The 2012 London Summit and International Family Planning: A Case Study (Teaching Notes)

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This case study was developed by Global Health Visions for the Center for Public Health Advocacy at the Johns Hopkins Bloomberg School of Public Health. The case study and teaching notes were edited by Alisa Padon, David Jernigan, Beth Fredrick, and Diane Coraggio. Sources included desk research and interviews with key stakeholders involved in the planning and execution of the Summit.¹

The Center for Public Health Advocacy is an interdepartmental center that works with public health professionals throughout the Johns Hopkins Bloomberg School of Public Health. The mission of the Center is to bring science to advocacy and advocacy to science, in order to improve and enhance health and well-being for all persons. The Center conducts research on advocacy methods to develop new and better ways to translate public health research into actions that can save lives; teaches and trains the public health workforce in effective advocacy; and acts as a resource on advocacy practice for faculty, students, and external stakeholders.

The ‘2012 London Summit and International Family Planning’ case study is a teaching tool. The case study contains several parts:

- **Parts A and B** – This portion of the case study provides extensive situational context and should be reviewed before the lesson.
- **Parts C and D** – This portion of the case study contains a synthesis of the outcomes and limitations of the case study scenario and should be reviewed after the group discussion.
- **Teaching Notes** – This piece provides instructors and facilitators with topical discussion questions and relevant policy questions. Teaching notes are also available at [http://www.jhsph.edu/research/centers-and-institutes/center-for-public-health-advocacy/](http://www.jhsph.edu/research/centers-and-institutes/center-for-public-health-advocacy/)
- **Annexes** – The annexes contain important historical context that will enhance the case study.

¹ Additional information on the methodology of this research can be found in Annex 1.
**Instructions**

The role of the case study instructor is to provide a path of inquiry and guide a process of discovery, not to explain or tell. Direction should be in the form of questions, if possible, incorporating student comments or questions based on the Case Study (Parts A and B). Question and exercise options follow below and can be used to guide the conversation.

Questions are grouped into four categories to accommodate various courses and audience backgrounds: I) family planning/topical, II) the 2012 London Summit, III) advocacy/political change and IV) closing questions. Within those categories, questions are ordered in line with possible progression of the discussion and include off-shoot questions and prompts to be used as needed, but question order can come second to the natural flow of the conversation. Where applicable, the page number within the case study or supporting materials that generated the text has been included.

Questions can be discussed in multiple formats. The traditional approach to presenting questions in-class for large group discussion can be substituted with giving questions prior to class or providing one or more questions to small groups of students for discussion and subsequent presentation.

Some questions have multiple parts, for example:

“Is it important to have multiple partners in these endeavors? To have joint private and public efforts? What does the partnership offer that independent efforts do not? What do independent efforts bring or allow that partnerships might hinder? What kind of partnerships are most essential for a global undertaking such as this? Under what circumstances might these assumption be false?”

Each question part can be asked individually, and students should be given plenty of time to think and discuss. Not all questions need to be asked.

The text in italics that follows the questions comes directly from the case report, the interviews or other background research. It may provide some insight into possible areas of discussion but is by no means exhaustive and is not meant to be lecture material or a substitute for student discussion.

There are some exercises embedded in the question list. These are designed to let students learn together, to increase the level of student involvement, to facilitate engagement among all students, especially those less willing to speak in front of the class, and to allow student-to-student discussion. Exercises can substitute for or build on the in-class discussion.

Particularly if the class has a range of expertise and background knowledge, a useful tool is to task students with generating their own question(s) prior to class. These questions will then be asked and discussed as a group during the class.

Sections A and B of the case study should be assigned reading prior to the course. Sections C and D are handed out after discussion in class. Annex 2: Historical Context can be handed out in class if the instructor uses exercise option B (p.5).

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2 This teaching note was developed by Alisa Padon PhD and edited by David Jernigan PhD.
I. Family planning/topical questions

Let’s start by establishing what we mean or what we think we mean by “family planning”.

A. What does family planning mean? (Prompts: Does family planning only mean fewer children? Does it mean better timing? Does it include access to abortion and assisted fertility in addition to contraceptive use?) What are the pros and cons of being more inclusive?
   - Reduce fertility by increasing access to contraceptives

B. What are the benefits of family planning? (p. 4)
   - Empowerment: To enable more women to decide freely and for themselves whether and how many children to have, and make sure they had access to the supplies and information and knowledge they needed to achieve that. (Julia Bunting interview)
   - Economic: To achieve population stabilization and improve access to education and employment
   - Quality of life: Improved and increased health, housing water, and other public services
   - Cost-effective in relation to other health interventions
   - Health: planned pregnancies and births that are spaced two or more years apart are safer and benefit the health of women and children

C. What is the mechanism of influence? That is, how does it bring about these benefits?
   - Young girls who are not pregnant or parenting can go to school and take on jobs to bring in income to support the family, end a cycle of poverty.
   - Having more people in the labor force than the population that depends on the labor allows resources to be diverted to development.

D. Is family planning always a good thing? How can family planning programs be bad? What larger issues drive how family planning programs and priorities are developed and implemented?
   - Coercive techniques and incentives – compromise individual freedom and choice

EXERCISE OPTION A (~30 minutes)

This exercise is a good way to open the discussion and ensure that everyone is comfortable sharing their views. It is ideal for smaller classes or when a divisive issue is raised, which can cause some individuals to retreat. Give each student a 3”x5” index card and ask them to write a few lines expressing a personal opinion on the following question:

Was all of the effort channeled into the 2012 London Summit worth it and why?

Collect the cards and redistribute them so that no one knows whose card they are holding. Then, ask each student to read that card aloud and take sixty seconds to agree or disagree with what it says. By the time everyone in the group has responded, the issue will have been examined from multiple perspectives and new insights and differing opinions will have emerged.
• Some advocating for a broader sexual and reproductive health and rights (SRHR) agenda saw family planning as using women for “population control”, and preferred terms such as “reproductive health” and “reproductive rights”
• Target-based programs have been equated with efforts to decrease population size of particular groups; racial/ethnic cleansing, and eugenics
• Diverts resources from other deserving or pressing issues such as HIV/AIDS

E. What is different about framing it as an SRHR/women’s rights issue? What was good about this framing? What was bad? Did it help or hurt ultimately?
  • Rights-based programs emphasized improved quality of care and attention to the full range of reproductive health needs including, abortion, prevention and treatment of sexually transmitted infections, infertility, and sexual violence.
  • Decreased emphasis on contraceptive services

F. If coercive or incentivized programs get the desired results, does it matter if they violate rights?
  • Individual rights versus public good
  • Coercive practices were bad for women and men and gave opponents of family planning fodder for objections to the practice as a whole; hurt the movement internationally.

G. Is the “rights” versus “results” a false dichotomy? Do we need to be less concerned about coercion today than 30 years ago? What’s changed/not changed? Is that true everywhere? (Julia Bunting interview)

H. Coercion limits freedom of choice. The lack of access to contraceptives, choice of a contraceptive method or poor-quality care limits freedom of choice. Is one kind of limitation to freedom worse than the other? Why?
I. Why do you think family planning programs were particularly affected with resources shifted to HIV/AIDS? (Prompt: why was it a good or bad candidate for a reduction in support? What are the likely consequences of either choice?)

J. Since resources were limited, would you have prioritized HIV/AIDS or family planning? Why? What information would you need to answer this question? How might a policymaker view the situation differently? What about a doctor in a developing country?

- Long versus short-term impact
- Groups affected
- Objective measures of severity
- Years of life lost
- Cost effectiveness

K. Family planning has been framed in many ways (family planning/population control/sexual and SRHR/economic development issue). Let’s talk about how to frame an issue to take to a global stage.

L. How do you handle issues that have religious aspects or touch on rights or values? How do you handle issues that affect a socially, culturally or economically disadvantaged group? (Prompt: Many countries rejected a family planning approach in the mid-1970s – how do you think the role of women in various societies may influence the interest that leaders have in providing contraceptive services? What other things made this issue a politically sensitive one?)
• Equating contraception with abortion
• Freedom of choice and independence for women
• Pressure to bear children, child marriage, polygamy

EXERCISE OPTION C (~30 minutes):
Break into small groups of 3 or 4 students. Each student takes 3 minutes to consider a public health issue that they believe needs attention/action. Each student presents their issue and the group takes 5 minutes to discuss the following questions:

1. What is at stake with this issue? Why is this issue important to address?
2. What can be achieved by taking action? Who benefits beyond those directly affected?
3. What data and evidence do you need to make the cognitive or rational case?
4. What ethical or emotional arguments can be used to gain support?
5. How can you make this issue broadly relevant, interesting, and urgent for non-technical audiences (e.g. media, policymakers, donors)?

As an alternative, have each group focus on one issue and present a pitch to others in the class, requesting action needed to address the issue.
II. The 2012 London Summit

A. The planners of the 2012 London Summit on Family Planning defined “unmet need” as the number of women who wish to avoid pregnancy but are not using any contraceptive (traditional or modern). What research or evidence do you need in order to answer this question? How would you approach trying to obtain these data?

i. Anecdotal or qualitative research – Can “unintended” mean different things? Don’t want a child but not using contraception/don’t want a child and using contraception incorrectly, etc.) Is unintended pregnancy seen as a problem by the woman, society?

ii. Surveys of women – proportion of women who report that a pregnancy or birth was unintended, that they do not currently want to have a child, are using or not using contraception. (Prompt: Does the survey incorporate differences in age or among wealth quintiles? Are unmarried women included? Is any group excluded? Do questions include all methods of contraception? Do questions ask about abortion, miscarriage and birth? Why is it important to include all three? Is anything significant missing to understand unintended pregnancy? Wantedness, contraceptive failure?)

iii. Observational/facility surveys – availability of contraceptive methods (Prompt: In what countries do you focus? Does rural vs urban make a difference? Where are contraceptives available? Do people get them from doctors? Hospitals? Pharmacies or drug shops? Does the type of contraceptive method(s) available matter?) (Prompt: are people availing themselves of the contraceptive methods available? Do you ask doctors how many contraceptive methods they have provided or prescribed? Might you get a different answer if you asked people about their actual use of contraceptives?)

B. How is the London Summit’s objective focused on modern contraceptive prevalence (mCPR) different from a demographic or population-related objective? Do the same concerns regarding coercion and targets translate to an objective related to mCPR?

C. How would you go about “costing the goal” of achieving 120 million new users of modern contraceptive methods? What information would you need?

- Cost of services, supplies, distribution, education, oversight, evaluation, etc.

D. The London Summit happens. What do you do if you are a proponent of SRHR or an advocate for prioritizing HIV/AIDS? What are your next steps?

E. What do you think was most important in making the London Summit happen? What other information, resources or activities would you have included if you were organizing the Summit?

- Already existing community of advocates
- Already existing family planning methods and technologies, and evidence that developing countries were interested in such methods, “freeing up the ability to focus on the gaps – funding and political support.”
- The GAVI pledging conference for increasing childhood vaccinations
- Data are a critical element for policy and advocacy action
F. How did the organizers involve low-income countries where unmet need for modern contraception is highest? Are there other ways to encourage buy-in and country ownership of the agenda? What are the downsides of engaging high-level political leaders?

G. DFID and the Bill & Melinda Gates Foundation established an operating structure for the London Summit and its outcomes (p.7 Part A). What do you think about the dimensions they outlined? Is anything missing?

H. What do you think of their financing plan? What are the implications of seeking more than half ($2.3 billion) from additional donations?

I. A second London Summit on Family Planning is to take place in 2017. Why is it needed? Will it have the same impact?

Additional Resources: Videos related to the 2012 London Summit may be accessed and used selectively to enliven discussion or support a question via the FP2020 Web site. http://www.familyplanning2020.org/commitments
III. Advocacy/political change questions

A. What were key challenges facing the revitalization of family planning programs and provision of contraceptive information, services, and supplies? How did the challenges change over time? How might the challenges be different with different health issues?

B. How might a policymaker’s view of efforts to revitalize family planning programs be different from someone in the pharmaceutical industry? What about a doctor in a developing country? What about a young woman in a country where women lack rights, are expected to marry young and have children?

C. Is it important to have many types of partners in these endeavors? To have joint private and public efforts? Civil society? What does diverse partnership offer that independent efforts do not? What do independent efforts bring or allow that partnerships might hinder? What kind of partnerships are most essential for a global undertaking such as this? Under what circumstances might these assumptions be false?

- Involving multiple groups can increase sharing of effort (more hands), reach (local vs global), funding, visibility, and accountability. (Julia Bunting interview)
- But multiple groups can clash, it takes diplomacy to work together collaboratively and dedicated resources to coordinate so many moving pieces and communicate effectively.
- Groups may have leadership and existing infrastructure to draw on.
- Private institutions such as the Bill & Melinda Gates Foundation, or other nongovernmental organizations (NGOs) can look for strategic investments that may be difficult for a bilateral donor (an official, government contribution) to support – typically, in a case of bilateral aid, money goes from the donor country directly to official partners and pre-defined priorities in the recipient country. (Leo Bryant interview)

- Bilateral aid represents flows (funds) from official (donor government) sources directly to official sources in the recipient country.
- Multilateral aid represents core contributions from official (government) sources to multilateral agencies (i.e. the UN, which has many agencies) where it is then used to fund the multilateral agencies’ own programs. In some cases, a donor can contract with a multilateral agency to deliver a program or project on its behalf in a recipient country.

- Depending on the type of partnership, you could have more or less commitment from one or more parties, perhaps with one lead and the others helping “a bit”. More commitment can mean covering more bases.
- If big names back something, whether it’s high-level representatives from governments or well-known private foundations, such as the Bill & Melinda Gates Foundation, there will often be lots of media interest.
- Partnering with country-level players is crucial in assuring that lessons learned, funding, etc. come back to the countries, which is where the strategy will delivered. (p. 15)
D. If the United States government had not been on board in 1994 at the Cairo International Conference on Population and Development, how would it have been different? What does the United States bring as a partner (good and bad)? (p. 5, p. 24)
- Funding
- Global presence
- Media attention
- Politics and pressure to agree to policy priorities (i.e. Reagan’s Mexico City Policy or Global Gag Rule)

E. Let’s talk about how to motivate political will and change. What is critical for policy and advocacy action?
- An objective or objectives that are SMART (specific, measurable, achievable, relevant and time-bound)
- Data
- Feasibility
- Publicity
- Timing

F. How can you strategically use timing or self interest to motivate individual politicians to take on issues? (p. 6)
- Align the activities/events with an election/political cycle, i.e. establish goals that are achievable in 3-5 years (Julia Bunting interview)
- In this case, advocates from Marie Stopes International met with Andrew Mitchell before the election to explain what needs to be done, offering an angle that can be used politically (i.e. better contraceptive delivery services provides freedom of choice). He was able to use this issue as a campaign promise, and because he was a new Secretary of State, he was interested in “making his mark”. It might have been a different story for a veteran politician. (Leo Bryant interview)

G. How do you navigate championing one issue versus the broader continuum of related issues that are all important and that some group or another cares deeply about? What are the benefits of championing just one issue? What are the benefits of taking on multiple issues?
- There is probably not any summit/coalition event/etc. where there is not someone complaining that their issue is being neglected.
- Do not “do nothing because you cannot do it all.”
- Agencies set their agenda for the year with certain priorities – if you can get multiple agencies’ agendas to align on specific topics, you will have meaningful partnerships with real buy-in.
- Single issues may be more achievable and realistic.
- Single issues allow for resources generated to be more meaningful, tailored, and specific.
- Single issues keep the groups smaller and, therefore, more focused.
- It may be easier with a single issue to frame it to incorporate the values of a wider range of supporters, such as with the focus on voluntary family planning, which recognized the rights and values of advocates but kept the initial issue intact and independent.
- On the other hand, single issues may alienate groups and be seen as exclusionary.
- Multiple issues may help getting more groups on board and more funding
H. How do you keep issue interest from being a “flash in the pan”, with a big song and dance but no follow up? How would the follow-on activities to the London Summit have looked different if they had been built into an existing infrastructure (e.g. the United Nations Population Fund)?

- **Systems put in place after the summit**: FP2020 partnership formed to track and advocate for progress on summit commitments.
- **Clear evaluative goals were established** to measure performance against targets, and the targets were specific – “120 million new users of contraception”, rather than “end unmet need for family planning”.
  - **Caveat** – need to consider media interest when designing goals; perhaps “end unmet need for family planning” would have been a more media friendly campaign than 120 million new users.
- **There was sustained pressure on governments** to develop plans for implementing all the pledges they had made.
- **Regular progress reports are being published.**
- **Link the specific issue to big issues**: family planning is a way to “empower women”, “lift up their families”, “lift up their communities”; family planning is “absolutely fundamental to any hope to tackling poverty in our world.”
IV. Closing questions

A. Did it all work?
   i. **HANDOUT: Section C.** Give students 5 minutes to quickly read and then summarize key points, limitations, and takeaways together in class.

B. Why do you think we read this case study? Why now? What can you draw from this case to use in your own work or advocacy related to family planning, reproductive health, or other issues?

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**Additional Resources:** WHO (2014). Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations.
http://www.who.int/reproductivehealth/publications/family_planning/human