Utilizing Incentives for Global Family Planning and Reproductive Health Services
Uptake: Altruistic or a Euphemism for Population Control?

Master’s Thesis

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In recent years, international development has increased the use of a controversial approach to improve initiative uptake and to achieve targeted outcomes: performance-based incentives. Although incentives have been effective additions to many international development projects, some scholars are highly critical of their usage in sectors such as family planning and reproductive health. Given this controversy, this thesis examines the historical use of incentives, primarily as a means to control the fecundity of populations, and unveils the institutionalization of human rights violations within the population control and family planning movements. Ultimately, this thesis provides policy solutions that suggest, in spite of a troubled history, incentives can be used to promote family planning and reproductive health services without violating the rights of men and women.
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1. INTRODUCTION

In recent years, international development has increased the use of a controversial approach to improve initiative uptake and to achieve desired outcomes: performance-based incentives (PBI). Incentives, which can be used to ameliorate supply and demand weaknesses, are defined in various ways such as performance-based aid (PBA), results-based financing (RBF), performance-based financing (PBF), or pay for performance (P4P), and draw upon an array of methods such as conditional cash transfers (CCT), vouchers, subsidies and the like. For the purpose of this paper, “PBI” serves as the umbrella acronym to address all supply-side and demand-side incentives used to link “payment to results achieved” or to catalyze and “strengthen health systems and achieve health targets,” specifically in regards to meeting the Millennium Development Goals (MDGs) by 2015 (Eichler, Mursaleena, & Beith, 2010, p. 3). MDG Target 5a, which aims to reduce the maternal mortality ratio worldwide by three quarters from 1990 to 2015, and MDG Target 5b, which seeks to accomplish universal access to reproductive health services by 2015, will be discussed at length in this thesis.

Changing behavior via monetary or material (vouchers, clothing, etc.) exchange can improve the capacity of entire health systems to ultimately save lives. Supply-side incentives can be utilized to encourage providers to actively seek out and serve marginalized peoples within their communities. Likewise, supply-side incentives can be used to urge providers to manage their services and supplies more efficiently or to give
confidence to community health workers, who often lack motivation in the face of daunting health challenges. Demand-side incentives, on the other hand, are powerful tools that may be deployed to assist households in overcoming barriers to access, whether those barriers are socio-cultural, financial, or otherwise.

Incentives have the ability to generate improved outcomes rapidly, a fact that is not true for educational programs, infrastructural programs, or the like. The timeframe needed for large-scale educational or empowerment programs to provide results without the help of incentives is off-putting especially when lives are at stake. Given the quick nature of incentives, and the fact that global health and development programs with incentive components have proven overwhelmingly efficacious in the face of daunting socio-cultural and financial challenges\(^1\), is it safe to say that incentives are appropriate additions to all international development initiatives? As an international development scholar, I am intrigued by the multi-sector successes of incentives; but as an individual, who is passionate about protecting the human rights of persons in low and middle-income countries (LMICs), I am perturbed by the philosophical and ethical questions that incentives provoke. Is it possible to incentivize family planning (FP) and reproductive health (RH) services sans coercion and without violating the basic principles of reproductive health and rights?

Betsy Hartmann, a renowned reproductive health scholar and global human rights activist, has been vocal in her opposition of incentives to meet FP targets. Her critique unveils the ethicalities of incentives, whilst urging reproductive health scholars and policy makers to be cognizant of the dangers that incentives within FP pose. Her research

warns of a return to the pre-Cairo International Conference on Population and Development (ICPD), “top-down population control” era and calls her readers to “take action before history repeats itself” (Hartmann, 2011, p. 1).

Hartmann’s analysis focuses primarily on human rights violations within FP (e.g., sterilization quotas in Bangladesh); however, histories of violations within the family planning movement (FPM) stretch much further back in time. In fact, evidence will show that human rights violations have been institutionalized within the FPM. The purpose of this paper, therefore, is to heed Hartmann’s warning. A closer, more extensive look at the birth and evolution of the FPM (commencing with Malthus, eugenics, and population control) is critical to understanding one side of the present-day ethical conundrums of promoting incentives for FP and RH uptake and expansion.

This paper does not address the plausibility or the potential efficacy of PBI in regards to FP or RH. Rather, this paper speaks to the larger philosophical question: Is it possible for reproductive health and international development programs deploy incentives without infringing upon human rights, or not? More specifically, I confront the importance of incorporating PBI into FP and RH programs as supplements to existing FP, RH and development efforts. It must be noted that my findings are not intended to work against current international development efforts, such as improved educational programs, empowerment programs, or infrastructural/access programs. I address incentives as merely complements to current efforts — not as replacements.
2. LITERATURE REVIEW

In most accounts, modern-day family planning and reproductive health efforts are heralded as altruistic endeavors. History, however, shows that this was not always the case. FP and RH emerged out of fear — primarily a fear that population would grow to outstrip agricultural production and resources — otherwise referred to as a “Malthusian catastrophe.” The potential for a population catastrophe segued into a preoccupation with decreasing or eliminating the fecundity of societal menaces such as the poor, the mentally disabled, and the unwanted minority. Thomas Malthus’ writings provided the foundation for the implementation of eugenic policies in nineteenth-century America and, furthermore, went on to inspire the early proponents of birth control and the birth control movement (Goldberg, 2009, p. 45). Oversimplifying the role of Malthus and eugenics within the global family planning movement (FPM) would result in an incomplete analysis of the implementation challenges that financial incentives face today.

2.1 Malthus

Thomas Malthus’ eighteenth and nineteenth-century writings were among the first to gain notoriety and invoke concern regarding population growth. Writing as both a clergyman and an economist, Malthus’ works characterize nature as a possessor of both

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2 Malthus was not the first to write about growing populations. Similar ideas were present as far back as Plato (See: Republic). Matthew Connelly (2008, p. 7) notes, “It has been argued that some kind of population policy is common to every culture. Most have been pro-natalist, in that they taught people by means more or less subtle—from tax breaks to witch hunts—to “be fruitful and multiply.”
positive and preventative checks and balances. Positive checks, such as famine, disease and war are nature’s corrective measures for overpopulation. Malthusian preventative checks, on the other hand, encourage birth rate reduction through various prophylactic methods such as moral restraint. ³ Malthus wrote,

It is observed by Dr. Franklin there is no bound to the prolific nature of plants or animals but what is made by their crowding and interfering with each other’s means of subsistence. Were the face of the earth, he says, vacant of other plants, it might be gradually sowed and over spread with one kind only; as for instance, with fennel: and were it empty of other inhabitants, it might in a few ages be replenished from one nation only; as, for instance, with Englishman…the germs of existence contained in the spot of earth, with ample food, ample room to expand in, would fill millions of worlds in the course of a few thousand years. Necessity, that imperious all-pervading law of nature, restrains them within prescribed bound. The race of plants and the race of animals shrink under this great restrictive law; and the race of man cannot by any efforts of reason escape from it (Malthus, 1826).⁴

To Malthus, giving impoverished persons more food was pointless, as it allowed them to reproduce and “perpetuate an unsustainable cycle” (Meyer & Seims, 2010, p. 2126). This concept became a recurring theme, the crux of latter movements.

Food production during Malthus’ time outpaced human reproduction, thus discrediting his theory. Today, much to Malthus’ would-be chagrin, world populations have managed to escape nature’s checks and balances and overcome necessity. While many current global circumstances appear Malthusian (e.g., famine still exists in spite of the Green Revolution), scientific innovation and biomedical advancements have allowed populations to survive and overcome fears of resource scarcity.

³ Malthus was not a proponent of contraceptives. “Prophylactic” refers to non-contraceptive, preventative measures.
⁴ This citation comes from an online sixth edition. The first edition was published in 1798.
Yet, Malthus’ theory lives on because his work laid the groundwork for movements that still exist today. One of his conclusions attributed the fertility of the poor to their poverty and that “one of the reasons they had ‘too many’ children was that they lacked the middle-class virtues of ‘moral restraint’ such as prudence, foresight, self-discipline and the capacity to manage their affairs in a rational manner” (Ross, 2000, p. 5). While Malthus was opposed to contraception, his arguments created a societal awareness of overpopulation, and the overpopulation of the poor became the perverse rationale for the prevention of socioeconomic ills via the control of individual fertility.

Malthusian thought coalesced into the infamous eugenics movement that swept Europe and the United States. In the latter half of the nineteenth century, the eugenics movement used Malthusian arguments to demonstrate that the “overpopulous poor’s moral deficiencies were innate,” and that the fertility of the poor threatened society in ways other than sheer numbers; the poor’s “excessive fertility” was deteriorating racial stocks (Ross, 2000, p. 5). Malthus inspired Charles Darwin’s work, which asserted the survival of the fitter gives rise to a “new, better-adapted species.” Darwin’s theory encouraged his cousin, Francis Galton to believe that “humans could be bred like racehorses” (Connelly, 2008, p. 2). Galton later became known as the father of eugenics.

2.2 Eugenics

The burgeoning population of the United States in the early twentieth century catalyzed American acceptance of the eugenics movement. Eugenics, coined by Galton in 1883, is defined as the science of improving stock, which is by no means confined to questions of judicious mating, but which, especially in the case of man, takes cognizance of all influences that tend in however remote a degree, to give the more suitable races or strains of blood a better chance of prevailing over the less suitable than they
otherwise would have had (Galton cited in Harvard Law Review, 2008, p. 1579).
The eugenics movement centered on the concept that society is inherently divided into two categories: the genetically superior and the genetically inferior, with the genetically inferior loosely defined as minorities, criminals, persons with low-IQs, the mentally and physically handicapped, or the “feebleminded.”

The American eugenics movement manifested in two forms: “Positive eugenics” and “negative eugenics.” Positive eugenics, for example, promulgated the idea that only genetically “fit” or “healthy” individuals were appropriate for reproduction. Negative eugenics, by default, discouraged the reproduction of societal “menaces.” Because scientific advancement permitted the unfit to survive and reproduce, socio-economic turmoil became conflated with the reproduction and fecundity of the genetically inferior.

Controlling the fertility of the genetically inferior to improve the racial stocks of the United States became known as “race hygiene,” and racial hygiene could only be achieved through the simultaneous promotion of positive and negative eugenics. As such, the fertility of both the fit and the unfit became a priority for the movement and other social movements of the time as well. In regards to positive eugenics, eugenicists believed that women should not be educated or allowed to advance in a career, as that would deter them from their reproductive duties (Ziegler, 2008, p. 216). Feminist eugenics, however, jumped on board the movement, afraid that birth control use among the elite, genetically pure of society, would aggravate the “degeneration of the good gene pool” (Wikler, 1999, p. 185). Feminists also used eugenics as a platform to promote
gender equality in order to prevent the decline of the race (Ziegler, 2008). In spite of these conflicting ideologies, middle and upper class women were denied birth control and sterilization and were, instead, encouraged to produce more children (Kluchin, 2009).

In addition to promoting positive eugenics, negative eugenic methods were deployed as well. Immigration was restricted, and immigrants were labeled deformed, diseased, and dangerous threats to American racial stocks (Dwyer, 2003, p. 107). Forced and coerced sterilization became a favored, negative eugenic method to reduce the reproduction of the unfit population. Women who exhibited “immoral behavior” (e.g. sex before marriage) were labeled imbeciles — their so-called “harlotry” justified their sterilization (Ziegler, 2008, p. 215). In 1927, the Buck v. Bell decision, using the due process clause as justification, permitted the compulsory sterilization of unfit persons as a means to protect the state. By 1937, sterilization policies had been successfully implemented in twenty-nine states (Barrett & Kurzman, 2004, pp. 509-510). From 1927 to 1957, approximately 60,000 Americans were sterilized in the name of eugenics, the majority of which were women (Stubblefield, 2007, p. 162).

Feminists supported eugenic laws. Yet, feminists also redefined eugenics and utilized eugenic arguments that were in line with the feminist goal of equality. See: Ziegler, M. (2008). Eugenics Feminism: Mental Hygiene, the Women’s Movement, and the Campaign for Eugenic Legal Reform, 1900-1935. Harvard Journal of Law and Gender, 31, 211-235.

Buck v. Bell has not been overturned, and many states still have sterilization laws. Skinner vs. Oklahoma (1942) only ended compulsory sterilization as a punitive measure. Additionally, there have been reports of involuntary sterilizations of differently-abled persons and criminals, which are commonly referred to as modern day eugenics. See: Powell, L. (2002). Eugenics and equality: does the Constitution allow policies designed to discourage reproduction among disfavored groups? Yale Law Policy Review, 20 (2), 481-512.
Since the birth control movement surfaced just as eugenics was coming of age, coerced contraception was not unopposed, either. Margaret Sanger, the founder of the modern birth control movement, advocated coercive contraception for the “physically or mentally incompetent, who could not themselves understand the benefits of smaller families (quoted in Chesler, 1992, pp. 195-196). Similarly, persons considered “defective” were initially institutionalized to prevent reproduction; later, after institutionalization was deemed too harsh, laws were created to restrict marriage licenses for “defectives” (Ziegler, 2008, p. 212).

Though once widely supported, the term “eugenics” became tarnished following World War II, when Hitler and his followers used the ideology to promote racial hygiene via the extermination of Jews and other “undesirable” populations. Understandably, following the Holocaust, eugenic fertility control policies were discredited as being associated with genocide. It must be noted, however, that eugenics was socially institutionalized before the Nazi atrocities. The rationale behind eugenic ideas, though seemingly spurious at present, rose out of respected academic fields such as anthropology, biology and medicine (Wikler, 1999, p. 186). Eugenics was incorporated into Progressive era social policies and American economics (Leonard, 2005). Eugenics fundamentally reshaped the American thought.

Eugenics as a distinct ideology died with Hitler, but the basic principles behind the movement remained. Eugenic principles segued into population control rhetoric. Gar Allen argues, “Population control was little more than eugenical thinking applied on a global scale” (1980, p. 25). Panic inspired the creation of the global population control movement, which was later cleverly marketed as the global FPM. Population control,
guised as the global family planning movement, could not escape the fact that it emerged out of “a spirit of grim Malthusian fear” (Goldberg, 2009, p. 43).

2.3 Global Population Control, Global Family Planning

As eugenics waned following Hitler’s atrocities, neo-Malthusianism, manifesting as population panic, emerged as a replacement. This time, the societal focus was not on the quality of populations (American eugenics) but rather on controlling the ever-increasing global population. “Population bombs” and “explosions” were suddenly the talk of the town, as Americans became acutely aware of expanding populations. Globally, death rates fell sharply, without a corresponding drop in births. World population grew at a rate no one had ever seen before—between 1930 and 1960 the number of people on earth increased by 50 percent, from two billion to three billion. Birth rates in Europe had been falling for centuries, but before World War II, most population growth was nonetheless in the developed world. The postwar population boom was different; most of it took place in Asia, Africa, and Latin America (Goldberg, 2009, p. 46).

The burgeoning global population led to fears that population would “outstrip resources, or prevent or slow economic development and poverty alleviation, or cause or add to environment degradation, or foster ill health especially in mothers and children, or cause or exacerbate social instabilities” (Zeidenstein, 2011, p. 42). The threat of overpopulation was also likened to nuclear war. Arthur Krock of The New York Times wrote that the pursuance of nuclear weapons to promote peace resulted in governments failing to acknowledge a “dangerous instrument for the destruction of civilization that [was] swiftly being assembled…the ‘population bomb’” (Krock quoted in Goldberg, 2009, p. 49).

But overpopulation was not merely rooted in fears of resource scarcity. Global overpopulation, in the eyes of Americans, was seen as an incubator for communism. The birth control movement had reduced the population of the Western countries without
touching populations in the East (Connelly, 2008, p. 98). Hugh Moore, founder of Dixie Cup, proclaimed in 1954,

Hundreds of millions of people in the world are hungry. In their desperation, they are increasingly susceptible to Communist propaganda and may be enticed into violent action. America’s aid program, conceived as a means of helping poor and hungry people, of combating Communism and of preserving peace, is doomed to failure as long as it disregards the present unprecedented world population explosion (quoted in Goldberg, 2009, pp. 44-45).

The global population control movement was borne out of this apprehension, though the movement was disguised in prospects of controlling world population for the global good — “a way to lift people out of poverty, even to save the earth” (Connelly, 2008, p. 8). It was posited that overpopulation was causing the poor to become even poorer, thus sabotaging foreign aid (Goldberg, 2009). Racist national security rhetoric and fears of “rebellion in unruly, underfed nations” caused American elites to jump behind the population control bandwagon in the 1950s (Ibid, p. 47). The population control movement was not humanitarian. It was paternalistic.

Controlling world population through contraception or other means was a controversial issue in the United States at the time. After all, American support for global population control began before the creation of the birth control pill and before contraception was legalized in the United States for married Americans (Meyer & Seims, 2010, p. 2125). Not to mention, religious convictions combined with constitutional bans resulted in a political hot potato vis-à-vis population policies.7 Eisenhower and Kennedy were off and on again supporters of population policies and procedures (Goldberg, 2009, pp. 49-50). President Johnson, though, was an avid supporter of global population control from the beginning. Johnson was so on board with global population control that, “in one

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shameful instance,” he used food aid as leverage to threaten India to control the country’s population (Ibid, p. 52).

Nonetheless, shortly after the first oral contraceptive was approved in 1960, the global population control movement gained momentum. It is here that we observe a terminological shift. The global population control movement that arose out of Malthusianism and eugenics collided with the embryonic birth control movement. In order to combat both the population explosion and the charge of imperialism, the U.S. had to perpetuate the idea that overpopulation threatened everyone, everywhere. The U.S. had to evoke “visions of a ‘global family’” (Connelly, 2008, pp. 6-7).

Connelly writes,

Scientists and activists organized across borders to press for common norms of reproductive behavior. International and nongovernmental organizations spearheaded a worldwide campaign to reduce fertility. Together they created a new kind of global governance, in which proponents tried to control the population of the world without having to answer to anyone in particular (2008, pp. 6-7).

Population control coalesced into the global family planning movement (FPM). The terms “population control” and “family planning” became interchangeable, thus muddying the rhetoric and literature. All of the aforementioned “fears” — undermined foreign aid, resource scarcity, communism and national security threats, etc. — were packaged into the top-down population control movement, repackaged into the FPM, and then globally sold as a way to “eliminate differential fertility between rich and poor both within nations and around the world” (Ibid, p. 379). The imperialistic notions of the population control movement were effectively masked by the shared notion of the global
family.8

The overarching goal of the population control movement (and therefore the FPM) was to inform nations around the world that they should play a more active role in controlling their populations. Nations were depicted as weak in the face of their citizens’ reproductive choices, and couples’ reproductive decisions were painted as threats to national sovereignty. Governments deserved a role in regulating their citizens’ fertility (Connelly, 2008, p. 13). Women, as breeders of the nation-state, jeopardized national sovereignty and national economic viability. They were primarily targeted.

The foremost step for philanthropic organizations and governments alike was to create demand for FP in order to meet population/demographic targets. Unmet need for contraception would have to be created by “changing the entire set of cultural priorities of the populations in [lesser developed] countries” (quoted in Grimes, 1994, p. 210). Proponents of the FPM were instructed by FP organizations to exhaust all means to reduce fertility and reproduction. These measures included the promotion of “demand-influencing activities” and community incentives to “create peer-pressure for limiting fertility or that may establish differential privileges in education or housing” (Connelly, 2008, p. 335). To promote birth control, FP was labeled progressive — a way to achieve ‘modernization’ in a single generation (Ibid, p. 7-8). As with the eugenics movement, prestige and smaller families went hand in hand.

The FPM manifested in different forms throughout the world. It is arguable that

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human rights violations ensued with each manifestation. In an effort to meet demographic targets, nations and organizations introduced incentives to promote the uptake of FP programs. The following sections underline the gross human rights violations that emerged out of these incentivized population control/FP programs. I have chosen examples that pertain specifically to my thesis (the ethics of incentives); though, many other initiatives without incentive components came with rights violations as well.

2.3.1 India, China, and Bangladesh

India is the first country to have used incentives to promote FP. The first incentives were deployed for vasectomies in Tamil Nadu region in 1956 (Sunil, Pillai, & Pandey, 1999, p. 563). In the 1960s, India experienced unprecedented population growth, thus leading to increased usage of incentives to promote sterilization of both men and women. In 1975, President Indira Gandhi declared Emergency Rule, which initiated the creation of several sterilization laws and regulations.

For instance, government employees were paid based on the number of people they sterilized (Hartmann, 1987, p. 237). From 1975-1977 sterilization camps were placed throughout the country. More than eight million sterilizations were performed in two years, and approximately seventy-five percent of those procedures were vasectomies (Singh, A., 2012). In the 1980s, the focus shifted from male sterilization to female sterilization. Higher incentives were initially offered for women to undergo sterilization. This later changed, as men were paid more to accept vasectomies (Ibid). Disincentives were used as well. Men and women who remained unsterilized after three children were threatened with leveraged food aid, fines, and imprisonment (Hartmann, 1987, p. 237).

Anecdote: I have yet to come across a violation-free, family planning success story dating before the ICPD in 1994, although it is possible that examples exist.
The conditions were horrifying, and many suffered infections and complications from unsanitary procedures (Ibid).

China’s “One-Child Policy” was created to induce negative population growth. Having one child only, which is below replacement levels, was intended to result in an ideal population size of six hundred thirty to seven hundred million people in a one hundred year timeframe (Hartmann, 1987, p.147). Hartmann argues that, despite the fact that the Chinese voluntary family planning system was working, the post-Mao leadership was compelled to reduce population further in order to open itself up to Western investment and achieve economic growth — China “resurrected Malthus” (Ibid, p. 148).

The one-child policy used punitive measures (disincentives) and rewards (incentives) to reduce the crude birth rate. Families with one child were given cash and welfare subsidies. The child of a one-child household received priority education later in life as well as potential employment. On the other hand, families with more than one child were taxed. Additionally, the second child would not receive social benefits that the family received for the first child, such as free education and healthcare (Hartmann, 1987, p. 149).

Incentivized family planning workers were hired to monitor women — to be pregnancy investigators, if you will. Women who had accepted the long-term IUD method were subject to so-called voluntary X-rays to make sure that the device was still in place, a scenario similar to the current attempts in the U.S. to use involuntary vaginal probes to make sure women are not aborting a fetus with a heartbeat. The community involvement in controlling the Chinese population led to additional rights violations. Chinese women were forced to get sterilizations and abortions against their will. Because
the collective was convinced that controlling population was everyone’s problem, the “line between persuasion and coercion thus [disappeared]” (Hartmann, 1987, p. 150). Ironically, during the incentivized period between 1979 and 1981, the population in China increased (Ibid, p. 153).

Bangladesh’s history of incentives for FP is equally as troubling. Millions of dollars were pumped into the country for FP, yet there was still overwhelming unmet need. Bangladeshi women desired contraception so badly that they sought Hartmann’s help; when Hartmann intervened, she witnessed devastating realities. Women were accepting FP methods without prior counseling or full understanding of risks and benefits. Because there was donor money flowing in (motivated by population control, as discussed above), there was external pressure to see results, or decreased population (Hartmann, 1987, pp. 208-210).

In the mid-1980s, Bangladesh implemented a top-down, crash population control program that was fueled with incentives for sterilization and disincentives for health workers that failed to meet acceptor quotas. Women were offered financial incentives for sterilization and lesser incentives for accepting long-term contraception, such as the IUD (Hartmann, 1987, p. 214). Hartman states, “In the flood season of 1984, for example, relief workers uncovered a pattern of destitute women being denied food aid unless they agreed to be sterilized” (2011, p. 1). These measures were, of course, coercive. Sterilizations increased significantly right before the rice harvest when the food supply was running low (Hartmann, 1987, p. 215).

These violations played a role in the backlash against the population control movement/FPM. Particularly, the feminization of population control and FP field — the
infiltration of women into the movement — gradually led to a general understanding that nations, organizations, and men were controlling the fecundity of women. Women’s rights were not being upheld through the promotion of male-designed fertility-reducing projects (Caulier, 2010, p. 357). It was this understanding that birthed the reproductive health and human rights movement.

2.4 Reproductive Health and Rights

The International Conference on Population held in Mexico City in 1984 highlighted the human rights of individuals and families. Directly following the conference in 1985, the “Kemp-Kasten” amendment (U.S. appropriations law) prevented the United Nations Population Fund (UNFPA) from receiving or using funds to support coerced abortion or forced sterilization. But the event that formally separated family planning policy from coercion, violation, and demographic targets was the International Conference on Population and Development (ICPD) of 1994 held in Cairo. Growing awareness surrounding the interconnectedness of population, poverty, patterns of production and consumption and the environment led to the creation of the conference (United Nations, 1995, p. 7). The overall theme of the ICPD was to pull attention away from population and demographic goals and to assert a human rights and ethical approach to family planning. This paradigm shift represented a new stage in the movement for reproductive health (RH) and human rights.

The ICPD was groundbreaking because the platform called for the defense of reproductive choices of men and women alike, and prohibited the use of funds to cover

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10 U.S. policy surrounding abortion changed constantly. Reagan prohibited the use of American funds for abortion; Clinton rescinded; George H.W. Bush reinstated the “gag rule”; Obama rescinded in 2009.
coercive and forced international family planning efforts in all forms. Principle 3 of the ICPD platform states that underdevelopment, or failure to meet preset development targets, “may not be invoked to justify the abridgement of internationally recognized human rights” (United Nations, 1995, p. 11). Principle 4 is perhaps the most revolutionary principle within the platform. It posits that the “cornerstones” of population and development-related programs should be “gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women.” Most importantly, Principle 4 acknowledges a woman’s capacity to control her own fertility and make her own RH choices (Ibid, p. 12).

Women are able to control their own fertility so long as sub-points 4.1 and 4.2 are met. The sub-points call for the empowerment of women with “the knowledge, skills, and self-confidence necessary to participate fully in the development process” which, in turn, “enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction” (United Nations, 1995, p. 22). Similarly, the role that men play in women’s reproductive decision-making is unquestionable and is highlighted within the ICPD. Sub-points 4.24 and 4.27 argue for an increased male role in reproductive and sexual health, since “in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government” (Ibid, p. 27).

Principle 8 and 8.20 (a), are the most critical principles in regards to this thesis. For that reason, I have quoted both directly for clarity:
**Principle 8**

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so (United Nations, 1995, p. 18).

**Excerpt from 8.20 (a)**

To promote women’s health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the difference observed between developing and developed countries and within countries. On the basis of a commitment to women’s health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion (United Nations, 1995 p. 57).

Although the ICPD was a stepping-stone in the right direction, some argue that the platform did not sufficiently acknowledge the complexities of achieving the principles within certain contexts. Ellen Foley, a Senegalese RH scholar, argues that the human rights approach taken at the Cairo conference “offers important protections against coercion and state-driven demographic targets. Its emphasis on the voluntary use of contraceptives and high-quality reproductive health services is a significant assertion of women’s reproductive rights.” She continues, “Yet the Cairo platform assumes that women (as an undifferentiated mass) have the ability to develop, articulate, and act on reproductive intentions that will be supported by the reproductive health services” (2007, p. 328). The ICPD sought to empower women, but it did not adequately address the socio-cultural and financial intricacies of women advocating for their own reproductive health. In many countries, women lack the authority necessary to speak up for their own
reproductive rights. Women’s reproductive lives are, overwhelmingly, determined by others.

The ICPD platform (specifically 8.20 above) expressed the need for “rapid and substantial reduction in maternal morbidity and mortality,” reduction in the “difference observed between developing and developed countries and within countries” and reduction in the “number of deaths and morbidity from unsafe abortion” (United Nations, 1995, p. 57). While grassroots education efforts and strategic empowerment programs are essential to sustainable international development, they do not equate to rapid reductions in mortality and morbidity. Changing behavior, especially in regards to reproduction, faces many religious, cultural, and financial challenges that may take decades to overcome.

Likewise, universal access to FP and reproductive health (RH) services does not occur overnight. Even in cases where men and women have access to RH services and FP, they may not choose to use it due to a variety of barriers (Eichler, Seligman, Beith, & Wright, 2010). The goals outlined in the ICPD are achievable, yet unrealistic if limited to educational and empowerment programs (in their current forms) alone. Those concerned about protecting human rights, empowering and educating women, reducing the unmet need for FP, eliminating clandestine abortions, and curbing unnecessary maternal mortality and morbidity, may ask: How many more women will die until current development projects succeed in providing universal access to healthcare, enhancing economic livelihoods, or achieving universal empowerment? In addition to continuing development’s long-term efforts of improving education, women’s status, and job opportunity, is there something that the field of RH can do now to boost existing program
effectiveness? Can incentives, for example, complement current RH and development efforts to promote and expand access to coercion-free, voluntary FP and RH services?

Too often incentives for family planning have included atrocious human rights violations. The widespread role that incentives have played throughout history suggests that human rights violations have been institutionalized within the FPM. It must be pointed out, however, that in all of the aforementioned examples of rights violations, population control remained the central focus of incentive programs. Incentivizing long-term birth control methods (IUDs, injectables) and invasive, irreversible methods (vasectomies, female sterilization) was clearly intended to rapidly decrease population growth for economic purposes.

Hartmann argues, “Only through respect for basic human rights can family planning be liberated from the yoke of population control and play a liberating role in the lives of women, and men, around the world” (1987, p. 157). It is evident that past programs neglected human rights in an effort to create an environment conducive to economic growth, international trade and investment. Because incentives are quick at producing desired outcomes, they were used against populations, by the state, to crash populations overnight. Incentives, as powerful tools, were misused to meet demographic targets. One of the goals of this thesis is to bring this abuse center stage. We can no longer write-off fast-acting, effective incentives as euphemisms for population control. Incentives must be reevaluated within the context of human rights.

According to Hartmann, FP and RH services must consist of the following: a mixed array of contraceptive methods that women can access and choose after being counseled on their benefits and risks; quality medical check-ups to ensure that women’s
FP needs are taken into consideration and medical follow-up if a method is accepted; comprehensive RH services (e.g., no one method is promoted over another method, like sterilization over the pill). Additionally, FP programs must respect the local culture and incorporate traditional FP — so long it is safe, effective, and free from pressure and coercion (Hartmann, 1987, p. 55-56). Incentives can exist within this context. They can be incorporated into FP and RH programs without violating human rights or the principles outlined in the ICPD.
3. INCENTIVES FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES UPTAKE

Given the troubled history of the global FPM, it is justifiable that incentives for global FP and RH services uptake evoke concern. Historically, incentives have been used to control population and meet preset targets; they have not been deployed to increase men and women’s access to FP and RH services. The following sections demonstrate the growing necessity for incentives within FP and RH and outline the importance of incentives as complements to current programs.

3.1 Defining Incentives and Explaining How Incentives Work

The Center for Global Development (CGD) has been at the forefront of researching and implementing performance-based incentives (PBIs) within initiatives. CGD’s formal definition of PBI for healthcare, as adopted from Rena Eichler, is the “Transfer of money or material goods conditional on taking a measurable health-related action or achieving a predetermined performance target” (2006, p. 5). The CDG’s work shows that incentives can help generate desired outcomes rapidly through a variety of means such as paying healthcare facilities and providers supplements based on performance (P4P), offering vouchers or subsidies to health workers to prevent burnout, or transferring cash to individuals with a conditionality (CCT).
More specifically, P4P is a strategy to improve health care delivery that relies on the use of market or purchaser power. Pay for performance, depending on the context, refers to incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payers, and improved quality and patient safety (McNamara, 2006, p. 5S).

P4P can function as a bonus on top of existing salaries, or it can be used to replace salaries. Both options are termed contingent compensation. An example of a demand-side incentive is the Conditional Cash Transfer (CCT). CCTs are essentially monetary or material transfers to individuals, which are attached to conditionality(ies). A hypothetical CCT program could provide households with some form of monetary or material transfer, so long as that household agrees to the condition of taking their children to the doctor or school, for example.

The goal of PBI is to link payment to results, thus increasing the accountability of facilities and workers (without hindering autonomy) and improving health system management (Eichler & Levine, 2009). There is significant evidence showing that supply-side and demand-side incentives work; they are predictable, easy to measure and can be used to achieve rapid results. Incentives can be used to replace expensive healthcare management systems, and are efficient means in which to align behavior with desired goals or outcomes. Incentives can work to overcome the aforementioned access barriers such as stigma, ignorance, and lack of motivation and poverty (Ibid, 2009).

11 Incentives are not new—providers are already paid based on performance, quality, and outcomes achieved. Thus, to clarify terminology in regards to the supply-side, I refer to PBIs as additional incentives that can be used to further enhance the quality of performance on the part of providers.

3.2 Why Incentives?

The MDGs are the primary motivators behind global health incentive components, “as countries recognize that current health system strengthening/health financing approaches will not produce desired results” (Eichler, Seligman, Beith, & Wright, 2010, p. 1). Merely increasing access to care via increased infrastructure and health workers has proven ineffective in some cases. This is because provider/consumer motivation and choice have been left out of the equation. Health-seeking behavior is dependent on many factors, all of which vary on a country-country/culture-culture basis.

Socio-cultural, financial, and motivational barriers provide a broad explanation as to why people do not seek care in spite of the availability of goods and services. Eichler and Levine note

Poor families in the developing world face significant constraints in accessing essential health care. Distance to health facilities, lost wages associated with illness, care taking and care seeking, facility fees, and other out-of-pocket costs all contribute to limiting the access of poor families to health care, particularly preventive care (2009, p. 90).

Paying for healthcare can be catastrophic for households and, in some cases, impoverishing (Xu, Evans, Carrin, Aguilar-Rivera, Musgrove, & Evans, 2007).

Persons/households may also be deterred by perception of quality of care (Sahn, Younger, & Genicot, 2003). Mistrust between patient and provider, too, presents a challenge to current efforts. Even when the patient can access care, they may choose not to because they do not feel like their information/medical history will be kept confidential. Misinformation and perceived side effects perpetuate skepticism, which also contributes to the underuse of health goods and services. Additionally, willingness to seek care is affected by the opportunity costs of seeking treatment, and the opportunity-
costs tend to be higher in urban areas (Eicher, 2006, p. 12; Saila-Ngita, Bravo-Ureta, & Pérez-Escamilla, 2003, p. 3). Investing in healthcare may not be of utmost concern in LMICs:

Part of this disconnect can be explained by the observation that households do not fully internalize the benefits of prevention and cure of infectious diseases that have externalities and the risks of not adhering to guidelines for consumption of antibiotics and other drugs that have the potential to create resistance. Financial and material incentives tied to indicators of performance can motivate consumers to obtain care and adhere to extended drug treatment regimens. Consumer directed incentives work by both removing barriers to seeking care and by inciting actions that consumers may not otherwise take (Eicher, 2006, p. 6).

In addition to quality of care (or perceived quality), misinformation, and poor resource management, misaligned incentives/disincentives for providers result in the underuse of healthcare, even when healthcare is widely available. Healthcare systems are intrinsically laden with disincentives that result in under service, subpar quality of care, and treatment imbalances (Rich, 2012). With a focus on efficiency, healthcare facilities and providers may be encouraged (by funders) to cut costs by cutting services. Or, conversely, providers may be encouraged to promote high-cost services over low-cost services in order to produce a stronger bottom line.\(^{13}\)

PBIs are effective tools that can be used to correct the above health care failures and imbalances. For a more detailed explanation of implementing supply-side and demand-side incentives to combat specific health system problems see Appendix 1:

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\(^{13}\) I am not in support of incentives deployed to increase profit, especially in LMICs and within the realm of family planning. Incentives should be used to knock down barriers to access and improve overall health outcomes, and not to achieve larger financial gains.
Examples of P4P and “other” system solutions to increase utilization of essential services by the poor and improve quality.

It has been demonstrated that FP and RH behaviors are sensitive to incentives (Heil, Gaalema, & Herrmann, 2012); however, the literature reveals conflicting evidence, both for and against the use of incentives to promote FP and RH service uptake. Attempts to improve health outcomes may actually result in perverse, unintended effects.\textsuperscript{14} This should be noted and carefully evaluated prior to implementing an incentive program.

Above all, international development has met its match with reproductive health and family planning. Green et al. reveal, “Sexual and reproductive ill health is the fifth-leading cause of death around the world, and the second contributor to the global burden of disease” (Greene, Joshi, & Robles, 2012, p. 92). The following sections discuss the importance of considering incentives for family planning (bringing incentives into the conversation) to ensure that FP does not become a neglected cause, to keep up with the growing unmet need to FP, and to decrease morbidity and mortality. Eichler and Levine say,

> When the goal is to reduce needless death and disease, and part of what is getting in the way is a misalignment between health goals and the real world behaviors of individual patients, health workers, and those who influence them, it may be time to consider performance incentives. These can complement other interventions, such as providing training, revamping infrastructure, and improving the supply of drugs and other inputs (2009, p. 23).

The ostensible epistemological similarities between Eichler and Levine’s logic/arguments and those of neo-Malthusians deserve mention. Hartmann continually

\textsuperscript{14} For example, an FP incentive program in Honduras actually increased the fertility rate due to a poorly designed payment structure. See: Eichler, R., & Levine, R. (2009). \textit{Performance Incentives for Global Health: Potentials and Pitfalls}. Washington, D.C.: The Center for Global Development for more information.
points fingers at neo-Malthusian population panic as the driving force behind incentive programs for FP or RH programs (Hartmann, 2005; Hartmann, 2011; NewsClickin, 2010). She argues that neo-Malthusianism is “cloaked in the language of choice and women’s rights, but the logic remains essentially the same: reducing population growth is lauded as the key to ending poverty and scarcity (Hartmann, 2005).

To be clear, incentives should not be launched to prevent so-called Malthusian catastrophes, nor should they be used as extensions of the late population control movement. Incentives should not be used to deprive men and women of their agency and they should not be coercive (See Appendix 2). My findings do not support Hartmann’s conclusion, and I do not intend for my analysis to mirror neo-Malthusian arguments. In fact, the core of my main argument is to show that we can no longer conflate population control and coercion with incentives. We must acknowledge the troubled history without allowing the history to hinder our perception of incentive usage.

The purpose of incentives is, indeed, to both speed up and increase the efficacy of FP and RH programs. Increasing the rapidity of the process (and by process I mean increased access to goods/services as well as the overhaul of barriers to FP and RH) via incentives should not be immediately discredited as a top-down, rights-violating endeavor, especially when lives and livelihoods are at stake. As such, I will briefly discuss the importance of incentives as complements to current efforts, not merely to reduce needless death, but also because of the growing prevalence of incentives in other health sectors. Incentives may be imperative additions to all programs in coming years; therefore, they must be taken seriously in regards to FP and RH.

3.3 Importance
Subpar progress has been made in recent decades in maternal and child health (MCH) in low-income countries, thus warranting increased innovation in reproductive health efforts (United Nations, 2010). MDG Target 5.A aims to reduce the maternal mortality ratio worldwide by three quarters from 1990 to 2015. Similarly, MDG Target 5.B seeks to achieve universal access to reproductive health services by 2015. Unfortunately, according to the World Health Organization, the rate of decline in maternal deaths is “just over half that needed to achieve the MDG target of a three quarters reduction in the mortality ratio between 1990 and 2015” (2012). The pressing need for increased supply and demand of reproductive health services is evident: women in the developing world have a 1 in 76 chance of dying during childbirth compared with 1 in 8,000 in the industrialized world (The Living Proof Project, 2009, p. 2). Incentives should play a role in mitigating these problems. Hypothetically, supply-side incentives could be used to motivate healthcare personnel to seek out and encourage women to receive antenatal care, and/or to facilities to deliver their babies. Likewise, incentives could be used to encourage the mother to come to a clinic to give birth.

Clandestine abortions, often resulting in complications, continue to plague reproductive health efforts as well. Eichler et al. state, “20 million women have unsafe abortions each year, and 3 million of the estimated 8.5 million who need care for subsequent health complications, do not receive it” (Eichler, Seligman, Beith, & Wright, 2010, p. 5). Incentives could target the supply and demand barriers that are responsible for women not receiving treatment for complications. Furthermore, though the reasons for which women want to have an abortion vary greatly, the problem can be partially attributed to an unmet need for FP and contraception.
Currently the global unmet need for contraception is high. An estimated 222 million women in the developing world have an unmet need for modern contraception (Heil, Gaalema, & Herrmann, 2012, p. 7). Additionally, the sixty-nine poorest countries in the world make up seventy-three percent of the total unmet need in the developing world. Between 2008-2012 the population in the poorest sixty-nine countries increased from one hundred fifty three million to one hundred sixty two million (Ibid, p. 7). Thus, it is speculated that global unmet need for contraceptives will increase exponentially in the coming years, as a new generation enters reproductive age (Greene, Joshi, & Robles, 2012, p. 95). It should been noted, of the 1,520 million women of reproductive age in the developing world, 57%, or an estimated 867 million, are in need of contraception. Most of these women are using a modern contraceptive method (645 million), but a significant minority are not and these women have an unmet need for modern contraception (Singh & Darroch, 2012, p. 4)

Eichler and Levine discuss strategies that can be implemented to resolve this crisis without having perverse effects such as a CCT tied to the conditionality of attending health education talks about family planning benefits and contraception (2009, p. 232).

In addition to reducing the unmet need for contraception, clandestine abortions and subsequent complications, and maternal mortality, incentives to promote FP and RH uptake may also be a cost-effective endeavor in the end. According to Singh and Darroch, an investment of an additional $4.1 billion in modern contraceptive services in LMICs would save approximately $5.7 billion in maternal and newborn health services, since unintended pregnancies and unsafe abortions are attributed to an unmet need for contraception (Singh & Darroch, 2012). Increased contraceptive use during the past two decades has remarkably resulted in a decrease in the number of maternal deaths — a forty
percent decrease to be exact — and that an additional thirty percent of the current maternal deaths could be prevented by decreasing the unmet need for family planning (Greene, Joshi, & Robles, 2012). As I have stated in previous sections, decreasing the unmet need for FP and RH services does not simply mean increasing the supply of FP and RH. Decreasing unmet need is also dependent on the removal of barriers to access, all of which can be addressed by programs with incentive components.

More imperatively, Eichler et al. speak to the necessity of including PBI into FP and RH initiatives. Since the popularity of PBIs in other sectors is growing, the authors warn that leaving PBI out of FP and RH may result in the neglect of FP and RH initiatives and services on the part of providers, donors and nations (Eichler, Seligman, Beith, & Wright, 2010). The growing popularity of PBI stems from the fact that donors want to know that their money is well spent. As such, national and sub-national PBI schemes are increasing, allowing governments to “exercise their influence through conditions attached to intergovernmental fiscal transfers” (Ibid, p. xii).

As incentives take over the multitude of international development programs, imbalances will be created. Dilemmas arise from the fact that conditionally-paid providers, facilities, or organizations may choose to offer incentivized services over non-incentivized services, thus creating (or perhaps, perpetuating) healthcare disparities. If PBI is avoided in the FP and RH programs/services, facilities/providers/health workers may “neglect provision of voluntary FP services, contributing to stagnating FP use, while the use of other rewarded services rises” (Eichler, Seligman, Beith, & Wright, 2010, p. 2). Additionally, in areas where resources and staff are hard to come by (LMICs), overworked healthcare workers may be apt to provide services that result in financial
rewards (Eicher, 2006, p. 23). The goal of universal access to FP and RH may be undermined by the increasing incentivization of other sectors.

Hartmann’s analysis, too, acknowledges the impacts of incentivizing one area of health but not another. When sterilization and IUDs were incentivized in Bangladesh, other forms of contraception were neglected as health workers vied for clients in the higher incentivized areas. She notes the “unhealthy competition” that this phenomenon created. Sterilizing more and more men and women equated to workers lying and withholding information from Bangladeshis out of fear that people would choose not to be sterilized; it meant high-performing workers “selling” potential clients to low-performing workers for an under-the-table profit (Hartmann, 1987, p. 217).

Incentives create imbalances if they are not deployed evenly across sectors. FP and RH cannot fall by the wayside as other goods and services are incentivized and promoted. This fact would effectively undermine all past and current development efforts. It is evident from aforementioned sections that FP and RH services are life-saving and cost-beneficial. The importance of FP, however, extends beyond this. It must be noted that RH is intrinsically linked to other development sectors. Failing to introduce incentives into FP may have negative, spillover effects beyond MDG 5.

FP and RH services lead to

- fewer unintended pregnancies; fewer maternal and newborn deaths; healthier mothers and children; greater family savings and productivity; and better prospects for educating children, strengthening economies, and reducing the pressure on natural resources in developing countries (Eichler, Seligman, Beith, & Wright, 2010, p. xi).

Neglecting incentives for FP and RH is a “missed opportunity to contribute to broader development goals” (Eichler, Seligman, Beith, & Wright, 2010, p. 29).
4. IMPLEMENTATION AND EVALUATING SUCCESS

The advantages of incentives for FP and RH are clear; but can incentives be implemented without violating human rights? The following discussion is anecdotal, but I believe my arguments effectively demonstrate that ingenuity can overcome the ethical conundrums of incentives. I use some examples proposed by other researchers; however, overall, I am dissatisfied by most of their suggestions and unconvinced that their programs will protect the rights of men and women. Therefore, I developed generalized suggestions for incentive implementation. Country and culture contexts should always be considered above my recommendations, and incentive programs should be tailored to fit the varying needs of people groups. See Appendix 2 for Eichler and Levine’s “Dos and Don’ts” of incentive implementation.

Demographic targets and rapid fertility reduction are never valid criteria to evaluate incentive program success. Therefore, to achieve MDG 5’s “universal access to reproductive health by 2015,” supply-side incentives can be deployed that do not target the fecundity of men and women but, rather, barriers to access. First, I suggest that facilities, providers, and healthcare workers should be incentivized to extend care into rural communities. Perhaps training/education/housing stipends can be offered to workers willing to relocate to underserved areas where access to FP/RH is limited. For instance, facilities/workers can be conditionally paid based on the number new patients that they
counsel on FP/RH. Facilities/workers should not be incentivized to meet FP “acceptor” quotas (e.g., paid based on x number of persons using an IUD, etc.). In order to reduce potential perverse effects, incentives for FP/RH should be similar in amount to incentives used to promote other services (Eichler, Seligman, Beith, & Wright, 2010, p. 29).

In regards to demand-side incentives, encouraging behavior change and breaking down barriers to access can be done via social “good” incentives such as education and healthcare. The positive externalities of social “goods” have spillover effects in many areas, and they could serve as the conditions tied to CCT programs. For example, a hypothetical CCT could provide educational/health care vouchers to men and women who come to FP/RH events or counseling sessions. Another example could be offering middle school students free high school education if they abstain from early marriage. Early marriage is correlated with early pregnancy and higher risk for the young mother (Saila-Ngita, Bravo-Ureta, & Pérez-Escamilla, 2003, p. 13).

This same concept could be used for older men and women as well. Young men and women could be provided a free college education or free healthcare so long as they commit to delaying their first child until after their college graduation. In this sense, the age of conception is postponed (thus reducing risk) and the education and potential empowerment of both men and women is supported by the social good conditionality. Likewise, post-college aged persons could be offered tax breaks for maintaining a small family, delivering their children in a facility or using a midwife. None of these suggestions are coercive, and none hinder choice. They are all voluntary solutions that, in fact, offer ample room for both individuals and couples to freely determine their reproductive lives.
5. CONCLUSION

One of my colleagues recently claimed that financial incentives for family planning are, by definition, coercive. The argument usually goes as follows: in low and middle-income settings, where money is hard to come by, offering incentives for initiative uptake is manipulative. One could liken this situation to bribing an addict with his/her addiction; attacking the enemy at his weakest point; textbook cultural imperialism, where the more powerful party inherently has the “one up.” Because of this, some argue that incentives, given their nature, violate basic human rights.

It is true that there have been formidable failures and violations throughout the history of family planning. Malthus’ writings provoked fear of overpopulation and segued smoothly into the infamous eugenics movement. Eugenics swept through nineteenth-century America, leaving a trail of human rights violations behind. Nazism ended eugenics; yet, eugenic ideas had already been institutionalized within American minds, academic disciplines, and policies before “racial cleansing” tarnished its name. As such, population panic emerged again, this time as a response to the “Red Scare” and burgeoning world population. American awareness of global population increases sparked the creation of several American and multinational organizations — all of which shared the common goal of reducing population for the global good. Though some were
motivated by altruism, decreasing population motivated most. Global population control was born and branded as global family planning. Reducing population, once again, became of utmost importance. Human rights violations were officially addressed at the ICPD in 1994, when women were finally deemed in charge of their own health, their own fecundity. “Reproductive health” replaced “top-down population control,” though the transition continues.

Therefore, the criticism vis-à-vis financial incentives for family planning uptake is both valid and warranted. After all, the terms “compulsory,” “coercion,” and “force” have been institutionalized within the movement. Thus, I agree with Hartmann: history should not be forgotten and therefore repeated. Incentives to promote family planning, present a slippery slope, but this is primarily a definitional and interpretational error due to the historical conflation of population control and incentives.

History and human failure have conflated population control, family planning, and reproductive health. But incentives to control individual fertility and incentives to increase access to FP and RH are apples and oranges. The former should be avoided. History should not hinder the mere consideration of incentives, nor should it prevent reproductive health scholars from thinking critically about incentives to ensure that men and women will continue to have access to family planning and reproductive health services as other sectors become increasingly incentivized.

Moreover, this thesis reveals the complexities of using incentive programs to promote family planning uptake. Increasing demand for family planning services without evoking Malthus, eugenics, or population control arguments will be a feat. But family
planning and reproductive health’s misguided past warrants an open-minded, creative future—one in which incentives and reproductive choice can coexist.
APPENDIX 1

Table 3:
Examples of P4P and “other” system solutions to increase utilization of essential services by the poor and improve quality

<table>
<thead>
<tr>
<th>Level</th>
<th>Constraint or Underlying Performance Problem</th>
<th>P4P Solutions</th>
<th>“Other” System Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household/Community Level</td>
<td>1. Households can’t afford to obtain quality care: Financial barriers</td>
<td>1.1 <strong>CCT Programs</strong>: directly increase household income and reduce prices of essential services. Also inhibits household decisions to purchase low cost substitutes. 1.2 <strong>Transportation subsidies</strong>: reduce direct cost of obtaining care. 1.3 <strong>Food support</strong>: Frees up income that would have been used to buy food. Reduces opportunity costs of seeking care especially for treatment of chronic conditions. 1.4 <strong>Financial rewards to providers for results (and/or penalties for poor performance)</strong>: Financial incentives to providers stimulate outreach and reduce financial barriers faced by households. 1.5 <strong>National to local transfers based on results</strong>: Can stimulate local solutions to reducing financial barriers to access. 1.6 <strong>Social insurance that provides universal coverage and pays providers based on performance</strong>: Can be part of a P4P intervention if payment is based on results. Will also minimize household decisions to consume low cost substitutes.</td>
<td>1.1 <strong>Waived or reduced fees</strong>. 1.2 <strong>Rules enforced that eliminate charging informal fees</strong>. 1.3 <strong>Universal coverage for a comprehensive package of services</strong>. 1.4 <strong>Construct functioning facilities close to where people live</strong>: Reduces financial barriers by reducing transportation and opportunity costs of seeking care. 1.5 <strong>Regulate quality of low cost substitutes</strong>: Eliminate counterfeit drugs and non-accredited health care providers through enforcement of regulations.</td>
</tr>
<tr>
<td></td>
<td>2. Health care services are hard to reach: Physical barriers to access.</td>
<td>2.1 <strong>Transportation subsidies</strong>: reduce direct cost of obtaining care. 2.2 <strong>Financial rewards to providers for results (and/or penalties for poor performance)</strong>: Financial incentives to providers stimulate outreach, offer more convenient clinic hours, and reduce financial barriers faced by households. 2.3 <strong>National to local transfers based on results</strong>: Can stimulate local solutions to reducing physical barriers to access.</td>
<td>2.1 <strong>Coordination and joint planning with Department of Transportation and Roads</strong>: May reduce travel times by building roads and enhancing transportation options. 2.2 <strong>Construct functioning facilities close to where people live</strong>: Reduces financial barriers by reducing transportation and opportunity costs of seeking care.</td>
</tr>
<tr>
<td>Household/Community Level (cont.)</td>
<td>3. Lack of information and social norms and inhibit seeking recommended preventive and curative care: Information.</td>
<td>2.4 <strong>Provide per diems and vehicles to enable providers to reach remote areas</strong>: Can be an incentive if per diems exceed incurred travel costs and vehicles are also used for personal use.</td>
<td>2.3 <strong>Implement strategies to reach remote areas</strong>: Mobile clinics, community health worker programs, per diems and vehicles to enable providers to reach remote areas. 3.1 <strong>Behavior Change Communication</strong>.</td>
</tr>
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38
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<tr>
<th>Level</th>
<th>Constraint or Underlying Performance Problem</th>
<th>P4P Solutions</th>
<th>“Other” System Solutions</th>
</tr>
</thead>
</table>
| Service Provision Level | 4. Inadequate supply, misdistribution, and poor motivation of health workers: Staffing challenges.             | 4.1 Financial rewards to providers for results (and/or penalties for poor performance): Financial incentives that reward results can motivate solutions to the model of service delivery that may include strategies to improve outreach to underserved areas, utilization of changed mix of health care workers, and payments conditional on achieving results (or penalties for not) can motivate effort and innovative solutions.  
4.2 National to local transfers based on results: Can stimulate solutions similar to 4.1. | 4.1 Training and continuing education: To upgrade skills of existing health workers and to train new ones.  
4.2 Alter the skill mix of health worker teams: to maximize effectiveness with the given supply of human resources.  
4.3 Improve health infrastructure and ensure availability of supplies and medicines: May improve motivation if needed inputs are in place.  
4.4 Increase salaries: May improve motivation even if salary increases are not performance based.  
4.5 Improve management and management support systems: career paths, management information systems, strengthen supervision, human resource strategy.  
4.6 Strengthen community participation: Support, engagement, interest, and oversight from local communities may increase responsiveness and effectiveness of health workers. |
|                       | 5. Weak technical guidance, program management, and supervision: Management challenges.                           | 5.1 Financial rewards to health service providing institutions for results (and/or penalties for poor performance): Financial incentives that reward results can strengthen management by causing service providing institutions to examine the range of constraints they face to achieving results and the systems, capabilities, and strategies they need to introduce to achieve |                                                                                                                                                    |
| Service Provision Level (cont.) | 6. Drugs and supplies not available: Drugs and Supplies.                                                        | 5.2 National to local transfers based on results: Can stimulate solutions similar to 5.1. |                                                                                                                                                    |
|                       | 6.1 Contract out drug procurement, storage, and distribution. Reward contracted entity (ies) based on results (example: reduced drug stock outs).  
6.2 Performance based incentives in inventory management and distribution: Increase responsiveness by improving management systems from central to regional levels and to facility levels. | 6.1 Improve management procedures and systems to strengthen procurement, storage and distribution.  
6.2 Establish essential drug lists.                                                                                           |                                                                                                                                                    |
| Health Sector Level   | 7. Inequitable and inefficient distribution of resources for health: Resource allocation.                        | 7.1 National to local transfers based on results.  
7.2 Payment to providers to provide services to the poor: Can be part of a social insurance scheme, a contracting process for the private sector, a system to reward public sector providers or a combination. | 7.1 Reform of resource allocation mechanisms: to improve equity, target scarce resources to cover the poor, and improve quality.  
7.2 Improve national financial planning: information and value driven financial planning and resource allocation with improved information such as National Health Accounts.  
8.1 Decentralize planning and management.  
8.2 Strengthen management capacities at the central and regional levels: training, continuous education, and hiring. |
<p>|                       | 8. Weak and overly centralized systems for planning and management: Planning and Management                     | 8.1 National to local transfers based on results: stimulate development of stronger local level management and planning. |                                                                                                                                                    |</p>
<table>
<thead>
<tr>
<th>Level</th>
<th>Constraint or Underlying Performance Problem</th>
<th>P4P Solutions</th>
<th>“Other” System Solutions</th>
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<td>Health Sector Level (cont.)</td>
<td>9. Weak drug policies and supply systems: Procurement and distribution.</td>
<td>9.1 Contract out drug procurement, storage, and distribution. Reward contracted entity (ies) based on results (example: reduced drug stock outs).</td>
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<td>10. Poor quality of care: Quality Assurance.</td>
<td>9.2 Performance based incentives in inventory management and distribution: Increase responsiveness by improving management systems from central to regional levels and to facility levels.</td>
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<td>11. Lack of Intersectoral action and partnerships: Cooperation.</td>
<td>10.1 Financial rewards to providers for results (and/or penalties for poor performance): Financial incentives to providers for results stimulate improvements in technical quality and responsiveness. Provide incentives so it is in providers’ interest to adhere to quality standards.</td>
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<td>12. Weak incentives for providers to be efficient and responsive: Incentives.</td>
<td>10.2 National to local transfers based on results: similar to 10.1.</td>
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<td>11.1 CCT programs are intersectoral.</td>
<td>9.1 Improve management procedures and systems to strengthen quantification, procurement, storage and distribution.</td>
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<td>9.2 Establish essential drug lists and standard treatment guidelines.</td>
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<td>9.3 Establish and enforce standards for drug sellers.</td>
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<td>10.1 Quality assurance standards: mandate and monitor.</td>
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<td>11.1 Establish intersectoral committees to focus on health.</td>
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(Eicher, 2006, pp. 15-19)
**APPENDIX 2**

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**Box ES-1: Best Practices to Consider When Including Voluntary FP in PBI Programs:**

**“Dos and Don’ts”**

**Individual client level:**
1. Do consider offering clients the opportunity to purchase coupons/vouchers (at full or subsidized prices) for a package of services that includes FP. Client payments for the purchase of vouchers promote voluntary FP choice and acceptance and can enable clients to receive services from providers they prefer, either public or private.
2. Do consider reducing financial barriers for voluntary sterilization clients to make the method readily accessible by subsidizing the cost of the procedure or offering reasonable compensation or in-kind support to those experiencing high service delivery costs, lost wages during convalescence, high transportation costs to reach a facility, or who require food during confinement.
3. Do consider offering compensation to offset the costs of transportation to enable clients to attend health education sessions and to receive FP counseling.
4. Do include attendance in health education sessions that discuss FP as one of the conditions of CCT programs.
5. Don’t pay clients or give them any benefits in exchange for accepting a method.
6. Don’t deny clients a benefit if they choose not to accept FP.

**Individual health worker level:**
1. Do consider paying health providers for FP services that include quality counseling as well as provision of a method. Payment should be reasonable, where “reasonable” implies payments that are in line with payments for other services. This includes compensation for services delivered to voucher clients.
2. Don’t reward health providers for achieving a target number of FP users or users of a particular FP method.
3. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior.

**Health facility, health team, or NGO level:**
1. Do consider rewarding the availability of a wide range of methods.
2. Do consider rewarding facilities or teams to attain performance objectives. Health facility or team targets or goals should not be distributed to health care providers as individual targets. Consider rewarding facilities or teams to attain performance objectives specified as number of clients counseled, or number of new FP clients accepting FP methods. Please note: health facilities and teams have more than one health worker. For facilities with one health worker, refer to the guidelines for individual health workers.
3. Do include FP counseling as a component of antenatal and postnatal care indicators.
4. Do reward performance indicators that combine FP services provided and measures of FP quality.
5. Don’t compensate for delivery of specific FP methods with payments that are out of line with payments for other services, as this may lead to coercive behavior.

**Sub-national or national level:**
1. Do consider opportunities to link fiscal transfers from national to sub-national levels of government to results related to population coverage of specific methods, counseling and education, improved quality, and increased access.

(Eichler, Seligman, Beith, & Wright, 2010, p. xiii)
BIBLIOGRAPHY


