The 2012 London Summit and International Family Planning: A Case Study (Parts A and B)

March 2017
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 professional 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 way 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.
“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, Bill & Melinda Gates Foundation (BMGF)

“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 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 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 and why 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, including this amount of new investment? This case study tells that story.

A. Setting the Scene

Access to safe, effective methods of contraception is one of the most cost-effective investments a country can make. 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 also supports many other critical elements of a productive society, including more education and greater opportunities for


In short, family planning is a critical intervention for healthy and productive lives and thriving communities.

**Family Planning History**

In the 1950s and 1960s, proponents began to warn governments of an impending “population crisis” and to call on them to support family planning services. In the 1970s and 80s, the idea of small families, achieved through family planning programs, spread rapidly and resulted in the widespread adoption of contraceptive use. During this time, governments and donors established a strong infrastructure of organizations working to advance this issue nationally and globally.

But not all countries adopted voluntary family planning programs. Programs such as China’s “one-child policy” and India’s incentive programs were considered coercive.

In 1980, the Reagan administration in the United States adopted a strong and highly visible position opposing abortion. Further, it declared that population growth was not a significant factor in economic development. Then HIV/AIDS emerged as a global issue, shifting focus, funding, and delivery service systems away from family planning to HIV/AIDS prevention and care.

At the same time a movement developed, largely comprised of women who believed that family planning programs used women as an instrument of population control (versus an intervention in support of women’s health and well-being). They argued that target-based programs could lead to coercion and a variety of human rights abuses. This movement grew in the 1980s and political complexities—for example, religious and conservative objections that equate family planning to abortion or promoting promiscuity among unmarried youth—continued to fuel and politicize the issue.

In 1994, 179 member states came together in Cairo at the International Conference on Population and Development (ICPD). The women’s rights movement determined that the ICPD Programme of Action (PoA) would reflect a vision based not on population targets but on the rights and well-being of individuals, with family planning as a subset.

> “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)

Governments began to change their official attitudes toward population and reproductive health and rights. Many countries that had established demographic targets dropped them in favor of rights-based programs, emphasizing improved quality of care and attention to reproductive health problems such as sexually transmitted diseases, infertility and sexual violence. The new focus brought with it a decline in attention to and resources for family planning:

- **Funding for contraceptives began to fall.** As noted by Scott Radloff (formerly U.S. Agency for International Development [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.”

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5 Steve Sinding’s Historical Context and “Family Planning: the unfinished agenda”

6 Steve Sinding’s Historical Context
- **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.7
- **Contraceptive prevalence rates began to decline in some countries.** Data from censuses showed that fertility decline had slowed in the 2000s and surveys in many countries showed flat or declining rates of contraceptive use.8

Jotham Musinguzi (Partners in Population and Development, Africa Regional Office) said, “In 2000 in New York at the United Nations, when the global community decided to [set] the [Millennium Development Goals] MDGs9 and family planning and reproductive health were not at the center stage, we realized we were obviously losing out.”

**Baby Steps Forward**

Several developments helped to set the stage for a serious and sustained effort to revitalize the family planning movement.10 Toward the end of the 1990s, 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.11 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.

A constellation of important events transpired at this time, including:

- **The first International Conference on Family Planning** was held in Uganda in 2009, and the second in 2011 in Senegal.
- **In the United States:** In 2009, Barack Obama was elected U.S. President and Hillary Clinton appointed as Secretary of State (SoS). For the first time a SoS spoke about the importance of contraception in a public policy speech. The United States increased its annual investment in international family planning from $420 million to approximately $600 million.12
- **At the Bill and Melinda Gates Foundation:** In 2008, the foundation launched a new family planning global strategy, and in 2011, Melinda Gates announced at the international conference on family planning in Senegal, that, “I plan to spend a great deal of my time advocating for the 215 million women13 who don’t want to have a child, but can’t access modern contraceptives.”14
- **In the United Kingdom:** In May 2010, the new Conservative Prime Minister David Cameron re-affirmed a commitment to achieving 0.7% overseas aid under his leadership and the UK Department for International Development (DFID). Andrew Mitchell, the newly appointed SoS for International Development, also showed interest in reproductive health and family planning as an issue where he could “make his mark”15.
- **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.

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7 London Summit Overview]
8 Steve Sinding’s Historical Context
9 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.
10 A more detailed timeline of key moments can be found in Annex 3.
12 Interview with Oying Rimon.
13 This unmet need figure was later evaluated and reconfirmed during summit planning.
14 http://www.pathfinder.org/blog/melinda-gates-announces-commitment-to-family-planning.html
15 Interview with Leo Bryant.
Further, private donors and donor countries had started to work together on family planning. These initiatives led to stronger relationships between donors, increased attention to family planning, and recognition of the potential of working together to achieve greater impact. As noted by Scott Radloff (formerly USAID), “There was the Reproductive Health Supplies Coalition, 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...on family planning supplies. We also began to have side meetings that brought the Gates Foundation and USAID, UN Population Fund (UNFPA), DFID together.”

Despite these efforts, no common framework, goal or platform existed for mobilizing action and resources for family planning at the global level. According to Oying Rimon (formerly BMGF), “The question was: how do you set up a platform for other donors to step up to the plate?”

The MDGs, established in 2000, were set to expire in 2015, to be replaced by the Sustainable Development Goals (SDGs). Some worried that if they missed the opportunity to place family planning as a central component of the SDGs, the issue would continue to be a low global priority until the SDGs expired in 2030.16

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

A Window of Opportunity
In June of 2011, DFID held a pledging event to raise funds for what was then referred to as the Global Alliance for Vaccines and Immunisation (now referred to as Gavi, the Vaccine Alliance), 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 Cameron, Heads of State, ministers and other leaders from donor and developing countries, UN agencies, the private sector and civil society committed to supporting Gavi’s work.

The Gavi pledging conference was a resounding success. Internally the UK government termed this event a “golden moment.”17 DFID wanted this to be the first of a series of annual moments it would host: “…the Gavi replenishment conference demonstrated to the Prime Minister and SoS 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 (formerly DFID).

Knowing the incoming UK SoS’s interest in it, Bunting pitched family planning for the 2012 “golden moment”.18 At first, DFID was hesitant to focus on family planning for a number of reasons, not 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?” Oying Rimon coordinated with Julia on how DFID and BMGF could partner on this event and bring other key players to the table.

Making the Decision
DFID and the BMGF agreed to co-host a “London Summit” focusing on family planning on July 11—World Population

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16 Interviews with Jotham Musinguzi and Tewodros Melesse.
17 Respondents varied in how they identified this; some referred to it as a “golden” moment and others a “gold” moment.
18 Interviews with Julia Bunting and Leo Bryant.
At this time, all of the “baby steps” forward had come together and set the stage for the Summit. As noted by Scott Radloff (formerly 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.”

Monica Kerrigan (formerly BMGF) said: “It would have been difficult without Prime Minister Cameron and Melinda Gates as the hosts—when you have high-level hosts saying that this is going to be their urgent priority and they’re going...nurture and work with countries on this, it made a huge difference.” Summit planners saw that having such champions would generate global attention and facilitate buy-in, resources and broad support. Kerrigan emphasized the value of Melinda Gates in her role as a new voice for family planning: “…Not only did she lead...in terms of the Summit and the rigor and evidence needed, but also...in creating a communications [platform including] the TEDxChange talk in Germany20. She met with leaders around the globe. She picked up the phone and called people when we needed her to.”

From 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 (formerly DFID)

A lot needed to be done, but given family planning’s long history, there was a lot in place on which planners could draw:

- **Resources—financial and human.** BMGF hired McKinsey & Company (a multinational management consulting firm) to provide project management, and leveraged necessary technical expertise through organizations such as the Guttmacher Institute,21 the Futures Group22 and the Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health.

- **A robust community of advocates.** There were coalitions, individuals and organizations championing family planning, and strong communities of support upon which to draw. USAID and UNFPA were brought in as key partners. This was critical as both organizations had leadership and existing infrastructure to contribute to the planning and execution of the Summit.

- **Sound data, policies and tools.** The key features of effective family planning programs were already established, and family planning was proven 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 cost-effective options for women, and there were signs that developing countries were interested in such tools. This freed up the ability to focus on the gaps—funding and political support.

But there were also critical barriers to overcome:

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19 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
20 In April 2012, Melinda Gates gave a TED Talk in Berlin entitled: “Let’s put birth control back on the agenda”.
21 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.
22 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.
• **Time was short.** As noted by Scott Radloff (formerly USAID), “A lot of us had doubts. 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]...?”

• **No shared global goal on family planning.** While there was a lot of evidence, there was no common global goal on family planning. As noted by Brian Siems (BMGF), “…we went back to the drawing board to see what a new goal could be... 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 was not sufficient.** As Oying Rimon (formerly BMGF) noted: “...we did an analysis of UNFPA...[they were] spending a small percentage of their money on family planning...[and needed to] strengthen their expertise in terms of their staffing, especially at the country level. Fortunately, UNFPA had new leadership...willing to take on these challenges.”

• **Fractured community.** 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.

## B. The Planning and the Summit

### 1. Setting up an operating structure

Developing an effective management structure was critical. The core planning group comprised 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, but this was critical for swift and nimble planning.

In order to tackle such a broad scope of work, DFID and the BMGF established six work streams, which included key stakeholders and experts:

- **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. Establishing 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 were not using contraception and had an unmet need for family planning. “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). Because modeling unmet need was a key aspect to subsequent work (setting the goal, projecting funding needs), it had to be

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completed before planners could move on. Oying Rimon noted that the concept of unmet need is also a moving target. 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 learn about family planning.

3. Setting the Summit goal

Establishing a time-specific goal and a common vision for the Summit took time and negotiation. Ultimately, the Summit goal was distinctive in two ways.

- **Family planning-specific**: Planners created a family planning-specific goal that intentionally excluded abortion and broader sexual and reproductive health and rights (SRHR). Planners agreed that the Summit should aim to reach 120 million more women and girls with modern contraceptive methods by 2020 and do so in a way that emphasized the need to ensure voluntary and quality services. 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 (Formerly BMGF): “…it wasn’t just about ‘let’s commit to family planning and the status quo’ – it was committing in a new way …to community and voluntarism and access.”

- **Achievable and realistic**: Some wanted the Summit to focus on eradicating all unmet need for contraceptive services and supplies—access for 222 million women and girls—while others focused on more achievable aims. Julia Bunting (formerly DFID) said, “We needed to break [the goal] down into bite-sized pieces that could mobilize people and engage people and prove that we could do something in this relatively short window [between 2012-2020], ultimately providing the incentive for continued and sustained effort.” Planners agreed that reaching 120 million more girls and women would be ambitious, evidence-based, and realistic.

4. Costing the goal

Once metrics were set, the group 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 & Company. As noted by Brian Siems (BMGF), “Agreeing with DFID on the goal was a good first big step and getting agreement on the costing of that goal was another.”

Reaching an additional 120 million women would cost an estimated $4.3 billion over the next eight years. This number included resources and infrastructure supported by developing countries. One hundred and fifty leaders from donor and developing countries, international agencies, civil society, foundations and the private sector pledged financial and technical support. Of the $4.3 billion, donors needed to contribute $2.3 billion above and beyond the amount of funding provided for family planning in 2010.

5. Setting up the post-Summit infrastructure

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

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24 London Summit Overview
• **Global partnership:** Organizers made a strategic decision not to build on an established institution such as UNFPA but to develop a new approach. As Brian Siems (BMGF) noted, “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.” They proposed a new entity—Family Planning 2020 (FP2020), housed at the United Nations Foundation—as a reference and accountability mechanism in support of the advancement of the Summit’s goal.²⁵

• **Pooled funding mechanism:** According to Brian Siems (BMGF), “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 [issues of] reproductive, maternal, newborn and child health. We got pretty far but we didn’t get far enough... 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.” Planners decided to postpone this component.

6. **Bringing stakeholders along and mobilizing commitments**

Planners sought to create a united effort and galvanize stakeholders across the globe to bring together commitments and pledges in support of the Summit goal:²⁶

• **Donors** pledged to sustain current investments and provide additional funds for contraceptive information, services and supplies; improve their coordination so that funds are used most effectively; and support advocacy for expanded contraceptive availability and for removing barriers to women’s and girls’ access.

• **Developing countries** committed 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)** engaged 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** pledged to expand advocacy for availability of services and supplies and removal of barriers; build community support; monitor services for quality, voluntarism, and informed choice; hold providers, policy-makers and funders accountable for their commitments; and implement innovative behavior change and service delivery interventions.

The International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), the UK Network for SRHR and the Reproductive Health Supplies Coalition’s Resource Mobilization and Awareness Working Group were critical to bringing civil society partners on board. One result of this work was the Civil Society Declaration to the London Summit on Family Planning, which was signed by 1,292 global civil society groups from 177 countries in support of the Summit’s goal.²⁷

7. **The Summit Itself**

Alongside the programmatic work, a core events and logistics planning team, led by DFID and BMGF, designed the program, coordinated with speakers, handled logistics, and made sure the actual event on July 11 went smoothly.

²⁵ The full description from the FP2020 website (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.

²⁶ These descriptions are drawn from The London Summit Overview

Highlights

“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, SoS for International Development, United Kingdom

On July 11, 2012, more than 150 leaders from around the world gathered in London to pledge or renew their commitment to family planning, converging on the idea that it was past time to put women’s reproductive health front and center on the global agenda. They recognized family planning both as a basic right and a key to reaching development goals.

The presence of the UK Prime Minister, the Heads of State of Malawi, Rwanda, Tanzania and Uganda, and more than a dozen ministers of health and development from both developing and developed countries demonstrated political will. The Summit also drew high-level representation from the UN, donors and bilateral agencies, representatives of private industry, and a select cadre of 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 emphasized the additional resources for family planning and the commitment by world leaders to expanding coverage to more women and girls. As noted by Monica Kerrigan (formerly BMGF), “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.”

Outcomes

- **Global community united around one goal** to secure global political commitments and resources to enable 120 million more women and girls to use contraceptives by 2020.
- **Exceeded financial goal**: A total of $2.6 billion was pledged from donors—exceeding the Summit goal of $2.3 billion.
- **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.
- **Commitments by the community**: UNFPA pledged to increase expenditure on family planning from 20% to 40%; BMGF doubled its annual budget for family planning to $140 million; Bloomberg Philanthropy committed $50 million; IPPF committed to triple sexual and reproductive health services provided; and, Merck, a global healthcare company, pledged $25 million over eight years.
- **Launch of FP2020**: Summit participants agreed to the formation of a mechanism to track and advocate for progress on Summit commitments.

Trade-Offs Along the Way

Organization and negotiations ahead of the Summit were challenging, complex and time consuming. In an effort to pull
the Summit together on time, organizers made several trade-offs, including:

- **Compromising the broader SRHR agenda**: While involvement of major donors excited some in the SRHR community, others thought there had been insufficient consultation with civil society. Further, many wanted the issue to be broader. “Some advocates said, ‘you are going backwards’. It’s not about family planning, it’s about SRHR,” said Oying Rimon. A focus on mitigating this tension from the outset may have led to more consensus, however even a broader SRHR focus would have left other groups unhappy (e.g. proponents of universal health care). Leo Bryant (MSI) echoed this: “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.”

- **Failure to include the Global South 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 Monica Kerrigan (formerly BMGF) noted, “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.”

- **Fewer new stakeholders engaged**: Whereas some interviewees noted the engagement of new actors (e.g. 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 natural alliances could have been nurtured (e.g. environmental groups).

- **Late arrival on fundraising**: Delays in establishing the unmet need metric and Summit goal held up the establishment of the fundraising target. As a result, donors were brought in late.30

- **Failure to establish the pooled financing mechanism**: Neither Summit planners nor the Summit itself was able to establish a pooled financing mechanism, and 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 (BMGF). This has led to a key weakness in the post-Summit architecture making it hard to track funding, keep donors accountable to meet their commitments, and easily distribute resources to the regions most in need.31

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30 Interview with Brian Siems.
31 Interview with Tewodros Melesse and others.
## Appendix A: List of Acronyms

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<th>Acronym</th>
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<td>BMGF</td>
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<td>UK Department for International Development</td>
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<td>FP2020</td>
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<td>Gavi</td>
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<td>International Conference on Population and Development</td>
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Appendix B: Acknowledgments and List of Interviewees

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. **Jotham Musinguzi** - Regional Director for the Africa Regional Office, Partners in Population and Development (PPD)
3. **Julia Bunting** – Formerly Team Leader of the AIDS and Reproductive Health Team, UK Department for International Development (DFID)
4. **Leo Bryant** - Senior Global Policy Advisor, Marie Stopes International (MSI)
5. **Monica Kerrigan** – Formerly Deputy Director of Family Planning, BMGF
6. **Oying Rimon** – Formerly Senior Program Officer, Global Health Policy & Advocacy for Family Planning, Reproductive, Maternal, Neonatal and Child Health and Nutrition, BMGF
7. **Scott Radloff** – Formerly Director of the Office of Population and Reproductive Health in the Bureau for Global Health, U.S. Agency for International Development (USAID)
The 2012 London Summit and International Family Planning: A Case Study (Parts C and D)

March 2017
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

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C. In the Long Run it’s the Marriage, Not the Wedding, That Counts

“There’s a lot of work to do to deliver on what we committed to 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)

The Summit was a useful tool for garnering global support for expanded access to contraception (the “wedding”), but was just the first step in actually achieving expanded access to contraception (the “marriage”). The Summit alone would not ensure voluntary family planning services reached 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. As noted by Brian Siems (BMGF), “... while making pledges, coming up with good goals, and logistical planning can be hard, it’s just the beginning.”

In the aftermath of the July 11, 2012 Summit, the family planning community made substantial progress but also faced limitations.

1. Progress toward Summit goals

- **Increased access:** In 2013, 8.4 million additional women and girls used modern contraception compared to 2012. This number was just below the projected benchmark of 9.4 million additional users in the first year.²
- **Increased funding:** In 2013, donor governments provided $1.3 billion in bilateral funding for family planning programs, a nearly 20% increase over 2012, and $460 million in core contributions to UNFPA.
- **Country progress:** Significant progress has been made in several countries (e.g. Uganda, Kenya, Malawi, Senegal, Ethiopia and the Philippines), including in 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.”

2. Refinement of post-Summit architecture for collaboration

- **FP2020 is now up and running.** Although the pooled funding mechanism never materialized, an FP2020 Secretariat, Reference Group and Working Groups have been established, and as noted by Monica Kerrigan (BMGF), “This innovative partnership continues to grow and develop... We have 35 pledging countries out of 69 and 20 have strong, costed implementation plans.”

Limitation:

² Statistics on increased access and increased funding are from PMA2020’s Progress Report 2013-2014
• Confusion on the 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 (PPDARO) 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...” Monica Kerrigan noted, “… 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 [in 2015, so] that FP2020 will be more fit for purpose.”

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

3. Development of monitoring and evaluation systems

✓ 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 (USAID), “...there were these lag times between when you would know if you were making progress or not.” Or as Melinda Gates put it: “If we were a business and we waited every five years to monitor progress, we would have been bankrupt by then.” Following the Summit, Track 20 and Performance Monitoring and Accountability (PMA2020) were launched. PMA2020 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 (BMGF) 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 the data for advocacy and/or decision-making.5

4. Emergence of new pricing agreements for commodities

✓ Implant Access Program: Following the Summit, 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 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. As noted by Monica Kerrigan (BMGF), “In partnership with countries and donors, the global community has tripled the procurements of implants and allowed women and youth

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3 Track 20 was established by Avenir Health (formerly Futures Institute) 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.

4 PMA2020 is a five-year project, established by the Bill & Melinda Gates Institute for Populations and Reproductive Health, that uses a mobile-assisted data collection system to contribute to global monitoring and evaluation. This 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 ten pledging FP2020 countries.

5 Interview with Tewodros Melesse.

6 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.

7 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.
expanded method choice for long acting reversible contraceptives... “

5. Higher visibility of family planning on the global agenda

✓ 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.” Family planning was featured prominently in the new set of SDGs.

✓ A re-energized family planning community: Prior to the Summit, not only had the issue stagnated, so had the energy of people working where the need for contraceptive information, services and supplies was greatest. Julia Bunting noted, “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.”

Limitation:

- Integration: There is still a divide between family planning, SRHR and the health sector more broadly, which limits impact. 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 Leo Bryant 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.”

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 SDGs may divert attention away from 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 likely increase the number seeking contraception to prevent pregnancy.

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

There are at least three overarching lessons to be drawn from this case study:

1. **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.

2. **The window opens quickly, and can close just as fast.** Be vigilant, advocate internally, and 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.

3. **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.

Shortly after the Summit, Andrew Mitchell moved on from his role as Secretary of State for International Development. 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 (USAID), “...who knows if the person who followed him would have taken the same steps and actions to make this happen.” 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)
The 2012 London Summit and International Family Planning: A Case Study (Annexes)

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Annex 1: Overview of Research Process

Methodology

This case study was drawn from a report developed by Global Health Visions for the Center for Public Health Advocacy at the Bloomberg School of Public Health at Johns Hopkins University. For the report, GHV’s review included the following components:

1. **Desk research:** 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, 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 the report and ensuing case study - 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 Background

Historical Background Note

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 rapidly 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, 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 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 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 in the mold of Margaret Sanger who believed that many such families, but especially the women, would readily adopt modern birth control if they had access to it and it was affordable.

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2 JHSPH commissioned Steven Sinding PhD, Professor of Clinical Population and Family Health at Columbia University Mailman School of Public Health, to develop this summary of the historical context to complement the GHV report and the case study drawn from it.
As 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 peaked 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 achieve them.

In Latin America, governments reluctant to confront Catholic teachings on birth control as well as 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 serious initiatives to address either population growth or family planning.

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 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 act, 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, 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 expressed 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 titled 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. 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 first decade of the 21st century, the rustlings of support began to emerge 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.

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.
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
- **May 2008**: Launch of the BMGF FP strategy
- **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
- **May 2009**: Obama increases investment in MCH and FP with the launch of the U.S. Global Health Initiative
- **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
- **May 2010**: UN Secretary General launches the Every Woman Every Child global movement
- **June 2010**: Melinda Gates and Nick Clegg launch of the Alliance for RMNCH; Demographic Dividend panel at the World Bank fall meeting
- **September 2010**: GAVI Pledging Conference – the first UK “Gold Moment” – raising $4.3b for immunization.
- **December 2010**: Melinda Gates announces FP will be a top priorities for her “this year and into the future”
- **January 2011**: BMGF and DFID agree to co-host an international FP Summit in July 2012
- **April 2011**: Melinda Gates gives a TED Talk on FP in Berlin
- **September 2011**: Andrew Mitchell leaves post at DFID and is replaced by Justine Greening
- **January 2012**: London Summit on Family Planning
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.