denies them control over their bodies; secure improvements in the quality, equity and gender responsiveness of public services, including reproductive health services; support women to build and advocate gender-responsive economic alternatives at all levels; convince governments and influential agencies that violence against women is a pivotal barrier to gender equality; and convince governments to enact policies, programs and legislative frameworks to guarantee women full enjoyment of their rights, including the right to sexual and reproductive health.
www.actionaid.org

Advance Family Planning

With its many partners, Advance Family Planning will persuade policy-makers to honor their London Summit on Family Planning commitments and, in general, seek increased political commitment and funding from public and private sources for family planning at the global, regional, country and local levels.
www.advancefamilyplanning.org

CARE International

CARE International commits to putting reproductive rights, women's empowerment and gender equality at the center of its sexual, reproductive and maternal health programming and policy work, by developing approaches for addressing gender and social barriers to increased family planning use and validating tools to measure the impact of these approaches on health outcomes. CARE will strengthen local governance mechanisms and the capacity of women and communities, particularly the most marginalized groups, to meaningfully participate in their own health, engage in local decision-making processes and to hold governments accountable to their commitments. CARE also commits to reaching the most vulnerable and marginalized populations to reduce inequality, ensuring women and girls' family planning and reproductive health needs are addressed in both development, emergency and post-conflict response activities. Finally, CARE is committed to building political will and mobilizing action at all levels – local to national to global – to ensure continued funding and prioritization of SRMH, scale-up of successful approaches, accountability to commitments and implementation of policies and programs that are rights-based, effective, culturally appropriate and address the needs of communities.
www.care-international.org/Media-Releases/care-commends-groundbreaking-london-summit-on-family-planning.html

DSW (Deutsche Stiftung Weltbevoelkerung):
DSW commits to continue and expand its advocacy for both expanded availability and removal of barriers and to help build community support for contraceptive access. According to its Strategic Plan, 2011-2016 DSW particularly commits to increase the number of: 1) advocacy interventions to prioritize sexual and reproductive health and rights (SRHR), family planning (FP) and gender policies and programs; 2) parliamentarians and policy champions pushing forward the SRHR/FP agenda including gender-sensitive development issues; 3) collaborative efforts to ensure sufficient and transparent funding for FP; 4) interventions to increase the access to FP.
www.dsw-online.org/topics/issues-we-are-concerned-with/sexual-and-reproductive-health/special-family-planning-summit

FHI 360
FHI 360 commits to allocating US $1 million of their resources through 2020 in support of the development and introduction of new contraceptive technologies that will provide women in the developing world with additional high-quality, low-cost family planning options to fill gaps and expand choice for women and girls. FHI 360 will also expand the evidence base for safe and effective family planning and will translate high-quality evidence into policy and practice. FHI 360 plans continue efforts to widen the array of safe, effective, acceptable and affordable contraceptives worldwide.
www.fhi360.org/en/AboutFHI/Media/Releases/res_newPledge082012

Guttmacher Institute
The Guttmacher Institute commits to updating and publishing 2012 estimates of the number of women in all developing countries in need of family planning, the costs of providing services to current users and of providing high-quality services to all women in need and the benefits of meeting the contraceptive needs of current and potential future users (complete). Aligned with the London Summit on Family Planning's goals, Guttmacher will help develop and implement a monitoring framework as well as evidence-based messaging and data. Guttmacher commits to continuing to employ evidence-based advocacy at the U.S., global and country levels to increase access to the broad sexual and reproductive health services, including family planning, and to protect reproductive rights. Guttmacher will help to inform the work of donors, civil society groups and other stakeholders by providing evidence and evidence-based messaging in support of the Summit's goals.
www.guttmacher.org

International Center for Research on Women (ICRW)

ICRW commits to expanding the evidence base on the importance of addressing socio-cultural barriers – including intimate partner violence, stigma and partner involvement – when striving to meet women's demand for reproductive control and use of family planning services. ICRW will leverage new evidence to inform the framing of national reproductive health/family planning policy, development assistance programs and corporate social responsibility programs. ICRW will expand the evidence base linking women's social and economic empowerment to family planning and sexual and reproductive health. ICRW will also produce new evidence related to adolescent sexual and reproductive health and rights and strengthen the connection between adolescent girls' education and sexual and reproductive health outcomes, including delayed marriage and childbearing. This new evidence will help inform the design of family planning and sexual and reproductive health programs and services delivered through governments, the private sector and civil society. In addition, ICRW will develop and validate metrics to improve its understanding of the benefits that education brings to women's access to and correct use of family planning.

www.icrw.org/media/news/icrw-commits-build-evidence-womens-access-family-planning-services

Interact Worldwide

Interact Worldwide commits to raising US $1.5 million by the end of 2013. Interact Worldwide also commits to advocating for the removal of policy, financial and regulatory barriers which limit access to family planning, especially for the poor and marginalized, partly through global and national work on universal health coverage. Interact Worldwide will improve the quality and effectiveness of family planning programs for excluded adolescents, implementing an information, education and communication campaign targeting adolescents, their families, their communities, their local government officials and service providers. This will include training programs for service providers in youth friendly services, as well as the recruitment and training of peer educators for adolescents and for older men and women in communities. Finally, Interact Worldwide will work to integrate the views of marginalized women and girls through extensive consultation during the design and evaluation of programs.

www.interactworldwide.org

International Planned Parenthood Federation (IPPF)

IPPF supports the Civil Society (CS) Declaration to the London Summit on Family Planning (LSFP). By 2020, IPPF will increase family planning services, saving the lives of 54,000 women, averting 46.4 million unintended pregnancies and preventing 12.4 million unsafe abortions. IPPF will treble the number of comprehensive and integrated sexual and reproductive health (SRH) services provided annually, including 553 million services to adolescents. IPPF will establish technical knowledge centers to train providers of family planning services and will develop a compendium of family planning, maternal, child, SRH, and HIV linkages indicators. IPPF will improve the advocacy capacity of Member Associations in at least 40 of the 69 Summit priority countries. IPPF will mobilize CS and governments to improve the legislative, policy, regulatory and financial environment for family planning, and will mobilize the international movement created through IPPF's role as Co-Vice Chair of the Stakeholder Group to the LSFP to hold governments accountable. IPPF will generate support for SRHR from regional bodies, the Oil Rich States, the G20, BRICS and emerging economies, advocate to the pharmaceutical industry for affordable pricing for contraceptives and raise awareness and change the attitudes of community, political and public opinion leaders to support SRHR for all.

www.ippf.org/news/press/familyplanningsummit

IntraHealth International

IntraHealth International commits to advocating for and expanding access to an increased number of skilled frontline health workers delivering quality family planning services in West Africa, building on its global commitment to ensuring health workers are present, ready, connected and safe. IntraHealth International commits to contributing to doubling West Africa's regional average contraceptive prevalence rate by 2020 – leveraging new and existing programs and partnerships with governments, donors, civil society and the private sector to: expand use of mobile technologies to increase health workers' access to accurate, up-to-date information on family planning and reproductive health services; foster greater integration of family planning with HIV/AIDS services and maternal, newborn and child health care; collaborate with regional and national accrediting agencies and professional associations to ensure that pre-service and in-service training curricula include state-of-the-art information on methods, services and behavior change; encourage greater involvement and support of male partners for the successful use of contraceptive methods and family planning and reproductive health services; support increased engagement and leadership of civil society and young people to promote healthy reproductive health behaviors, including greater social and cultural acceptability of family planning; and advocate for increased political support and investment in family planning by government partners.

www.intrahealth.org

Ipas

Ipas is committing US $10 million per year towards family planning-focused work. In addition, Ipas will advocate for the removal of policy and regulatory barriers which limit access to family planning and increase recourse to unsafe abortion, will increase the frequency and improve the quality and effectiveness of education and behavior change programs on family planning and will integrate these efforts with other sexual and reproductive health and rights programs. Ipas will also train new cadres of health care workers – 4,000 per year – to provide a wider range of sexual and reproductive health services, including post-abortion family planning services, integrating family planning and other SRH services with primary care. Ipas will support research on post-abortion family planning service delivery, will advocate for improved medical service delivery protocols and will support the availability of affordable contraceptives and other products through WomanCare Global International, a UK charity closely affiliated with Ipas. Finally, Ipas will also promote increased participation of women and other stakeholders in health policy and decision making and will increase support for SRHR, including family planning and the prevention of unsafe abortion, among religious and community leaders.
www.ipas.org

JHPIEGO

JHPIEGO commits to providing new, incremental funds in the amount of US $200,000 to support innovations in the provision of implant/injectable services at the community-level, using front-line health workers. JHPIEGO also commits to advocating for task-shifting to improve access to long-acting family planning methods in underserved settings and training matrons or auxiliary midwives to provide implants in underserved settings.
www.jhpiego.org

Marie Stopes International (MSI)

MSI commits to enabling a total of 20 million women, in the world's poorest countries, to use contraceptives by 2020. To reach this commitment, MSI will use its range of service delivery channels to reach 6 million new family planning users; provide another 4 million existing family planning users with greater quality and choice than they currently have from their existing provider; and sustain the provision of family planning choices for the 10 million women who already used MSI services in 2011. In addition, MSI will work in partnership with governments to help identify, address and remove policy, financial and other barriers to access to contraceptives, information and services.
www.mariestopes.org/londonsummit

Merck for Mothers

Merck for Mothers commits US $25 million over eight years.
www.merckformothers.com/newsroom/london_summit

Pathfinder International

Pathfinder International commits to increasing financial support for family planning programs in Pathfinder's existing program countries and at least two new countries. Pathfinder will raise an additional US $3 million by 2014 to augment its already robust family planning related programs. One third of this commitment will be used to reach young people in the underserved regions such as West Africa. Pathfinder will also advocate for the removal of policy and regulatory barriers which limit access to family planning. It will initiate new work with communities to prevent early marriage in two countries in Francophone West Africa and work with partners to deliver family planning as a package of comprehensive reproductive health care, livelihood and environmental conservation activities in remote areas of Western Tanzania.

www.pathfinder.org/news/pathfinder-pledges-additional-3Million-for-family-planning

Planned Parenthood Federation of America and Planned Parenthood Global

Planned Parenthood Federation of America commits to reaching 2 million more women in the United States with reproductive health care, including life-saving preventative screenings and family planning counseling and services. Planned Parenthood will work with its nearly 80 affiliates across the U.S. to expand reproductive health services to areas and communities currently lacking access. Additionally, through the organization's international arm, Planned Parenthood Global, it commits to supporting its in-country partners in Africa and Latin America to reach 1 million people by 2015 with sexual and reproductive health information, supplies and services, emphasizing family planning. Planned Parenthood Global will continue to invest in the long-term autonomy and sustainability of local organizations implementing a human rights-based approach to delivering the highest quality reproductive health care. It will support innovative pilot projects to improve quality of care overall and bridge barriers for those most in need of information and services, yet who have the least access to them. Planned Parenthood Global will also expand projects focusing on young people, especially using social media, to reach an additional half a million adolescents with information and access to services when they need them.

www.plannedparenthood.org/global

Population Action International (PAI)

PAI commits to advocating for expanded access to voluntary, high-quality family planning and reproductive health services and supplies. PAI will support policy engagement and capacity transfer among Southern civil society organizations; conduct policy-relevant research to support evidence-based advocacy; mobilize financial resources and create the policy environment necessary to expand access; and promote accountability at the global, regional and national levels to meet the demand for contraception.

www.populationaction.org/press-releases/statement-london-summit-on-family-planning

Population Council

The Population Council commits to increasing access to and availability of family planning and other reproductive health services in countries where people are unable to achieve their reproductive health goals. The Population Council will promote reproductive rights to reduce inequalities in access to and use of reproductive health services related to wealth, age and gender; strengthen health systems so that contraception can be provided through a range of health services; develop and test the effectiveness, safety and acceptability of new reproductive health technologies designed to benefit women and men in developing countries; and engage pharmaceutical companies to license, register and/or manufacture technologies developed by the Population Council to expand choice in developing country markets.
www.popcouncil.org/mediacenter/newsreleases/2012_FPCommitment

Population Reference Bureau

Population Reference Bureau commits to increasing support for family planning through evidence-based advocacy initiatives and materials, as well as increasing the quality and quantity of media coverage on family planning.
www.prb.org

Rotarian Action Group for Population and Development (RFPD)

RFPD, as a resource to all Rotary clubs/districts worldwide for Rotary's area of focus 'Maternal and Child Health,' commits to promote and support all efforts by Rotarians to improve maternal and child health and provide family planning information and resources. RFPD commits to scaling up its model project in Northern Nigeria to expand to other Nigerian states beginning in 2012, opting for further introduction of the model also in other countries. RFPD will continue to expand its efforts in empowering women, promoting responsible parenthood and helping to improve the logistics and supply of family planning services in countries in need. *RFPD operates in accordance with Rotary International policy, but is not an agency of, or controlled by, Rotary International.*
www.maternal-health.org

Reproductive Health Supplies Coalition (RHSC)/Resource Mobilization and Awareness Working Group (RMAWG)

As part of RHSC, RMAWG commits to helping to fulfill commitments made by convening country-level consultations in the world's poorest countries to identify the most pressing policy barriers that restrict service delivery and access in each country and jointly define effective actions to address these barriers. RMAWG will publish and circulate widely the results of these consultations. Focusing on civil society engagement and partnerships, RMAWG also commits to raising awareness, mobilizing resources, driving policy change and implementation and holding governments and donors accountable for their commitments at both the global and national level.
www.rhsupplies.org/nc/news/newsview/article/new-policy-document-is-a-blueprint-for-change

Save the Children

Save the Children commits to strengthening the capacity of 143,600 frontline providers to deliver quality sexual and reproductive health and family planning services that are friendly to adolescents. Save the Children will focus on providing these services to those that are particularly vulnerable and hard-to-reach and will reach more than a quarter of a million adolescent girls. Working to raise awareness of the health and rights of young people, Save the Children will create safe spaces for young mothers and address the needs of girls vulnerable to sexual and gender-based violence. Recognizing the role of education in empowerment, Save the Children will scale up its work to increase girls' enrollment, retention and graduation from basic education in four conflict-affected and fragile states, with a view to replication elsewhere. Save the Children will increase access to education for 250,000 girls, bring 10,000 women into teaching and provided professional development to 40,000 women teachers. On a global level, Save the Children will advocate for policies that will remove financial barriers to contraception, increase girls' education and provide for the sexual education and economic empowerment of women. Save the Children will form partnerships that will raise awareness of rights, empower women and girls and stimulate demand for family planning.

www.savethechildren.org.uk/get-involved/campaigns/family-planning-girl-power-saves-lives

WomanCare Global and PSI

WomanCare Global (WCG) and PSI will expand access to and stimulate demand for family planning by merging WCG's supply chain management and quality assurance expertise with PSI's health communications and social marketing of products and services. With the focused deployment of resources for family planning programs from existing funding sources, this partnership will expand access to an array of reproductive health products and manage the large-scale distribution, increase usage of long-acting, reversible contraceptives, monitor quality of products and evaluate programs and will provide training and other forms of support. Specific tactics include the registration of a broad range of reproductive health products and the utilization of the existing wholesale and retail distribution infrastructure to make products widely available, supplemented by outreach events and the engagement of community-based health workers. The partnership will focus on an integrated pilot effort in four markets in Africa.

www.womancareglobal.org and www.PSI.org

Developing Countries

Bangladesh

Bangladesh will increase access and use for poor people in urban and rural areas, improving choice and availability of Long Acting and Permanent Methods (LaPMs), including for men, and post-partum and post-abortion services. The government will work with the private sector and non-governmental organizations (NGOs) to: address the needs of young people, especially young couples; reduce regional disparities, working with leaders and communities to delay early marriage and child birth; and increase male involvement. One-third of Maternal Newborn and Child Health (MNCH) centers will provide adolescent Sexual and Reproductive Health and Rights (SRHR) services. Monitoring to ensure quality of care will be strengthened, including informed consent and choice, and to support women to continue use of family planning.

Bangladesh's Announcement at the London Summit on Family Planning

Burkina Faso

Burkina Faso, through the leadership and advocacy of the First Lady, pledges to take action in terms of policy, funding and programming. The aim will be to maintain family planning as a central priority of development policies, effectively enforcing existing legal instruments on reproductive health and reducing the cost of contraceptive commodities. Burkina Faso will work toward increasing the resources allocated to family planning in state budgets. It will also seek to boost partnerships with the private sector and civil society organizations for service provision, to define and develop strategies for engaging men, and to establish regular and active monitoring of the availability of contraceptive commodities at all levels.

Burkina Faso's Announcement at the London Summit on Family Planning

Cote D'Ivoire

Cote d'Ivoire's President has issued a Declaration on Maternal Health. Family planning availability through health facilities will increase from 60% in 2010 to 100% in 2015, and community based services will be strengthened. Resources allocated to family planning will be increased, including contraceptive commodities. Contraceptives have been included in the recommended list of essential medicines and subsidized to improve affordability. The family planning method mix will be expanded, and access to family planning methods for women living with HIV and youth will be provided as part of national strategy to eliminate mother-child transmission.

Ethiopia

Contraceptive use has doubled in Ethiopia since 2005. The government will further increase its funding to uphold the rights of all people to access and choose voluntary family planning through the strong network of primary health care providers. In particular, the needs of married and unmarried adolescent girls will be met through partnerships with non-government and private providers, as well as expanding youth-friendly services. The government will also improve access for isolated pastoralist communities.

www.moh.gov.et/english/newsandupdates/Pages/LondonFamilyPlanningSummitEthiopiasParticipation

Ethiopia's Announcement at the London Summit on Family Planning

Ghana

Ghana is committed to making family planning free in the public sector and supporting the private sector to provide services. Services will be available for sexually active young people through youth promoters and adolescent friendly services. Improved counseling and customer care will be prioritized. Contraceptive choices are being expanded to include a wider range of long acting and permanent methods along with including task shifting options and improvement of post-partum and post-abortion family planning services. The government has put in place a comprehensive multi-sectorial program to increase demand for family planning as a priority intervention in the MDG 5 Acceleration Framework, including advocacy and communications to improve male involvement, such as the "Real Man" campaign.

Ghana's Announcement at the London Summit on Family Planning

India

India will include family planning as a central element of its efforts to achieve Universal Health Coverage. Through the largest public health programme in the world, the National Rural Health Mission and the upcoming National Urban Health Mission, addressing equity, ensuring quality, including adolescents and integration into the continuum of care are slated to be the cornerstones of the new strategy. The centre-piece of its strategy on family planning will be a shift from limiting to spacing methods, and an expansion of choice of methods, especially IUDs (Intrauterine devices). To enable women to delay and space their births, India will distribute contraceptives at the community level through 860,000 community health workers, train 200,000 health workers to provide IUDs, and shall substantially augment counselling services for women after childbirth. Expenditure on Family Planning alone out of the total Reproductive, Maternal, Newborn and Child Health and Adolescent Health (RMNCH+A) bouquet is expected to cross US $2 billion from 2012 to 2020. This will ensure free services and commodities through public health facilities for 200 million couples of reproductive age group and adolescents seeking contraceptive services.

India's Announcement at the London Summit on Family Planning

Indonesia

Over half of Indonesia's women of reproductive age are using contraception to plan their families, with strong political leadership and a national movement for reproductive health and family planning. This has helped improve economic growth and reduce poverty through the resulting demographic dividend. Key factors have been support from religious leaders, participation of the private sector and quality of care, and communications campaigns. The government right now provides free services to 7 of 33 provinces since 2010; but will include family planning freely throughout the country in the Universal Health-care Coverage program in 2014; and will broaden access and choice especially in poorer regions, through the strengthening of all public and private clinic services and provision of preferable long-acting and permanent methods. Indonesia is investing in South-South exchange to share experiences. The government commits to maintaining its investment in finances for family planning programs, which has increased from US $65.9 million in 2006 to US $263.7 million in 2012

Indonesia's Announcement at the London Summit on Family Planning

Kenya

Kenya has enshrined the individual's rights to quality reproductive health care, including family planning information, services and supplies, in the Constitution. The government's budgetary allocation to family planning has grown from US $2.5 million in 2005/2006 to US $6.6 million in 2012/2013. The government is working closely with development partners to secure increased finance for family planning commodities and services. As part of the efforts to address family planning needs for the poor and hard-to-reach segments of the population, the government will scale up its Voucher System which provides reproductive health services, including family planning, in five rural and urban districts in Kenya. The government has already established over 70 Youth Empowerment Centres. The target is to have one in each constituency to provide a one-stop-shop for youth friendly information, including family planning. The target is to increase the contraceptive prevalence rate from 46% to 56% by 2015.

Malawi

With the goal of "no parenthood before adulthood," Malawi commits to raising the country's contraceptive prevalence rate to 60% by 2020 with a focused increase in those aged 15 to 24. Malawi will create a family planning budget line in the main drug budget by 2013/2014 and will raise the age of marriage to 18 by 2014. In addition, Malawi will develop a comprehensive sexual and reproductive health program to meet the needs of its young people and will work to strengthen effective policy leadership for family planning. It will also demonstrate accountability in the utilization of available resources and improve financial allocation for health systems supporting family planning. Malawi will increase coverage of services through the expansion of public/private partnerships, increase community access to family planning methods and strengthen forecasting and data management for effective supply chain operation.

Malawi's Announcement at the London Summit on Family Planning

Mozambique

Mozambique is committed to continuing to provide free integrated sexual reproductive health services and commodities in all health facilities, and to cover 5% (2012), 10% (2015) and 15% (2020) of contraceptives needs. Family planning information and services for the youth will be revitalized. Access to long acting and permanent methods will be increased from about 1% to 5% of women by 2015. Post-partum and post-abortion counseling on family planning and contraception will be expanded by training at least 500 health providers throughout the country by 2015. A public-private partnership to strengthen the distribution of contraceptives will increase the number of health facilities with at least three contraceptive methods from one-third to 50% by 2015.

Mozambique's Announcement at the London Summit on Family Planning

Niger

Niger has a high level of political engagement. It will quadruple its family planning budget for 2013, as well as increasing its overall health and reproductive health budgets. There will be policy change to include injectable contraceptives in the method mix provided by community health workers; a focus on new strategies for reaching disadvantaged groups, including through 'Friends of Youth' centers; and new mobile clinic services for isolated communities. Niger will scale up its effective network of Ecole Des Maris (Schools for Husbands), to involve and increase acceptance among men, work with faith based networks, and integrate family planning in the school health curriculum.

Nigeria

Nigeria commits to achieving the goal of a contraceptive prevalence rate of 36% by 2018. This will enhance maternal and child survival, thereby contributing to the government of Nigeria's initiative to save one million lives by 2015. In addition to Nigeria's current annual commitment of US $3 million for the procurement of reproductive health commodities, Nigeria commits to provide an additional US $8.35 million annually over the next four years. This increases Nigeria's total commitment for the next four years from US $12 million to US $45.4 million, an increase of almost 300%. The federal government will work with the state and local governments to secure complementary budgets for family planning and reproductive health service delivery. Nigeria's commitments include training frontline health workers to deliver a range of contraceptives and action to improve equity and access to family planning for the poorest. The government of Nigeria will partner with the private sector, civil society, traditional and religious institutions and development partners.

Nigeria's Announcement at the London Summit on Family Planning

Pakistan

Pakistan commits to working toward achieving universal access to reproductive health and raising the contraceptive prevalence rate to 55% by 2020. Pakistan will take forward its 2011 commitment with the Provinces for all public and private health facilities to offer birth spacing services. The amount spent on family planning, estimated at US $151 million in 2011/12 will be increased to nearly US $200 million in 2012/13, and further in future years. The federal government assesses the contraceptive requirement as US $186 million over the period 2013 to 2020, which will need to be provided for. Contraceptive services will be included in the essential service package of two provinces in 2012, with the others following in 2013. Supply chain management, training and communication campaigns will be strengthened. Family planning will be a priority for over 100,000 lady health workers, who cover 70% of rural areas. Public-private partnerships and contracting out mechanisms will help scale up access, and work with religious leaders and men to promote the benefit of birth spacing will continue.

Philippines

The Philippines has long believed that access to family planning information, services and supplies is a fundamental and essential right that is key to inclusive growth and sustainable development. The government is working to establish a national policy on reproductive health and population development, and to allocate funds to implement this vital policy. The Philippines will commit $15 million in 2012 for the purchase of family planning commodities for poor women with an unmet need. Family planning services will be provided to poor families with zero co-payment. In addition, the government will be upgrading public health facilities and increasing the number of health service providers who can provide reproductive health information. We are also intensifying efforts with partners who can help give women the information and counseling they need.

Rwanda

Rwanda commits to ensuring the availability of family planning services in each of the 14,841 Rwanda administrative villages (Imidugudu) through delivery by the 45,000 community health workers already in service. Rwanda will expand existing information and dissemination programs about family planning to the general public and will increase awareness of the various choices available. Focusing on convenience and reducing the frequency of visits to health providers, the government of Rwanda will introduce long-lasting contraceptive methods, including permanent ones, and high quality integrated family planning services in every hospital and health center.

www.presidency.gov.rw/component/content/article/president-kagame-gives-keynote-speech-at-london-family-planning-summit

Senegal

Senegal commits to making family planning a national top priority, increasing the commodity budget from the government by 200% and doubling the overall budget for the management of the family planning program. Senegal's vision is for women to have equal access to high quality and affordable maternal, newborn and child health services, including family planning. Senegal's action plan builds on six fundamental pillars: 1) generate demand especially through mass media communication and community mobilization with targeted messages for women and to increase involvement of men and young people; 2) leverage networks of religious leaders and national and local champions to advocate for family planning ; 3) improve the supply chain and reduce stock outs to zero especially through the Informed Push Model; 4) improve the quality of care and services; 5) expand mobile outreach, social marketing and franchising to ensure access in peri-urban and rural areas; and 6) generalize community-based distribution to bring family planning to the most vulnerable and remote areas. Senegal will continue its commitment to introducing innovative approaches to family planning, such as the acceptability study of Depo Provera subQ, a new self-injectable contraceptive that should highly facilitate access for women.

Senegal's Announcement at the London Summit on Family Planning

Sierra Leone

Sierra Leone commits to increasing its annual health budget from 8% to 12% by 2013 and gradually thereafter until the Abuja target of 15% is met. Within that it is committed to increasing the family planning budget from 0.42% in 2012 to 1% by 2020, recognizing that this will be 1% of a projected increasing budget for health overall. Private sector providers and training more health workers will help scale up family planning services and community outreach to marginalized populations, including young people. Voucher schemes will be piloted with a view of enabling the poorest to get access. Civil society groups will play a key role in advocacy and monitoring availability and access to voluntary family planning.

Solomon Islands

Solomon Islands recognizes family planning as a very important component of reproductive and child health, and as an important consideration for development plans. Solomon Islands is recommitting to supporting programs that will help stop preventable deaths of women and babies, including making family planning a priority under the reproductive health program part of the government's National Health Strategic Plans for 2006-2015. Solomon Islands is also committing to making men partners in all reproductive health issues, including voluntary family planning.

South Africa

South Africa is prioritizing the need to strengthen family planning services while emphasizing dual protection. The government has recently revised its contraception and fertility policy which will be launched publically with a campaign around family planning during August 2012. This policy addresses the full range of issues relating to contraception within a human rights context and also requires that the full range of family planning methods is available at public health facilities. In order to strengthen implementation, South Africa is developing standard operating procedures for community health workers who are part of outreach teams, for nurses in clinics, as well as for midwives in maternity units. It wants community health workers to be able to promote family planning during their visits to homes, and health professionals to use every encounter with a user of its services to also promote family planning. South Africa recognizes the need to target teenagers in particular given its relatively high rates of teenage pregnancies.

South Africa at the London Summit on Family Planning

Tanzania

Tanzania is committed to doubling the number of family planning users to 4.2 million by 2015 to reach a national contraceptive prevalence rate of 60%. The government will increase its financial allocation for family planning, while strengthening partnerships to continue implementing the National Family Planning Costed Implementation Program (NFPCIP). Additionally, the government will execute a FP2020 Action Plan (2013-2015) to address regional disparities and inequalities through training, capacity-building, community-based services, and interventions targeting young people and post-partum women, with a particular focus on the Lake and Western Zones. Through public-private partnerships and training for service providers and local staff, the government will improve contraceptive commodity security, logistics systems, and method mix. Strategic communications will be used to address barriers to family planning use, through a country-wide campaign carried out at the national and sub-national level.

Uganda

Uganda commits to universal access to family planning and to reduce unmet need for family planning from 40% to 10% in 2022. It will increase the annual government allocation for family planning supplies from US $3.3 million to US $5 million for the next five years and improve accountability for procurement and distribution. It will develop and implement a campaign for integration of family planning into other services, including partnerships with the private sector, by supporting the alternative distribution channel for the private sector and scaling up of innovative approaches, such as the community-based distribution, outreaches, social marketing, social franchising and youth friendly service provision. Uganda will strengthen institutional capacity of the public and community-based service delivery points to increase choice and quality of care at all levels (through staff recruitment, training, motivation and equipment).

www.statehouse.go.ug/media/news/2012/07/12/president-museveni-challenges-leaders-women-empowerment-birth-control-efforts-

Zambia

Zambia will double its budgetary allocation to family planning commodities, striving to eliminate the unmet need for family planning and improve universal coverage through an expanded method mix and increased access, particularly to the underserved population. It will address policy barriers to allow task shifting to community health assistants and trained community based distributors to increase access to the underserved communities. Led by the Ministry of Community Development Mother and Child Health, the government will initiate new dialogue with religious and traditional leaders at local level to generate demand, dispel the myths and 'open up the dialogue' on family planning.

Zambia's Announcement at the London Summit on Family Planning

Zimbabwe

Zimbabwe commits to ensuring that women and girls have greater access to quality sexual and reproductive health services and will reduce the unmet need for family planning from 13% to 6.5% by 2020. The family planning budget, including the procurement of contraceptive commodities, will be doubled from the current 1.7% to 3% of the health budget. This includes support for improved access for women and girls from the poorest wealth quintiles, including the removal of user fees for family planning services by 2013. Zimbabwe will improve method mix and strengthen the integration of family planning with reproductive health, HIV and maternal health services; develop innovative service delivery models to meet the needs and rights of adolescent girls; and reduce their unmet need from 16.9% to 8.5% by 2020. Zimbabwe will strengthen public-private partnerships, including civil society organizations in the provision of community-based and outreach services and implement a national campaign to increase national awareness of family planning, and health worker training and sensitization.

Zimbabwe's Announcement at the London Summit on Family Planning

Donor Countries

Australia

Australia commits to spending an additional AUD 58 million over five years on family planning, doubling annual contributions to AUD 53 million by 2016. This commitment will form a part of Australia's broader investments in maternal, reproductive and child health (at least AUD 1.6 billion over five years to 2015). This commitment is subject to annual budget processes.
www.ausaid.gov.au/MediaReleases

Denmark

Denmark commits an additional US $13 million over eight years.
Denmark's Announcement at the London Summit on Family Planning

European Commission

The European Commission commits to an additional US $28.3 million to family planning services in 2013.

France

In 2011, France pledged to spend an additional €100m on family planning within the context of reproductive health through to 2015, in nine countries in francophone Africa.

Germany

Germany commits €400 million (US $491.6 million) to reproductive health and family planning over four years, of which 25% (€100 million or US $122.29 million) is likely to be dedicated directly to family planning, depending on partner countries' priorities.
Donor Commitments: London Summit on Family Planning Panel

Japan

Japan has placed great importance on family planning for many years, especially in combining maternal health and family planning with community-based approaches, and has succeeded in drastically reducing the maternity mortality rate. In order to share this experience with countries in need, Japan has been providing assistance to a number of countries over the last half-century and will continue to do so. Since 2000, Japan has given more than US $570 million toward assistance in family planning and two years ago Japan announced a commitment of US $5 billion over five years. This year, Japan commits to disbursing US $36 million to UNFPA and IPPF. At TICAD 5 (Tokyo International Conference on African Development) in June 2013, Japan intends to make family planning a key agenda item. Japan recognizes the importance of the Millennium Development Goals (MDGs) and has been working to ensure that MDG 4 (reduce child mortality) and 5 (improve maternal health) will be achieved. Furthermore, Japan is also leading the discussion, in cooperation with other countries like the UK, on post-MDGs. In support of its core values of poverty reduction and human security, Japan believes that family planning would be considered a key pillar in the post-2015 agenda.
Donor Commitments: London Summit on Family Planning Panel

Korea

Korea commits to more than double its support for maternal and child health, including family planning, from US $5.4 million in 2010 to at least US $10.8 million a year beginning in 2013. Maternal and child health, including family planning, will continue as a priority area in Korea's official development assistance (ODA) policy. Korea will expand its overall ODA program from .12% of its GNI in 2010 to .25% by 2015.

Donor Commitments: London Summit on Family Planning Panel

Netherlands

The Netherlands commits €370 million in 2012 for sexual and reproductive health and rights, including HIV and health, and intends to extend this amount from €381 million in 2013 to €413 million in 2015. Within this, the Netherlands intends to increase its focus on sexual reproductive health and rights, including family planning. This commitment is dependent on continued political support from a new government that will be elected next September.

www.government.nl/news/2012/07/11/knapen-champions-reproductive-rights

Norway

Norway commits to doubling its investment from US $25 million to US $50 million over eight years.

www.regjeringen.no/en/dep/ud/press/news/2012/support_familyplanning

Sweden

Sweden's priority is to work in the most effective way for the rights and improved health of women and girls in the most vulnerable countries in Africa. The Swedish government will continue to be a major player, both financially and politically, in the issue of family planning. Sweden will increase spending on contraceptives from its 2010 level of US $32 million per year to US $40 million per year, totaling an additional US $40 million between 2011 and 2015. Sweden also commits to ensuring that support of family planning utilizes existing structures for financing and support, and is contributing to the broader agenda of Millennium Development Goal's (MDG) 4 and 5. The government plans to increase its contribution to MDG 4 and 5 from its current amount of US $450 million per year.

Integrating Family Planning with Health Services Panel: London Summit on Family Planning

United Kingdom

The UK is committing £516 million (US $800 million) over eight years towards the Summit goal of enabling an additional 120 million women and girls in the world's poorest countries to be using modern methods of family planning by 2020. This commitment is part of the UK's broader commitment to double efforts on family planning, increasing investments from £90 million per year (average spend over 2010/11 and 2011/12) to £180 million per year over the eight years from 2012/13 to 2019/20. The UK has put girls and women front and center of its aid program and being able to plan the size of her family is a fundamental right that the UK believes all women and girls should have. Between now and 2020, UK support to the Family Planning Summit Goal will enable an additional 24 million girls and women in the world's poorest countries, who wish to avoid an unintended pregnancy, to use voluntary family planning information, services and supplies, so that they are able to decide, freely and for themselves, whether, when and how many children to have. Meeting this need will prevent over 20 million unintended pregnancies and in doing so avert the deaths of 42,000 girls and women for whom an unintended pregnancy carries the risk of fatal consequences. British support will contribute to ensuring that governments and partners are enabling access to a wide range of affordable, high quality contraceptive methods. It will also support partners including governments, civil society and faith-based organizations to tackle the social and cultural barriers to using contraception through education, counseling, information campaigns, and working with partners and communities, and to ensure safeguards against coercion and discrimination.

www.dfid.gov.uk/News/Latest-news/2012/family-planning-london-summit-2012

Foundations

Aman Foundation

The Aman Foundation commits US $5 million over the next five years on a matching basis with the Bill & Melinda Gates Foundation, in additional funds for family planning programs and initiatives in Karachi, Pakistan. These funds are for the purpose of facilitating research in integrated family health service delivery and family planning programs that are strategic to increase the number of new family planning users through improved quality of services, introduction to new contraceptive methods, innovative service delivery interventions and demand generation. The Aman Foundation also commits to enhancing partnerships with local community-based organizations, the private sector and the public sector through an integrated community-based approach. The Aman Foundation will improve quality and effectiveness of family planning programs and services in the targeted project areas, and will help to increase women's and girls' ability to make informed decisions and have access to the most appropriate family planning services and supplies.

www.amanfoundation.org

Bill & Melinda Gates Foundation

The Bill & Melinda Gates Foundation commits to investing more than US $1 billion to help reach the goal of providing 120 million additional women with contraceptives, information and services by 2020. That means doubling its investment in family planning from US $70 million a year to US $140 million a year for eight years – totaling an additional US $560 million. The Foundation believes that supporting family planning is one of the most cost-effective investments a country can make in its future. The Gates Foundation recognizes the right of women to have the power to create a better life for themselves and their families, and is committed to supporting the leadership of developing countries in addressing barriers that prevent women from accessing lifesaving contraceptives. The Foundation will also support research and development to create new contraceptives that can better serve the needs and circumstances of more women in the poorest countries around the world.

www.gatesfoundation.org/speeches-commentary/pages/melinda-french-gates-london-summit-120711

Bloomberg Philanthropies

Bloomberg Philanthropies commits to becoming a partner in this groundbreaking initiative for family planning with a contribution of US $50 million over the next eight years. Bloomberg Philanthropies will continue their work to improve maternal and child health in some of the world's poorest regions. For example, in Tanzania, Bloomberg Philanthropies has improved access to emergency obstetric care and raised the standard of care for mothers and their children in some of the most isolated parts of the country. Bloomberg Philanthropies is committed to the importance of integrating family planning services with obstetric care.

Donor Commitments: London Summit on Family Planning Panel

The Children's Investment Fund Foundation (CIFF)

CIFF enthusiastically supports the goals set by the London Summit on Family Planning, as integral to the broader program of support to the UN Secretary General's Every Women Every Child initiative. In conjunction with the global family planning initiative, CIFF will pursue landscaping and develop an action plan in the area of reproductive health with the intention of contributing strategically, tangibly and at scale to further the aims of this initiative. CIFF recently provided both funding and human resources to ensure greater accessibility of long-acting and reversible methods of contraception, and will continue their work to enable women and governments to acquire these products at affordable prices. CIFF is compelled by evidence on the need to address reproductive health concerns of adolescents, as these girls and young women and their offspring are most severely impacted by failures to access the knowledge and tools for family planning. CIFF urges those leading this initiative to join in ensuring that this population is reached. CIFF will apply its expertise in program monitoring and impact measurement to help in the development of a robust monitoring and accountability process, to help track progress towards stated Summit goals.

www.ciff.org

The David and Lucile Packard Foundation

The David and Lucile Packard Foundation confirmed its existing funding of US $24 million per year between now and 2020 for family planning. As part of this commitment, the Packard Foundation will establish grantmaking strategies that are aligned with goals of the London Summit on Family Planning. The Foundation will work to strengthen donor and recipient country government's partnership, political will and funding commitments for family planning. The Packard Foundation commits to continuing to improve the quality and effectiveness of family planning programs and services in the targeted regions where Packard is present, and to increasing women's and girls' ability to make informed decisions, utilizing the most appropriate family planning programs and services in their context. Packard Foundation funding is subject to decisions by its Board of Trustees and the performance of the Foundation's endowment.

www.packard.org

United Nations Foundation

The United Nations Foundation commits to fulfilling and building upon its 2010 US $400 million commitment to Every Woman Every Child and its continued work to achieve universal access to reproductive health care. The UN Foundation commits to strengthening renewed leadership and investment in reproductive health by unlocking new bilateral and multilateral resources to address the global unmet need for family planning by 2015; promoting the voices of global leaders as well as new and influential voices to inform, engage, and ensure greater focus and attention to the issue of reproductive health; improving the lives of adolescent girls through investments in developing country programs focused on adolescent girls' needs, and advocacy for budgets, policies and laws to protect their sexual and reproductive health, rights and services; championing the use of mobile technologies to improve health throughout the world; and launching and co-leading the Family Planning and Reproductive Health pillar of the Millennium Development Goal Health Alliance to target and engage private sector partners to ensure access to a full range of contraceptive methods. The UN Foundation also made commitments as part of their Universal Access Project, Women and Population's Adolescent Girl Portfolio and Pledge Guarantee for Health Alliance.

www.unfoundation.org

William and Flora Hewlett Foundation

The William and Flora Hewlett Foundation commits to continue providing financial support to international family planning and reproductive health indefinitely. For the next eight years, the Hewlett Foundation expects to maintain at least the current level of committing US $22 million annually to international family planning and reproductive health, including extending approximately US $13 million in grants for a combination of direct service provision and advocacy specifically related to family planning. In the near term, the Hewlett Foundation will support an effort to develop and cost out options for an external accountability mechanism around the financial and political commitments made at the London Summit on Family Planning. The Hewlett Foundation also expects to receive funding for a project to visualize data that can better understand the concept of "unmet need" for family planning, and will intensify engagement in the Ouagadougou Partnership and its focus on accelerating access to family planning services in Francophone West Africa with the Gates Foundation, USAID and the French Government.

www.hewlett.org/programs/global-development-and-population-program/quality-family-planning

Private Sector

Female Health Company

Female Health Company commits US $1.65 million in savings per year for eight years based on a bonus of 5% of 60 million current public sector volume units worldwide (US $1.13 million in savings per year for eight years, 5% of estimated 41 million units annually in Sub-Saharan Africa and South Asia) in "no cost" product. The distribution of the bonus product will be at the public sector's discretion and savings will increase as the public sector volume increases. Additionally, Female Health Company will also invest US $14 million in training and education over six years.

www.femalehealth.com

UN, Multilaterals and Partnerships

Norway, Bill & Melinda Gates Foundation and United Kingdom

Norway, the Bill & Melinda Gates Foundation and the UK will work together to increase the availability, access and use of quality, life-saving family planning commodities, each committing US $200 million of their total Summit commitment until 2020, amounting to a combined commitment of US $600 million. We welcome others to join in the development of a broader partnership. This work will be guided by the recommendations of the UN Commission on Life-Saving Commodities for Women and Children (Chaired by President Jonathan and Prime Minister Stoltenberg). To ensure availability of high quality commodities in greatest demand we will deploy a range of market-shaping strategies in partnership with key players, such as multilateral agencies, manufacturers, partner governments and the largest procurers to reduce prices, improve quality, minimize market risks and improve value for money. We will also work to strengthen the quality of forecasting, streamline regulatory pathways to reduce barriers to entry and create demand for improved new products. Innovative approaches such as mobile phone technology will also be explored to ensure better access to meet demand from women, improve availability at the community level and increase knowledge of family planning opportunities among women, families and front line health workers.

UNFPA

UNFPA will double the proportion of its resources focused on family planning from 25% to 40 % based on current funding levels, bringing new funding of at least US $174 million per year from core and non-core funds. This will include a minimum of US $54 million per year, from 2013-2019, in increased funding for family planning from UNFPA's core resources.
www.unfpa.org/public/home/news

The World Bank

The World Bank continues to strongly support family planning and reproductive health through its five-year Reproductive Health Action Plan, which focuses on the 57 poor countries with the highest maternal mortality and fertility rates. In the first two years under this plan, the Bank has already increased its multisector financing, capacity, analytical and advisory work, and monitoring of reproductive health in the priority countries. In support of the goals of the Summit and in partnership with the UK and Norwegian governments, the Bank commits to scaling up support for results-based financing for health – helping countries match financing to specific, measurable targets toward improving maternal and child health, including expanding access to family planning. The Bank will work closely with global partners in the Partnership for Maternal, Neonatal, and Child Health to see how support for these programs can be expanded even further. The Bank will continue to do its part, working with Ministries of Finance and others in its partner countries, to help ensure that support for family planning and reproductive health is, and remains, a key element of country development strategies.
World Bank: Statement for the London Family Planning Summit

World Health Organization (WHO)

Family planning is critical to health and development. Expanded use of modern contraceptive methods can prevent more than one third of maternal and one tenth of child deaths. To make access to family planning universal; WHO, in collaboration with donors and partners, commits itself to: 1) Working with countries to integrate the *WHO Medical Eligibility Criteria Family Planning wheel* and related tools and guidelines into health systems to expand access to, and quality of, family planning services; 2) Expanding choice and method mix through contraceptive research and development and assessment of the safety and efficacy of new and existing methods; 3) Scaling up the availability of high-quality contraceptive commodities through product prequalification and Expert Review Panel (ERP) fast track mechanisms; 4) Synthesizing and disseminating evidence on effective family planning delivery models and actions to inform policies, address barriers and strengthen programs; and 5) In the context of the Commission on Information and Accountability for Women's and Children's Health, working with countries with highest levels of unmet needs to examine inequalities and vulnerabilities and reasons for unmet need. www.who.int/reproductivehealth/topics/family_planning

[END]

APPENDIX: New Financial Commitments by Donors and Private Sector at the London Summit on Family Planning (USD Millions) – (*also included in the commitment summary narratives*)

Donor	Increased contribution to reach 120m more women by 2020	Increase in Annual Contribution by 2015	Notes
Aman Foundation	5	1	$5m over 5 years
Australia	59.5	26.6	Australia plans to spend an additional AUD58 million over 5 years on family planning, doubling annual contributions to AUD53 million by 2016. This commitment will form a part of Australia's broader investments in maternal, reproductive and child health (at least AUD1.6 billion over five years to 2015). This commitment is subject to annual budget processes.
Bill & Melinda Gates Foundation	560	70	Double from $70m a year to $140m a year for 8 years
Bloomberg Philanthropies	50	6.25	$50m over 8 years
enmark	13	1.625	Additional $13m over 8 years
uropean Commission	28.3	n/a	Additional $28.3m contribution in 2013
amily Health International	1	n/a	$1 million of own resources until 2020 in support of the development & introduction of new contraceptive technologies.
emale Health Company	23	2.9	$1.65m savings/yr for 8 years, based on bonus of 5% of 60 m current public sector volume units worldwide ($1.13m in savings/yr for 8 years, 5% of estimated 41m units annually in Sub-Saharan Africa and South Asia) in "no cost" product. Distribution of bonus product will be at public sector's discretion. Savings increase as public sector volume increases. Additionally, FHC will invest $14m in training/education over 6 yrs.
rance	125	25	In 2011, France pledged to spend an additional €100m on Family Planning within the context of reproductive health through to 2015, in nine countries in francophone Africa.
ermany	122.3	30.575	€400m ($491.6m) to Reproductive Health and Family Planning over 4 years, of which 25% (€100m, or $122.29) are likely to be dedicated directly to Family Planning, depending on partner countries priorities.
Korea	43.2	5.4	Doubling support for maternal and child health, including family planning, from $5.4m a year to $10.8m a year, from 2013.
Merck for Mothers	25	3.125	$25m over 8 years
Netherlands	160	55	Commit €370m in 2012 for Sexual and Reproductive Health and Rights, including HIV and health, and have the intention to extend this amount from €381m in 2013 to €413m in 2015. Within this, the Netherlands intends to increase its focus on SRHR, including Family Planning. This commitment is dependent on continued political support from a new government that will be elected next September.
Norway	200	25	Double from $25m to $50m per year for 8 years
Sweden	32	8	Additional $40m 2011-2015 for Family Planning.
UNFPA	378	54	UNFPA will double the proportion of its resources focused on Family Planning from 20-25% to 40% based on current funding levels, bringing new funding of at least $174m per year from core and non-core funds. This will include a minimum of $54m per year, from 2013-2019, increased funding for Family Planning from UNFPA's Core Resources.
United Kingdom	800	100	Contributing £516m ($800m) over 8 years as part of a commitment to double efforts on family planning.
TOTAL	**2,625.3**	**414.5**	

Notes for Editors about New Financial Commitments Made by Donors and Private Sector
The estimated resource requirement for sustaining the current use of contraception by 260 million women in the 69 poorest countries is approximately US $10bn over eight years from 2012 to 2020. These resources – which are principally provided by country governments through their health budgets and are supported by contributions from consumers and external donors – need to be sustained. Reaching an additional 120 million women will require resources equivalent to an additional US $4.3bn over the next eight years. This number includes resources and infrastructure supported by developing countries. Of the $4.3bn total resource requirements, donors will need to contribute $2.3bn in funds above and beyond the level of funding provided for family planning in 2010.

Many donors have already announced increased commitments to family planning between 2012 and 2015 as part of the 2010 G8 Muskoka Summit and the UN Secretary General's 'Every Woman Every Child' initiative. These additional contributions, disbursed from 1 January 2012 onwards, are above and beyond the level of funding provided for family planning in 2010 and therefore contribute to the additional funding sought for the Summit to reaching an additional 120 million women and girls. The Summit has agreed a methodology with donors for estimating the proportion of wider health commitments that contribute to family planning.

[END]

APPENDIX 2
PRESS RELEASE FROM 2012 LONDON SUMMIT ON FAMILY PLANNING

The London Summit on Family Planning

Wednesday 11th July 2012

"I want to bring every good thing to one child before I have another."
Mother from Korogocho; a slum outside Nairobi, Kenya

A groundbreaking Summit

In July 2012, partners from across the globe are coming together to support the right of women and girls to decide, freely and for themselves, whether, when and how many children they have.

Today, more than 220 million girls and women in developing countries who don't want to get pregnant are not able to access and use modern contraceptives, information, and services[i]. This results in over 60 million unintended pregnancies every year and puts girls and women at serious risk of death or disability during pregnancy and childbirth, and unsafe abortion. In 2008, there were around 14 million births to adolescent girls in developing countries, most often before they were physically, emotionally or economically prepared.[ii] Access to family planning increases girls' and women's opportunities and life choices, and also supports the social and economic development of their families, communities and nations.

On 11 July 2012, the UK Government and the Bill & Melinda Gates Foundation – in partnership with UNFPA, national governments, donors, civil society and faith-based organisations, the private sector, the research community, and others – will launch a groundbreaking effort to make affordable, lifesaving contraceptives, information, services, and supplies available **to an additional 120 million girls and women in the world's poorest countries by 2020**[iii].

In addition, country governments, supported by the global community, will commit to sustaining coverage for the estimated 260 million women in these countries who are currently using modern contraceptives, so that by 2020, a total of 380 million women and girls in the world's poorest countries will have voluntary access to modern methods of contraception[iv]. These efforts will also lead to increased access in other countries through, for example, revitalizing interest in family planning internationally and strengthening the market for quality, affordable contraceptives, including new and under-used methods.

The London Summit on Family Planning will mobilize commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020.

Picture: Peter Caton/ IPPF

"I knew [early marriage and pregnancy] would mean dropping out of school, moving away from friends and family and then childbirth. I had heard of girls dying when giving birth. If I was married tomorrow, what would I lose? My independence, my vision, my dreams."

Hosna, Bangladesh

At the centre - respect for rights

The Summit's vision is to ensure that women and girls in developing countries can have the freedom to access and use family planning, without coercion or discrimination.

The Summit and its follow-up will place rights front and centre, promoting and respecting people's human rights, and working to ensure those rights become a reality, especially for the poorest and most vulnerable girls, boys, women and men. The Summit and its follow-up align with the broader framework established by the International Conference on Population and Development (ICPD) almost 20 years ago[v]. The Summit will affirm the fundamental importance of voluntary family planning, and freedom of access to a full range of contraceptives for married and unmarried women and adolescent girls. The Summit will have a strong focus on equity and empowering all girls and women to realize their rights to family planning.

Photo: Marie Stopes International

Miriam lives in Mali, where 65% of women aged 20-24 were married by the age of 18.

At just 18 years old, Miriam has two children under three to look after. She had no knowledge of modern family planning methods, until she visited a health centre, where she learned about the different options and decided to use an IUD.

Six months later, Miriam is still happy with her choice:

"My whole family is at peace now. My husband doesn't have to worry about financing another pregnancy and another child, the children I already have are better cared for and I can take some time to rest."

Access, choice and equity

The Summit will call for the global community to tackle the many barriers which prevent girls and women using modern contraception, such as lack of political commitment, restrictive laws and policies, and social, cultural and financial barriers to access and use, including gender inequalities and neglect and abuse of people's rights. Limited resources, poor quality services, fragmented procurement, weak supply chains, and lack of quality and affordable contraceptive methods to meet people's needs are further challenges.

Efforts to strengthen family planning should also be integrated into broader reproductive, maternal, newborn and child health, including postpartum and post-abortion care, and comprehensive sexual and reproductive health services, including HIV. These efforts will support and strengthen the continuum of care while filling critical gaps in access to family planning.

Unprecedented commitments

The London Summit on Family Planning is an opportunity to generate global commitments to make high quality, voluntary family planning services more available, acceptable and affordable. In doing so, we can accelerate the achievement of the MDGs (including MDG5b, universal access to reproductive health), and mobilize further commitments to the UN Secretary General's Global Strategy for Women's and Children's Health, "Every Woman, Every Child", and other innovative public-private and civil society partnerships.

London Summit on FAMILY PLANNING

New and unprecedented political commitment and resources will be called for at the Summit, resulting in a huge return on our collective investments. If the global community supports countries' own ambitio ns and plans, and in doing so, enables 120 million more wome n and girls with unmet need in the 69 poorest countries to use contraceptives between 2012 and 2020, more than 110 million unintended pregnancies, and approximately 50 million abortions (of which the majority would be unsafe) , will be prevented. Over 200,000 fewer women and girls will die in pregnancy and childbirth, and nearly three million fewer infants will die in their first year of life. [vi]

All members of the global community have a role to play in meeting the Summit's ambitious goals, and are being called upon to work together to:

- Ensure access to voluntary family planning, with respect for the rights of individuals and couples to make informed decisions about family planning within enabling policy and legal frameworks;
- Increase the demand and support for family planning including increasing the support of men, families and communities, and removing other barriers to access and use;
- Improve supply chains, systems and service delivery models, including through innovative public, private and not -for-profit partnerships;
- Improve market dynamics, including country forecasting capabilities and increasing the availability and quality of a range of family planning methods;
- Procure additional commodities, inclu ding new methods which fill gaps in meeting demand;
- Strengthen monitoring and accountability, including beneficiary and community -based monitoring, to improve access to and voluntary use of contraceptives, and track financial resource flows to family plann ing;
- Advocate for sustained government and donor funding, and to protect and promote global commitments to sexual and reproductive health and rights, including family planning.

"I want to go back to nursing school. I am sure that, with family planning, I will be able to achieve what I want because I will not be having another baby in the near future."

Ruth Jotua, 24 years old, a mother of two from the Nsanje region, Malawi

Pictures: Lindsay Mgbor/DFID

These commitments will enable effective changes to take place at the internati onal, country, and local levels to overcome the barriers that currently prevent girls and women from accessing contraceptives. Summit follow -up arrangements will work with the processes, frameworks and organisations that are already in place, and build on the remarkable commitment of partners from across the spectrum of family planning stakeholders.

A cost-effective investment

Access to voluntary family planning has transformational benefits for women and girls and is one of the most cost-effective investments a country can make in its future. It is estimated that every US$1 spent on family planning can save up to $6 on health, housing, water, and other public services.

ture: Lindsay Mgbor/DFID

Access to contraceptives also leads to:

- Fewer deaths among women and newborn babies and wider health benefits;
- More girls completing their education and greater opportunities for girls;
- Healthier and more prosperous families and communities;
- Reduced demands on social sector budgets.

T London Summit on Family Planning provides an unprecedented opportunity to drive this vital a ıda forward, generating new global commitments that will save and transform the lives of millions of g and women, and in doing so, boost the health, prosperity and development of families, communities, a nations for generations to come.

[i] Singh S and Darroch JE, *Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012*, New York: Guttmacher Institute and United Nations Population Fund , UNFPA, 2012.
[ii] Facts on the sexual and reproductive health of adolescent women in the developing world. Guttmacher Institute and IPPF. April 2010.
[iii] These countries—69 in total—are defined as those with a Gross National Income (GNI) of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method).
[iv] Family Planning Summit 2012, *Technical Note: date sources and methodology for c alculating 2012 baseline, 2020 objectives, impacts and costing s,* Family Planning Summit Metrics Group, 2012
[v] http:// www.unfpa.org/public/ cache/ offonce/home/ sitemap/ icpd/ International -Conference-on-Population-and-Development
[vi] See footnote 4

APPENDIX 3
FP2020 STRATEGY OVERVIEW

BILL & MELINDA GATES foundation

FAMILY PLANNING

STRATEGY OVERVIEW

OUR MISSION

Guided by the belief that every life has equal value, the Bill & Melinda Gates Foundation works to help all people lead healthy, productive lives. Our Global Health and Development Programs are dedicated to this mission by helping to ensure that lifesaving advances reach those who need them most.

We focus on problems that have a major impact on the poor in the developing world but that get too little attention and funding. Where proven tools exist, we support sustainable ways to improve their delivery. Where they don't, we invest in research and development of new interventions, such as vaccines, drugs, and diagnostics.

Our financial resources, while significant, represent a very small fraction of the overall funding needed to improve global health on a large scale. We therefore advocate for policies and financial resources to promote greater access to health solutions. Strong partnerships are also essential to our success in making a difference and saving lives.

THE OPPORTUNITY

Family planning is hailed as one of the great public health achievements of the last century, and yet over 200 million women worldwide who want to use contraceptives don't have access to them.[1] The world's poorest women and men are not empowered to decide the number of children and timing of their births, despite the fact that complications during pregnancy and childbirth are a leading cause of death for women in Africa.[2] Voluntary family planning empowers women and men to decide when to have a child and to avoid unintended pregnancies and abortions. This results in healthier families, communities, and nations. In addition, some methods of family planning prevent both pregnancy and sexually transmitted infections, including HIV.[3]

The number of women who do not have access to an effective method of family planning remains unacceptably high. Less than 20 percent of women in sub-Saharan Africa and 34 percent of women in South Asia use modern contraceptives.[4] As a result, each year, there are 75 million women in developing countries who experience unintended pregnancies; 20 million of whom resort to unsafe abortions.[1,3] It is estimated that providing these women with access to modern contraceptives would reduce maternal deaths by 25 percent, newborn deaths by 18 percent, and unintended pregnancies by 73 percent.[3,5]

By 2050, the global population is expected to grow to over 9 billion people, an increase of more than 50 percent over 2005 levels.[6] This growth will only exacerbate the current health inequities for women and children, put pressure on social services and resources, and contribute significantly to the global burden of disease, environmental degradation, poverty, and conflict. Family planning is one of the best investments a country can make in its future.

OUR STRATEGY

Our vision of success is that all women and men in developing countries know about and have access to quality family planning. We support voluntary family planning as a means to meet the needs of men and women and to significantly reduce maternal and infant deaths.

At the global level, our strategy seeks to revitalize family planning as indispensable to achieving the Millennium Development Goals (MDGs). We are investing in raising awareness of the importance of family planning among donors, country governments, and the private sector; enhancing the efficiency of contraceptive procurement and distribution; and engaging donors, governments, and civil society to better coordinate efforts and increase resources to fund family planning.

Our strategy at the country level is to increase modern contraceptive use and improve family planning services for the growing number of urban poor in sub-Saharan Africa and South Asia using innovative, low-cost interventions that address the supply of and demand for family planning.

Our strategy prioritizes the creation of innovative contraceptive technologies to satisfy the global unmet need for high-quality and affordable contraceptives. To gain better efficiencies in spending and healthcare delivery, we are also investing in researching how to best integrate family planning into existing HIV and broader maternal and child health services and programs. Each of our main intervention areas is described below.

INTERVENTION AREAS

Advocate for more and better use of funds and raise the visibility of family planning

There are significant challenges in the financing and procurement of contraceptives—high price of quality mid- to long-acting contraceptives; volatile and unpredictable donor funding; uncoordinated and antiquated global procurement processes. The challenges create inefficiencies, add to costs, and lead to stock-outs of contraceptives, wastage of products, poor management of in-country supply chains, and variable product quality.

Our strategy aims to address these challenges by discovering and developing new contraceptive technologies that meet women's needs, advocating for increased funding for family planning, better coordination among donors and governments to deliver products, and enhanced efficiency of contraceptive procurement and delivery. Our investments to support these goals include the following initiatives:

- advocacy for funding and improved policy commitments at all levels of national governments, among bilateral and multilateral donors, and from the private sector
- strengthening the capacity of civil society organizations to promote family planning
- advocacy for the integration of family planning and HIV with the Country Coordinating Mechanisms for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
- conducting an economic analysis of the return on investment of family planning expenditures on policy goals such as the MDGs

Increase the use of contraceptives in urban areas among the poor and vulnerable

In 2008, the urban share of the world's population reached 50 percent for the first time.[7] It is predicted that most future global population growth will occur in towns and cities in developing countries. In particular, urban populations in Africa and South Asia—the most rapidly growing regions in the world—are projected to double between 2000 and 2030.[7] Urban births are concentrated among the poorest populations; a significant number of these births are unintended; and the maternal, infant, and reproductive health status of the urban poor is comparable to—or worse than—that of rural residents.[8]

Our strategy focuses on enhancing the delivery of family planning services to people living in impoverished urban areas. Our main investment in this area is the Urban Reproductive Health Initiative, which aims to provide high-quality, cost-effective, and voluntary family planning services to some of the world's most vulnerable people—the urban poor of Asia and sub-Saharan Africa. The initiative harnesses the private sector and demand channels while linking country-level implementation teams in India (Uttar Pradesh), Nigeria, Kenya, and Senegal to identify and share the most effective approaches for meeting the family planning needs of the world's urban poor. The initiative also has a strong measurement and evaluation component to ensure data-driven implementation, rigorous evaluation, strengthened approaches related to equity, and widespread sharing of evidence to scale up and replicate findings.

Develop innovative contraceptive technologies

There are many reasons why women do not use contraceptives even when they want to avoid pregnancy. Some women have misperceptions about their risk of becoming pregnant, while others have concerns about the side effects of modern contraceptive methods. In some cases, opposition from husbands or family members may discourage contraceptive use. Lack of access to an adequate mix of modern contraceptives is another barrier.[9]

Our objective is to address barriers to nonuse and accelerate the uptake of contraceptives in sub-Saharan Africa and South Asia through the discovery and development of new technologies.

We are now investing in the quality assurance, regulatory approval, and careful introduction of two products in selected countries of sub-Saharan Africa and South Asia. The first is Sino-implant (II)®, by Shanghai Dahua Pharmaceuticals in China. Sino-implant (II) is a long-acting, effective, and low-cost implant that is now registered in 20 developing countries. Efforts are now underway to finalize the prequalification of this product, negotiate public sector price ceiling agreements, work with distributors to secure regulatory approvals, and provide technical assistance for its introduction in various countries.

The second product is depo-subQ provera 104® in the Uniject™ injection system (DMPA-subQ in Uniject), a new subcutaneous presentation of the popular injectable contraceptive depot medroxyprogesterone acetate (DMPA,

brand name Depo-Provera®). Currently, DMPA is delivered through intramuscular injection, necessitating a health worker to provide the method in most countries. The new DMPA-subQ in Uniject, which is manufactured by Pfizer, has the potential to be delivered by nonmedical providers, such as trained community health workers, and possibly by women themselves. Implants and DMPA are especially popular in sub-Saharan Africa, and we are hopeful that these new methods can increase coverage and use of family planning. Efforts are now underway to assess the training, systems, policies, and infrastructure necessary to sustainably implement DMPA-subQ in Uniject.

Additional contraceptive methods are needed to address the diverse needs of communities around the world. We are investing in additional products that we hope will meet the needs of women and couples. These investments include an on-demand oral contraceptive pill, the Nestorone®-ethinylestradiol vaginal ring, a 6-month injectable, and potential innovations in nonhormonal methods and nonsurgical female sterilization.

Close key knowledge gaps in family planning

There remain several critical knowledge gaps related to increasing access to family planning. Our strategy supports investments to address these gaps by conducting intensive research and development to:

- test models for integrating family planning with HIV prevention and care services to increase access to family planning among HIV-positive men and women
- determine whether the integration of family planning into maternal and child health, HIV, postpartum, and post-abortion services results in a significant increase in modern contraceptive use
- Obtain more definitive data on HIV acquisition with the use of hormonal contraceptives to inform policy and program implementation

PROGRESS

Our partners have had some successes in strengthening donor contributions and coordination affecting contraceptive supply. Some examples of this include:

- In September 2010, the Alliance for Reproductive, Maternal and Newborn Health was launched to accelerate progress toward MDGs 4 and 5. U.S. Secretary of State Hillary Clinton, UK Deputy Prime Minister Nick Clegg, Australian Minister Kevin Rudd, and Melinda Gates, co-chair of the Gates Foundation, launched the alliance at the United Nation's Summit on the MDGs. During its first year, the alliance focused on forging effective partnerships and improving family planning programs in 10 high-need countries in sub-Saharan Africa and South Asia.
- The Reproductive Health Supplies Coalition grew from 18 member organizations to over 100 members, which coordinate donors and address the fundamental technical and advocacy issues regarding contraceptive supplies.
- In February 2011, donors jointly funded the Francophone West Africa Conference—Population, Development and Family Planning conference in Burkina Faso, which was attended by nine country delegations that included ministers of health, finance, and planning. Each of the country delegations presented action plans for strengthening their national family planning programs and policies. At the meeting, the Government of France pledged €450 million (euros) over the next five years in support of MDGs 4 and 5 in West Africa with a focus on family planning.[10]
- In Uganda, a policy prohibiting community health workers from providing injectable contraceptives was reversed.[11] Another policy change allowed NGOs to access contraceptives from the central warehouse of the National Medical Stores.[12]
- In late November 2011, more than 2,200 participants came together for the historic Second International Conference on Family Planning, the largest ever to focus on family planning. The participants represented 88 countries, and included researchers, program managers, clinicians, parliamentarians, policy makers, and journalists. The conference drew top-tier political commitment including the President of Senegal's pledge to commit an additional $1 million (U.S.) for contraceptives in Senegal, and DFID's pledge of an additional 40 million pounds for global commodity security.

CHALLENGES

A large challenge to our work in family planning is that the global community, including both private and public sector stakeholders, is still not sufficiently galvanized to fund family planning to meet the unmet need for contraceptives among women in sub-Saharan Africa and South Asia. Governments and other donors are focused on other health priorities, and family planning is competing for scarce monetary and human resources at the country and global levels. We are working hard to hold national governments and the global donor community accountable for their pledges to improve family planning by communicating the importance of voluntary family planning in reducing maternal and child deaths, enhancing the livelihood of women, and reducing poverty.

Shortages of contraceptives are a major challenge that undermines our country programs' ability to achieve results. We are funding an in-depth assessment to assess the strengths, limitations, and performance gaps within the contraceptive supply chain to allow for a deeper analysis of forecasting, financing, procurement, inventory management, and distribution of contraceptives in both the public and private sectors.

Another challenge is that some current contraceptives remain too costly for procurement groups and in some cases, for the women who use them. In the area of implants, we have begun discussions with manufacturers to address the high cost of implants, and the potential for volume purchases and price reductions for developing countries. We are also helping manufacturers in developing countries gain prequalification from the World Health Organization in order to expand the market and allow for more competition and low-cost options for procurement groups.

WORKING TOGETHER

Reaching the millions of women and couples who desire effective family planning methods requires the dedication of all of our government, donor, private sector, research, nongovernment, and community partners. Because our resources are limited in relation to what is needed to address the unmet need for family planning globally, we work closely with existing and emerging donors to ensure that funds are spent well, improve policies, enhance the efficiency of procurement and delivery of services, and ultimately, to save and improve lives.

TO LEARN MORE

About the Global Health Program:
www.gatesfoundation.org/global-health

About Family Planning:
www.gatesfoundation.org/familyplanning

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APPENDIX 4
FP2020 INDICATORS

Family Planning 2020 Core Indicators

The intent of constructing a core set of indicators for Family Planning 2020 (FP2020) was to provide an annual global readout of key progress markers that would be applicable to and available from the 69 countries with a GNI per capita equal to or less than $2,500 (2012). Since then a set of Core Indicators has been selected through a systematic process to determine whether countries are on track to reach their goals, to assess strategies and inform decision-making, to provide the tools to answer fundamental questions concerning the overall performance of FP2020, and, importantly, to measure how well individual needs are met.[i]

The Core Indicator table is separated into two categories:

(1) Indicators that are reported annually for 69 countries.
(2) Indicators that are reported annually in a subset of countries in years that they have a Demographic and Health Survey (DHS) and/or data from the PMA2020[ii] project.

Indicators that are reported annually for 69 FP2020 focus countries		
icator	*Indicator Definition*	*Data Source and Availability*
Number of additional users of dern methods of contraception	The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012.	Estimated using data from surveys such as the DHS, RHS, MICS, PMA2020 and other nationally representative surveys; service statistics and population data
Contraceptive Prevalence Rate, dern Methods (mCPR)	The percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.	Estimated using data from surveys such as the DHS, MICS, PMA2020, RHS[iii] and other nationally representative surveys; modeling using surveys and service statistics
	<u>Disaggregation:</u> When possible (in years with a DHS or data from PMA2020) by: wealth quintile, age, marital status, urban/rural, ethnicity, etc.	
3. Percentage of women with an unmet need for modern methods of contraception	The percentage of fecund women of reproductive age who want no more children or to postpone having the next child, but are not using a contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception.	Estimated using data from surveys such as the DHS, MICS, PMA2020, RHS[iv] and other nationally representative surveys; modeling using surveys and service statistics
	<u>Disaggregation:</u> When possible (in years with a DHS or data from PMA2020) by wealth quintile (comparing the lowest to the highest quintile), age, marital status, parity, urban/rural, ethnicity, etc.	

4. Percentage of women whose demand is satisfied with a modern method of contraception	The percentage of women (or their partners) who desire either to have no additional children or to postpone the next child and who are currently using a modern contraceptive method. Women using a traditional method are assumed to have an unmet need for modern contraception.	Estimated using data from surveys such as the DHS, MICS, PMA2020, RHS[v] and other nationally representative surveys; modeling using surveys and service statistics
5. Number of unintended pregnancies	The number of pregnancies that occurred at a time when women (and their partners) either did not want additional children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies.	Estimated using modeling
6. Number of unintended pregnancies averted due to modern contraceptive use	The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.	Estimated using modeling
7. Number of unsafe abortions averted due to modern contraceptive use	The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.	Estimated using modeling
Number of maternal deaths erted due to modern ntraceptive use	The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.	Estimated using modeling
ercentage of women using each dern method of contraception	The percentage of total family planning users using each modern method of contraception.	Surveys such as the DHS, MICS, PMA2020, RHS, and other nationally representative surveys; service statistics
Percentage of facilities stocked , by method offered, on the day assessment	Percentage of facilities stocked out of each type of contraceptive offered, on the day of assessment	Survey, service statistics
11a. Percentage of primary SDPs that have at least 3 modern methods of contraception available on day of assessment	The percentage of service delivery points that have at least 3 modern methods of contraception available on the day of the assessment. This indicator considers methods (such as injectables), not products (such as the 3 month or 6 month injectable) or brands (such as Depo-Provera)	Survey data, service statistics
11b. Percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment	The percentage of secondary and tertiary service delivery points that have at least 5 modern methods of contraception available on the day of the assessment. This indicator considers methods (such as injectables), not products (such as the 3 month or 6 month injectable) or brands (such as Depo-Provera). The determination of which health facilities are defined as "secondary" or "tertiary" will be made at the country level, based on existing classifications.	Survey data, service statistics

12. Annual expenditure on family planning from government domestic budget	Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.	COIA/WHO, NIDI/UNFPA, Kaiser Family Foundation; country availability will depend on COIA and NIDI implementation. All 69 countries are expected to be available in future.
13. Couple-Years of Protection (CYP)	The estimated protection provided by family planning services during a one year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that	Service statistics
	period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.	

Indicators that are reported annually for a subset of FP2020 focus countries		
icator	*Indicator Definition*	*Data Source and Availability*
. Method Information Index	An index measuring the extent to which women were given specific information when they received family planning services. The index is composed of three questions (Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects?). The reported value is the percent of women who responded "yes" to all three questions.	DHS, PMA2020 Survey in select years
	Disaggregation: By method.	
. Percentage of women who re provided with information family planning during their last contact with a health service provider	The percent of women who were provided information on family planning in some form at the time of their last contact with a health service provider. The contact could occur in either a clinic or community setting. Information could have been provided via a number of mechanisms, including counseling, information, education and communication materials or talks/conversations about family planning.	DHS, PMA2020 Survey in select years
	Disaggregation: By wealth quintile	
16. Percentage of women who decided to use family planning alone or jointly with their husbands/partners	The percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.	DHS, PMA2020 Survey in select years
	Disaggregation: By wealth quintile	
17. Adolescent birth rate	The number of births to adolescent females, aged 15-19 occurring during a given reference period per 1,000 adolescent females.	DHS, PMA2020 Survey in select years

18a. Contraceptive Discontinuation Rate	Among women of reproductive age who began an episode of contraceptive use 3-62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, reported by whether the woman discontinued while in need of contraception, discontinued because she is not in need of contraception, and the total all-reasons discontinuation rate.	DHS surveys in select years
	Disaggregation: By contraceptive method	
18b. Contraceptive Method Switching	Among women of reproductive age who began an episode of contraceptive use 3-62 months before being interviewed, the percentage of episodes where the specific method is discontinued within 12 months after beginning its use, and use of a different method begins after no more than one month of non-contraceptive use.	DHS surveys in select years
	Disaggregation: By contraceptive method	

[i] 2020 Partnership in Action 2012-2013, published December 2013, www.familyplanning2020.org
[ii] ://pma2020.org/
[iii] C-assisted Reproductive Health Surveys
[iv] C-assisted Reproductive Health Surveys
[v] C-assisted Reproductive Health Surveys