



Person-Centered Measurement: Ensuring Prioritization of Individuals' Values, Needs, and Preferences Within the Global Contraceptive Measurement Ecosystem

Claire W. Rothschild,  Kelsey Holt,  Funmilola M. OlaOlorun, Julius Njogu, Abednego Musau, and Christine Dehlendorf

Despite growing enthusiasm for measurement approaches that capture individuals' needs, values, and preferences, there remains a lack of conceptual clarity regarding person-centered measurement in the global field of contraception. In this commentary, we propose a working definition of person-centered measurement within the contraceptive field and describe how this definition can be applied to existing and novel contraceptive indicators. We argue that person-centered measures of contraception must both reflect an individual's self-identified values, needs, and/or preferences related to contraception and allow an individual to assess the extent to which these values, needs, and/or preferences have been fulfilled. As a result, a person-centered measure allows the individual to define for themselves whether a "good" outcome has been achieved. While person-centered measures are a critical component of measuring the performance of contraceptive programs, measurement frameworks must also include non-person-centered measures that allow evaluation of normative constructs such as human rights and reproductive justice.

Claire W. Rothschild, Population Services International, Washington, DC 20036, USA. Email: croth-schild@psi.org. Kelsey Holt, University of California, San Francisco, San Francisco, CA 94143, USA. Funmilola M. OlaOlorun, Department of Community Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria. Julius Njogu, Population Services International, Nairobi, Kenya. Abednego Musau, Population Services International, Nairobi, Kenya. Christine Dehlendorf, University of California, San Francisco, San Francisco, CA 94143, USA.

This article is part of the special issue: *Rethinking Family Planning Measurement with a Rights, Justice, and Person-Centered Lens*.

© 2025 The Author(s). *Studies in Family Planning* published by Wiley Periodicals LLC on behalf of Population Council.

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

There is a growing consensus in the global field of contraception that new measures and measurement approaches are needed (Speizer, Bremner, and Farid 2022; Fabric 2022; Senderowicz 2020). Critiques of standard indicators used to monitor and evaluate contraceptive programs—many of which were developed during the height of the population control era and have remained little-changed in the intervening half century (Bradley and Casterline 2014)—highlight the problematic approaches of defining contraceptive use as a universally positive outcome and of classifying contraceptive “need” for women without directly asking them what they need or want (Speizer, Bremner, and Farid 2022; Rothschild, Brown, and Drake 2021; Holt, Galavotti, et al. 2023; Rothschild et al. 2024; Senderowicz 2020). Take, for example, the core indicators used by the Family Planning 2030 (FP2030) initiative to track global progress in family planning (FP) programming (Online Appendix: Supplemental Materials, Table A1): Nine of the 22 indicators measure contraceptive use, focusing on modern methods; three indicators capture aspects of supply-side contraceptive method availability; and another six indicators measure fertility and health outcomes, such as number and percentage of births that are unintended (Track20). Only one indicator measures quality of contraceptive counseling, while another single indicator captures self/joint contraceptive decision-making—an aspect of contraceptive autonomy (Senderowicz 2020). FP2030 has itself highlighted the need for “improving measurement of rights and empowerment principles” (FP2030 2023). Similar critiques have been leveled at the U.S.’s Healthy People 2030 public health initiative, which includes a performance indicator on the use of effective birth control methods (Gomez et al. 2024).

In March 2024, an international expert working group meeting was convened by the International Union for the Scientific Study of Population (IUSSP) in Mombasa, Kenya, under the auspices of “Rethinking Family Planning Measurement with a Reproductive Justice and Rights Lens” (IUSSP 2024). A focus of the expert group meeting and following convenings was to align on a global measurement “ecosystem”—or set of priority indicators—that better reflects principles of human rights and reproductive justice in FP programming. To do so, the group discussed the need for inclusion of indicators related to contraceptive agency, self-efficacy, and autonomy, and social and gender norms relevant to contraception and reproductive health more broadly. In addition, the group discussed the need for measures that explicitly capture people’s individual preferences and subjective experiences. While much of the conversation focused on the need for so-called “person-centered” measures, several discussions during the meeting of what person-centeredness means as applied to measurement and how it in turn relates to principles of human rights and reproductive justice went unresolved. Notably, there was a lack of common understanding of whether measures of agency, empowerment, or one’s intention to use contraception are inherently person-centered (IUSSP 2024). The goal of this commentary is to improve conceptual clarity on person-centeredness in the context of contraception, focusing on the role of person-centered measures in advancing a broader rights-based and justice-informed contraceptive measurement agenda.

WHAT MAKES A CONTRACEPTION-RELATED MEASURE OR INDICATOR “PERSON-CENTERED”?

In its landmark 2001 report, the U.S. Institute of Medicine (IOM) Committee on Quality of Health Care brought this terminology to the global health stage. The IOM defined patient-centered care as “care that is respectful of and responsive to individual patient preferences, needs, and values and [that ensures] that patient values guide all clinical decisions” (IOM 2001). Following the IOM report, there were calls for the need to expand focus from the “patient”—the narrowly defined and passive beneficiary of care—to a holistic “person” with multifaceted values and experiences that influence their healthcare preferences and outcomes. This critique served as the basis for a reconceptualization of *patient*-centered care as *person*-centered care (Ekman et al. 2011). Reflecting the fundamental concept of patient-centered care, person-centered care aims to put people at the center of their health care through approaches such as empathy, respect, shared decision-making, and personalization (Eklund et al. 2019).

It follows that a contraception-related measure can be defined as person-centered if it assesses to what extent the construct being studied aligns with what people *themselves* want, need, and/or value related to contraception. Yet, myriad examples exist in the contraception literature of a broader interpretation of the concept of person-centeredness as it relates to measurement. An example of the lack of standardized terminology related to person-centered measurement is illustrated by a recent initiative aiming to measure person-centered contraceptive care, which describes a “person-centered measurement” approach that uses simulated clients, reflections with clinicians involved in implementing the intervention, and comparative analysis of healthcare providers’ language (Baayd et al. 2024). While simulated clients, clinician interviews, and analysis of provider language can be used to measure person-centered *care*, these measurement approaches themselves are not person-centered because they produce measures that do not capture clients’ own assessments of the care received.

We propose that person-centered *measurement* is fundamentally different from the measurement of person-centered *care* itself: the former is related to how the measure is framed and interpreted, while the latter is related to the construct being measured—for example, content or processes of care that are person-centered. In their 2018 narrative review of interventions to improve person-centered quality of FP care, Diamond-Smith, Warnock, and Sudhinaraset make a distinction between “person-centered care *processes* (i.e., dignity, autonomy, privacy/confidentiality, communication with providers/patients, social support in the facility including family members, supportive care, and trust in providers) and person-centered *outcomes* (i.e., patient satisfaction and experiences)” (Diamond-Smith, Warnock, and Sudhinaraset 2018). In the example above, we argue that methods to assess person-centered care through means that are not self-reported (such as simulated clients or clinician interviews) are valid methodologies for assessing person-centered care processes. However, they are not person-centered measurement approaches: first, they do not capture individual’s self-identified needs, values, and/or preferences; and second, they do not assess the extent to which the care provided aligns with those needs, values, and/or preferences. Sudhinaraset’s Person-Centered Family Planning scale provides another example of a measure of person-centered care that is not itself person-centered. To assess the extent to which

care is dignified and respectful, for example, the scale includes a question about whether the healthcare provider called the client by their name (Sudhinaraset et al. 2018). Because this item is interpreted based on a normative, universal standard for person-centered care (e.g., calling the client by their name is “good” person-centered care), it does not reflect an individual’s values and preferences and therefore is not—as a measure—person-centered.

Coming back to the idea of a measurement “ecosystem” for the contraception field, we emphasize that not all measures in the ecosystem *should* be person-centered. Person-centered measures are just one component of assessing fulfillment of rights and reproductive justice; a measurement ecosystem would not be comprehensive if it did not also include “objective” indicators, such as those related to technical quality of care. Person-centered measures reflect an individual’s subjective experiences. An individual’s assessment of quality of care, for example, may demonstrate that the care they received fully met their expectations, even when care fails to meet a minimum threshold for technical quality (Thompson and Sunol 1995; Bjertnaes, Sjetne, and Iversen 2012). For this reason, technical measures of care quality that are not person-centered are often critical for the appropriate interpretation and actioning of patient satisfaction indicators.

PROPOSED DEFINITION OF A PERSON-CENTERED CONTRACEPTION MEASURE

To provide clarity around the meaning of person-centeredness in contraception measurement, we propose a definition that hews more closely to definitions of patient- and person-centeredness in the health literature (Eklund et al. 2019; IOM 2001; Diamond-Smith, Warnock, and Sudhinaraset 2018).

We suggest that a measure (or indicator) can be considered person-centered if it meets both of the following criteria:

1. *The measure assesses an individual’s self-identified values, needs, or preferences:* Because person-centeredness centers the individual, a person-centered measure must capture that individual’s self-identified values, needs, and/or preferences. A person-centered measure cannot be one that is directly observed by the researcher (e.g., an observation of the client–provider interaction) or reported by the provider (e.g., a provider knowledge test) because such external assessments lack consideration of the individuals’ own perspectives or experiences. Even if a measure is reported by the individual (e.g., self- or person-reported), it may not meet this requirement *if* it does not capture some aspect of the individual’s values, needs, and/or preferences.
2. *The measure reflects the individual’s own definition of a “good” or a “bad” outcome:* In order to reflect the degree of person-centeredness of a particular outcome, person-centered measures must capture the extent to which an individual’s experiences or behaviors align with or fulfill their own self-defined values, needs, and/or preferences. Thus, a person-centered measure must reflect the person’s own assessment of the extent to which their needs, values, and preferences have or have not been met. A person-centered measure is one that allows the individual—rather than the

researcher or an external normative framework—to define what a “good” versus a “bad” outcome is for themselves related to the construct being measured.

Take, for example, two common indicators used in contraceptive research: intention-to-use contraception in the future and fertility intentions (e.g., desire for a [or another] child in the future). Both indicators meet criterion #1, as they are reported by the individual under study and they reflect that individual’s self-identified preferences for future contraceptive use and future fertility, respectively. We would not consider either measure to be person-centered, however, because neither indicator reflects the individual’s assessment of the extent to which their preferences have or have not been met (criterion #2), thus leaving interpretation of the measure as “good” or “bad” open to the observer, researcher, or other consumers of the data.

It is important to note that criterion #2 (above) can be satisfied in two ways. First, individuals can be asked to directly assess the extent to which a construct (e.g., behavior or experience) aligns with their preferences, values, and/or needs. For example, Bullington et al. (2023) have described “self-perceived” measures of informed choice in contraceptive counseling, which directly ask the respondent whether they received enough information to make a good choice for themselves about contraception. In this example, the respondent assesses for themselves what “enough information” means based on their own values and preferences, thereby fulfilling both criteria above and making this a person-centered measure. This can be contrasted with what Bullington et al. call “researcher-ascribed” measures of informed contraceptive choice, in which the researcher makes normative judgments about requirements that must be met in order for informed choice to occur.

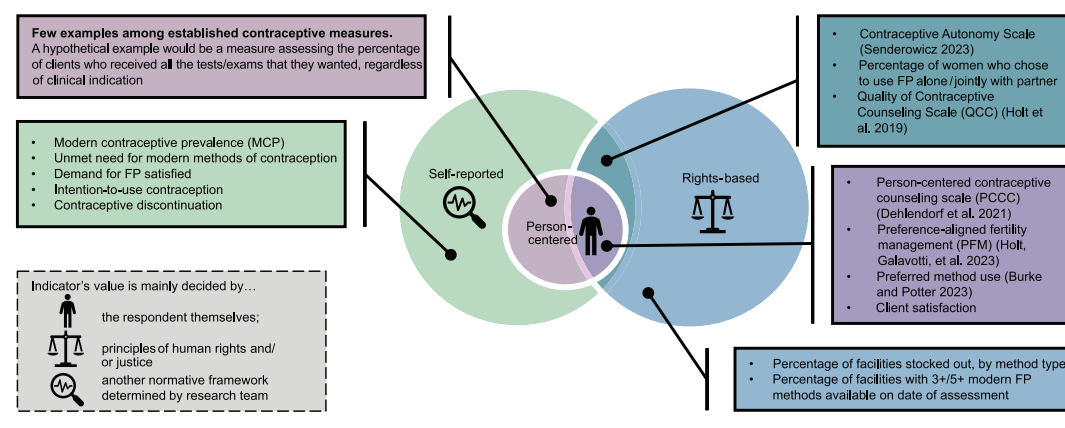
In addition to person-centered measures that directly ask participants to evaluate the extent to which an experience or behavior aligns with their preferences, there is a second, emerging type of person-centered indicator that indirectly assesses to what extent the construct being measured is concordant (or discordant) with individual preference. Holt, Galavotti, et al. (2023) have proposed, for example, a novel measure called preference-aligned fertility management (PFM), which is constructed by asking the respondent if they want to be using contraception right now; if they *are* using contraception right now; and if the contraceptive method they are using right now is the one they want to be using. A respondent is coded as practicing PFM (a “good” outcome) if their contraceptive use and method type align with their preferences, irrespective of whether their preference is to use or not use contraception. Another indicator of this type proposed by Burke and Potter is preferred method use, which is defined as concordance between use and stated preference for a specific contraceptive method type (including non-use as an acceptable preference) (Burke and Potter 2023; Gomez et al. 2024). The PFM and preferred method use indicators differ from the “self-perceived” measures described previously in that they do not directly ask the individual whether her contraceptive use matches her preferences. However, because PFM is interpreted based on the respondent’s self-identified preferences—what the respondent says she wants—rather than based on some external normative framework, we consider PFM and preferred method use to fulfill both criteria above and to be person-centered measures.

While straightforward in theory, defining what does and does not qualify as a person-centered measure becomes more complicated upon application. Table 1 presents several examples of measures of the same contraceptive constructs that we would and would not

TABLE 1 Illustrative examples of person-centered and non-person-centered measures of contraceptive constructs

Construct	Example of a person-centered measure	Analogous measure that is not person-centered
Dignified/respectful contraceptive care	<i>Item from Quality of Contraceptive Counseling Short Version (QCC-10) scale (Holt, Karp, et al. 2023):</i> The provider gave me the time I needed to consider the contraceptive options we discussed	<i>Item from Performance Monitoring for Action (PMA) client exit interview questionnaire:</i> How long did you wait between the time you arrived at this facility and the time you were able to see a provider for the consultation (in minutes/hours)? (Does not fulfill criteria #1 or #2)
	<i>Item from the Person-Centered Family Planning Scale (Sudhinaraset et al. 2018):</i> Did the doctors, nurses, or other staff at the facility treat you with respect?	<i>Item from EngenderHealth REDDI Client-Centered Counseling Skills Observation Checklist (EngenderHealth):</i> Did the provider greet the client with respect? (Does not fulfill criteria #1 or #2)
	<i>Item from the PCCC measure (Dehlendorf et al. 2021):</i> Think about your visit. How do you think [Provider Name] did: Giving me enough information to make the best decision about my birth control method.	<i>Method Information Index (Jain et al. 2019):</i> 1. Were you informed about other methods of family planning? 2. Were you informed about possible side effects or problems you might have with the method? 3. Were you told what to do if you experience any side effects or problems? (Does not fulfill criteria #1 or #2)
Informed contraceptive choice	<i>Item from the QCC-10 scale (Karp et al. 2023):</i> I received all the information I wanted to know about my options for contraceptive methods.	<i>Contraceptive Autonomy Scale - Informed Choice Domain (Senderowicz et al. 2023; Senderowicz 2020)</i> 1. Knows how to use a method from each group 2. Knows a benefit/advantage of non-use of family planning 3. Knows a risk/disadvantage of non-use of family planning 4. Knows a benefit/advantage of their method 5. Knows a risk/disadvantage of their method 6. Knows what to do in case of side effects 7. Was told about the method of removal/permanence (Does not fulfill criteria #1 or #2)
	<i>Preference-aligned fertility management index (Holt, Galavotti, et al. 2023):</i> Concordance between contraceptive use and method type and one's preferences, irrespective of whether their preference is to use or not use contraception	<i>Unmet need for family planning measures:</i> Discordance between contraceptive use and stated fertility intentions (Fulfills criterion #1 but does not fulfill criterion #2) <i>Intention-to-use contraception measure:</i> Stated intention to use contraception or not in the future (Fulfills criterion #1 but does not fulfill criterion #2)
Contraceptive use		

FIGURE 1 A classification of illustrative person-centered, rights-based, and/or self-reported family planning indicators



consider to be person-centered measures. Below, we reflect on several areas of possible confusion.

HOW DO PERSON-CENTERED MEASURES DIFFER FROM RIGHTS-BASED OR REPRODUCTIVE JUSTICE-INFORMED MEASURES?

A human rights-based approach is one that is “normatively based on international human rights standards and operationally directed to promoting and protecting human rights” (United Nations 2024). Extending this definition to measurement, a rights-based measure’s purpose is to assess to what extent human rights are being fulfilled, regardless of whether an individual themselves expects or demands those rights. The Reproductive Justice framework, developed by Black American feminists following the 1994 International Conference on Population and Development, is itself a rights-based framework that builds upon principles of human rights and emphasizes the role that intersectional forms of oppression—including racism, classism, and sexism—play in determining whether individuals’ human right to reproductive autonomy is upheld (Gilliam, Neustadt, and Gordon 2009; Cadena, Chaudhri, and Scott 2022; In Our Own Voice: National Black Women’s Reproductive Justice Agenda 2024). Rights-based measures, including reproductive justice-informed measures, are inherently normative, in that their design and interpretation are based on a conceptual model that defines whether an outcome is a positive one or not according to whether an individual’s right to reproductive freedom is upheld. Given that an individual’s own preferences may differ from what is defined as positive according to a rights-based lens, we argue that rights-based measures related to contraceptive programming are not inherently person-centered (Figure 1). Critical to this distinction is that the main decision-maker—the actor or set of principles that guide how the measure is interpreted—differs by measure type: for a person-centered measure, the main decision-maker is the individual themselves, whereas for a rights-based

(but non-person-centered) measure, this decision is guided by a set of principles (e.g., human rights or reproductive justice).

Examples of rights-based contraceptive measures include but are not limited to measures related to availability and technical quality of contraceptive care—for example, measures of healthcare providers' clinical knowledge; availability of a specific number of different contraceptive method types within a facility; and contraceptive method stock outs. These measures can be considered rights-based in that they aim to assess whether care was available and technically appropriate; they are not person-centered measures, because interpretation is guided by a normative, rights-based conceptual model of what high-quality contraceptive care should include and not by the person's own perception of the adequacy or appropriateness of the care they received. To provide another example, Sustainable Development Goal indicator 5.3.1 on early marriage (the proportion of girls and women aged 20–24 years who were married or in union before age 15 and before age 18) is considered a rights-based indicator reflective of gender equality and empowerment. We do not consider this indicator to be person-centered, as it does not capture the individual's perspectives, values, or preferences related to early marriage. Similarly, the percentage of women who report deciding to use FP alone or jointly with their partner is a Demographic and Health Survey indicator and a core indicator in the FP2030 measurement framework, widely interpreted as a reflection of individual autonomy and voluntariness of FP use (FP2030 2023). Self/joint FP decision-making is a justice-informed measure that is *not* person-centered under our definition, as interpretation is based on normative values of autonomy and not on whether the respondent's FP decision-making aligns with her individual preferences and values.

For another example, we take the case of measurement of informed contraceptive choice. Using a justice-informed conceptual model of informed contraceptive choice, Senderowicz et al. (2023) have proposed that informed choice occurs when a number of factors are in place, including knowledge of a range of different contraceptive methods; understanding of both advantages and disadvantages of the selected method; and knowledge of side effects of the selected method, among others. Scoring of the informed choice domain of Senderowicz's Contraceptive Autonomy Scale—to what extent informed choice is present or not—is guided by whether all items comprising informed choice are present, rather than by the respondent's own assessment (Senderowicz 2019, 2020). This approach can be contrasted with the informed choice-related item of the Person-Centered Contraceptive Counseling (PCCC) measure, which asks contraceptive clients, “How do you think your provider did giving [you] enough information to make the best decision about [your] birth control method?” (Dehlendorf et al. 2021). In this example, the respondent assesses for themselves what “enough information” means based on their own values and preferences, making this a person-centered measure. It is important to note that a limitation of some person-centered contraception measures is that they assume that the construct being measured, such as information or choice, is in itself valued by the respondent. For example, in the case of the PCCC measure, the respondent defines for themselves whether informed choice occurred, yet they are not asked the degree to which they value informed contraceptive choice in the first place.

Defining rights- and justice-based measures as distinct from person-centered measures does not indicate that one type of measure is preferable. Rather, both are important and reflect different aspects of the extent to which programs and policies are enabling optimal contracep-

tive experiences. For instance, in the example of the PCCC and the Contraceptive Autonomy Scale measures, both capture important but distinct aspects of informed contraceptive choice. The former is focused on whether people are receiving care that meets their needs, given their current context and desires, which is critical for understanding people's experiences in their sociocultural context. In contrast, the latter provides insight into whether care is aligned with human rights principles.

ARE ALL MEASURES OF CONTRACEPTIVE EMPOWERMENT NECESSARILY PERSON-CENTERED?

Because the constructs of self-efficacy, agency, autonomy, and empowerment center respect of individuals, it may be falsely assumed that measures of these constructs are person-centered by definition. As we argued in the case of person-centered outcomes versus person-centered processes, measures of person-centered constructs are not necessarily themselves person-centered. The Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation's Reproductive Empowerment Scale is an example of a measure of empowerment that we would not define as person-centered. In the MEASURE scale, participants who respond affirmatively to statements such as "you can initiate conversations about using contraception with your partner" are coded as having higher levels of empowerment than respondents who respond in the negative (Mandal and Albert 2020). While covert use is often driven by inequitable gender norms and patriarchal social and familial structures (Kibira et al. 2020), qualitative studies highlight the nuances of covert use, with some covert users expressing views that male partners should not be involved in contraceptive decisions and others viewing covert use as an example of empowered decision-making within a constrained context (Kibira et al. 2020; Hoyt et al. 2022). If such a measure were redesigned from a person-centered perspective, it might ask women the extent to which they could exercise power in their decisions to use contraception in the way that they want to—thereby leaving interpretation of power to the individual. Further, as is increasingly recognized within the contraception field, one's right to informed choice related to contraception is contingent upon the individual's agency in decision-making—not just related to having information but their ability to form values-based preferences and have critical consciousness of the societal conditions that constrain their reproductive autonomy (Holt et al. 2024; Edmeades et al. 2018). Emergent measures of agency related to contraceptive decision-making will fill an important void within the measurement ecosystem but will not all inherently be *person-centered*; for example, measures of critical consciousness capture empowerment *processes* but are not person-centered outcomes as individuals' own preferences and values are not considered.

HOW DO PERSON-CENTERED MEASURES DIFFER FROM PATIENT-REPORTED OUTCOMES?

Health services researchers have increasingly called for the use of patient-reported outcomes (PROs) in assessing person-centered care and healthcare quality (Garcia and Spertus 2021; Liu, Bozic, and Teisberg 2017; cms.gov Measures Management System 2023). In the context

of value-based payments in the U.S. healthcare landscape, Liu, Bozic, and Teisberg (2017) propose that person-centered measurement should focus on measures of healthcare quality that reflect patients' stated priorities for care and their experiences of care. Under our definition, all person-centered measures would be defined as PROs. However, while some PROs qualify as person-centered measures under this definition, many do not: being self-reported is necessary for meeting criterion #1 for our proposed definition of a person-centered measure but not sufficient. To fulfill criterion #1, a measure must be both self-reported *and* the measure must capture some aspect of preference, values, or self-identified needs. Take as an example patient-reported measures of physical activity. Such measures meet the definition of PROs (since they are self-reported by the patient) but would not be considered person-centered under our definition, because self-reported physical activity measures do not capture individual values, preferences or needs (criterion #1) or the individual's interpretations regarding what level/type of physical activity is "good" versus "bad" according to their own values (criterion #2).

CONCLUSION

In this commentary, we attempt to address some of the unresolved conceptual discussions at the 2024 IUSSP panel related to how person-centered measurement fits within the movement towards a global rights-based and justice-informed measurement ecosystem—as described above, a suite of measures that, together, provide a comprehensive picture of the status of contraceptive experiences from multiple perspectives within a particular program, country, region, or globally (IUSSP 2024). We put forth a definition for person-centered contraception measures based on two criteria: person-centered measures are (1) self-reported and capture constructs related to values, preferences, and/or needs and (2) with response scales that reflect the individual's own interpretation of what is a "good" or a "bad" outcome. As the global contraceptive community continues to critique, develop, and validate new measures, we emphasize that person-centered measures are one (but certainly not the only) important component of a measurement ecosystem. Normative measures and measurement approaches will play a critical role in such a framework: to hold contraceptive programming accountable to a set of universal standards rooted in human rights and reproductive justice frameworks. Indeed, in order to comprehensively assess whether contraceptive programming is meeting rights-based and justice-informed standards, we need to include *non*-person-centered indicators, including measures of the health system and policy environment; technical quality of care; and the extent to which care incorporates essential person-centered processes to uphold dignity, respect, and autonomy. However, it is also critical that person-centered measures that capture people's lived experiences and subjectivities, which are not currently included in the suite of global sexual and reproductive health and rights (SRHR) measurement frameworks (FP2030 2023), be prioritized. Qualitative data will be critical to the development and validation of such measures, ensuring that quantitative, person-centered measures validly reflect individuals' own qualitative assessments of the construct under study. The inclusion of such qualitatively validated, person-centered measures within a suite of contraceptive indicators will ensure that global efforts to measure progress in global contraceptive programming

capture not only universal standards, but also reflect the needs, values, and preferences of the individuals whom these global efforts are meant to serve.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to disclose.

REFERENCES

- Baayd, J., C. Quade, A. Gero, and R. G. Simmons. 2024. "O08 - Measurement That Matches Our Values: Person-Centered Measurement of a Person-Centered Contraceptive Initiative." *Contraception* 139: 110566. <https://doi.org/10.1016/j.contraception.2024.110566>.
- Bjertnaes, Oyvind A., Ingeborg Strømseng Sjetne, and Hilde Hestad Iversen. 2012. "Overall Patient Satisfaction With Hospitals: Effects of Patient-Reported Experiences and Fulfilment Of Expectations." *BMJ Quality & Safety* 21 (1): 39. <https://doi.org/10.1136/bmjqs-2011-000137>.
- Bradley, Sarah E., and John B. Casterline. 2014. "Understanding Unmet Need: History, Theory, and Measurement." *Studies in Family Planning* 45 (2): 123–50. <https://doi.org/10.1111/j.1728-4465.2014.00381.x>.
- Bullington, Brooke, Leigh Senderowicz, Nathalie Sawadogo, Katherine Tumlinson, Ana Langer, Soura Abdramane, Pascal Zabre, and Ali Sie. 2023. "Measuring Informed Choice: comparing self-perceived and researcher-ascribed measures." Paper was presented at the Population Association of America Annual Meeting, New Orleans, Louisiana, USA. <https://events.rdmobile.com/Lists/Details/1726817>.
- Burke, Kristen Lagasse, and Joseph E. Potter. 2023. "Meeting Preferences for Specific Contraceptive Methods: An Overdue Indicator." *Studies in Family Planning* 54 (1): 281–300. <https://doi.org/10.1111/sifp.12218>.
- Cadena, Denicia Sam, Aisha Chaudhri, and Cherisse Scott. 2022. "Contraceptive Care Using Reproductive Justice Principles: Beyond Access." *American Journal of Public Health* 112 (S5): S494–99. <https://doi.org/10.2105/AJPH.2022.306915>.
- Dehlendorf, Christine, Edith Fox, Ilana A. Silverstein, Alexis Hoffman, Maria Paula Campora Pérez, Kelsey Holt, Reiley Reed, and Daneille Hessler. 2021. "Development of the Person-Centered Contraceptive Counseling Scale (PCCC), a Short Form of the Interpersonal Quality of Family Planning Care Scale." *Contraception* 103 (5): 310–15. <https://doi.org/10.1016/j.contraception.2021.01.008>.
- Diamond-Smith, Nadia, Ruby Warnock, and May Sudhinaraset. 2018. "Interventions to Improve the Person-Centered Quality of Family Planning Services: A Narrative Review." *Reproductive Health* 15. <https://doi.org/10.1186/s12978-018-0592-6>.
- Edmeades, Jeffrey, Laura Hinson, Meroji Sebany, and Lydia Murithi. 2018. *A Conceptual Framework for Reproductive Empowerment: Empowering Individuals and Couples to Improve Their Health*. Washington, D.C., International Center for Research on Women.
- Ekman, Inger, Karl Swedberg, Charles Taft, Anders Lindseth, Astrid Norberg, Eva Brink, Jane Carlsson, Synneve Dahlin-Ivanoff, Inga-Lill Johansson, Karin Kjellgren, Eva Lidén, Joakim Öhlén, Lars-Eric Olsson, Henrik Rosén, Martin Rydmark, and Katharina Stibrant Sunnerhagen. 2011. "Person-Centered Care — Ready for Prime Time." *European Journal of Cardiovascular Nursing* 10 (4): 248–51. <https://doi.org/10.1016/j.ejcnurse.2011.06.008>.
- EngenderHealth. "REDI: A Client-Centered Counseling Framework. Participant's Handbook." Washington, DC: EngenderHealth. <https://www.engenderhealth.org/wp-content/uploads/imported-files/REDI-Participants-Handbook-Part-2-Training-Handouts.pdf>.
- Fabic, Madeleine Short. 2022. "What Do We Demand? Responding to the Call for Precision and Definitional Agreement in Family Planning's "Demand" and "Need" Jargon." *Global Health: Science and Practice* 10 (1): e2200030. <http://www.ghspjournal.org/content/10/1/e2200030.abstract>.
- FP2030. 2023. FP2030 Measurement Framework.
- Garcia, Raul Angel, and John A. Spertus. 2021. "Using Patient-Reported Outcomes to Assess Healthcare Quality: Toward Better Measurement of Patient-Centered Care in Cardiovascular Disease." *Methodist Debaque Cardiovascular Journal* 17 (1): e1–e9. <https://doi.org/10.14797/vuwd7697>.

- Gilliam, Melissa L., Amy Neustadt, and Rivka Gordon. 2009. "A Call to Incorporate A Reproductive Justice Agenda Into Reproductive Health Clinical Practice and Policy." *Contraception*, 79 (4): 243–46.
- Gomez, Anu Manchanda, Reiley Diane Reed, Ariana H. Bennett, and Megan Kavanaugh. 2024. "Integrating Sexual and Reproductive Health Equity Into Public Health Goals and Metrics: Comparative Analysis of Healthy People 2030's Approach and a Person-Centered Approach to Contraceptive Access Using Population-Based Data." *JMIR Public Health Surveillance* 10: e58009. <https://doi.org/10.2196/58009>. <https://publichealth.jmir.org/2024/1/e58009>.
- United Nations Sustainable Development Group. 2024. "Human Rights-Based Approach." New York: United Nations. <https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach>.
- Holt, Kelsey, Sneha Challa, Phoebe Alitubeera, Lynn Atuyambe, Christine Dehlendorf, Christine Galavotti, Ivan Idiodi, Ayobambo Jegede, Elizabeth Omoluabi, Peter Waiswa, and Ushma Upadhyay. 2024. "Conceptualizing Contraceptive Agency: A Critical Step to Enable Human Rights-Based Family Planning Programs and Measurement." *Global Health: Science and Practice* 12 (1). <https://doi.org/10.9745/ghsp-d-23-00299>.
- Holt, Kelsey, Celia Karp, Bella V. Uttekar, Ximena Quintero, Ewenat Gebrehanna, Lakhwani Kanchan, and Icela Zavala. 2023. "Reduction of the Quality of Contraceptive Counseling (QCC) scale to a short version (QCC-10) in Ethiopia, India, and Mexico." *Contraception* 118: 109890. <https://doi.org/10.1016/j.contraception.2022.09.128>.
- Holt, Kelsey, Christine Galavotti, Elizabeth Omoluabi, Sneha Challa, Peter Waiswa, and Jenny Liu. 2023. "Preference-Aligned Fertility Management as a Person-Centered Alternative to Contraceptive Use-Focused Measures." *Studies in Family Planning* 54 (1): 301–8. <https://doi.org/10.1111/sifp.12228>.
- Hoyt, Jenna, Jessie K. Hamon, Shari Krishnaratne, Emmanuel Houndekon, Dora Curry, Miriam Mbembe, Seth Marcus, Misozi Kambanje, Shannon Pryor, Ariko Angela Barbra, Herbert Muhumuza, Nathaly Spilotros, and Jayne Webster. 2022. "‘It Was My Own Decision’: The Transformational Shift That Influences a Woman’s Decision to Use Contraceptives Covertly." *BMC Women’s Health* 22 (1): 144. <https://doi.org/10.1186/s12905-022-01731-z>.
- Håkansson Eklund, Jakob, Inger K. Holmström, Tomas Kumlin, Elenor Kaminsky, Karin Skoglund, Jessica Högländer, Annelie J. Sundler, Emelie Condén, and Martina Summer Meranius. 2019. "‘Same or Different?’ A Review of Reviews of Person-Centered and Patient-Centered Care." *Patient Education and Counseling* 102 (1): 3–11. <https://doi.org/10.1016/j.pec.2018.08.029>.
- In Our Own Voice: National Black Women’s Reproductive Justice Agenda. 2024. "Reproductive Justice." Accessed November 13, 2024. <https://blackrj.org/our-causes/reproductive-justice/>.
- Institute of Medicine Committee on Quality of Health Care in America. 2001. "Crossing the Quality Chasm: A New Health System for the 21st Century." Washington, DC: National Academies Press (US)
- International Union for the Scientific Study of Population. 2024. "Rethinking Family Planning Measurement with a Reproductive Justice and Rights Lens." Accessed November 6, 2024. <https://iussp.org/en/rethinking-family-planning-measurement-reproductive-justice-and-rights-lens>. Paris: IUSSP.
- IUSSP. 2024. "Assessing Approaches to Demand-Side Family Planning Measurement with a Reproductive Justice and Rights Framework": IUSSP Expert Group Meeting Report. Paris: IUSSP.
- Jain, Aparna, Kumudha Aruldas, Elizabeth Tobey, Arupendra Mozumdar, and Rajib Acharya. 2019. "Adding a Question About Method Switching to the Method Information Index Is a Better Predictor of Contraceptive Continuation." *Global Health: Science and Practice* 7 (2): 289–99. <https://doi.org/10.9745/ghsp-d-19-00028>.
- Karp, Celia, Funmilola M. OlaOlorun, Georges Guiella, Peter Gichangi, Yoonjoung Choi, Philip Anglewicz, and Kelsey Holt. 2023. "Validation and Predictive Utility of a Person-Centered Quality of Contraceptive Counseling (QCC-10) Scale in Sub-Saharan Africa: A Multicountry Study of Family Planning Clients and a New Indicator for Measuring High-Quality, Rights-Based Care." *Studies in Family Planning* 54 (1): 119–43. <https://doi.org/10.1111/sifp.12229>.
- Kibira, Simon P. S., Celia Karp, Shannon N. Wood, Selamawit Desta, Hadiza Galadanci, Fredrick E. Makumbi, Elizabeth Omoluabi, Solomon Shiferaw, Assefa Seme, Amy Tsui, and Caroline Moreau. 2020. "Covert Use of Contraception in Three Sub-Saharan African Countries: A Qualitative Exploration of Motivations and Challenges." *BMC Public Health* 20 (1): 865. <https://doi.org/10.1186/s12889-020-08977-y>.
- Liu, Tiffany C., Kevin J. Bozic, and Elizabeth O. Teisberg. 2017. "Person-Centered Measurement: Focusing on the Three C’s." *Clinical Orthopaedics and Related Research* 475 (2): 315–17. <https://doi.org/10.1007/s11999-016-5205-5>.

- Mandal, M, and L.M. Albert. 2020. "Reproductive Empowerment Scale: Psychometric Validation in Nigeria." Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina.
- Rothschild, Claire W., Win Brown, and Alison L. Drake. 2021. "Incorporating Method Dissatisfaction Into Unmet Need for Contraception: Implications for Measurement and Impact." *Studies in Family Planning* 52 (1): 95–102. <https://doi.org/10.1111/sifp.12146>.
- Rothschild, Claire W., Alhaji Bulama, Roselyn Odeh, Salome Chika-Igbokwe, Julius Njogu, Katherine Tumlinson, and Abednego Musau. 2024. "Preference-Aligned Fertility Management Among Married Adolescent Girls in Northern Nigeria: Assessing A New Measure of Contraceptive Autonomy." *BMJ Global Health* 9 (5): e013902. <https://doi.org/10.1136/bmjgh-2023-013902>.
- Senderowicz, Leigh. 2019. "“I Was Obligated to Accept”: A Qualitative Exploration of Contraceptive Coercion." *Social Science & Medicine* 239: 112531. <http://www.sciencedirect.com/science/article/pii/S0277953619305258>.
- Senderowicz, Leigh. 2020. "Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator." *Studies in Family Planning* 51 (2): 161–76. <https://doi.org/10.1111/sifp.12114>.
- Senderowicz, Leigh, Brooke W. Bullington, Nathalie Sawadogo, Katherine Tumlinson, Ana Langer, Abdramane Soura, Pascal Zabré, and Ali Sié. 2023. "Measuring Contraceptive Autonomy at Two Sites in Burkina Faso: A First Attempt to Measure a Novel Family Planning Indicator." *Studies in Family Planning* 54 (1): 201–30. <https://doi.org/10.1111/sifp.12224>.
- Speizer, Ilene S., Jason Bremner, and Shiza Farid. 2022. "Language and Measurement of Contraceptive Need and Making These Indicators More Meaningful for Measuring Fertility Intentions of Women and Girls." *Global Health: Science and Practice* 10 (1): e2100450. <http://www.ghspjournal.org/content/10/1/e2100450.abstract>.
- Sudhinaraset, May, Patience A. Afulani, Nadia Diamond-Smith, Ginger Golub, and Aradhana Srivastava. 2018. "Development of a Person-Centered Family Planning Scale in India and Kenya." *Studies in Family Planning* 49 (3): 237–58. <https://doi.org/10.1111/sifp.12069>.
- CMS.gov Measures Management System. 2023. "Patient-Reported Outcome Measures."
- Thompson, Andrew G. H., and Rosa Sunol. 1995. "Expectations as Determinants of Patient Satisfaction: Concepts, Theory and Evidence." *International Journal for Quality in Health Care* 7 (2): 127–41. <https://doi.org/10.1093/intqhc/7.2.127>.
- Track20. "FP2030 Indicators." https://www.track20.org/pages/data_analysis/core_indicators/overview.php.

ACKNOWLEDGMENTS

We wish to thank the members of the IUSSP panel "Rethinking Family Planning Measurement with a Reproductive Justice and Rights Lens" for their support and feedback on earlier iterations of this work. The authors received no specific funding for the authorship or publication of this commentary.