CASE STUDY

Seizing the Moment:
How the London Summit on Family Planning Revitalized International Family Planning

September 2015

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<table>
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<tr>
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<th>Description</th>
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<tbody>
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<td>International Conference on Population and Development</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>Partners in Population and Development</td>
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<td>Reproductive Health Supplies Coalition</td>
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“Today is a chance for us to reflect on everything we’ve accomplished so far and to move forward together with new conviction to empower women to lift up their families and to lift up their communities. There’s a very simple reason that the partners called the summit together, and that is that hundreds of millions of women who don’t have access to contraceptives demand our action.” – Melinda Gates, Co-Chair of the Bill & Melinda Gates Foundation

“Women should be able to decide freely and for themselves whether, when and how many children they have. It is absolutely fundamental to any hope to tackling poverty in our world.” – David Cameron, UK Prime Minister

These powerful words, spoken by Melinda Gates and David Cameron at the London Summit on Family Planning on July 11, 2012, illustrated a turning point in the history of family planning. On that day, more than 150 leaders from governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community stood up and pledged their commitment to enabling 120 million more women and girls to use contraceptives by 2020. More than 20 governments made commitments to address the policy, financing, delivery and socio-cultural barriers women face in accessing contraceptive information, services and supplies. Donors also pledged an additional $2.6 billion in funding.

How did this group of people end up in the same room, bringing attention to the importance of family planning? How did the Summit mobilize commitments from these and other leaders from around the world, and this extraordinary amount of new investment? In short, the planners of the London Summit seized the moment – and this is their story.

The Storytellers
This storyline was drawn from desk research and interviews with key stakeholders involved in the planning and execution of the Summit.¹ Key informants, their titles and the organizations they represented at the time of the Summit were:

1. Brian Siems - Portfolio Manager for the Family Health Team, Bill & Melinda Gates Foundation (BMGF)
2. Enrique Ona - Secretary of Health, Philippines
4. Jotham Musinguzi - Regional Director for the Africa Regional Office, Partners in Population and Development (PPD)
5. Julia Bunting - Team Leader of the AIDS and Reproductive Health Team, UK Department for International Development (DFID)
6. Leo Bryant - Senior Global Policy Advisor, Marie Stopes International (MSI)
7. Monica Kerrigan - Deputy Director of Family Planning, BMGF
8. Oying Rimon - Senior Program Officer, Global Health Policy & Advocacy for Family Planning, Reproductive, Maternal, Neonatal and Child Health and Nutrition, BMGF
10. Tewodros Melesse – Director-General, International Planned Parenthood Federation (IPPF)

¹ Additional information on the methodology of this research can be found in Annex 1.
A) Setting the Scene

Access to safe, effective methods of contraception is considered one of the most cost-effective investments a country can make in its future. Studies show that every US $1 invested in family planning services yields up to $6 in savings on health, housing, water and other public services. Improving access to voluntary, quality contraceptive information, services and supplies is also an intervention that supports many other critical elements of a productive society, including leading to more education and greater opportunities for girls, helping to end the cycle of poverty for them and their families.

In short, the evidence is clear (and has been for some time): family planning is a critical intervention for healthy and productive lives and thriving communities.

Family Planning History

The history of family planning is an important context for understanding how and why the London Summit on Family Planning (“the Summit”) came to be. In the 1950s and 1960s, global discussion of family planning gained added urgency as proponents began to warn governments of an impending “population crisis” and to call on them to support family planning services.

The period between 1974 and the mid-1980s has been called the “golden era” of international family planning as the idea of small families, achieved through voluntary family planning programs, spread rapidly and resulted in the widespread adoption of contraceptive use. During this time, a strong infrastructure of organizations working to advance this issue was established.

But not all countries adopted family planning programs that were voluntary. China has been accused of having coercive programs and in the past, India was also criticized for having incentive programs that were viewed as coercive. Such government-imposed policies that are perceived as opposing the rights of women have fueled protests among some women’s rights groups who saw family planning as an instrument of population control (versus an intervention in support of women’s health and well being), as discussed below. These critics of family planning programs believed that target-based programs could lead to coercion and a variety of human rights abuses. This movement slowly grew in the 1980s and political complexities – for example, religious and conservative objections that equate family planning to abortion or promoting promiscuity among young unmarried youth – continued to fuel and politicize the issue.

The Pendulum Swings

Two major issues arose in the 1980s that brought this golden era to an end. The first was an abrupt change in U.S. policy following the election of Ronald Reagan as U.S. President in 1980. Reagan’s administration adopted a strong and highly visible position opposing abortion. Further, it declared that population growth was not a significant factor in economic development, casting a shadow over the population movement and undermining the macro-economic development rationale for family planning that had influenced progress from the 1950s onward. The second issue was the emergence of HIV/AIDS, which shifted focus and funding away from international cooperation on family planning, with an accompanying reorientation of family planning service delivery systems to HIV/AIDS prevention and care.

While the dramatic change in U.S. policy and the HIV/AIDS pandemic were the two major factors that led to diminished attention and funding devoted to family planning programs, there was a much less well noticed threat that began to develop in the late 1970s or early 1980s and slowly grew through the decade of the ‘80s. This was a movement, largely

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3 London Summit Overview. Additional information on the rationale for family planning can be found in: Ahmed S et al, Maternal deaths averted by contraceptive use: an analysis of 172 countries, The Lancet 2012; Speidel J et el, Making the case for U.S. international family planning assistance, 2009
4 Content in this section is drawn from Steve Sinding’s Historical Context paper, found in Annex 2.
5 Steve Sinding’s Historical Context and “Family Planning: the unfinished agenda”
6 Steve Sinding’s Historical Context
comprised of women who believed that family planning programs were primarily interested in women as an instrument of population control and not in women’s health and well being for their own sakes. They pointed to demographic goals and the targets derived from those goals for family planning fieldworkers to achieve, often expressed as “new acceptors” of contraception or in terms of the “contraceptive prevalence rate.”

In 1994, 179 member states came together in Cairo at the International Conference on Population and Development (ICPD), which set out to articulate a new vision on the relationships between population, development and individual well being. In the lead up to the event, it became clear that the women’s rights movement was well organized and determined that the ICPD Programme of Action (PoA) would reflect a new vision of population and development, one based not on population goals and targets but on the rights and well-being of individuals. The U.S. delegation played a major role in the shaping of this new paradigm.

This “paradigm shift,” as it was called by many, alarmed traditional leaders of the population movement because they thought it diverted attention from the goal of reducing fertility and achieving population stabilization. The final PoA went so far as to drop family planning from the title, which became “Reproductive Rights and Reproductive Health”. “Family Planning” was relegated to a chapter subheading.7

“That was the moment where the community shifted to a much more rights-based approach to family planning at large, coupled with the expansion of the family planning conversation into the broader sexual and reproductive health and rights [space].” – Brian Siems (BMGF)

Leaders of the women’s rights and women’s health movement regarded the ICPD as a great triumph. As a negotiated document with United Nations (UN), donor and country support, governments began to change their official attitudes toward population and reproductive health and rights. Many countries that had established demographic goals and targets dropped them in favor of what came to be called rights-based programs, emphasizing improved quality of care and attention to reproductive health problems such as sexually transmitted diseases, infertility and sexual violence. At the same time, some donor countries actively encouraged their developing country partners to shift from population-oriented policies to reproductive health and, increasingly, reproductive rights policies.8

The new focus on reproductive health and rights brought with it a decline in attention to and resources for family planning:

- **Funding for contraceptives began to fall.** As noted by Scott Radloff (USAID), “I often felt like we [USAID] were the lone ranger out there – other donors had moved on to HIV/AIDS, to malaria, to other health issues.”
- **Contraceptive supplies became limited.** Women who depended on public resources for their family planning supplies found it increasingly difficult to find reliable sources of supply.9
- **Contraceptive prevalence rates began to decline in some countries.** Data from censuses at the end of the first decade of the 2000s showed that fertility decline had slowed and surveys in many countries showed flat or declining rates of contraceptive use.10

Several interviewees noted that the absence of family planning from the Millennium Development Goals (MDGs)11 was another clear indicator that the issue fallen off the global agenda. Jotham Musinguzi (PPD) said, “When in 2000 in NY at

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7 Ibid
8 Ibid
9 London Summit Overview
10 Steve Sinding’s Historical Context
11 The Millennium Development Goals (MDGs) are the series of eight time-bound and quantified targets agreed to by global leaders in 2000 to reduce extreme poverty in its many dimensions by 2015. This framework has helped to galvanize development efforts and guide global and national development priorities between 2000-2015.
the UN, when the global community decided to [set] the MDGs and family planning and reproductive health were not at the center stage, we realized we were obviously losing out.”

Supporters of family planning became increasingly concerned. Thus, beginning in the last decade, advocates and practitioners in the community began to turn their attention to a revival of family planning as a key component of the global health and development discourse.

Baby Steps Forward

Several developments helped to set the stage for a serious and sustained effort to revitalize the family planning movement. For example, toward the end of the 1990s and continuing into the first decade of the 21st Century, economic research confirmed the “demographic dividend”, which refers to the accelerated economic growth of a country when the labor force grows more rapidly than the population dependent on it, freeing up resources for investment in economic development and family welfare. This provided a strong economic case for family planning. Following the Reagan administration’s questioning of the macro-economic argument for family planning in the 1980s, advocates now had evidence to persuade governments to invest in family planning programs, and to illustrate to developing country leaders that the return on investment in family planning was broader than just health.

Further, the family planning community started to coalesce around a few key events. The first international family planning conference was held in Uganda in 2009, and the second in 2011 in Senegal. The significance of these conferences as noted by Jotham Musinguzi (PPD) was: “We worked together to bring the first ever international conference post-Cairo. One of the reasons that we had was in the back of our minds, it was high time that we started revamping efforts on family planning at the international level.”

But funding was still nowhere near where it had been, and political will to incorporate family planning into the development arena was weak if not absent. However, a constellation of important events transpired at this time, including:

- **In the United States:** In 2009, the U.S. saw President Obama elected and Hillary Clinton appointed as Secretary of State (SoS). The U.S. Government, the main funder of international family planning over the last 40 years, re-ignited its interest under this new administration, triggering key policy changes in support of family planning. For the first time a SoS spoke about the importance of contraception in a public policy speech, which occurred on the anniversary of the ICPD in January 2010. Further, the U.S. increased its annual investment in international family planning from $420 million to approximately $600 million.

- **At the Bill and Melinda Gates Foundation:** In 2008, the Bill & Melinda Gates Foundation (BMGF) launched a new family planning global strategy, representing a significant commitment and resource allocation to this issue. Then in 2011, Melinda Gates announced that family planning would be one of her top priorities “this year and into the future.” In her video message at the international conference on family planning in Senegal, Melinda Gates said, “Over the past several years, I have learned that small investments in family planning pay huge dividends for women, their families, and whole nations. Looking ahead, I plan to spend a great deal of my time advocating for the 215 million women who don’t want to have a child, but can’t access modern contraceptives.”

- **In the United Kingdom:** In May 2010, the Conservative Party won the UK election and David Cameron, the new Prime Minister, quickly re-affirmed the commitment to achieving 0.7% overseas aid under his leadership. Andrew Mitchell, the newly appointed Secretary of State for International Development, was also showing interest in reproductive health and family planning as an issue where he could “make his mark.”

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12 A more detailed timeline of key moments can be found in Annex 3.
14 Interviews with Jagdish Upadhayay and Oying Rimon.
15 Interview with Oying Rimon.
16 This unmet need figure was later evaluated and reconfirmed during summit planning.
18 Interview with Leo Bryant.
Further, private donors and donor countries had started to work together on family planning. Formal collaborations included: Foundation Presidents,19 the G8 Muskoka Initiative on Maternal, Newborn and Child Health,20 the Alliance for Reproductive, Maternal and Newborn Health (R MNH),21 and, the Ouagadougou Partnership in Francophone Africa,22 as well as the Reproductive Health Supplies Coalition (RHSC),23 which led the Hand to Hand Campaign.24 These initiatives led to stronger relationships between donors, increased attention to family planning, and recognition of the potential of working together on this issue to achieve greater impact. As noted by Scott Radloff (USAID), “There was the RHSC, which was an international gathering of organizations that had a common interest in family planning, and for a while that became a focal point for donor interactions. Donors came together at the annual IPPF meetings as well. The RHSC began to be a point where people would focus attention on family planning supplies. We also began to have side meetings during those meetings that brought the Gates Foundation and USAID, UNFPA, DFID together.”

Globally, attention and commitment to the health of women and children was bolstered in 2010 when the UN Secretary-General launched Every Women Every Child, which included targets specific to family planning.

Overall, efforts between 2008 and 2011 helped bring the community together, and showed an emerging interest in scaling up and coordinating efforts. But, for family planning, there still was not one common framework, goal or platform for mobilizing action and resources at the global level. There had not been a major rallying moment for family planning on the global stage since the ICPD in 1994. According to Oying Rimon (BMGF), “The question was: how do you set up a platform that would allow for the other donors to step up to the plate?”

Further, the MDGs were set to expire in 2015 and stakeholders from around the world were discussing the post-2015 development framework and the Sustainable Development Goals (SDGs), the series of global goals that would replace the MDGs. Family planning players worried about history repeating itself – that if the opportunity to place family planning as a central component of the SDGs was missed, the issue would continue to be deprioritized until the expiry of the SDGs in 2030.25

They needed an opportunity to get family planning back on the agenda.

B) The Window of Opportunity Opens

Then, the summer of 2011 arrived. In June, DFID held a pledging event to raise funds for the Global Alliance for Vaccines and Immunisation (Gavi), a public-private partnership aimed at improving access to new and underused vaccines for children living in the world’s poorest countries. Hosted by Prime Minister David Cameron, the meeting convened Heads of State, ministers and other leaders from donor and developing countries, UN agencies, the private sector and civil society to make commitments to support Gavi’s work.

19 An annual meeting of all foundation presidents involved in reproductive health. From interview with Oying Rimon
20 An initiative of G-8 countries, led by Canada, to accelerate progress toward MDGs 4 and 5; donors pledged $7.3 billion in new and additional funding over five years (2010-2015). Communiqué can be found at: http://www.g8.utoronto.ca/summit/2010muskoka/communique.html
21 The Alliance for Reproductive, Maternal and Newborn Health consists of four core partners—the Australian Agency for International Development (AusAID), DFID, USAID, and BMGF —and aims to help governments and other partners accelerate progress toward MGDs 4 (to reduce child mortality) and 5 (to improve maternal health) in ten priority countries.
22 The Ouagadougou Partnership is a joint effort between the governments of eight francophone West African countries and international development organizations aimed at promoting the integration of family planning and reproductive health programs into national development plans in West Africa.
23 RHSC is a global partnership of public, private, and non-governmental organizations dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality supplies to ensure their better reproductive health. RHSC brings together diverse agencies and groups with critical roles in providing contraceptives and other reproductive health supplies, including multilateral and bilateral organizations, private foundations, governments, civil society, and private sector representatives.
24 The RHSC led-Hand to Hand Campaign’s goal was to achieve 100 million new users of contraception in low-income countries between 2010 and 2015. Little documentation about this campaign was found, however according to Brien Siems: “There was the Hand-to-Hand campaign that the RHSC led, to get 100m users between 2010-2015, which was a pie in the sky goal. It wasn’t advertised or embraced in the same way. Countries set their own goals around family planning.”
25 Interviews with Jotham Musinguzi and Tewodros Melesse.
The Gavi pledging conference was a resounding success. Key results included:

- **Financial commitments of $4.3 billion** (exceeding its initial target of for $3.7 billion) to immunize more than 250 million of the world’s poorest children against life-threatening diseases by 2015 and prevent more than four million premature deaths. Governments more than doubled their previous commitments and new donors came to the table.
- **Developing countries** committed to maintain or increase the co-financing of their vaccine programs and leverage the partnership to immunize their children.
- **Vaccine manufacturers** announced just before the Summit that they would offer lower prices on a range of vaccines supported by Gavi.

Internally this event was called a “golden moment” by the UK government, and after witnessing its overwhelming success, DFID wanted this to be the first of a series of annual moments it would host. “We’d had a new conservative-led coalition government since the spring of 2010, and the Gavi replenishment conference demonstrated to the Prime Minister and Secretary of State for International Development that the UK could ‘punch above its weight’. The event was not only meaningful for international development at large but generated unprecedented support from the UK public for why development matters,” said Julia Bunting (DFID). DFID saw this platform as an opportunity to shed light on key issues that had been neglected and wanted to make this an annual signature event.

Seeing the window, Julia Bunting at DFID pitched family planning for the 2012 event – an issue that the in-coming Secretary of State was very interested in. Simultaneously, on the BMGF side, Oying Rimon, whose remit was to revitalize the global agenda for family planning, coordinated with Julia Bunting on how the two organizations could partner on this event and bring other key players to the table.

At first, DFID was hesitant to focus on family planning for a number of reasons, not the least because it was politically sensitive. As Julia recounts, “At that time there was a plan to go for something nutrition related. But as the fall turned into winter 2011, the people working on nutrition hadn’t worked out exactly what they wanted to do. So in late November, I essentially put my hand up again and said, “I’ve got an idea and I can do it by next summer, can I have a go please?”

**A Decision is Made**

Because the nutrition teams in both DFID and BMGF were not yet ready for the golden moment, it was agreed that family planning would be better positioned for taking center stage in 2012.

DFID moved forward on discussions with the BMGF on being a core partner, and DFID and the BMGF agreed to co-host the London Summit on July 11 - World Population Day. Julia noted, “Literally over Christmas and the New Year of 2011-2012, the Secretary of State and Melinda had some conversations, the Secretary of State went to the Prime Minister right at the beginning of January and said, “This is it!” We got the final sign off by the second week in January to go for it with a six-month timeline.”

USAID and UNFPA – both long-term global leaders on this issue – had been consulted as key partners during initial discussions, and were immediately on board. This was critical as both organizations had leadership and existing infrastructure to draw from and leverage in the planning and execution of the Summit. UNFPA also had new leadership in Babatunde Osotimehin, who had prioritized the need to address the unmet need for family planning and increase

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26 Respondents varied in how they identified this; some referred to it as a “golden” moment and others a “gold” moment.
27 Interviews with Julia Bunting and Leo Bryant.
28 World Population Day is held annually on July 11 to bring attention to the urgency and importance of population issues in the context of overall development plans and programs and the need to find solutions for these issues.
UNFPA’s programmatic investments in meeting those needs.

At this time, all of the “baby steps” forward had come together and set the stage for the Summit. New research and data on family planning continued to be produced by a variety of institutions and planners felt that together, these structures would provide a good starting point for planning the Summit, which is further detailed below. As noted by Scott Radloff (USAID), “Timing isn’t everything but it is very important that the timing is right. I think it was globally also a time when more donors, more country leaders, government and international leaders had come to realize that family planning had been neglected for too long and needed revitalizing. That’s part of the timing too - it was the right time, for interests in family planning had coalesced.”

It was also clear that the commitment from leadership was a forcing mechanism, and many felt the opportunity was too good to pass up. Monica Kerrigan (BMGF) said: “It would have been difficult without Prime Minister Cameron and Melinda Gates as the hosts – when you have that high level hosting saying this is going to be their urgent priority and they’re going to support this and nurture and work with countries on this, it made a huge difference.” While this coupling was particularly unique, the fact that there were high-level champions willing to lend their voice and provide new leadership was a key ingredient for success. From the outset, Summit planners saw that having such champions would be a game-changer for the Summit, as they would generate global attention and facilitate buy-in, resources and broad support. Monica Kerrigan emphasized the value of Melinda Gates in her role as a new voice for family planning: “… if you look at the timeline of what she did, it was unprecedented. Not only did she lead us at the foundation in terms of the Summit and the rigor and evidence needed, but also the work that she did creating a communications portfolio or initiative – she did the TEDxChange talk in Germany and that really put [her] out there. She met with leaders around the globe. She picked up the phone and called people when we needed her to. Her determination and commitment I think remains unprecedented. She was able to galvanize the community and be a new broker, bringing people together to make a big difference.

It was determined that despite the short time frame for planning (six months), the event would provide an unprecedented opportunity to challenge donors, developing countries, the private sector and civil society to come together and jump-start a bigger commitment for supporting family planning on the global stage, and thereby enhance the achievement of the MDGs and the post-2015 SDGs.

Putting the Idea into Action

“The next six months were basically a whirlwind, trying [to work out] what we were going to do and how we were going to do it, what we were aiming to achieve, who we could pull together, what we were asking them to commit to, what we were asking them to fund and the mechanisms, and all of that stuff. It became a lot of heavy lifting.”

— Julia Bunting (DFID)

A lot had to get done in a short time if the planners’ vision was to be realized. Fortunately, given family planning’s long history, there was a lot in place that planners could draw from, such as:

- **Resources – financial and human.** DFID and the BMGF staff quickly assigned teams to drive planning around the London Summit, but capacity was limited. So planners (namely BMGF) also quickly deployed resources to bolster the capacity of these small teams by hiring McKinsey (a multinational management consulting firm) to provide project management, and leveraging necessary technical expertise through organizations such as the Guttmacher Institute,30 the Futures Group and the Bill and Melinda Gates Institute for Population and Reproductive Health based at Johns Hopkins University. As noted by Scott Radloff (USAID), “I think a lot of credit goes to the Gates

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29 In April 2012, Melinda Gates gave a TED Talk in Berlin entitled: “Let’s put birth control back on the agenda”.
30 Guttmacher Institute works to advance sexual and reproductive health and rights through an interrelated program of research, policy analysis and public education designed to generate new ideas, encourage enlightened public debate and promote sound policy and program development.
31 Futures Group is a global health consulting firm; one of its key tiers of work is to support governments, donors and other partners to improve and expand women’s access to high-quality family planning services.
**A robust community of advocates.** Despite waning global support, advocacy on family planning had continued; there were coalitions, individuals and organizations championing family planning, and strong communities of support that could be drawn upon. Jotham Musinguzi (PPD) said, “Some of us looked at the 2012 opportunity as a really good opportunity and if we missed this one then obviously our field, our community, our issues would continue to be marginalized. We thought it was an opportunity that we couldn’t afford to miss.”

**Sound data, policies and tools.** As noted previously, family planning had consistently proven itself to be a unique medical intervention in the breadth of its potential benefits. Furthermore, a variety of family planning tools and technologies were in place to offer a variety of cost-effective options for women, and there were signs that developing countries were interested in such tools. Such progress allowed the planners to remind stakeholders that the key features of effective family planning programs were already established, freeing up the ability to focus on the gaps – funding and political support.

But, equally, there were many critical barriers to overcome:

- **Time was short.** The Gavi “golden moment” took 18 months to plan and many were skeptical that pulling together a similar event could happen in just six months without an established financing facility and structure on which to build. As noted by Scott Radloff (USAID), “A lot of us had doubts. This was such a short time period - how do you organize an event at this scale where there would be large commitments across multiple donors, multiple governments, multiple NGOs [non-governmental organizations] - and how would all that happen in a six-month period of time?” While he agrees that the team could have achieved more with a longer preparatory period, Oying Rimon (BMGF) said the short period to plan also worked to their advantage as it “forced us to really concentrate on what needed to be done.”

- **No shared global goal on family planning.** While there was a lot of data, there was no common global goal on family planning. Planners chose not to adopt the Hand to Hand Campaign’s goal of getting 100 million new users of modern contraception by 2015 - they felt this had not taken off and was not being used at the country level. As noted by Brian Siems (BMGF), “… the goals that we had in the community – there wasn’t anything to hang our hat on so we went back to the drawing board to see what a new goal could be.” Additionally, given the history of coercion, Brian said: “Setting any kind of numeric goal was in itself somewhat controversial, because of the unique history of family planning and the way other countries have set top down goals and targets on family planning.”

- **Existing architecture wasn’t sufficient.** UNFPA, the traditional development agency on population, had limitations. As Oying Rimon (BMGF) noted: “We did an analysis of UNFPA using their own documents and other studies conducted by the Bixby Center at [the University of California, San Francisco], and the report by the Center for Global Development (funded by Hewlett). If you look at these analyses, UNFPA was spending a small percentage of their money on family planning… The reports also recommended that UNFPA strengthen their expertise on family planning in terms of their staffing, especially at the country level. Fortunately, UNFPA had new leadership receptive to new ideas and willing to take on these challenges.”

- **Fractured community.** ICPD was now almost 20 years prior, yet the community was still fractured over how to achieve progress on family planning within the broader sexual and reproductive health and rights (SRHR) agenda and women’s rights.

**Summit Planning Kicks Off**

“[The Summit] was very simple in many ways in its vision and in its metrics – this goal that we now have to achieve 120 million additional users by 2020 - but it wasn’t simple to get there. That process of agreeing what the metrics should be, actually setting that as a goal as an ambition, the process of how we would come together, what the event would look like, what would happen after the event.” – Julia Bunting (DFID)

Summit organizers had their work cut out for them; addressing these barriers would take time, coordination and

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management. The various components of planning and organization that had to be achieved in the short time period were numerous, including:

1. Set up an operating structure.

Developing an effective management structure was critical. The core group for planning was the BMGF, DFID, USAID and UNFPA, with DFID and the BMGF providing the overarching management. Some outside of the core group perceived this process to be exclusionary, and while even the planners will admit it was “a pretty closed door process” this was critical for swift and nimble planning. As noted by Oying Rimon (BMGF), “It’s critical to bring in other foundations, donors, key NGOs, but there needs to be a core group.”

In order to tackle such a broad scope of work, DFID and the BMGF took the lead in setting up working groups and platforms for coordination. This involved establishing six work streams, which included key stakeholders and experts. These work streams were:

- **Metrics and Analysis**: Compiling the numbers to document unmet need and support goal setting
- **Financing Mechanisms**: How new funds would be raised and used
- **Outreach**: Working with multilaterals (e.g. UNFPA, World Bank), developing countries, bilateral donors, foundations, the private corporate sector and civil society
- **External Communications**: Stage management and public relations
- **Events, Logistics and Protocol**: Making sure the Summit actually happened
- **Project Management**: Overall oversight of the planning (DFID and BMGF)

2. Establish a baseline metric for unmet need.

In order to establish the Summit goal, planners needed to ensure they had accurate information on the number of women who wanted to prevent pregnancy but did not have access to family planning tools (unmet need). When they set out, planners thought creating baseline metric would be easy and factored in a brief period for this work. But this was time consuming. “It took us so much longer to establish a baseline of users than anybody had thought. It took us all of January just to get a sense of the numbers without any sort of goal setting around it,” said Brian Siems (BMGF). And because modeling unmet need was a key aspect to subsequent work (setting the goal, projecting funding needs), it had to be completed before planners could move on to other aspects of planning. This slow start created delays across the planning process.

Oying Rimon also noted that experts agreed that the concept of unmet need is a moving target – making setting a baseline metric challenging. This is because in some countries, where use of modern methods of family planning is still low, increase in modern contraceptive prevalence rate could increase the “need” for contraceptives, as more eligible couples know more about family planning from their neighbors and friends or the media.

**Global Unmet Need: At least 215 million women and girls**

In 2012, 215 million women and girls in developing countries who want to delay, space or avoid becoming pregnant are not using effective methods of contraception, resulting in over 75 million unintended pregnancies every year.

3. Set the Summit goal.

Another key challenge was to establish a goal within a specific timeline, and a common vision about what should be accomplished at the Summit. This took time and negotiation because there were many differences of opinion on what this goal should look like. Ultimately, the Summit goal did two main things differently:

- **Family planning-specific**: Planners decided to create a family planning-specific goal that was intentionally exclusive of abortion and broader SRHR. As noted by Brian Siems, “We were forging a different kind of coalition from within the broader SRHR piece...”

**Key Decision Point:**
A family planning-specific goal, intentionally exclusive of abortion and broader SRHR.
It was agreed that the goal should promote a new, evidence-based agenda by not only aiming to reach 120 million more women and girls with modern contraceptive methods by 2020 but doing so in a way that was voluntary, which was important considering the history of coercion. The Summit goal supported the right of women and girls to decide, freely and for themselves, whether, when and how many children they have. As noted by Monica Kerrigan (BMGF): “I think that another big piece of the London Summit was that it wasn’t just about ‘let’s commit to family planning and the status quo’ – it was committing in a new way that recognized the importance of community and voluntarism and access. It really turned the dial.”

- **Achievable and realistic:** Some wanted the goal to focus on to eradicating unmet need (i.e. reach all who didn’t have access – at least 215 million women and girls), while others wanted something that was more achievable and realistic. Julia Bunting (DFID) emphasized the need to create a shorter-term milestone, but with an eye toward the broader goal of eradicating unmet need: “We needed to start somewhere because the idea of universal access was too big a concept and too long a timeframe for anyone to get their head around. We needed to break it down into bite-sized pieces that we could mobilize people and engage people [around], and prove that we could do something in this relatively short window [between 2012-2020] and would hopefully then provide the incentive for continued and sustained effort.”

Brian Siems reflected, “One of the first big moments, once we had data, was having conversations - first with Melinda [Gates] and then with Melinda and Andrew Mitchell to say “look, we’re not going to get to the goals that the community has already established so we’re going to need a new one.” Getting agreement on setting a different kind of goal and one that was actually realistic yet achievable - that was Melinda’s push to us the whole way through. She didn’t want us signing up for goals that you couldn’t actually reach because [the Gates Foundation is] a rigorous data-driven organization.” Planners agreed that reaching 120 million more girls and women would be ambitious but not unrealistic.

**Summit Goal:** The London Summit on Family Planning will mobilize commitments to support the rights of an additional 120 million women and girls in the world’s poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020

In order to do so, the Summit sought to mobilize global policy, financing, commodity and service delivery commitments from donors, developing countries, the private sector and civil society.\(^3\)

4. **Cost the goal.**

Once metrics were set, the group then turned to understanding the financial needs; this work was driven by the BMGF and DFID with support from experts like the Guttmacher Institute and McKinsey. As noted by Brian Siems, “We agreed on a goal in the February timeframe. We then did a lot of the costing around it, that was in March, where we agreed on the $2.3 billion figure, which was made up of lots of different assumptions... Agreeing with DFID on the goal was a good first big step and getting agreement on the costing of that goal was another.”

**Cost of the Summit goal of reaching 120 million new users of contraception:** $4.3 billion, with $2.3b needing to come from donors

Reaching an additional 120 million women would cost $4.3 billion over the next eight years. This number includes resources and infrastructure supported by developing countries. Of the $4.3 billion total resource requirements, it was projected that donors needed to contribute $2.3 billion in additional funds - above and beyond the amount of funding provided for family planning in 2010.

5. **Set up the post-Summit infrastructure.**

The next big challenge was getting an agreement on how to operationalize the Summit goals, which included setting up a global partnership and defining a financing mechanism.

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• **Global partnership:** Although there were robust discussions about having UNFPA serve as home to post-Summit work, organizers made a strategic decision not to build on an established institution but to develop an a new approach. As Brian Siems noted, “We felt pretty strongly that we needed to get a more neutral body that was overseeing this. You had the same actors who have been party to the status quo of family planning for the last 20 years that are also sitting around the table. We wanted this to be different, we wanted to be sure we had some ability to shine a light both internally and externally and that’s why we knew we wanted an independent secretariat, an independent reference group.” A new entity - Family Planning 2020 (FP2020) - was therefore developed as a reference and accountability mechanism aimed at supporting the advancement of the Summit’s goal of enabling 120 million more women and girls to use contraceptives by 2020.34 It would be housed at the United Nations Foundation.

• **Pooled funding mechanism:** Planners also had ambitions to set up a funding mechanism where donors would invest in family planning. According to Brian Siems (BMGF), “And then the financing – we had designed a pooled funding mechanism... We wanted to start a pooled fund for service delivery and demand-side work for the family planning community that could be expanded to the broader RMNCH [reproductive, maternal, newborn and child health] continuum. We had done a good bit of design around it and had even begun discussions with the World Bank.... We got pretty far but we didn’t get far enough before May because of how long it took to cost things and design all the stuff out with DFID. And May-June was way too late to both get financial pledges from countries and to have them surrender control of those over to something they had never heard of. This was the piece that we just said was going need more time. “ Planners decided to postpone this component until after the Summit.

6. **Bring stakeholders along and mobilize commitments.**

Planners sought to create a united effort, as much as they could, and galvanize stakeholders across the globe to bring together commitments and pledges in support of the Summit goal. This included.35

• **Donors:** To commit to sustaining current investments and providing additional funds for contraceptive information, services and supplies; improving their coordination so that funds are used most effectively; and supporting advocacy for expanded contraceptive availability and for removing barriers to women’s and girls’ access.

• **Developing countries:** To make bold political commitments to increase access to family planning information, services and supplies, by making additional domestic resources available, and tackling policy, demand and service delivery barriers.

• **Private sector:** Manufacturers need to engage with funders and procurers in new and expanded partnerships to make a greater range of quality contraceptive products available, affordable and accessible to women and girls in the poorest countries.

• **Civil Society:** To continue and expand their advocacy for both expanded availability and removal of barriers, with funding from donors and, where appropriate, governments. Civil society groups can also help build community support for contraceptive access, monitor services for quality, voluntarism, and informed choice, and help hold providers, policy makers and funders accountable for their commitments. They can also conduct behavior change interventions and implement innovations in delivering services.

Several interviewees highlighted work done by IPPF, MSI as well as by the UK Network for SRHR and RHSC’s Resource Mobilization and Awareness Working Group, as being critical for bringing civil society partners on board. Leo Bryant (MSI) noted, “The coordination role became important to DFID to make sure lots of agencies felt they had

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34 The full description from the FP2020 website ([www.familyplanning2020.org](http://www.familyplanning2020.org)): FP2020 is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. Led by an 18-member Reference Group, guided technically by Working Groups, operated daily by a Secretariat and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live should have access to lifesaving contraceptives.

an opportunity to engage in the process.” One of the results of this work was the Civil Society Declaration to the London Summit on Family Planning. This declaration, spearheaded by IPPF, was supported by 1,292 global civil society groups from 177 countries and represented an unprecedented show of unanimity from civil society in support of the Summit’s goal.36

7. Host the Event

Alongside all of the programmatic work, a core events and logistics planning team, led by DFID and BMGF, was tasked with designing and coordinating the actual event on July 11. They designed the program, coordinated with speakers, invited guests and ensured the day would go seamlessly.

Highlights of the London Summit on Family Planning37

“This is a breakthrough for the world’s poorest girls and women which will transform lives, now and for generations to come. The commitments made at the Summit today will support the rights of women to determine freely, and for themselves, whether, when and how many children they have.”- Andrew Mitchell, Secretary of State for International Development, United Kingdom

On July 11, 2012, leaders from around the world gathered in London to pledge or renew their commitment to family planning. More than 150 leaders from governments, NGOs, multilaterals, civil society and the private sector all converged on the idea that it was time—past time—to put women’s reproductive health front and center on the global agenda. They recognized that family planning is both a basic right and a transformative intervention: that it is the key that unlocks our ability to reach our development goals.38

Political will was demonstrated by the presence of the UK Prime Minister and the Heads of State of Malawi, Rwanda, Tanzania and Uganda, along with more than a dozen ministers of health and development from both developing and developed countries (including Secretary of Health for the Republic of the Philippines Dr. Enrique Ona and Joint Secretary of India’s Ministry of Health and Family Welfare Anuradha Gupta).

The Summit also drew high-level representation from the UN, donors and bilateral agencies (including UNFPA Executive Director Babatunde Osotimehin; USAID Administrator Rajiv Shah; World Health Organization Director-General Margaret Chan; and BMGF Co-Chair Melinda Gates); representatives of private industry; and a select cadre of invited heads of civil society organizations from around the world.

“When I travel and talk to women around the world they tell me that access to contraceptives can often be the difference between life and death. Today is about listening to their voices, about meeting their aspirations, and giving them the power to create a better life for themselves and their families.” – Melinda Gates, BMGF

Global media coverage was strong and headlines celebrated the fact that family planning was resourced and leaders were committed to expanding coverage to more women and girls. As noted by Monica Kerrigan, “I think that over the 48 hours of the Summit, there were more than 100 articles, TV and radio stories on the Summit. The buzz was huge, never before had we seen this attention... There was a rolling thunder around the Summit - that was critically important.”

Key Summit Outcomes

✓ Global community united around one goal to secure global political commitments and resources that will enable 120 million more women and girls to use contraceptives by 2020.

38 This language was drawn from http://progress.familyplanning2020.org/Family-Planning-2020
✓ **Exceeded financial goal**: A total of $2.6 billion was pledged from donors - exceeding the Summit goal of $2.3 billion.

✓ **A focus on results**: Not only did an initial 20 countries pledge to address policy, financing and delivery barriers to family planning, but they outlined plans detailing how this would be done and how it would contribute to the overarching goal of reaching 120 million new users of family planning.

✓ **Commitments by the community**: Examples include: UNFPA’s pledge to increase expenditure on family planning from 20% of expenditure to 40%; BMGF’s doubling of its annual budget for family planning from $70 million to $140 million; Bloomberg Philanthropy’s $50 million commitment; IPPF’s commitment to triple sexual and reproductive health services provided annually; and, the pledge by Merck, a global healthcare company, of $25 million over eight years as part of Merck for Mothers – the company’s 10-year initiative to reduce maternal mortality around the world.

✓ **Launch of FP2020** - the mechanism formed to track and advocate for progress on Summit commitments.

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**Trade-Offs Along the Way**

The organization and negotiation ahead of the Summit was hard, complicated and time consuming. Looking back, interviewees noted that in an effort to pull the Summit together on time, several trade-offs were made, including:

- **The broader SRHR agenda was compromised**: Although planners expected strong opposition from groups that traditionally opposed family planning (e.g. conservatives, faith-based groups), this did not significantly materialize. The reaction of the SRHR community however was mixed. While some were excited that major donors were involved in supporting this initiative, others thought there had been insufficient consultation with civil society. Further, many wanted the issue to be broader, questioning the narrow focus on just family planning. “We got a lot of pushback from some of the more ideological women’s groups. Advocates for sexual and reproductive health and rights said, you are going backwards. It’s not about family planning, it’s about SRHR,” said Oying Rimon. Several interviewees thought this could have been mitigated through further foundational work, but agreed that even if a broader SRHR focus had been chosen, other groups would have remained unhappy (e.g. proponents of universal health care). This idea was echoed by Leo Bryant (MSI) who said, “The thing with the development sector is that everybody bangs their own drum; everyone’s issue is a neglected issue. To some extent it’s impossible to please everybody.”

- **Global South was not brought along sufficiently**: Not enough countries were engaged in the lead up to the Summit, nor were enough countries engaged in making pledges (e.g. countries in Latin America). This would later be perceived by some as a key weakness, as the country level was where the strategy would be delivered. As noted by Monica Kerrigan (BMGF), “We had great government people, great private-sector people, but more or less it was people who could fund themselves. We perhaps missed those small but catalytic grassroots NGOs that are doing incredible work in countries around the world.”

- **Not as many new stakeholders were engaged as originally hoped**: Whereas some interviewees noted the engagement of new actors (e.g. new donors such as Nike Foundation, Bloomberg Philanthropies, Children’s Investment Fund Foundation and the Aman Foundation), others said it was mainly “a coalition of the willing” that missed the opportunity to bring in others for whom family planning was not a central component of their work but with whom there was a natural alliance that could have been nurtured (e.g. environmental groups).

- **Arrived at fundraising late**: Because delays in establishing the unmet need metric and Summit goal held up the establishment of the fundraising target, donors were brought in late; pledges were being solidified up until the last minute.\(^{39}\)

- **The pooled financing mechanism never came to be**: The pooled financing mechanism was never fully developed and eventually, after the Summit, the idea was scrapped entirely. “Then, there wasn’t really an appetite after the Summit to keep figuring that piece out and we’ve suffered from it to this day,” said Brian Siems. This has led to a key

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\(^{39}\) Interview with Brian Siems.
weakness in the post-Summit architecture as it is now hard to track funding, keep donors accountable to meet their commitments, and easily distribute resources to the regions most in need.40

C) It’s the Marriage, Not the Wedding, That Counts in the Long Run

“There’s a lot of work to do to deliver on what we committed and how we committed to do it. Even if we achieve close to those numbers by 2020, the job is only half done…. How do you sustain that momentum and that interest and that passion for the time it takes to deliver really big outcomes that take a period of time to do?” – Julia Bunting (DFID)

Throughout planning many people said, “don’t forget: it’s the marriage - not the wedding - that is important.” The Summit was the wedding; world leaders came together to celebrate and toast the “happy couple”- the future of family planning. The Summit was a useful for tool for garnering support for expanded access to contraception to 120 million more women and girls, but was just the first step in achieving the long-term goal of increasing access to contraception (the “marriage”).

Therefore, it is important to keep in mind that meetings are not what make the work happen. While the Summit was a key tactic to building global consensus, this event alone would not ensure voluntary family planning services reach an additional 120 million women and girls in the world’s poorest countries by 2020. Instead, once the Summit ended, advocates and practitioners had to shift their focus to long-term work. Jagdish Upadhyay said, “We have a very dual objective and that dual objective requires a long-term commitment from politicians, key players and resources. That objective requires a slightly different effort than just doing a conference.” Next steps will not be easy. As noted by Brian Siems, “… while making pledges, coming up with good goals and logistical planning can be hard, it’s just the beginning.”

As the family planning community has carried the gains of July 11 forward, it has seen some important wins and is also facing some key limitations.

1. Progress has been made toward Summit goals.

**Progress:**

- **Increased access:** In 2013, 8.4 million additional women and girls used modern contraception compared to 2012. This number is just below the projected benchmark of 9.4 million additional users in the first year, but is still a significant milestone.41

- **Increased funding:** In 2013, donor governments provided $1.3 billion in bilateral funding for family planning programs – representing a nearly 20% increase over 2012 – and $460 million in core contributions to UNFPA.

- **Country progress:** Interviewees identified several countries where significant progress has been made since the Summit (e.g. Uganda, Kenya, Malawi, Senegal, Ethiopia and the Philippines), and noted advances specific to domestic financing (e.g. an increased number of countries with budget lines for family planning). As noted by Tewodros Melesse (IPPF): “[Funding from the country level is] not sufficient, it’s never going to be sufficient but at least symbolically they have a commitment.”

Of note is the contribution of the Summit to the passage of the Philippines Reproductive Health Law. The former Secretary of Health, Enrique Ona, said his team was able to draw on outputs from the Summit (e.g. data, research, political commitments) to strengthen its argument for the reproductive health law, which had been pending at the congressional level for decades. He added, “…in essence it gave us, me personally, the confidence that indeed the global community was also very supportive of our effort to pass a law that would improve maternal health, and at the same time gave us all the necessary global information with regard to reproductive health and family planning.”

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40 Interview with Tewodros Melesse and others.
41 Statistics on increased access and increased funding are from PMA2020’s Progress Report 2013-2014
2. Post-Summit architecture has continued to be refined.

Progress:

- **FP2020 is now up and running.** Since its launch, the FP2020 Secretariat, Reference Group and Working Groups have been established, and as noted by Monica Kerrigan (who is currently seconded from the BMGF to FP2020), it has emerged as a well-respected partnership with several key achievements. She said, “This innovative partnership continues to grow and develop... We have 35 pledging countries out of 69 and 20 have strong costed implementation plans.”

Limitation:

- **Confusion on the mandate/role of FP2020:** Interviewees identified several weaknesses relating to FP2020, including the lack of clarity on its role and a disconnect between FP2020 and countries. As Jotham Musinguzi noted, “I think our weakness is still how the FP2020 Secretariat in Washington links directly to the countries and facilitates countries to be able to move with their own challenges and commitments. If we’re not careful, these commitments made by heads of states will fall through the cracks…” With new partnership, some growing pains are to be expected, said Monica Kerrigan, adding, “I think in so many respects, FP2020 is still nascent; it’s very challenging to wave a magic wand and create a Secretariat and global partnership that’s going to be catalytic right away. We’re going through a strategic review process right now and I think the world will see in 2016 that FP2020 will be more fit for purpose.”

- **Accountability tensions:** The need for mechanisms to account for progress on goals and the fulfillment of donor commitments was noted. Tewodros Melesse said, “There should be a clear connection between results/achievements and resources.”

3. Monitoring and evaluation systems have been developed.

Progress:

- **New systems established:** Previously, planners and policy makers relied on Demographic and Health Surveys (DHS), which came out every five years, to see how well programs were working. As noted by Scott Radloff, “We really didn’t know how well programs were doing until a new DHS [demographic and health survey] would come out. So there were these lag times between when you would know if you were making progress or not.” Or as Melinda Gates puts it: “If we were a business and we wait every five years to monitor progress, we would have been bankrupt by then.” Following the Summit, key progress was made in this area with the launch of two new programs—Track 20 and Performance Monitoring and Accountability (PMA2020) – that are now improving data collection and use at the country level. PMA2020, for example, provides performance data comparable to DHS every 6 or 12 months. “We put in place one of the most robust monitoring and data collection structures in at least the RMNCH world, and now the data investments we launched to help us gauge progress towards this goal are going to be a platform for a lot of things beyond family planning, which is exciting,” Brian Siems said.

Limitation:

- **Country ownership:** While these new initiatives effectively collect data, more can be done to assure that local stakeholders are bought into this process and use evidence for advocacy and/or decision-making.

4. New pricing agreements for commodities have emerged.

Progress:

- **Implant Access Program:** Following the Summit, in 2013 a group of public and private organizations came together and formed the Implant Access Program (IAP) - a global collaboration to expand access to contraceptive implants in

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42 Track 20 was established to track progress of the global FP2020 initiative. Its strategy is to support national efforts in participating FP2020 countries to collect, analyze and use data to track progress in family planning and to develop effective program strategies and plans.

43 PMA2020 is a five-year project that uses a mobile-assisted data collection system to contribute to global monitoring and evaluation. Innovative data collection system supports routine, low-cost, rapid-turnaround, nationally representative surveys on family planning, water and sanitation at household and facility levels in 10 pledging FP2020 countries.

44 Interview with Tewodros Melesse.

45 The partnership includes the BMGF; the Clinton Health Access Initiative (CHAI); the governments of Norway, Sweden, the UK and U.S.; the Children’s Investment Fund Foundation; and UNFPA.
the world’s poorest countries through a combination of price agreements, training and education programs, and supply chain strengthening. One key achievement of the IAP has been to secure price reduction agreements of about 50% with two pharmaceutical firms.46 As noted by Monica Kerrigan, “To date, this has been one of the most successful achievements post-London Summit. In partnership with countries and donors, the global community has tripled the procurements of implants and allowed women and youth expanded method choice for long acting reversible contraceptives. The business case and analytical due diligence has driven increased interest from private sector partners to join FP2020 to expand access, quality and choice using supply and demand channels. On the way to the London Summit and now in FP2020 we recognize the critically important role of the private sector to drive changes by harnessing their expertise in forecasting, distribution, mass media, product development, etc.”

5. Family planning has been more visible on the global agenda.

Progress:

- **Family planning in the global discourse:** As noted by Jagdish Upadhyay (UNFPA), “Lost ground came back to us, we started talking again about family planning.” This includes discussions surrounding the post-2015 development agenda. Whereas family planning was entirely missing from the MDGs in 2000, it is now featured squarely in the new set of SDGs, with one target focusing specifically on family planning.

- **A re-energized family planning community:** Prior to the Summit, not only had the issue stagnated, so had the energy of people working in the community and in countries where the need contraceptive information, services and supplies was greatest. Julia Bunting noted, “After having worked in the field for almost a decade, I know that people were tired and couldn’t see progress, the numbers weren’t changing, no one could understand why no one cared about the issues.” She continued, “For me, the Summit energized the community, creating a global movement of people who did care, who did commit to wanting to work together to making the world a better place for the women that we were seeking to serve. In many ways it achieved that at some level - people were energized, they came together, they were committed and people are doing things.”

Limitation:

- **Integration:** There is still a divide between family planning, SRHR and the health sector more broadly, which limits impact. For instance, even though opportunities to integrate services across the reproductive, maternal, newborn, child and adolescent health continuum exist (e.g. offering a new mother information on birth spacing and contraceptives), these are often not maximized. Monica Kerrigan emphasized, “…obviously women and girls don’t need just contraception, they need other things too, and so how do we provide them with the information and services that they need in all aspects of their life?” Further, interviewees noted the importance of broadening the scope of partnerships to include non-traditional partners in health and beyond. As Julia Bunting noted, “If we really want to achieve the ultimate goal of universal access, then this is not something that the family planning “community” can do on its own.”

Looking Ahead to 2020

Will the Summit’s overarching goal be achieved? Will donors and developing countries fulfill their full commitments? The realization of these promises will require sustained effort, attention and resources by stakeholders around the world. As one interviewee noted, “I question whether there has been enough effort to sustain high-level global attention to this or to deliver the level of resources required to deliver the 120 million new users goal – which was chosen because it was felt they were realistic.”47

These challenges are ongoing and continue to be top of mind for the community at large, which reinforces why the family planning community will need to focus on:

- **Maintaining the momentum:** From 2015 to 2020, political leadership will change, donor priorities will shift and the

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46 Bayer HealthCare AG reduced the cost of its contraceptive implant, Jadelle, from $18 to $8.50 per unit; Merck agreed to reduce the cost of two contraceptive implants (Implanon and Implanon Nxt) by 50% for six years in 70 of the poorest countries around the world.

47 Interview with Leo Bryant.
SDGs may divert attention away from fundamental health and development interventions such as family planning. The community will need to maintain a strong structure and people to continue the work, identify emerging opportunities and apply fresh tactics in order to maintain the momentum. As noted by Jagdish Upadhyay, “[Looking ahead,] if we don’t have the same level of passion and level of political commitment, things may not go anywhere. You cannot organize another meeting.”

- **Ensuring follow through on commitments**: It will be critical to keep leaders accountable and committed to delivering what they promised on July 11. As noted by Brian Siems, “Even when countries make big commitments to their family planning programs, it doesn’t translate automatically to what providers are doing on the ground; it doesn’t translate to what their parliaments or congresses are going to fund. There’s still a lot of hard work during the marriage.” This includes ongoing advocacy and engagement at the country level to involve new political leaders.

- **Keeping pace with population growth**: Even as more women and girls use contraception, population growth will increase the number who will want to use contraception to prevent pregnancy. It would be a mistake to recalibrate expectations for 2020 without recognizing the millions of women who would not have been deprived of access to family planning without the Summit.

### D) Conclusion

The willingness of DFID and BMGF to take leadership on this initiative represented a key turning point and opportunity for revitalizing family planning. Together they put resources, political commitment and voices behind this issue – components that had been missing for decades. While the primary outcome will only be fully known in 2020, its short-term goals were resoundingly achieved and significant steps forward have been witnessed on multiple levels.

It is our opinion that this story has three overarching lessons:

- **Focus matters**. A common goal and shared agenda drives alignment and allows supporters be clear on what they are signing up to achieve. This sort of focus can be disruptive, but in the end all interviewees cited it as critical for success.

- **The window opens quickly, and can close just as fast**. Identify and maximize a window of opportunity when it arises. Watch for a window - be vigilant, advocate internally, raise your hand again. There may be some tradeoffs, but if you wait too long the opportunity might be lost. In the meantime, the evidence base and strategic relationships can be built to spark and capitalize on new opportunities.

- **Understand that the global moment is just the first step of a long road to impact**. The “wedding” is just the start. The real work is ensuring the delivery of commitments, goals and impact.

Interestingly, shortly after the Summit, Andrew Mitchell moved on from his role as Secretary of State for DFID. What if planners waited one year longer in order to have everything “perfect”? Would they still have had a platform? As noted by Scott Radloff, “If we had waited another year, Andrew Mitchell wouldn’t have been there - who knows if the person who followed him would have taken the same steps and actions to make this happen.” Julia Bunting feels even more strongly on this, saying: “I firmly believe if we hadn’t seized that moment it never would have happened.”

While we cannot be sure that the Summit would not have happened, it is clear things could have been different. Windows of opportunity are special, they are limited, and they close just as quickly as they open. Being ready to leverage the opportunity is critical for success.

> “I think it was a moment in time when lots of different actors had helped seed the ground and it finally was a real moment to seize it.” – Monica Kerrigan (BMGF)
Annexes

1. Overview of Research Process
2. Historical Context
3. Timeline of Key Moments
4. Press Release from the Summit
Annex 1: Overview of Research Process

Methodology

The overarching aim of this report is to inform the development of an academic case study that will be prepared for the Institute of Public Health Advocacy at the Bloomberg School of Public Health at Johns Hopkins University. Our review included the following components:

1. **Desk research:** We completed a thorough review of key documents provided by JHU that set the scene for the 2012 London Summit on Family Planning.

2. **Key informant interviews:** In August and September of 2015, we conducted ten phone interviews with key informants representing the variety of stakeholders involved in the planning and execution of the Summit. The list of interviewees is provided on page four of this report.

Guiding Questions for Key Informants

1. Please tell us about your involvement in the 2012 London Family Planning Summit. From your perspective, how did the story unfold from the seed of an idea in 2011 to the execution of the Summit in 2012?

2. What was it about the environment at that point in time that made it ripe for moving the family planning agenda forward? What were the key obstacles in this environment?

3. Within this time period (2011-2012), what were the defining moments leading up to the Summit? (Note: Defining moments are critical decisions or events that would have made the difference between success and/or failure.)

4. How did the reproductive health and family planning communities perceive the strategy around creating Family Planning 2020 (FP2020) and its goals, as well as the principles behind strategy? What feedback did you hear in the lead up to the Summit about the strengths and weaknesses of this strategy?

5. Who were the key players in making the London Summit a success, and/or those essential to work with to find common ground?

6. From your perspective, what were the key successes, major weaknesses and lessons learned on the planning and execution of the Summit? What would you recommend to those undertaking a similar effort, but on a different issue?

Limitations

- **Number of informants:** The key limitation of this report was the number of informants included in the research. Multitudes of stakeholders were involved in planning and executing the Summit, along with advancing the family planning and sexual and reproductive health agenda more broadly. Due to the scope of this project, we were not able to interview all of them and instead selected a cohort that represented the key sectors involved – government (donor and developing country), foundations, civil society, and advocacy players. Had more time been available to engage additional stakeholders, broadening the scope of perspectives may have been valuable (including, for example, the faith community and others that were more distant from planning efforts).

- **Outside voices:** Nearly all of the key informants interviewed were centrally involved in the planning of the Summit, and represented the core planning group and key partners. As a result, their views - and consequently this report - present a perspective of those who were central to this effort in some form. If the scope of interviewees had been expanded to include representatives of developing countries and country-based members of civil society, namely those who were not involved in the Summit, this would have likely identified different views and issues.
Annex 2: Historical Context

This piece of work was commissioned by JHSPH to complement this report. The author, Steve Sinding, provides a full historical context of family planning, while this report focuses on the period of 2011 to 2012.

Historical background

By Steve Sinding

Since the late 18th Century, when the Rev. Thomas Malthus published his controversial *Essay on the Principle of Population* (1798), concern has existed among economists and demographers regarding the effect of rapid population growth on economic development and social stability. This concern, however, remained largely confined to the academic world until, shortly after the end of World War II, demographers discovered that an unprecedentedly rapid rise in population was occurring in Asia. The 1950 round of censuses around the world revealed population growth rates in many of the large countries of East and South Asia that alarmed policy elites in the Western world, particularly the United States and Great Britain, and gave rise to what became the modern “population movement,” a conscious political response to the perceived threat of a demographic explosion in the developing world.

Although any attempt to place a starting point on this movement is arbitrary, a good case can be made for placing its beginning in 1952, for in that year two key institutions that became the vanguard of the movement were established. John D. Rockefeller 3rd, an heir to the Rockefeller fortune, created the Population Council in New York City that year, while at the same time the godmother of birth control in America, Margaret Sanger, was organizing the International Planned Parenthood Federation (IPPF) at a meeting in Bombay (now Mumbai), India. These two institutions are chosen because they became paramount in the efforts during the 1950’s and into the 1960’s to warn governments of an impending “population crisis,” as it came to be called, and to inspire them to subsequent action.

It was largely through the efforts of the Population Council and IPPF, along with the Population Crisis Committee formed and headed by Gen. (Ret.) William Draper, that the U.S. Government, through its Agency for International Development became a major donor to family planning programs around the world beginning in 1966, and the United Nations formed its Fund for Population Activities (UNFPA, today known as the UN Population Fund) in 1968. Also of critical importance in these early years were the Ford Foundation and the Rockefeller Foundation, which provided much of the funding for the early work of both the Population Council and IPPF. The Council focused on social science and biomedical research, while IPPF played a key role in the establishment and spread of family planning services through indigenous nongovernmental member associations, known then as Family Planning Associations (FPAs).

After the invention of the oral contraceptive (the Pill) and the intrauterine device (IUD) around 1960, the primary approach adopted by the population movement was, in fact, voluntary family planning, despite the fact that many leading scholars and researchers at the time were convinced that this approach could not be successful in reducing high fertility rates in developing countries. Their argument was that the poor agricultural subsistence populations that dominated most developing countries had large families as a matter of necessity and choice and could not be persuaded by well-intentioned Westerners or local urban elites to reduce their high birthrates. Rather than family planning programs, they argued, governments should invest in “development,” particularly health and education programs and employment-generating industries, to create conditions more conducive to lower family size norms. On the other side were family planners of the Margaret Sanger persuasion who believed that many such families, but especially the women, would readily adopt modern birth control if they had ready access to it and it was affordable.

Once governments became gradually more involved after 1966 – the rich countries through their development aid programs and developing countries through their public health systems (such as they were) – and significant amounts of money became available to finance family planning services, the debate between the development
school and advocates for the family planning approach became more intense. The debate culminated in 1974 at the UN-sponsored first World Population Conference in Bucharest, Romania.

The United States and its allies arrived at Bucharest pushing for a global population growth goal of replacement level fertility (or an average of slightly more than two children per woman) by the year 2000 and urging that each country set a national goal consistent with the international goal. Most developing countries, especially those outside East and Southeast Asia, joining forces with the Soviet Union and its socialist bloc allies, rejected this "population control" approach and argued that "development is the best contraceptive." Coming as it did in the midst of the UN’s first “Development Decade,” the countries of what were then sometimes known as the Second (socialist) and Third (developing) Worlds seized the opportunity afforded at Bucharest to insist that the rich countries commit vastly increased resources to development aid.

The Bucharest conference ended in an impasse, agreeing simply that “all couples have the basic human right to determine freely and responsibly the number and the spacing of their children and to have the information, education, and means to do so” – this in the context of a comprehensive approach to development.

Interestingly and somewhat surprisingly, given the conflicts and subsequent lack of consensus at Bucharest, a significant majority of developing countries adopted family planning-based population policies in the years immediately following the World Population Conference. Approaches varied greatly across the different regions. In East Asia countries such as Korea, Taiwan, Thailand and Indonesia mounted large and aggressive family planning programs designed to achieve specific demographic goals. Likewise, the South Asian behemoths, India and Pakistan, adopted ambitious population targets but were unable to mount programs that could actually achieve them.

In Latin America governments, reluctant to confront Catholic teachings on birth control and confront the Church hierarchy, instead encouraged private, mostly IPPF-affiliated, groups and the commercial sector to provide family planning services. Across the Muslim world many governments became concerned about too rapid population growth and sponsored measures through their public health programs to make family planning services available. The only region that essentially ignored the issue altogether was Africa, where very few governments or private groups took either population growth or family planning seriously.

The period between 1974 and the mid-1980s has sometimes been called the “golden era of international family planning.” It was a time when the idea of small families, achieved through voluntary family planning programs, spread rapidly and resulted in the widespread adoption of contraceptive use. Between 1965 and 1990, the percentage of women in developing countries using modern contraceptives on a regular basis increased from around 10 percent to over 50 percent. To be sure, not all countries adopted programs that were entirely voluntary. Foremost among these was China, which, in 1980, introduced its highly controversial “one-child policy,” a coercive program that banned unauthorized childbearing and restricted urban couples to one offspring and most rural ones to no more than two. India briefly introduced a catastrophic program of compulsory (mostly male) sterilization – a policy that resulted in the defeat of Indira Gandhi’s government in 1978. Bangladesh and Indonesia also introduced policies that in eyes of some critics bordered on coercion.

It is important to mention these exceptions to the general commitment to voluntary programs not only because the countries that implemented them were so large but also because the violation of the principle of voluntarism subsequently became a rallying cry for critics of the “family planning approach,” as we shall see.

Two major issues arose in the 1980s that brought this golden era to an end. The first was the dramatic and abrupt change of policy in the United States that followed Ronald Reagan’s election as President in 1980. Reagan and his advisers, in an acknowledged effort to woo Roman Catholic voters by winning the support of Church leaders, adopted a strenuous and highly visible policy of opposition to abortion, challenging the 1973 U.S. Supreme Court decision in Roe v Wade that legalized abortion under most circumstances nationally. Furthermore, influential figures in the Reagan Administration persuaded the President and his inner circle to change two decades of U.S. international population policy by declaring that population growth, per se, is not a significant factor in economic development. While it took time for these policy changes to gel, by 1984 they were firmly established within the
Reagan Administration and they burst on the international scene at the second global population conference, the International Conference on Population, held in Mexico City in the summer of 1984.

The U.S. had long been the leading advocate among donor countries for policies and programs to reduce population growth rates and was far and away the largest funder of such programs. Its dramatic, and to most countries shocking, about-face – particularly its declaration that population growth is “neither a positive nor a negative, but a neutral factor in development” – cast a dark shadow over the population movement from which it never fully recovered. Even though Reagan’s policies were overturned during the subsequent Democratic administrations of Bill Clinton and Barack Obama, the damage done during the 12 years of Ronald Reagan’s and George H.W. Bush’s presidencies was impossible fully to undo. Most importantly, the macro-economic development rationale for family planning that had done so much to convince finance ministers and economic development authorities in developing countries to adopt population policies and which helped to sustain the movement from the 1950s onward was largely undermined, thanks also to an influential study by a committee of the prestigious U.S. National Academy of Sciences in 1986 that noted there was scant evidence that high fertility had a significant impact on economic development, a view that received widespread international exposure.

The second factor to emerge in the 1980s that shifted focus and funding away from international cooperation on population was the discovery and then the rapid spread of HIV and AIDS. As the number of infections grew and countries became increasingly panicked about the potential impact of this then incurable and untreatable disease, donor and developing country funds rapidly shifted away from family planning and into programs designed to try to slow or even stop the spread of AIDS. Service delivery systems that had been slowly and painstakingly constructed to provide family planning services were quickly reoriented toward HIV and AIDS prevention and care. Even before the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, many governments around the world had shifted their focus away from family planning and very little effort was made to integrate HIV/AIDS programs with preexisting family planning and reproductive health services. It must be said that the population movement was initially very reluctant to associate itself with efforts to combat HIV/AIDS. The result was that AIDS activists looked elsewhere for support and, as they became successful in persuading governments to take action, turned their backs on the family planning community.

While the dramatic change in U.S. policy and the HIV/AIDS pandemic were the two major factors that led to diminished attention and funding devoted to family planning programs, there was a much less well noticed threat that began to develop in the late 1970s or early 1980s and slowly grew through the decade of the ’80s. This was a movement, largely comprised of women who were angry about family planning programs that they believed were primarily interested in women as an instrument of population control and not in women’s health and well being for their own sakes. They pointed to demographic goals and the targets derived from those goals for family planning fieldworkers to achieve, often expressed as “new acceptors” of contraception or in terms of the “contraceptive prevalence rate.”

These critics of family planning programs believed that target-based programs could, and often did, lead to coercion and to a variety of human rights abuses. As examples, they cited the coercive Chinese and Indian programs mentioned above, as well as many other instances in which family planning workers treated women not as valued clients but as instruments to achieve government-imposed quotas. The critics alleged that contraceptive research was designed not to improve women’s health but to achieve demographic goals and they argued that dangerous side-effects of some contraceptives were ignored or denied by officials determined to bring down birthrates. Sometimes the leaders of this movement characterized it in terms of human rights and other times as a women’s health movement.

Thus, the attitudes toward population growth and family planning programs had shifted considerably from the late 1970s, when something like a global consensus seemed to exist, to the early 1990s when significant threats to the movement had clearly emerged.

It was in this environment that the United Nations, having convened international population conferences in 1974 and 1984, agreed in 1992 once again to sponsor a decennial conference, this time to be called the International Conference on Population and Development (ICPD). It was to be held in Cairo, Egypt in September, 1994. Planning
for the ICPD began two or three years in advance with a series of preliminary technical and regional meetings, followed by international preparatory committee (prepcom) meetings, of which there were three at UN headquarters in New York.

As the preparatory process proceeded, it became clear that the women’s rights movement had organized well. Activists worked hard to ensure that delegates sympathetic to their views were represented on national delegations and they lobbied extensively to have their views represented in the various drafts of the central document to be negotiated at the ICPD itself, the Programme of Action (PoA). They were determined that the ICPD Programme of Action would reflect a new vision of population and development, one based not on population goals and targets but on the rights and well being of individuals.

The term “family planning” was to many of these activists code language for the coercive population control policies they believed were characteristic of the past 20 years and more. Rather, they preferred to use the more recently coined terms, “reproductive health” and “reproductive rights” and these newer terms did become the most prominent feature of the PoA.

This new vision, or “paradigm shift” as it was called by many, alarmed traditional leaders of the population movement because they thought it diverted attention from the all important goal of reducing fertility and achieving population stabilization. While the term family planning was not expunged entirely from the ICPD PoA as it emerged from the final negotiations at Cairo, it appeared almost as an afterthought. Indeed, Chapter VII of the PoA, which outlined specific program actions to be undertaken by UN member states, had been entitled Family Planning and Reproductive Health. In the final document, family planning was dropped from the title, which became “Reproductive Rights and Reproductive Health.” “Family Planning” became a chapter subheading.

Leaders of the women’s rights and women’s health movement regarded the ICPD as a great triumph and they were largely justified in doing so. All around the world governments began to change their official attitudes toward population and reproductive health and rights. Many of those which had established demographic goals and targets dropped them in favor of what came to be called rights-based programs emphasizing improved quality of care and attention to reproductive health problems such as sexually transmitted diseases, infertility, and sexual violence. At the same time, donor countries actively encouraged their developing country partners to shift from population-oriented policies to reproductive and, increasingly, sexual rights policies.

But amidst all the enthusiasm for reproductive health and rights, somehow family planning was slowly being lost through oversight and neglect. With the world now preoccupied with HIV/AIDS and no longer particularly concerned about high fertility and population growth, funding for such fundamental items as contraceptives began to disappear and women who depended on public resources for their family planning supplies found it increasingly difficult to find reliable sources of supply. Contraceptive prevalence rates began to decline in some places as the priority given to family planning was superseded by other health priorities and other services. As the availability of family planning services diminished after 1994, supporters of family planning, whether motivated by demographic concerns or not, became increasingly concerned. Indeed, many of those who staunchly supported the shift to a reproductive health approach worried that the decreased emphasis on contraceptive services – a development they neither anticipated nor desired – would be injurious to women. Thus, beginning sometime in the last decade we began to see the rustlings of support for the revival of family planning as a key element in primary health care services.

USAID had never abandoned family planning as the core commitment of its own population and reproductive health support to developing countries. Likewise, several American foundations like Gates, Hewlett, and Packard retained a strong commitment to family planning. The UK Government began to join the incipient movement, particularly after David Cameron’s Conservative Party regained control of the Government in 2010.

The population movement that began in the early 1950s and gradually gathered steam through the remainder of that decade and the 1960s had two acknowledged rationales and one largely unspoken one. The publicly expressed arguments were, first, a broad consensus that economic development and social progress and stability depended on bringing explosive population growth under control; and, second, a commitment to maternal and
child health and women’s empowerment that required enabling couples, women in particular, to gain control over whether and when to bear children. The unspoken rationale was concern in many of the rich countries that uncontrolled population growth in the developing world would represent a long-term threat to their national security – a concern that diminished somewhat as fertility rates fell through the 1970s and ‘80s, and into the ‘90s.

As we have seen, the first rationale was also seriously undermined in the 1980s, causing many governments, particularly in the donor countries, to lower the priority they accorded to family planning in their international assistance programs. That left the health and welfare rationale as the principal underpinning of family planning programs, reinforced particularly after Cairo by the human rights and women’s empowerment arguments.

Then, toward the end of the 1990s and continuing into the first decade of the 21st Century, a new insight emerged from a group of economists who were looking at the interaction of reduced fertility and economic development in some of the countries of East Asia – the so-called Asian Tigers – that had experienced spectacular economic growth in the 1960s and ‘70s. What they found was that policies and programs implemented by those governments that effectively reduced birthrates contributed importantly to economic development by reducing sharply the proportion of the population that was economically dependent on those of working age. The reduction in the proportion of the population under the age of 15 not only reduced the costs of education and health facilities and services but also enabled many women to enter the workforce and contribute to family incomes and wealth. The result was a massive improvement in savings, consumption, living standards, and economic growth. The researchers called this phenomenon a “demographic dividend” and the findings have led many heretofore skeptical economists to revise their views of the population growth/economic development equation. It has also provided family planning advocates with renewed ammunition for their efforts to persuade governments to invest in family planning programs.

Data from censuses at the end of the first decade of the 2000’s showed that fertility decline had slowed and surveys in many countries showed flat or declining rates of contraceptive use. In addition, the severest critics of the family planning approach to population policy began to realize that declining support for contraceptive services was undermining their dream of expanding reproductive health and rights. These developments helped to set the stage by the end of that decade for a serious and sustained effort to revitalize the family planning movement, to which we now turn our attention.
Annex 3: Timeline of Key Moments

Key Moments: 2008-2012

- **January 2008**: Obama administration takes office and overturns the “global gag rule” on FP organizations

- **January 2009**: SoS Clinton declares the USG’s renewed support for and dedication to international FP/RH programs in a speech commemorating the anniversary of ICPD

- **June 2009**: G-8 launches the 5-year, $7.3b Muskoka Initiative on Maternal, Newborn and Child Health

- **February 2010**: Launch of Ouagadougou Partnership in West Africa

- **September 2010**: UN Secretary General launches the Every Woman Every Child global movement

- **September 2011**: Melinda Gates and Nick Clegg launch of the Alliance for RMNCH; Demographic Dividend panel at the World Bank fall meeting

- **January 2012**: BMGF and DFID agree to co-host an international FP Summit in July 2012

- **July 2012**: London Summit on Family Planning

- **May 2008**: Obama increases investment in MCH and FP with the launch of the U.S. Global Health Initiative

- **May 2009**: UK elections: David Cameron becomes Prime Minister and re-affirms his commitment to increase aid spending to 0.7% of GDP. Appoints Andrew Mitchell as Secretary of State for International Development.

- **June 2009**: GAVI Pledging Conference – the first UK “Gold Moment” – raising $4.3b for immunization.

- **December 2011**: Melinda Gates announces FP will be a top priorities for her “this year and into the future”

- **April 2012**: Melinda Gates gives a TED Talk on FP in Berlin

- **September 2012**: Andrew Mitchell leaves post at DFID and is replaced by Justine Greening
PRESS RELEASE BY DFID AND THE BILL AND MELINDA GATES FOUNDATION

Landmark Summit Puts Women at Heart of Global Health Agenda Global leaders unite to provide 120 million women in the world’s poorest countries with access to contraceptives by 2020

London, July 11, 2012 – Voluntary family planning services will reach an additional 120 million women and girls in the world’s poorest countries by 2020 thanks to a new set of commitments announced today by more than 150 leaders from donor and developing countries, international agencies, civil society, foundations and the private sector.

The announcement was made at the London Summit on Family Planning, co-hosted by the UK Government’s Department for International Development and the Bill & Melinda Gates Foundation. This unprecedented effort showcased innovative partnerships and leadership at the country level, empowering women to reach their full potential. The Summit underscored the importance of access to contraceptives as both a right and a transformational health and development priority.

Secretary of State for International Development, Andrew Mitchell, said: “This is a breakthrough for the world’s poorest girls and women which will transform lives, now and for generations to come. The commitments made at the Summit today will support the rights of women to determine freely, and for themselves, whether, when and how many children they have.”

“Enabling an additional 120 million women in the world’s poorest countries to access and use contraception, something women in the developed world take for granted, will save millions of lives and enable girls and women to determine their own futures.”

By 2020, the collective efforts announced today will result in 200,000 fewer women dying in pregnancy and childbirth, more than 110 million fewer unintended pregnancies, over 50 million fewer abortions, and nearly three million fewer babies dying in their first year of life.

Melinda Gates, co-chair of the Bill & Melinda Gates Foundation, said: “When I travel and talk to women around the world they tell me that access to contraceptives can often be the difference between life and death. Today is about listening to their voices, about meeting their aspirations, and giving them the power to create a better life for themselves and their families.”

The Summit has raised the resources to deliver contraceptives to an additional 120 million women which is estimated to cost $4.3 billion. More than 20 developing countries made bold commitments to address the policy, financing and delivery barriers to women accessing contraceptive information, services and supplies. Donors made new financial commitments to support these plans amounting to $2.6 billion – exceeding the Summit’s financial goal.

Access to safe, effective methods of contraception is considered one of the most cost-effective investments a country can make in its future. Studies show that every US $1 invested in family planning services yields up to $6 in savings on health, housing, water, and other public services.
Contraceptive use also leads to more education and greater opportunities for girls, helping to end the cycle of poverty for them and their families. Up to a quarter of girls in Sub-Saharan Africa drop out of school due to unintended pregnancies, stifling their potential to improve their lives and their children’s lives.

The Summit galvanized the global community to create transformational change, calling for innovative solutions and robust public-private partnerships that put women at the heart of the equation. Commitments announced today will give women more options, easier access, and improved health care.

The Summit supports and builds on the momentum created by the UN Secretary General’s Global Strategy for Women’s and Children’s Health, “Every Woman, Every Child,” and innovative public-private and civil society partnerships developed through the Reproductive Health Supplies Coalition. The Summit also aligns with the broader framework established by the International Conference on Population and Development (ICPD) almost 20 years ago.