Population Program Strategic Plan

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Glossary of Terms

EC:	Emergency Contraception (the "morning-after pill"), a hormonal method that significantly reduces rates of unintended pregnancy if taken within 72 hours of unprotected sex
FP:	Family Planning
FP/RH:	Family Planning and Reproductive Health
Female Condom:	A woman-controlled barrier method that protects against unwanted pregnancy and sexually transmitted infection
ICPD:	U.N. International Conference on Population and Development held in 1994
ODA:	Overseas Development Assistance
RH:	Reproductive Health
STIs:	Sexually Transmitted Infections
TFR:	Total Fertility Rate
UBASE:	Universal Basic and Secondary Education
UNFPA:	United Nations Population Fund
USAID:	United States Agency for International Development
WHO:	World Health Organization

POPULATION PROGRAM STRATEGIC PLAN

Summary

The Hewlett Foundation has supported the Population Program for almost forty years because of a deep concern with the issues of global population growth, the health and well-being of women and children, sustainable development, and environmental protection. At the Board's and President's request, the Population Program staff has undertaken a review of the Program to understand how best to address these concerns in the twenty-first century, taking into account changes in technology, demography, infectious diseases, and geopolitics. The proposed strategy builds upon the Program's historic strengths while responding to conditions that could not have been foreseen in times past.

Program Mission. We propose this revised statement of the goals of the Population Program:

> To promote voluntary family planning and good reproductive health (FP/RH) outcomes for everyone because of the benefits this brings to individuals, societies, and our entire global community.

The Context. Four relatively recent major challenges affect the environment in which the Program must work in the coming years:

1. Complacency, shared even by key stakeholders, stemming from a mistaken belief that the problems of unwanted fertility and pregnancy-related ill-health have been solved. Although family planning programs have succeeded globally in meeting many contraceptive needs and reducing population growth rates, progress has been highly uneven between and within regions and countries. Many areas of urgent need remain.

2. New goals and ways of channeling international development assistance that have not included FP/RH as a priority.

3. The unfolding tragedy of HIV/AIDS, which profoundly affects the type and magnitude of FP/RH needs, while at the same time providing an unprecedented opportunity to expand comprehensive services.

4. Ideological hostility, both in this country and overseas, that undermines evidence-based approaches to the provision of FP/RH services and information and threatens to exacerbate FP/RH problems.

Proposed Strategy. In light of our mission and these challenges to it, and building on the strengths of the current program, we propose three objectives as the bases for grantmaking guidelines. For simplicity, we refer to these as "guidelines" throughout the document. The first two guidelines will focus on the world's poorest regions—particularly sub-Saharan Africa and South Asia—where the highest proportions and numbers of people live in greatest poverty and

which will account for more than 80 percent of the growth in the world's population over the next fifty years:

1. Improving access to family planning and reproductive health (FP/RH) care by

    a. Expanding access to existing but underused FP/RH options, such as emergency contraception, female condoms, and safe abortion technologies; and
    b. Leveraging FP/RH service delivery opportunities in HIV/AIDS programs because of the common goal of preventing unsafe sexual practices.[1]

2. Ensuring adequate funding and evidence-based policies for good FP/RH through

    a. Research concerning the relationships between FP/RH and poverty alleviation and economic growth, including the mediating role of basic and secondary education;
    b. Research and education about the development consequences of high fertility and variations in fertility trends in developing countries; and about service delivery expansion consistent with good science and public health practices; and
    c. Training the next generation of population scientists in developing countries, with a particular emphasis on sub-Saharan Africa.

3. Promoting FP/RH in the United States by

    a. Advancing policies and programs that enhance the FP/RH of Americans; and
    b. Expanding FP/RH education and service delivery to vulnerable populations in California. (Support of on-the-ground services to vulnerable groups in the Bay Area and Central Valley will be conducted in partnership with the Regional Grantmaking Initiative.)

The proposed strategic plan is designed to benefit

- the entire global community and its environment and resources by enabling sustainable rates of population growth;
- communities and societies whose members can emerge from a life of bare subsistence and address development problems and promote equity;
- individuals, particularly women and girls, in terms of their physical and emotional health and well-being; and
- children whose parents want them and who have more time to help them mature into responsible and productive adults.

[1] Unsafe sexual practices include those that are involuntary, and/or take place without accurate information, or without protection against unwanted pregnancy and STIs, including HIV/AIDS.

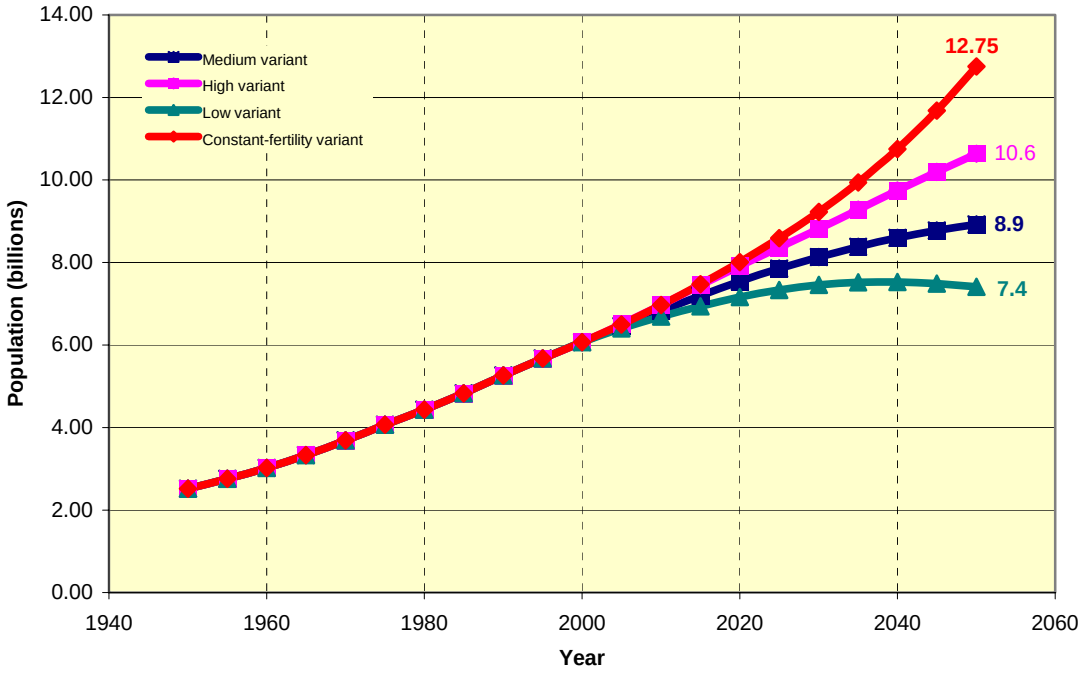
Introduction and Proposed Directions

The Opportunities and Challenges Ahead

Family planning and reproductive health (FP/RH) programs have been among the most successful development interventions in the past fifty years. As modern contraception was made available to women and men in developing countries, large numbers of couples elected to control the number and timing of the births of their children. As a result, total fertility rates fell from a global average of five children per woman in the 1960s to just under three now. [2] This increased ability to determine when to begin, space, and end childbearing has provided millions of women with opportunities to stay in school, engage in paid employment, and enjoy better relationships with their partners and children. [3]

Control over the timing and number of pregnancies has broadened women's options in life, thus further reducing the number of children women want to have. This virtuous cycle, whereby improvements in FP/RH lead to healthier mothers who have a smaller number of well cared for and better educated children who in turn become more productive workers which in the aggregate promotes economic development, significantly contributes to the recent downward revisions of projected world population size. The decline in unwanted fertility is so significant that the U.N. now forecasts that by 2050 three out of four developing countries will be at or below replacement fertility. The U.N.'s medium projection is that the world's population will grow from 6.3 billion in 2003 to 8.9 billion people in 2050.

Figure 1: World Population Projections



[2] Haub, C. *2003 World Population Data Sheet*, Population Reference Bureau. Washington, D.C., 2003
[3] Ashford, L. *How Does FamilyPlanning Influence Women'sLives?:* Policy Brief, Population Reference Bureau. Washington, D.C., May 2000.

Despite the success in reducing unwanted fertility, the work that lies ahead may be even more daunting than that faced in the past. As the U.N.'s projections recognize, "the realization of these projections is contingent on ensuring that couples have access to family planning. . . . The potential for considerable population increase remains high."[4] In order to meet the U.N.'s "medium variant" prediction depicted in Figure 1 to reach 8.9 billion by 2050, fertility rates must fall from 2.83 currently to 2.02 on a global scale, including reductions from 5.22 to 2.4 in Africa and from 2.72 to 1.91 in Asia.

If the global decline in fertility rates slows or stalls, for example, at 2.5 children as the "high variant" assumes, the total population is estimated to reach 10.6 billion by 2050 and will keep growing thereafter. Such stalling—even a turn back up—has recently appeared in many developing countries, including Bangladesh, Egypt, and Kenya. The causes of the stalled declines are not well understood but are likely the result of a retrenchment in FP/RH effort and the fact that the highest unmet need is found among the lowest income levels within every country. Better ways to reach these most vulnerable women must be found, and the Population Program will support work to understand the root causes of these recent reversals and to help programs better meet the FP/RH needs of these populations. The need to do so is urgent both from the perspective of the individual woman and also for the macroconsequences of sustainable development. To put this in perspective, maintaining current fertility patterns would result in 12.75 billion people by mid-century.

The "medium variant" assumes—and we consider this assumption to be plausible—a continuing increase in the demand for family size limitation and requires an even larger increase in family planning services to satisfy the enormous predicted change in fertility preferences. For instance, it is estimated that even now more than 200 million couples that desire family planning are not receiving the necessary services.[5] As the largest cohort of women enter reproductive age (a result of past population growth), there will be an increased demand for family planning just from the absolute increase in their number.

These projections forecast that almost all of the growth will occur in the developing world, where there is already high unmet need for contraception, weak health infrastructure, and limited ability to cope with the economic and social consequences of continued population growth. For example, the populations of Burkina Faso, Mali, Niger, Somalia, Uganda, and Yemen are projected to quadruple. Under the medium variant predictions, Africa's population will grow from 851 million in 2003 to 1.8 billion in 2050, and Asia's population will grow from 3.8 billion to 5.2 billion. Under these scenarios, half of the world's population increase will occur in eight countries, only one of which, the United States, is in the developed world, with the other seven being India, Pakistan, Nigeria, China, Bangladesh, Ethiopia, and the Democratic Republic of Congo. As a result, those living in developing countries will constitute an increasing proportion of the world population (86 percent in 2050 vs. 78 percent in 2000).

[4] Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2003. *World Population Prospects: The 2002 Revision. Highlights.* New York: United Nations.
[5] S. Singh et al (2004) *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care.* New York: Alan Guttmacher Institute.

It is a sad fact that the countries with the highest rates or numbers of unwanted fertility are also the same places where maternal and child health indicators are the poorest and where the citizens disproportionately live under conditions of unspeakable hardship—on less than one dollar a day per person. Here a vicious cycle comes into play, whereby high-risk and unwanted pregnancies weaken the health of mothers, children remain uneducated, and, as a result nations are denied the benefits of a productive workforce and a pathway to escape poverty. Some of these are the same countries where the blight of AIDS is gutting economies by killing off adults in their prime and creating a generation of orphans.

Fifty years into its existence, the population field is facing persistent challenges and new threats that shape the context in which we work:

- **The ongoing need to help women and men around their world achieve their reproductive intentions and meet their health needs.** The U.N. population projections make a clear case for continued investment in family planning education and programs and in the economic and social development of the least-developed countries of the world. Even the existing worldwide demand for family planning services, much less the projected increase in the demand for smaller families, far outstrips the resources going into these programs. Without a major commitment by developing and donor nations to ensure access, couples will not have the means to achieve smaller desired families. The advent of the HIV/AIDS pandemic in the geographical areas of great FP/RH need calls for a new commitment to broadening access to preventive practices and technologies.

- **A changing context for international development assistance and priority setting.** In the 1960s, when the field of "population" was established, the emphasis was almost entirely on reducing rates of population growth, which at the time were uniformly high throughout most of the developing world. As global population growth rates have fallen, attention and funding among key stakeholders have shifted to other development priorities, despite continuing high fertility rates in large regions of the world. Since there is a dearth of evidence concerning the impact of FP/RH on poverty alleviation and economic growth, it has been difficult for the population field to make the case for its continued relevance. The dominant development paradigms now center on poverty alleviation, equity, and addressing the HIV/AIDS pandemic. Although FP/RH have contributions to make in all of these areas, the connections are poorly understood.

- **Ideological hostility toward family planning and reproductive health.** This compounds complacency about population issues to reduce attention to FP/RH, and undermines sound evidence about effective family planning. Within the United States, this hostility contributes to our having the worst FP/RH indicators of all industrialized democracies, with large inequities by income, geography, and ethnic background. Domestic FP/RH policies are increasingly influencing international policies and funding priorities. Helping our own citizens achieve good FP/RH outcomes goes hand in hand with outcomes overseas.

General Principles Underlying the Strategic Plan

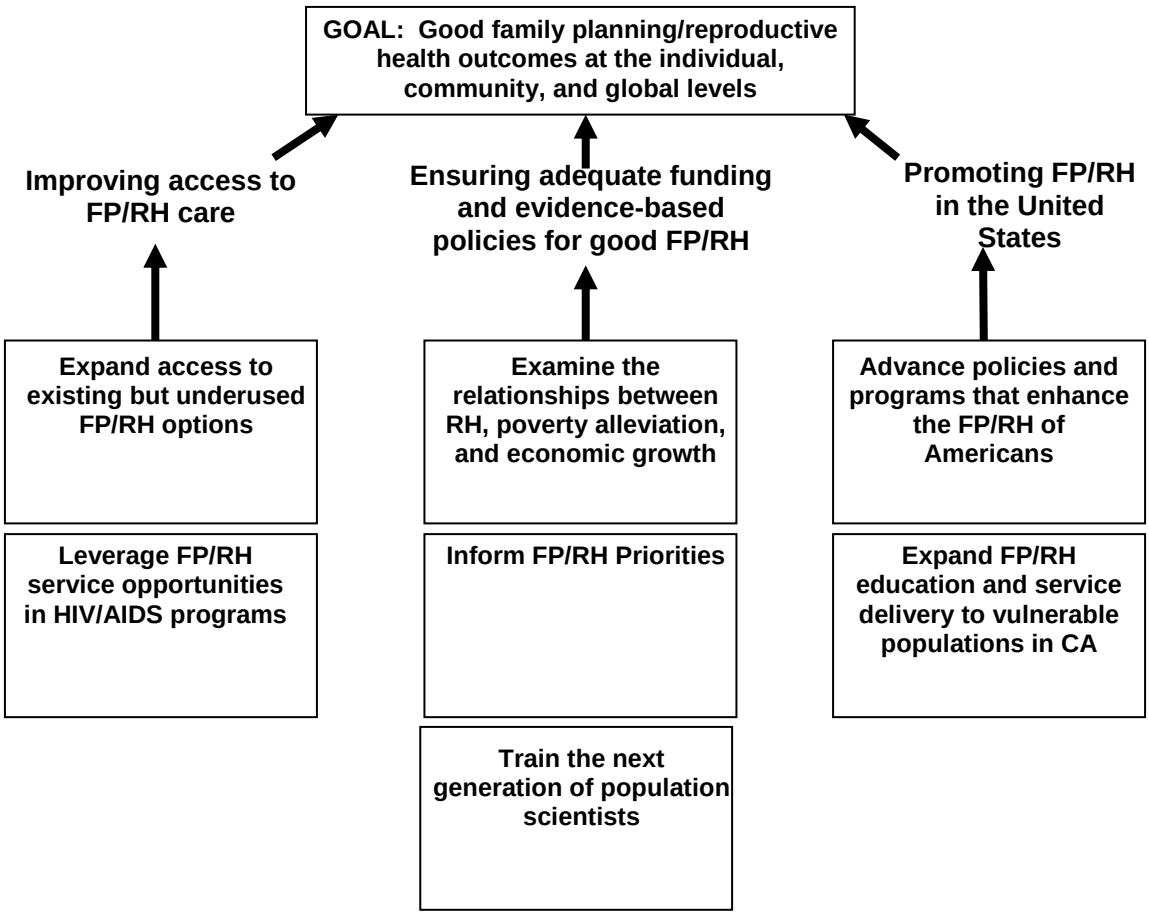
The proposed mission statement for the Population Program is to promote voluntary family planning and good FP/RH outcomes for everyone, because of the benefits this brings to individuals, societies, and our entire global community.

Achieving this mission requires the Foundation to be practical in supporting work that can bring about concrete improvements in people's lives while taking into account the complex context in which these activities take place. Good FP/RH is influenced by a number of factors, including culture, values, and norms, that are deep, far-reaching, and not generally susceptible to direct change. The proposed program strategic plan focuses on provision of services, policies, and the allocation of resources—areas that are more amenable to intervention.

Underlying all of the proposed guidelines is the belief that FP/RH requires high-quality programs that help women and their partners achieve their fertility goals and be protected from sexually transmitted infections. We have identified particular points of leverage where we can make measurable impact. Given the scope and urgency of FP/RH needs, the Foundation must promote better use of existing resources, particularly the accessibility of safe and effective technologies, that directly contribute to improved FP/RH outcomes and status. Thus, FP/RH must become a central priority on the international development agenda and must be protected from ideologically-driven attacks. This in turn requires demonstrating the impact of family planning on the dominant development objectives of poverty alleviation, economic growth, and combating HIV/AIDS. Because ideology also contributes to the relative marginalization of family planning and reproductive health, the Foundation must strengthen an evidence-based policy dialogue in the developing world, in the U.S., and in other donor countries.

To implement these principles, we propose the three program guidelines:

1. Improving access to family planning and reproductive health care
2. Ensuring adequate funding and evidence-based policies for good family planning and reproductive health
3. Promoting family planning and reproductive health in the United States


GOAL: Good family planning/reproductive health outcomes at the individual, community, and global levels
Improving access to FP/RH care
Ensuring adequate funding and evidence-based policies for good FP/RH
Promoting FP/RH in the United States
Expand access to existing but underused FP/RH options
Examine the relationships between RH, poverty alleviation, and economic growth
Advance policies and programs that enhance the FP/RH of Americans
Leverage FP/RH service opportunities in HIV/AIDS programs
Inform FP/RH Priorities
Expand FP/RH education and service delivery to vulnerable populations in CA
Train the next generation of population scientists

Guideline One: Improving Access to Family Planning and Reproductive Health Care

While access to family planning and reproductive health (FP/RH) services has generally increased throughout the world over the past fifty years, it is the challenge of the twenty-first century to find better ways to deliver services to millions who want, but do not have, them. This guideline will enable more women and men throughout the world—particularly in developing countries—to achieve good FP/RH outcomes by making accessible and available information and services to determine the number and timing of their childbearing, to prevent sexually transmitted infection, and to allow them to make informed decisions about their own sexual and reproductive health. Access to these types of services is a critical element of individual autonomy and self-determination. It directly promotes the well-being of individuals, particularly women and girls, and contributes to sustainable population growth.

The scale of the global needs for access to FP/RH care exceeds the ability of any one actor to meet. The Population Program proposes to concentrate on particular niches that we believe offer special opportunities for making a difference and are in keeping with the Foundation's history and values. The Program will particularly support: (1) expanding access to existing and underused FP/RH options; and (2) leveraging service delivery opportunities in HIV/AIDS programs. In these efforts, the Program will place particular emphasis on sub-Saharan Africa and parts of Asia, where access to FP/RH care is most limited.

1. Expanding access to existing but underused FP/RH options

The global estimate of existing unmet need for contraception (defined as women who express a desire to space or limit their next births, but who are currently not using contraception) indicates that almost 25 percent of women in sub-Saharan Africa and 13 percent in Asia (excluding China) have unmet needs.[6] The demographic impact of meeting this need is greatest where fertility is also high, as it is in sub-Saharan Africa (total fertility rate (TFR) of 5.6 children) and in Asia (TFR of 3.1). Generally, within countries in these regions, the poorest women exhibit higher unmet need than do wealthier women. The number of potential contraceptive users in need of services is also projected to increase because the large cohort of individuals entering reproductive age (due to past high fertility) and changing desires for smaller families.

Further evidence of the need for appropriate services is the high number of unintended pregnancies, an estimated 46 million of which end in induced abortion each year, with nearly 20 million of these estimated to be unsafe.[7] Unsafe abortions contribute about 13 percent of the nearly 500,000 worldwide annual pregnancy-related deaths and cause considerable morbidity. The urgent need for services and information is also underscored by an epidemic of curable sexually transmitted infections (an estimated 340 million cases in 1999, two-thirds of which occurred in sub-Saharan Africa and South and Southeast Asia)[8] and of HIV/AIDS, clearly the

[6] Ross, A. and Winfrey, W. "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate". *International Family Planning Perspectives*, 28(3): 138-43, 2002.
[7] *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: World Health Organization, 2003.
[8] *Global Prevalence and Incidence of Select Curable Sexually Transmitted Infections: Overview and Estimates.* Geneva: World Health Organization, 2001.

largest health threat the world is facing. In 2003, 5 million people were infected with HIV, with almost 70 percent of the cases in sub-Saharan Africa and more than half of them women.[9]

We believe that the Foundation can add great value to the FP/RH field by promoting existing and effective technologies that currently have limited availability but have widespread potential benefits. These technologies include certain contraceptive methods and procedures—such as emergency contraception, the intrauterine device, female and male sterilization, female condoms, and safe abortion-related tools like manual vacuum aspiration equipment or medical abortion (ending pregnancy without surgery through drug regimens involving, for instance, mifepristone and misoprostol). Despite their demonstrated effectiveness and contributions to public health and client goals, these technologies have only limited support from many government and other private donors.

Evidence shows that having an array of contraceptive methods available to potential users substantially increases both uptake and continuing use and results in fewer abortions.[10] Availability of a range of methods has not improved uniformly, and the lag is especially great in Africa.[11] As an example, emergency contraception (EC) has emerged as a safe and powerful new tool to prevent unintended pregnancy. In fewer than 50 percent of developing countries, though, are EC pills part of the standard set of services that are supposed to be provided by government clinics, and thirty developing countries (12 in Africa) still lack a registered product.[12]

Therefore, the Foundation plans to support grantees working on

- *Service delivery programs*. Clinics and their community outreach programs are the most direct point of FP/RH care for millions of people around the world. As populations have grown, service delivery programs are being challenged to keep pace. The Foundation will support efforts to improve the quality of care, technical competence, breadth of services, technologies provided, and outreach of grantees like Marie Stopes International, which provided family planning services to 3.6 million couples in thirty-five countries in 2002, and the International Planned Parenthood Federation, which provided more than 10 million family planning visits in the same year.
- *Legal and policy environment*. The legal and policy environment has a significant impact on the availability of FP/RH care. There are specific policy barriers that offer a partial explanation for why the FP/RH options technologies we identify are not more widely accessible—for example, regulations that limit contraceptive distribution to married women and prohibit mid-level health personnel from providing legal first-trimester abortion services. The Foundation will therefore continue to support efforts to adapt policy to newly available products (e.g., emergency contraception); develop and disseminate social science and

[9] *AIDS Epidemic Update: 2003*. Geneva: Joint United Nations/World Health Organization Program on HIV/AIDS.
[10] Ross, J. et al. "Contraceptive Method Choice in Developing Countries". *International Family Planning Perspectives*, 28(1): 32-40, 2000. Marston, C. and Cleland, J. (2003). *Relationships Between Contraception and Abortion: A Review of the Evidence*, 29(1): 6-13, 2003.
[11] Ross, J. and Stover, J. "The Family Planning Program Effort Index: 1999 Cycle". *International Family Planning Perspectives*, 27(3): 119-129, 2001.
[12] International Consortium for Emergency Contraception. Personal communication. 2004.

medical data relevant to policy and regulations; mobilize the necessary technical and political will for neglected and controversial services; and overcome inertia in policy processes.

- *Research*. The population field has a long-standing tradition of applying social science and medical evidence to FP/RH care. As the existing unmet need for contraception demonstrates, the causes of FP/RH programs' failure to adequately serve clients' needs and to reach the most marginalized and poorest populations must be better understood. Studies to determine the key factors on the client and provider sides that promote adoption of newer and underused FP/RH technologies are essential, as are the evaluations of various interventions to determine what can be replicated on a wide scale.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Service delivery partners to implement projects for specific technologies identified • Advocacy and policy dialogue to remove barriers to care initiated • Research studies designed and initiated	• Number of health care providers trained in FP/RH technologies • Number of services provided by grantees in select FP/RH options • Select policies and norms that enable greater access to FP/RH care in place • Analysis and dissemination of research studies to key audiences	• Increased utilization of FP/RH options • Decreased incidence of unintended pregnancy • Decreased incidence of unsafe abortion

2. Leveraging FP/RH service delivery opportunities in HIV/AIDS programs

Family planning and reproductive health and HIV/AIDS deal with human sexuality; require interventions that provide information and services to people who are or will be sexually active; employ tools to change behavior and preventive technologies and actions (such as condom use or reducing unprotected sexual activity); and require vast infrastructures to reach out to those who need information and services. From the individual's perspective, the same act of unprotected sexual intercourse puts oneself at risk potentially for both unintended pregnancy and a sexually transmitted infection.

Up to now, the programs and infrastructures that target different aspects of reproductive health have rarely overlapped. This unfortunate lack of connection results in countless missed opportunities for counseling, direct service, and referrals that could reduce sexually transmitted infections in the first place and reduce unintended pregnancy among HIV- and HIV+ women. A recent estimate suggests that more than half a million pregnant HIV+ women, 83 percent of whom are in sub-Saharan Africa, would have wanted to space or limit their births prior to becoming pregnant.[13] And, after they give birth, many will want to adopt family planning to better plan future births.

[13] Stover, J. The Benefits of Providing Family Planning Services within PMTCT Programs. Presentation at consultative meeting on the linkages between reproductive health and HIV/AIDS: family planning and prevention of mother to child transmission, May 3-4, 2004.

Between 1995 and 2001, the total amount of international donor assistance to HIV/AIDS activities has grown sixfold.[14] The proliferation of international responses to the HIV/AIDS pandemic provides an unprecedented opportunity to build upon the HIV/AIDS infrastructures and activities (such as behavior change and education to prevent HIV transmission, voluntary HIV counseling and testing, prevention of mother-to-child transmission, and AIDS treatment) to expand access to FP/RH care and help clients make informed decisions about a range of needs.[15]

The Population Program therefore plans to explore the underdeveloped opportunities for linking FP/RH prevention and service delivery interventions with HIV/AIDS programs. The Program has long experience in supporting innovative service delivery programs that are based on the principles of primary prevention. Indeed, the Hewlett Foundation was one of the first supporters of Columbia University's pioneering Prevention of Mother-to-Child-Transmission Plus initiative, which for the first time combined prophylaxis for the newborn and antiretroviral treatment for the mothers. Furthermore, the Foundation's reputation as an impartial broker can foster information exchange and build programmatic and policy linkages between the now somewhat distinct fields of FP/RH and HIV/AIDS.

While there have been some small-scale efforts to deliberately link FP/RH and HIV/AIDS programs, a great deal more can be done to capitalize on the possibilities. In the next few years, we will concentrate on supporting service delivery organizations, as well as research and education to identify and articulate the case for connecting family planning and HIV programs. Demonstration projects may play an important role in feeding research findings into actual service delivery. The Foundation will also play a role in convening technical experts, policymakers in developed and developing countries, as well as other donors, to raise the profile of this issue and stimulate new approaches to service delivery, research, and advocacy.[16]

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Communication between FP/RH and HIV/AIDS	• Number of concrete projects linking FP/RH and HIV/AIDS	• Increased number of FP/RH programs that meet the

[14] *Financial Resource Flows for Population Activities in 2001*. New York: UNFPA, 2003.
[15] Askew, I and Berer, M. "The Contribution of Sexual and Reproductive Health Services to the Fight Against HIV/AIDS: A Review". *Reproductive Health Matters* 11(22): 51-73, 2003.
[16] The Foundation will not support the research and development of HIV/AIDS microbicides or vaccines. While these are tools for HIV prevention, they appear to be adequately funded by other donors, and we believe substantial progress can be made simply by capitalizing on currently missed opportunities. Nor will the Program support AIDS treatment, except insofar as there is an intersection with family planning and other preventive services.

communities through expert meetings, policy briefs, and consultations • Pilot and demonstration projects identified	implemented • Lessons learned and research findings on the links between FP/RH and HIV/AIDS disseminated to decisionmaking audiences	comprehensive needs of their clients • Decreased incidence of STIs, including HIV • Fewer unintended births by HIV+ women

Guideline Two: Ensuring Adequate Funding and Evidence-based Policies for Good Family Planning/Reproductive Health

This guideline aims to place population and family planning/reproductive health (FP/RH) on the international development agenda as a significant means for improving the health and economic well-being of people in developing countries. This guideline will encompass both policy research and advocacy, and will strengthen population science capacities, particularly in sub-Saharan Africa.

Population policy was originally rooted in macro-level concerns about economic and environmental development. In the last twenty years, the field has shifted to focus on the rights of individual women. Concepts hardly recognized in the 1960s and 1970s, such as characterizing FP/RH as a human right, became the vocabulary of the discipline. At the 1994 Cairo conference, 179 nations endorsed a rights-oriented, woman-centered agenda of FP/RH.

The many positive implications of these developments also had a downside: since Cairo, declining global fertility rates have reduced the sense of urgency about population growth, and population has lost its connection to the broad societal development issues of poverty alleviation and economic growth. In the words of one of our colleagues, FP/RH was relegated to the category of "rural roads and good eyesight—nice things to do."[17] At the same time, the population field may have missed opportunities to conduct or frame its research in ways that helped those outside the field see its value in achieving development goals in a changing context. This has left the field much more vulnerable to attacks by its ideological opponents.

Among other things, this guideline aims to clarify

- the link between FP/RH status and the ability of individuals and households to raise themselves out of poverty, and
- the impact of demographic factors, such as population growth, age structure, and dependency ratios, on economic development, including poverty alleviation and economic growth.

Making these relationships clearer to those charged with setting development priorities in both developing and developed countries will contribute to more informed decisionmaking. The three elements of this guideline are (1) examining the relationships between FP/RH, poverty alleviation, and economic growth, (2) informing FP/RH priorities, and (3) training the next generation of population experts.

1. <u>Examining the relationships between FP/RH, poverty alleviation, and economic growth</u>

High levels of reproductive ill-health, including unwanted pregnancy and maternal mortality and morbidity, limit the ability of women, households, and communities to fuel economic growth and escape poverty, and may create barriers to public- and private-sector investments in development. In an effort to develop policy solutions to these problems, the Foundation will work with leaders in the development economics and FP/RH fields to support a research agenda that clarifies the relationships between demographic and FP/RH variables and economic

[17] Maggie Catley-Carlson, personal communication, February 2004, New York, NY.

development. While there is evidence that demographic factors and FP/RH play an important role in shaping these economic variables, additional research is needed to better understand the links.

There are two main audiences for this work: (1) economists in academia and development banks (such as the World Bank), and (2) ministers of finance in developing countries. These groups influence or directly control the allocation of enormous resources both in overseas development assistance and in national budgets. Yet, for the most part, neither has been a strong advocate for public investments in FP/RH policies and services. Most development economists are not familiar with demographic and population research, the impact of FP/RH on human welfare, or its potential to promote economic growth and alleviate poverty.

The Foundation will support work related to economic development in three areas:

Research on the relationships between population and FP/RH and economic development. To encourage evidence-based development policy**,** the Foundation plans to help translate what is known about the impacts of achieving good FP/RH outcomes into a language more familiar to economists, as well as support further research on how demographic and FP/RH variables affect economic development, including economic growth and poverty alleviation.

Recent evidence of the economic opportunities that developing countries experience during a transition from high to low fertility has stimulated new interest in this area.[18] The Foundation plans to support investigations of individual-level impacts (for example, determining the impact of reproductive ill health on workforce or household productivity and the process of rising from poverty[19]), and national- or international-level impacts (for example, how changes in fertility patterns and population structure impact the ability of nations to invest in their citizens to change economic growth trajectories[20]). In view of the Foundation's history of supporting social science research related to demographic trends and FP/RH in developing countries, we hope and expect others to follow our lead in supporting this work.[21]

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[18] Bloom, D., Canning, D., and Sevilla, J. *The Demographic Dividend: A new perspective on the economic consequences of population change*. Santa Monica, CA. RAND, 2003

[19] For example, if there was a significant reduction in maternal mortality or abortion-related ill health, what would the impact be on household incomes or national economic growth rates?

[20] One specific formulation of this question, sometimes called the "Demographic Bonus," asks: At specific points in a transition from high to lower fertility and high to lower mortality, do countries experience a point where smaller numbers of very young and very old citizens relative to the working-aged population make it possible for countries to invest heavily in education and health services for the entire population? Such investments may help create a workforce better equipped than its predecessor to participate in a globalized economy, attract investment, and fuel economic growth. This theory is not yet well accepted among development economists, and many questions remain about the conditions under which such an opportunity for investing in people can be seized.

[21] A number of funding partners have already emerged for this new work, speaking to the enthusiasm in the population and FP/RH field for a focus on the broader development agenda. Both the World Bank and the United Kingdom's Department for International Development would like to be involved with the priority-setting process and to cosponsor a meeting late this year to launch the resulting research agenda. Given the potential magnitude of these research projects, we have been gratified by the interest of these two major funders, as well as other large foundations.

Research on and advocacy for universal basic and secondary education. In the presence of family planning information and services, educational attainment is profoundly correlated with positive FP/RH outcomes, including reducing unwanted fertility and promoting economic development. The Population Program will continue to work with the Education and Global Affairs Programs to promote universal basic and secondary education (UBASE).

Advocacy with respect to overseas development assistance (ODA) and FP/RH. The preceding two components focus primarily on research, with education and advocacy following from the research results. In this component, we propose to continue to support advocacy organizations in the donor countries of North America, Asia, and Europe to encourage strong overseas development allocations and related policies for comprehensive FP/RH.[22] These organizations will continue to assist their own governments, the World Bank, the World Health Organization, European Union representatives, elected officials, the media, and other stakeholders to better understand the importance of ODA for FP/RH, and the role of FP/RH in achieving the Millennium Development Goals and combating HIV/AIDS. These same organizations will also help communicate and disseminate the research studies discussed above, to document the impact of ideologically-driven policies, and to promote and protect FP/RH and rights in international forums and other relevant venues.

In implementing this strategy, we will also work to strengthen policy capacities among developing country partners, relying on existing networks and centers of demographic and development expertise. To date, the Foundation has relied mostly on partners in developed countries for this work. This new emphasis supports the goal of developing the next generation of population scientists, described later in this section.

[22] The Foundation will support a smaller number of advocacy groups than in the past, reflecting the need to select those groups with the capacity to effectively address complex economic issues and the access to decisionmakers necessary to reach the appropriate audiences.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Reaching consensus on a research agenda for economists' work among experts • Forging partnerships to support research work • Developing, along with Foundation colleagues, a proposed strategy to work on universal basic and secondary education • Increased discussion around demography and FP/RH in development debates during the 2005 United Nations meetings on the Millennium Development Goals and its follow-on activities	• Completion and communication of research on the links between population and FP/RH and economic development through increased publication of articles in top journals and inclusion in development debates • Increased developing country presence at decisionmaking levels in development debates	• Improved policies around population and FP/RH at the World Bank and other international financial institutions and development agencies • Integration of population and FP/RH into national and subnational development plans • Active and effective participation by African experts in determining and implementing population and FP/RH policies within development agendas • Appropriate resource allocations to population and FP/RH

2. Informing FP/RH priorities

As fertility rates have fallen in many parts of the world, concerns about the impact of high fertility on individuals, communities, and the world has diminished. The U.N.'s projections show a marked decrease of fertility rates in the past fifty years, from 5.0 children per woman in 1950 to 2.8 in 2000. It also shows an optimistic projection for all regions of the world, moving to 2.0 children per woman in 2050 as a global average. Figure 3[23] shows the optimism embedded in these projections more clearly—for example, in Africa, where fertility rates have fallen by about 1.5 children per woman in the past fifty years, the U.N. projects a reduction of nearly twice that size in the coming fifty years.

[23] Source of data: http://esa.un.org/unpp/, downloaded April 2004.

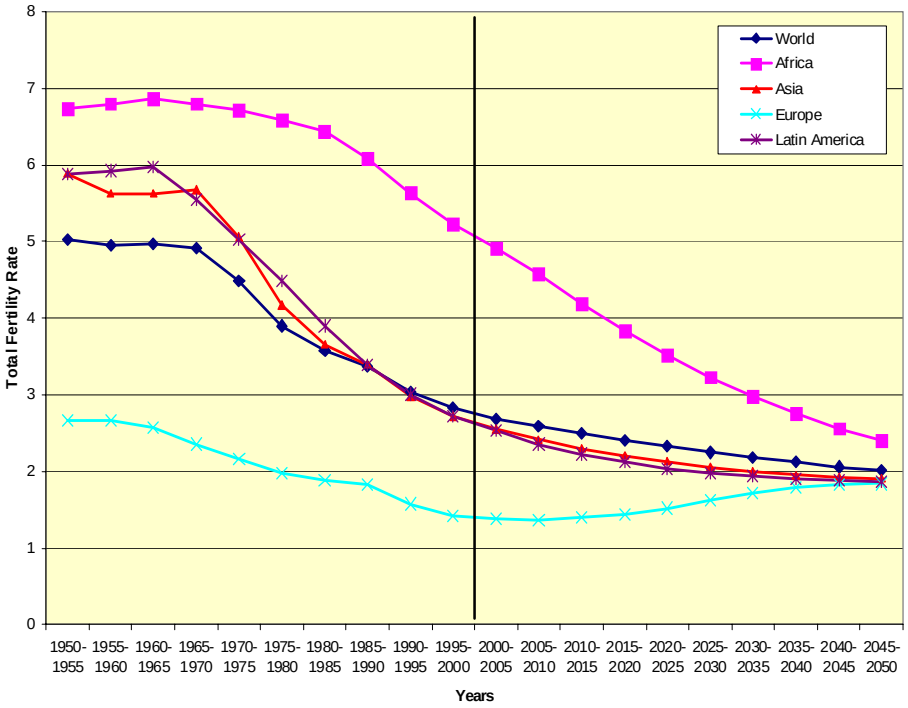


Figure 3: Fertility Rates 1995—2003, and Projected Fertility Rates 2003—50

As noted in the introduction, there are a number of assumptions underlying these projections.[24] Indeed, recent studies suggest that the impact of the reduced provision of FP/RH information and services over the past few years may be reversing these trends toward lower fertility and improved FP/RH. Further research into demographic trends will help to understand the trends and their causes, and provide policymakers with information about what these changes mean for population projections and potential policy and program responses.

The Foundation will continue to support research and advocacy to improve understanding of population issues and counteract apathy about them. Increased understanding and awareness of population trends can help increase the visibility of fertility issues among the general public, policymakers, and those who allocate resources, reminding them that despite great successes in making FP/RH information and services available, the job of helping individuals and couples

[24] The United Nations Population Division's "World Population Prospects: The 2002 Revision" must make assumptions about fertility, mortality, and international migration. A more complete discussion of these is available at http://www.un.org/esa/population/publications/wpp2002/WPP2002-HIGHLIGHTSrev1.PDF. In brief, the medium-fertility assumptions include projecting that

- future fertility declines will follow a path derived from models of fertility decline based on "the past experience of all countries with declining fertility during 1950-2000"
- low-fertility countries will maintain TFRs (total fertility rates) below 2.1 during most of the projection period and reach 1.85 by 2045—50,
- no country's TFR will fall below 1.85 children per woman for the final time period (2045—50), and for any country with observed fertility below 1.85, the assumption is that TFR may decline further before increasing slowly to reach 1.85 for the final time period.

achieve their desired number and timing of births is not yet done. Three particularly important areas of research are:

- *Demographic trends and stalled fertility*. A few very large countries, such as Egypt, Bangladesh, and the Philippines, saw fertility fall from very high levels to between 2.5 and 3.6 children per woman, and have remained at this level without further declines for some time. A more nuanced understanding of the fertility dynamics that create these stalled fertility transitions, or mid-fertility plateaus, will help determine what, if any, policies could help families in these countries meet their fertility desires.

- *The impact of HIV/AIDS on demographic trends*. Of the nearly 40 million people living with HIV/AIDS globally, more than half are in sub-Saharan Africa. The HIV/AIDS pandemic has had a significant effect on population growth rates and demographic structures. As an example, the most recent population projections released by the United Nations indicated that population growth will continue in many African countries impacted by AIDS, with the exception of Malawi, Namibia, and Zimbabwe, where AIDS will halt population growth, and South Africa, Botswana, Lesotho, Mozambique, and Swaziland, where populations will actually decline due to the disease.[25] Additional studies of the demographic impacts of HIV/AIDS are required to assess the impact the pandemic will have on demographic trends in the short and long terms.

- *Disparities in fertility rates within countries*. FP/RH outcomes are highly correlated with economic status: "Within countries, women from wealthier families usually have fewer children, higher contraceptive use, and more education than women from low-income families in the same society," with the wealthiest women nearly five times more likely to use contraception than the poorest women.[26] The use of national averages masks major differences between rich and poor. With the Program's focus on those living on less than a dollar per day, research deconstructing some of these aggregate statistics will help to design interventions and policies to target those most in need with greatest effectiveness and efficiency.

The above research has additional policy relevance in that in some topic areas, the Program may be able to support work that examines the role of scientifically accurate information and good public health practice in the prevention of unwanted pregnancies and STIs, including HIV/AIDS. The Program considered but decided against supporting research to examine connections between demographic factors and political unrest because previous studies on this subject were unable to identify any concrete causal relationships.

[25] Transitions in World Population. Population Reference Bureau,, Washington, D.C., 2004
[26] Ibid.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Identify research agenda on stalled fertility transitions, HIV/AIDS and demography, and deconstructing demographic trends beyond using nationally averaged statistics • Strengthen relationships with research and advocacy organizations undertaking research work	• Increased publications in reputable academic journals by African scholars • Stimulating a more balanced debate about demographic trends, including FP/RH issues in conversations currently focusing only on aging and other demographic phenomena • Increased use of evidence, including evidence funded by the Hewlett Foundation and from developing country institutions, at decisionmaking levels in development debates	• Appropriate allocations of resources to population and FP/RH, and within the FP/RH field, with decisions based upon evidence, including that funded by the Hewlett Foundation • Improved policies around population and FP/RH at the World Bank and other international financial institutions and development agencies, with decisions based upon evidence, including that funded by the Hewlett Foundation

3. Training the next generation of population scientists

The Hewlett Foundation has supported advanced training for population experts since 1978, and currently supports twenty-one academic programs in the United States and others overseas—in Egypt, Thailand, Costa Rica, and Brazil. The rationale for this work is that good demographic and FP/RH research, programs, policies, and advocacy in developing countries require highly trained people who understand the FP/RH field in local contexts. Hewlett has participated in the training of hundreds of population and FP/RH experts during its many years in this field. Questions remain about whether these experts return to the developing world; whether they stay in the fields of FP/RH, demography, and development; which institutions exist to provide them with job opportunities; and whether they are able to have productive careers in positions where they can help to inform policy.

Training the next generation of leaders and experts in the population field is essential to strengthening the capacities of developing countries to participate effectively in the design and implementation of FP/RH projects. Indeed, after many years of rhetoric about increasing the role of developing countries in the design and implementation of ODA programs, concrete opportunities have emerged to put developing countries in more proactive and directive roles. For example, rather than donors preparing plans for the use of ODA resources, developing countries must submit their own proposals in order to apply for funds from the proposed U.S. Millennium Challenge Account and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In reality, though, experts with training in demography and FP/RH to participate in these activities are scarce, and donors have cut back on efforts to train population experts in the past ten years, with the United Nations Population Fund (UNFPA) and the Mellon Foundation both withdrawing from funding training in the past several years. The Hewlett Foundation is now the only major source of funding for doctoral-level training of population scientists from the

developing world, exacerbating the challenge facing the population field to ensure a critical mass of trained experts. The problems are particularly acute in Africa.

Given the potential for an increased role for institutions in developing countries around ODA and development policies, we see a window of opportunity to invest in institutions that train population and development experts from developing countries *in* developing countries. The practice of taking students out of their home countries and bringing them to the United States for training is expensive and decreases their likelihood of returning to their country of origin. Training students closer to home also has the potential to increase the capacity of indigenous institutions.

We propose to strengthen a small number of African population training programs. Stronger African training institutions provide employment opportunities for researchers upon completion of their studies, creating jobs in African countries for population experts, which will increase students' demand for training as the potential for productive employment in the field is increased. We plan to build upon and collaborate in ongoing initiatives in sub-Saharan Africa begun by other foundations.[27] We will also continue to support some international training programs based in the United States, giving particular consideration to institutions with high-quality academic training and that have links with African training centers.[28]

[27] Recent work by the Gates, Rockefeller, Ford, and MacArthur Foundations and the Carnegie Corporation have targeted African universities for major investments, which may help Hewlett select those sites where investments in population training programs have the greatest chance of succeeding.

[28] Decisions about how to narrow the number of centers supported in the U.S. and expand the number in Africa are starting with a thorough review of the Foundation's current training work, which will begin in the summer of 2004. A panel of training experts is being assembled to advise the Foundation as it moves to fewer, larger training investments and a deepening involvement with African institutions.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Identifying and assembling expert advisory panel for training work • Completing assessment of Hewlett Foundation's historical work in training • Selecting African and U.S. training programs for continued partnership, with the input of our expert advisory panel	• Selecting institutions for training work and reaching agreements with cofunders and institutions in Africa about how to strengthen or support their work • Enrolling well-prepared students in African demography and FP/RH training programs with strong curricula and strong and/or improving teaching capacity	• Increased concentration of demography and FP/RH experts in Africa, and strong African population and FP/RH policy, research, and training institutions • Active and effective participation by African experts in determining and implementing population and FP/RH policies within development agendas • Increased publications in reputable academic journals by African scholars • Increased developing country presence at decisionmaking levels in development debates

Guideline Three: Promoting Family Planning and Reproductive Health in the United States

This guideline proposes continued support to U.S. organizations in order to improve family planning and reproductive health (FP/RH) and protect the reproductive rights of America's vulnerable populations, with a special emphasis on California. This support is especially needed now, at a time when the national government and some state governments are imposing ideologically-based restrictions on access to FP/RH information and services, and when governments are responding to fiscal problems with draconian cuts in social spending, including funds that have traditionally supported FP/RH.

By addressing U.S. policies, this guideline will also strengthen the work of U.S.-based advocacy organizations that promote international population programs. Domestic and international debates and policies regarding FP/RH have increasingly become closely linked, with negative policies being exported and reimported and to the detriment of FP/RH education and services everywhere.

FP/RH in California faces some particular problems, more related to the demography of its residents than to ideology. Therefore, in addition to work at the national level, we propose to build on the Hewlett Foundation's tradition of contributing to the region in which it is located by expanding FP/RH education and service delivery to vulnerable populations in California.

This guideline encompasses the following two components: (1) advancing policies and programs that enhance the FP/RH of Americans, and (2) expanding FP/RH education and service delivery to vulnerable populations in California.

1. Advancing policies and programs that enhance the FP/RH of Americans

Rates of unintended pregnancy, abortion, sexually transmitted infections, and teen pregnancy in the U.S. are among the highest of all industrialized countries. Almost half of the 6.3 million pregnancies in the U.S. each year are unintended; approximately 40 percent of these end in abortion.[29] Disparities in FP/RH behavior and outcomes are pronounced across socioeconomic status, geography, and racial/ethnic groups. For instance, while abortion rates have declined for most American women, they have *increased* among the country's economically disadvantaged women, including poor teenagers.[30] A significant proportion of American women rely on subsidized services (through Title X[31] or Medicaid) for family planning and related preventive care, but funding for these programs has not kept pace with the need. Taking inflation into account, the $275 million funding for Title X in 2003 is, in constant dollars, 57 percent lower than it was in 1980.[32] At the same time, federal funding for abstinence-only-until-marriage education has increased, despite the absence of strong evidence of the effectiveness of abstinence

[29] *Contraceptive Use: Facts in Brief.* New York: Alan Guttmacher Institute, 2004.
[30] Jones, R.K. et al. "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001". *Perspectives on Sexual and Reproductive Health*, 34(5): 226-236, 2002.
[31] Created in 1970, Title X is the federal program that supports the establishment and maintenance of family planning clinics and the provision of contraceptives and related services to low-income women and teenagers.
[32] Fact Sheet: Title X (Ten) National Family Planning Program: *Critical Women's Health Program Struggles to Meet Increasing Need*. Washington, D.C.: National Family Planning and Reproductive Health Association, 2003.

programs in delaying sexual activity and protecting young people against unwanted pregnancies and STIs. In fact, the FY04 federal budget includes $270 million for these programs, double the amount spent in 2003. Abstinence-only approaches have also been incorporated into the international HIV/AIDS prevention programs funded by USAID.

Despite the obvious public health needs, access to FP/RH information and services for all American women is far from universal. Therefore, with a combination of general operating support and project grants, the Foundation will continue to support U.S. organizations that advance the policies and programs to enhance FP/RH domestically and implement advocacy and legal strategies that guarantee broad access to reproductive health.

Areas of interest to expand access to information and services include emergency contraception availability, private insurance coverage of contraceptives, and comprehensive sexuality education for young people. We propose to continue supporting organizations working to expand public funding streams, and legal defense groups working to counter restrictions on access and rights. Through support of targeted medical education and professional health care provider networks, the Program will also contribute to maintaining a pool of health care providers trained to provide comprehensive FP/RH services.

As part of the effort to develop proactive strategies, a new (and relatively small) area of grantmaking will include efforts to reach out to new constituencies and frame FP/RH in relevant ways. To build long-term policies that are responsive to and representative of an increasingly diverse American public and one that is not fully engaged in FP/RH issues, it will be important to develop ways both to highlight and to communicate how the issues affecting FP/RH access are linked to broader concerns, such as economic justice and equity, or women's rights and participation, that are meaningful to policymakers and the public.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Relevance and timeliness of policy briefs distributed to key decisionmakers • Number of legal actions in response to restrictions on abortion access and that promote good FP/RH outcomes for all • New stakeholders engage in FP/RH advocacy	• Select policies adopted that increase access to FP/RH • Number of influential leaders from targeted constituencies advocating for FP/RH	• Increased levels of public funding streams • Reduced number of unintended pregnancies in vulnerable populations • Reduced number of STIs in vulnerable populations

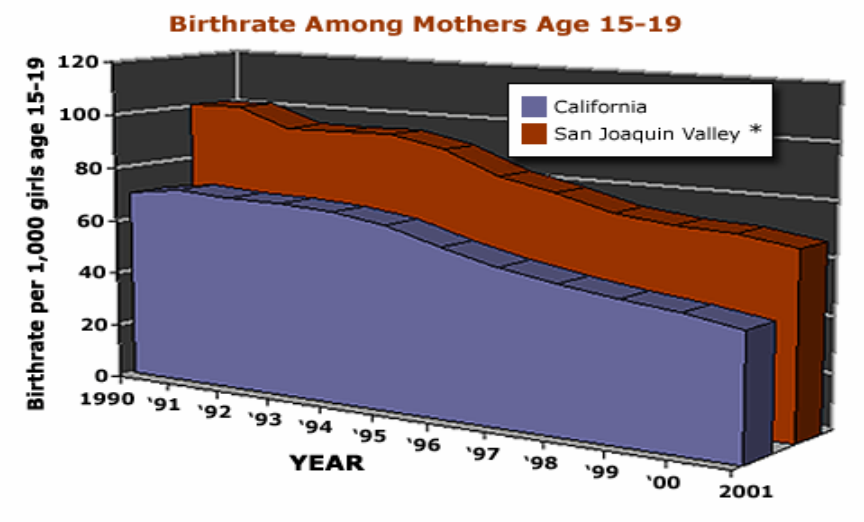
2. <u>Expanding FP/RH education and service delivery to vulnerable populations in California</u>

The Population Program proposes to work in close collaboration with the Foundation's nascent Regional Grantmaking Initiative to address the FP/RH needs of vulnerable populations in California through direct on-the-ground services. Although this component is new, the Population Program has made a number of California-related grants in the past—to the Public Policy Institute of California, Planned Parenthood Affiliates Service Center, and the University of California, San Francisco.

California has traditionally provided an environment conducive to good FP/RH. As in the international context, however, there are major gaps and inequities in access to FP/RH education and services, and potential future threats. In general, the women with least access to services are young, low-income, and nonwhite. For instance, low-income women[33] make up less than 40 percent of California's women of reproductive age, but account for 60 percent of California's births.[34] Of the estimated 1.57 million women in need of state-subsidized contraceptive services in 2000, 37 percent were not served.[35] While nationwide rates of sexually transmitted infections have been brought to historic lows, chlamydia rates in California have *increased* 45 percent among youth ages 15 to 19.[36]

Despite the general decline in teen birth rates in California since 1991, California teenagers continue to have rates of unintended pregnancy and STIs that would be considered a crisis in many developed countries. Teen birth rates for California are higher than those for every other Western democracy in the world,[37] and they are expected to accelerate because of the growth in the youth population, especially Latinas. Despite having the lowest overall teen birth rate in the state, the Bay Area contains several "hot spots" of high rates, including areas of East Palo Alto, San Mateo, and South San Francisco. The San Joaquin Valley (in the Central Valley) has the highest teen birth rate of any region in California, twice that of the Bay Area.[38]

[33] Low-income women in this case are defined as women with incomes less than 200 percent of the federal poverty level. The 2004 federal poverty level was defined as earning less than $12,490 per year for a family of two.
[34] Johnson, H.P. "Maternity Before Maturity: Teen Birth Rates in California". *California Counts: Population Trends and Profiles*, Vol. 4, No. 3, 2003.
[35] "Family PACT Program Report FY00/01", University of California, San Francisco Center for Reproductive Health Research and Policy, June 2002.
[36] "The Health Status of California's Youth" Research Brief. University of California, San Francisco National Adolescent Health Information Center, 2003.
[37] Kirby, D. "Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy", Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 2001.
[38] "Teen Birth Rate Hot Spots in California, 1999-2000", California Department of Health Services, Maternal and Child Health Branch, Epidemiology and Evaluation Section, 2001.



* Birth rate for the San Joaquin Valley is the average of the rates for Fresno, Kern, Kings, Madera, Merced, Tulare, San Joaquin, and Stanislaus counties.
Source: California Department of Health Services

In this updated strategy, we have identified two particular leverage points. First, the Program will support research and analysis of the specific FP/RH needs and most effective interventions to reach underserved and vulnerable populations in California. For instance, Latinos are the fastest-growing segment of the California population and will soon outnumber any other single ethnic group. Also, little is known about the FP/RH needs of California's American Indian and Southeast Asian populations, who are disproportionately represented among the poor and uninsured and have high rates of unintended pregnancies and STIs.[39]

Second, together with the Regional Grants Initiative, the Program will address the FP/RH needs of low-income youth in the Bay Area and San Joaquin Valley. Teen birth is one of the most robust correlates of poverty. Yet pending state budget cuts and dwindling funding by private foundations are eliminating the primary funding sources for adolescent pregnancy prevention. We are already developing a suite of grants for adolescent pregnancy prevention programs in the Bay Area. We propose to support medically accurate sexuality information, outreach that resonates with younger constituencies, culturally appropriate services to communities of color, and service delivery to some of the most difficult and vulnerable populations to reach.

[39] Reed, D. "Recent Trends in Income and Poverty". *California Counts: Population Trends and Profiles*, Vol. 5, No. 3, Public Policy Institute of California, 2004.

Indicators of Progress

Short Term 1–3 years	Medium Term 3–5 years	Long Term 5+ years
• Increased number of youth participating in pregnancy prevention programs • Increased capacity of pregnancy prevention programs to work collaboratively • Initiate research to understand FP/RH needs of specific populations	• Increased number of projects tailored to address the specific needs of vulnerable populations (e.g., age group, race/ethnicity, socioeconomic status) • Mid-term evaluation recommendations disseminated	• Reduced adolescent pregnancy rates • Reduced number of unintended pregnancies and sexually transmitted infections in vulnerable populations • Evaluations of programs conducted and findings disseminated

Appendix 1

Definition of "Good Family Planning/Reproductive Health" (FP/RH)

Although the term can be defined in different ways, the Population Program believes that FP/RH means that women and men, anywhere they may live and regardless of race, ethnicity, or income, are able to

- obtain medically accurate information about all aspects of reproduction in good time for informed decisionmaking,
- enter into sexual relationships only willingly, without physical or economic coercion,
- avoid unintended pregnancies and births,
- terminate unwanted pregnancies in dignity and safety,
- avoid sexually transmitted infections, particularly HIV/AIDS, and
- experience safe pregnancy and childbirth.

Some Components of Good FP/RH

Availability of medically accurate sex education

Sex education, particularly in the poorest developing countries, is sporadic at best and has never been properly evaluated. In many high-AIDS-prevalent countries such as Uganda, as well as many school districts within the U.S., there are concerted efforts, to promote "abstinence-only" sex education. In addition to preaching that sex outside of marriage is morally wrong, this approach claims that it will have a lifelong negative emotional and physical impact and denigrates the use of condoms and other forms of contraception by exaggerating their failure rates and minimizing their role in reducing sexually transmitted infections and unwanted pregnancies. In contrast, medically accurate sex education emphasizes the benefits of abstinence while also teaching about contraception and disease-prevention methods. These programs are proven to help people postpone early sexual activity and protect themselves from disease and pregnancy when they do become sexually active wile respecting the diversity of values and beliefs represented in communities and complementing and augmenting the sexuality education received from families, religious and community groups, and health care professionals.

Coercive sexual relationships

Sexual coercion and sexual violence occur in every society and in all social classes. Primary victims are women and girls. A study of thirty-six countries, in the North (industrialized countries) and the South (developing countries), documented that 10-60 percent of women have experienced violence from their partners. The incidents included physical and emotional abuse as well as forced sex. Many studies have also documented women's fear of physical violence if they use contraception or attempt to persuade their partners to use condoms. There are

documented associations between the sexual abuse of young girls and subsequent teenage pregnancy.[42]

Unwanted pregnancies and births

Each year 76 million unintended pregnancies occur in developing countries. Although complete elimination is not possible because of mistakes in contraceptive use, inconsistent use, and technological failure, increased availability of modern contraception could reduce this number to 24 million. Thus, satisfying the unmet need for contraceptives in the developing world could reduce unwanted pregnancies by 52 million.[43] In the United States, approximately 50 percent of all pregnancies are unintended and this proportion rises to 75 percent for women in poverty and teens. Overall, American women use contraception less effectively than women in other industrialized democracies.

Termination of unwanted pregnancies

It is difficult to obtain accurate information on abortion in the developing world, where it is almost never legal and safe. What is known is that abortion is a very common event—an estimated 46 million occur annually—and that the rate at which women obtain abortion has a very weak relationship to its legal status.[44] For women in developing countries, abortions often occur under dangerous and even life-threatening conditions. Approximately 67,000 women die each year from unsafe abortion, almost all in developing countries.[45] Even less is known about the health impact of unsafe abortion, but given the frequency with which this procedure occurs, the morbidity effects are likely to be widespread.

Sexually transmitted diseases and HIV

Approximately 40 million men, women, and children are living with HIV/AIDS, more than 70 percent of whom are Africans.[46] In sub-Saharan Africa, the level of HIV/AIDS is significantly higher among young women than young men. At particular risk are young, married women whose husbands are usually several years older and may come into the marriage already infected. Other sexually transmitted infections are extremely common. Some 340 million of curable STIs occur annually, with rates highest in sub-Saharan Africa, Latin America, and the Caribbean.[47]

Pregnancy and childbirth

Although pregnancy and childbirth are almost risk free in the developed world, the situation is very different in the poorest countries. There are only twenty maternal deaths per 100,000 live births in the North. By comparison, there are over 900 and 500 maternal deaths per 100,000 live births in sub-Saharan Africa and South-Central Asia respectively. Whereas antenatal care is

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[42] L. Heise, Ellsberg and Gottmoeller. "A global overview of gender-based violence". *International Journal of Gynecology and Obstetrics*, 78, Suppl. 1, 2002.
[43] Singh, S. et al. *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care.* New York: Alan Guttmacher Institute, 2004.
[44] Henshaw, SK et al. "The Incidence of Abortion Worldwide". *International Family Planning Perspectives* 25: Suppl.: S30-S38, January 1999.
[45] *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva. World Health Organization, 2003
[46] *AIDS Epidemic Update: 2003*. Geneva: Joint United Nations/World Health Organization Program on HIV/AIDS.
[47] *Global Prevalence and Incidence of Select Curable Sexually Transmitted Infections: Overview and Estimates.* Geneva. World Health Organization, 2001.

almost universal in the North, only about two-thirds of pregnant women in the developing world receive any care at all.[48]

[48] *Antenatal Care in Developing Countries: Promises, achievements and missed opportunities.* Geneva. World Health Organization, 2004.