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A Common-Ground Approach to an Expanded U.S. Role

A Report of the CSIS Global Health Policy Center

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INTERNATIONAL FAMILY PLANNING: A COMMON-GROUND APPROACH TO AN EXPANDED U.S. ROLE

Janet Fleischman and Allen Moore¹

Introduction: Opening a New Debate

The election of President Barack Obama has fundamentally changed the landscape for the debates around U.S. support for international family planning (FP) programs. The personal engagement of top leadership, notably the president himself and Secretary of State Hillary Clinton, combined with policy and budgetary announcements that make averting unintended pregnancies a priority issue, clearly signal the administration's intention to promote family planning as part of a comprehensive approach to global health.

Despite the polarization that often surrounds the debates on these issues in the United States, largely over their perceived linkage to the highly charged issue of abortion, an unprecedented opportunity now exists to significantly expand international FP programs based on a common-ground approach.

The core element of this approach is the need to move toward universal access to FP services—defined throughout this paper as education, counseling, and contraceptive commodities²—provided on a voluntary basis to females and couples.

¹ The CSIS Global Health Policy Center commissioned this paper from Janet Fleischman, senior associate at the Global Health Policy Center, and Allen Moore, distinguished fellow at the Stimson Center. The goal was to examine the history of U.S. family planning assistance, the factors that created the current polarization, and the prospects for the United States to advance a more constructive agenda on family planning based on a common-ground approach. It is based on research and interviews with a wide spectrum of individuals of diverse opinions on U.S. policy toward international family planning, conducted from October 2008 to June 2009.

² Most public health experts place FP services within the broader context of reproductive health (RH) services, including antenatal and postpartum maternal and newborn care, safe birthing services, prevention and treatment of sexually transmitted infections (STIs), postabortion care, obstetric fistula care, and pap smears/cervical cancer screening. But while most people interested in public health are highly supportive of a broad array of services typically called “reproductive health,” the term “RH” generates controversy in some circles because certain international definitions of “RH services” include access to safe and legal abortion. It should be noted, however, that the definition given by the World Health Organization (WHO)

The common ground does not include abortion, which is prohibited by U.S. laws governing foreign assistance. In most developed countries, a wide array of contraceptive options are available so people can plan whether and when to have children. It is precisely that acceptance and availability of FP services in the developed world that forms the basis for a common-ground policy toward international FP services.

Family planning represents an urgent global health priority for the twenty-first century. FP services help women and men around the world make informed decisions about the number and spacing of their children, which is a major determinant of newborn, child, maternal, and family health.³ By extension, the economic well-being of families, communities, and even countries is improved by access to FP services. It is estimated that 200 million women (and their spouses or partners) in developing countries would like to delay or avoid pregnancy but presently lack access to the necessary services and commodities.

The many benefits of FP are compelling:

- *FP services save lives.* By equipping women and couples with the power to decide whether and when to have children, FP significantly and demonstrably reduces infant mortality, maternal mortality, and child mortality, and improves maternal, child, and family health, including by reducing teen pregnancy. Nearly 10 million children die before age five, usually at birth or in the first month of life, often linked to pregnancies less than a year apart. An estimated 536,000 women die each year from pregnancy-related causes, 99 percent of whom live in the developing world. Complications from pregnancy and childbirth are the leading cause of death for adolescent girls ages 15 to 19 in developing countries.
- *FP services reduce abortion.* Unmet need for contraception is recognized as the leading cause of an estimated 52 million unintended pregnancies annually in the developing world. Those

makes no reference to abortion. According to WHO, “reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.” See WHO, “Reproductive Health,” http://www.who.int/topics/reproductive_health/en/. Nonetheless, this paper will generally refer only to FP. That is not an attempt to ignore or diminish the importance of related services, but rather an effort to keep a focus on expanding access to FP services and to keep abortion out of this discussion.

³ See WHO, “Maternal Mortality,” http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html. According to the WHO, more than half of maternal deaths occur in sub-Saharan Africa and one-third in South Asia. In developing regions, the maternal mortality rate (MMR) is 450 maternal deaths per 100,000 live births, compared to 9 in developed regions. A total of 14 countries—Afghanistan and the rest in sub-Saharan Africa—have MMRs of at least 1,000.

pregnancies, in turn, are the major cause of an estimated 20 million unsafe and usually illegal abortions. These abortions lead to an estimated 68,000 maternal deaths and a far larger incidence of other adverse health consequences.

- *FP services have major “secondary” benefits to families and communities.* There are broad social, economic, and environmental benefits from millions of women and men choosing to control the spacing and number of children, all tied to family size and to helping communities address rapid population growth. Such benefits include improved prospects for economic development; lower demand for food; reduced environmental degradation; greater ability to prevent and control disease; and improved educational and economic opportunities, especially for women and girls. There is also great potential for individual benefits such as delayed child marriage, delayed first pregnancies, and reduced domestic violence.

The return on investment in FP is significant. Studies in Zambia show that every dollar invested in FP led to four dollars saved in other development areas.⁴ With FP a primary contributor to achieving health and development objectives, including the Millennium Development Goals,⁵ it is essential to expand FP services. This is especially true to meet the new target (5.B) under MDG 5—to ensure universal access to reproductive health by 2015, including unmet need for family planning.⁶

It is estimated that the cost of bringing FP services to the 200 million women (and couples) who do not currently have access is between \$17 and \$19.50 per woman annually—or from \$3.4 billion to \$3.9 billion. If two-thirds of that comes from the individuals in need and their governments (this is the current average, though the poorest countries typically cannot afford to contribute two-thirds), then the amount needed from outside donors would be from \$1.13 billion to \$1.3 billion. The United States has traditionally supplied about 45 percent of donor funding, so the additional U.S. share, consistent with historical experience, would be from \$510 million to \$585

⁴ J. Joseph Speidel et al., *Making the Case for U.S. International Family Planning Assistance* (Baltimore: Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins School of Public Health, January 2009), p. 10, http://www.jhsph.edu/gatesinstitute/_pdf/policy_practice/Papers/MakingtheCase.pdf.

⁵ The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015 that respond to the world's main development challenges and were adopted by 189 nations during the UN Millennium Summit in September 2000. The eight MDGs are: Goal 1: Eradicate extreme poverty and hunger; Goal 2: Achieve universal primary education; Goal 3: Promote gender equality and empower women; Goal 4: Reduce child mortality; Goal 5: Improve maternal health; Goal 6: Combat HIV/AIDS, malaria and other diseases; Goal 7: Ensure environmental sustainability; Goal 8: Develop a Global Partnership for Development.

⁶ See United Nations, “Millennium Development Goal Indicators,” <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>.

million. That would represent more than a doubling of current U.S. spending on global FP to about \$1 billion, since the United States is investing \$455 million in such programs in 2009.⁷

The authors of this paper seek to identify opportunities to solidify U.S. leadership on international FP and to provide recommendations for moving forward by building on areas of common ground. This includes committing the United States to achieving universal access to voluntary FP as quickly as possible. This paper calls for expanded linkages between FP services and existing global health program platforms supported by the United States. This is a key pathway to improving cost effectiveness and establishing sustainability. Since the United States has exercised leadership for several decades in the area of FP, its main new challenge would be to lead the global community toward the goal of universal access both through the power of its voice and its example—by moving aggressively toward doubling its annual investment in response to global need. Increased U.S. investment would be leveraged by encouraging other bilateral and multilateral partners to expand their own contributions. With the 15th anniversary of the International Conference on Population and Development (ICPD) being commemorated in October 2009, the administration has an opportunity to announce its new policy, to develop a timeline for implementation, and to define specific objectives over a period of time.

No one should assume that this common-ground approach will evolve easily. Notwithstanding the potential for consensus, the 2008 reauthorization experience for the President's Emergency Plan for AIDS Relief (PEPFAR) provides a cautionary tale about the deep divisions that could impede progress toward strengthening FP programs. That debate turned ugly when “pro-life” members of the House of Representatives accused committee leadership of promoting a “pro-abortion” agenda. The subsequent resolution left raw feelings, resulting in divisions between the family planning and HIV/AIDS groups that linger to this day. The PEPFAR experience provides powerful evidence that achievable progress will require sustained, high-level leadership from the president, the secretary of state, and other key administration officials, as well as Congress.

Political leaders should make a common-ground approach a priority, define specific objectives, keep the lines of communication open to all interested parties, and set the tone for the debate. The opportunity for genuine progress is real, but it will require a new climate of goodwill, cooperation, and compromise.

⁷ See Speidel et al., *Making the Case*; Sally Ethelston and Elizabeth Leahy, “Reproductive Health: How Much? Who Pays?” *PAI Research Commentary* 1, issue 6 (June 2006), http://www.populationaction.org/Publications/Working_Papers/Reproductive_Health_-_How_much_Who_pays/Reproductive_health.pdf; and Global Health Council, “Needs and Costs,” http://www.globalhealth.org/womens_health/needs_cost/.

Opportunities and Challenges in the Obama Administration

The United States has long been the world leader in providing international FP services, yet support for these programs has been fraught with challenges, notably by the explosive domestic debates over abortion, which too often pit “pro-life” forces against the family planning and public health communities. This has created an enduring gap in U.S. policy approaches, fed by suspicion, acrimony, and ill will.

President Obama has expressed his own clear interest in this set of issues. In his commencement speech at Notre Dame in May 2009, the president acknowledged the complicated realities but called for a new tone of civil dialogue: “Each side will continue to make its case to the public with passion and conviction. But surely we can do so without reducing those with differing views to caricature.”⁸

Immediately after his election, President Obama took some early steps related to international family planning policy. On January 23, 2009, he took the expected step of rescinding the so-called Mexico City Policy⁹ that prohibited U.S. funds from going to any international organization that uses its own funds to provide any service relating to abortion, including counseling, referral, or advocacy. The policy was first imposed by President Ronald Reagan in 1984; rescinded by President Bill Clinton in 1993; and then reinstated by President George W. Bush in 2001. In announcing the most recent change, President Obama cited the need to find common ground. “For too long, international family planning assistance has been used as a political wedge issue, the subject of a back and forth debate that has served only to divide us....my Administration will initiate a fresh conversation on family planning, working to find areas of common ground to best meet the needs of women and families at home and around the world.”¹⁰ The president also reinstated funding for the UN Population Fund (UNFPA), another point of contention caught up in the debate over abortion.¹¹

While the President Obama’s action was no surprise, it is significant that he chose to reverse Mexico City quietly and after the anniversary of the Supreme Court’s *Roe v. Wade* decision. The low-key approach and the administration’s willingness to address these issues openly and directly

⁸ “Remarks by the President in Commencement Address at the University of Notre Dame, May 17, 2009,” http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Notre-Dame-Commencement/.

⁹ The Mexico City policy is named for the 1984 Mexico City Conference on Population and Development. Critics of the policy often refer to it as the “global gag rule.”

¹⁰ The White House, Office of the Press Secretary, “Obama Rescinds Mexico City Policy,” January 23, 2009.

¹¹ The FY2009 Appropriations bill contains a statutory earmark for \$50 million for UNFPA. This assistance is designated for specific activities, such as safe childbirth and emergency obstetric care, contraceptives to prevent unintended pregnancy and the spread of sexually transmitted diseases, prevention and treatment of obstetric fistula, combating harmful traditional practices, and the provision of maternal health services in disaster areas. The assistance can be used in any of the countries where UNFPA works, other than China.

could provide just the right opportunity to transform the debate from its current rigidity toward broad agreement on a new direction.

On May 5, President Obama outlined his plans for global health spending in FY2010. He proposed to devote \$63 billion over the next six years to “a new, comprehensive global health strategy” with “attention on broader global health challenges, including child and maternal health, family planning....” One of four stated objectives is to “avert millions of unintended pregnancies.”¹²

The detailed budget request that followed received a mixed response. There was a collective sigh of relief that global health spending would continue to rise during a period of severe budget constraint, albeit more slowly than in recent years. AIDS advocates were disappointed at the marginal increase requested for AIDS programs, especially after campaign statements had led them to expect more robust increases from an Obama administration. In contrast, family planning organizations were largely pleased that the president was both elevating the importance of family planning and requesting additional funding. In recent years under President Bush, the administration would typically request cuts from the prior year of around 20 percent, only to see the Congress both restore the proposed cuts and increase spending above the previous year. President Obama has requested an increase of \$20 million, for a total of \$475 million for family planning, for FY2010. President Bush’s last budget request, for FY2009, was \$302 million. In July 2009, both houses of Congress took actions that could increase spending in FY2010 even further. The full House approved an appropriations bill that would increase funding for family planning to \$588 million and \$60 million for UNFPA. The Senate appropriations committee approved \$578 million for family planning, plus \$50 million for the UNFPA.

Since January, the new administration has started to develop a strong foundation for finding common ground on family planning. Almost no one would disagree with the president’s objective of averting unintended pregnancies. The discussion now should turn to how to accomplish this critical goal. If all parties approach the issue with good faith and respect, there should be a clear basis on which to build a common-ground approach on FP.

U.S. Policy on International Family Planning

The United States has a strong history of supporting FP as part of its foreign assistance programs, and it remains the global leader in this area, providing both technical and financial assistance. Under the Office of Population and Reproductive Health at the U.S. Agency for International Development (USAID), the United States provides 35 to 40 percent of donor-supplied contraceptives to the developing world and supports the Demographic and Health Surveys (DHS) that provide essential information about family planning and health dynamics in many countries. The cornerstone of U.S. policy is to provide information and commodities on a voluntary basis to

¹² The White House, “Statement by President Obama on Global Health Initiative,” May 5, 2009.

women and couples who seek such services. USAID's family planning programs support technological advances in family planning methods, ensure a steady supply of contraceptive commodities, expand access to family planning services, and assist governments in reviews of family planning policies and regulations.¹³

Between 2000 and 2007, USAID provided FP assistance in more than 35 countries, which has contributed to an increase in the average modern contraceptive prevalence rate from 32 to 38 percent; an increase in the total satisfied demand for FP from 44 to 52 percent; and a decrease in total fertility rates from 4.6 children per woman to 4.1.¹⁴ In FY2007, FP and reproductive health (RH) programs represented 11 percent of the total health budget of USAID; child survival and maternal health also consumed 11 percent; infectious diseases 14 percent; vulnerable children 1 percent; and HIV/AIDS, 64 percent.¹⁵ A U.S. objective of FP programs is to "graduate" countries from the need for U.S. FP assistance, and various countries, including Morocco and Brazil, have "graduated" in recent years.¹⁶

USAID also supports maternal and child health programs intended to improve health outcomes for mothers and children in developing countries. These programs include basic RH and other services such as providing antenatal care, skilled birth attendants, postnatal and newborn care; strengthening health systems; and linking with other U.S.-supported programs, including FP and RH.¹⁷ Most experts agree that providing women with adequate access to comprehensive RH care, including FP, could help cut maternal mortality by nearly three-quarters.¹⁸

U.S. FP and RH programs are subject to a range of restrictions, largely related to abortion. USAID-supported FP programs are regularly audited to ensure that they meet three conditions: they must be voluntary; they must include informed consent; and they must include multiple methods of contraception, including natural family planning. The FP and abortion restrictions currently carried in annual appropriations bills (see text box) demonstrate vividly the extent to which U.S. law prohibits any funding for abortion services overseas. Even though the President Obama has rescinded the Mexico City policy, these laws relating to abortion are expected to remain in place.

¹³ USAID, "USAID Family Planning Program: A History of Achievement," http://www.usaid.gov/our_work/global_health/pop/history.html.

¹⁴ USAID, *Report to Congress: Child Survival and Health Programs Fund Progress Report, Fiscal Year 2007* (Washington, D.C.: USAID, 2007), p. 68, http://pdf.usaid.gov/pdf_docs/PDACL981.pdf.

¹⁵ *Ibid.*, p. 89.

¹⁶ See USAID, "USAID Family Planning Program."

¹⁷ USAID, "Overview: A Strategic Approach for USAID Maternal and Child Health (MCH) Programming," http://www.usaid.gov/our_work/global_health/mch/publications/docs/mch08_overview.pdf.

¹⁸ See Series on Maternal Survival, *The Lancet* (September 2006), <http://www.thelancet.com/series/maternal-survival>.

Abortion-related Language in Annual Appropriations Bills

The Biden Amendment: No foreign assistance funds may be used to pay for any biomedical research that relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning.

The DeConcini Amendment: Funds shall be available only to voluntary family planning projects, which offer either directly or through referral to, or information about access to, a broad range of family planning methods and services.

The Helms Amendment: No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.

The Kemp-Kasten Amendment: No foreign assistance funds can be made available to any organization or program that, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.

Peace Corps Restriction: No funds shall be used to pay for abortions.

The Siljander Amendment: No foreign assistance funds may be used to lobby for or against abortion.

The Tiahrt Amendment: Service providers or referral agents may not implement or be subject to numerical targets or quotas of total number of births, number of family planning acceptors, or acceptors of a particular family planning method; there may be no incentives, bribes, gratuities, or financial reward for family planning program personnel for achieving targets or quotas, or for individuals in exchange for becoming a family planning acceptor.

The high-water mark for U.S. funding for FP programs was almost \$577 million in 1995, after the ICPD in Cairo. Current spending in constant dollars is more than one-third lower. However, Congress consistently overrode the Bush administration's proposed reductions in international FP budget requests, which meant that spending has been relatively consistent in real terms with spending levels since the early 1970s. For FY2009, the Congress provided \$455 million for FP, with an additional \$50 million for the work of UNFPA, other than in China (due to Kemp-Kasten concerns related to coercive abortion or involuntary sterilization).¹⁹ A broad range of international FP advocates now supports an increase in funding for FP programs to at least \$1 billion in 2010, more than double the current U.S. funding.

¹⁹ See Population Action International (PAI), "House Initially Approves Historic Increases for Family Planning and Reproductive Health Programs," http://www.populationaction.org/Issues/U.S._Policies_and_Funding/historic_increase.shtml.

Unmet Need for Family Planning Services

Most analysis of FP services focuses on addressing the “unmet need” for family planning. The unmet need refers to women or couples who would prefer to avoid or postpone a pregnancy but are not using any contraceptive method. There are many factors that contribute to unmet need, including lack of knowledge about or access to contraceptive options, myths or misinformation about contraceptive options, and social or cultural disapproval of family planning. Unmet need is often influenced by socioeconomic factors, such as women’s level of education, employment status, geographic location (rural versus urban), and degree of autonomy, with poor women in developing countries least likely to have access to FP services.²⁰ Not surprisingly, DHS data show a strong correlation between limited women’s education and high total fertility rates (TFR).

Unmet need for contraception varies depending on the region, but it is estimated that over 200 million women do not use contraceptives but would like to limit and/or space their children.²¹ An estimated 24 million women in various sub-Saharan countries would like to limit or space children but are not currently using any contraceptive method. That is the region where the need for technical assistance and funding is most acute. The actual numbers of women with the highest unmet need—more than half the global total—are in Asia, especially in south and central Asia,²² though Asia has also mobilized the largest amount of domestic resources to fund population programs.²³

FP programs are also a critical way to prevent abortions. According to the World Health Organization (WHO), out of 80 million unintended pregnancies every year worldwide, some 20 million result in unsafe, illegal abortion, and 97 percent of those occur in developing countries.²⁴ A 2005 study showed that abortion rates in the Europe and Eurasia region declined with rising rates of modern contraceptive methods.

The dangers of unplanned pregnancies, especially in first pregnancies among teens, are another critical area of concern. Pregnancy is the leading cause of death in teenage girls in developing countries. Girls age 15 to 19 are twice as likely to die from pregnancy-related complications as women in their 20s, and their infants face a 50 percent higher risk of dying before the age of 5.

²⁰ Elizabeth Lule et al., “Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia,” HNP Discussion Paper, World Bank, Washington, D.C., December 2007, p. 2, <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/FertilityRegulationsFinal.pdf>.

²¹ See Speidel et al., *Making the Case*, and WHO, “Promoting Family Planning,” http://www.who.int/reproductivehealth/topics/family_planning/en/.

²² Speidel et al., *Making the Case*, p. 3.

²³ UNFPA, “UNFPA Global Population Policy Update,” Issue 64 (June 1, 2006), <http://www.unfpa.org/parliamentarians/news/newsletters/issue64.htm>.

²⁴ See “*The Lancet*: Executive Summary of *Lancet* Sexual and Reproductive Health Series,” p. 5, <http://www.familycareintl.org/UserFiles/File/SRH%20Exec%20Summary.pdf>.

Girls less than 15 years old are five times as likely to die as women in their 20s from pregnancy-related complications.²⁵ The majority of sexually active adolescent girls in sub-Saharan Africa do not use modern contraceptives—only 12 percent of married adolescents use modern methods, though data from 11 countries show an unmet need of 50 percent. In many countries, some 70 percent of unmarried adolescents do not use modern methods.²⁶ U.S. policy on adolescent maternal health encourages these young women to utilize health services, including prenatal as well as postpartum care, where information about birth spacing and FP can be provided.²⁷

Domestic Policy on Family Planning

It is important to note that there are important policy and legal differences between U.S. domestic and global programs in FP and RH. Domestic programs are carried out under Title X of the Public Health Service Act. First enacted into law in 1970, Title X²⁸ finances comprehensive FP and related preventive health services, including access to contraceptive services, supplies, and information for all who want and need them. By law, priority is given to persons from low-income families. Title X funds may not be used in programs where abortion services are offered.²⁹ However, Title X projects must offer pregnant women neutral and factual information, nondirective counseling, and referrals on request for all of their pregnancy options. This includes prenatal care and delivery, infant care, foster care or adoption, and abortion information.³⁰ Planned Parenthood of America is a major recipient of Title X funding.³¹

It should also be noted that RU-486, a nonsurgical abortion technique considered effective for the first seven weeks of pregnancy, has been approved by the FDA. Although federal Medicaid reimbursement will only cover RU-486 in the case of rape, incest, or if the woman's life is in

²⁵ “Birth Spacing/Pregnancy Spacing: World Vision’s Newest Strategy to Improve and Sustain the Well-being of Children” (presentation to the International Programs Group, World Vision, Washington, D.C., June 2009).

²⁶ UNFPA, “Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy,” p. 8, http://www.unfpa.org/upload/lib_pub_file/722_filename_adol_eng.pdf.

²⁷ USAID, Maternal and Child Health, http://www.usaid.gov/our_work/global_health/mch/mh/techareas/adolescent.html.

²⁸ Title X is the U.S. domestic family planning program for low-income women. Congress has proposed bringing total Title X funding to \$315 million in 2009.

²⁹ See Office of Population Affairs, U.S. Department of Health and Human Services (HHS), “Family Planning,” <http://www.hhs.gov/opa/familyplanning/index.html>.

³⁰ Center for Reproductive Rights, “Title X Family Planning,” <http://reproductiverights.org/en/document/title-x-family-planning>.

³¹ This is noteworthy because it is precisely the concerns expressed by some conservative groups about two international organizations that provide abortion services in some of their sites—the London-based International Planned Parenthood Federation (IPPF) and its affiliates and Marie Stopes International—becoming eligible for U.S. FP funding that has been a major driver for those who support the Mexico City policy.

jeopardy, certain state Medicaid programs do pay for RU-486 and other abortion services exclusively with state funds.³² RU-486 is not included in the package of FP commodities provided in USAID programs because it is considered to be an abortifacient (i.e., a product that interrupts the natural development of an embryo already attached to a woman’s uterus). This contrasts with “emergency contraception” (EC), commonly known as the “morning-after” pill, which supplies large doses of hormones that are generally believed to prevent the joining of sperm and egg. For U.S. policy purposes, EC is considered to be a contraceptive rather an abortifacient, but in practice USAID does not purchase EC as a dedicated product.³³

In summary, whereas women with financial need in the United States have access to government-funded FP/RH services, including abortion referral, an altogether different set of rules applies for U.S.-funded FP programs overseas. These conflicting standards are largely attributed to two factors: (1) U.S. constitutional protections regarding free speech and doctor-client privilege as reflected in Title X; and (2) the ability of a handful of passionate, and effective, antiabortion advocates in the Congress to have impact on the legislative process affecting foreign assistance, while they face greater opposition to such efforts in the U.S. domestic arena.

PEPFAR–HIV/AIDS Prevention and FP

The PEPFAR reauthorization debate underscored the polarization around issues of linkages between HIV/AIDS and FP/RH. Despite the clear intersection between the PEPFAR goals and the priorities for FP/RH, the effort to include explicit linkages in the reauthorization bill unleashed strong opposition, from both expected and unexpected quarters.

A draft House bill circulated in early 2008 included language calling for specific plans for linkage and referral systems for FP and women’s health services, as well as for nutrition and food support, child health services and development programs, and services for victims of violence. The drafters decided to include language about linkages in both directions, meaning that HIV services could be provided in FP clinics and that FP services could also be provided in HIV programs. There appeared to be two motives: a desire to address the family planning needs and interests of HIV-positive women and women at high risk of HIV infection; and a desire on the part of some family planning supporters to tap into PEPFAR funds as another source of funding for global FP services,

³² See Donna Lieberman, letter to the editor, “RU-486 and Medicaid,” *New York Times*, April 8, 2001, <http://query.nytimes.com/gst/fullpage.html?res=9D07EEDF133EF93BA35757C0A9679C8B63&partner=rssnyt&emc=rss>.

³³ Ultimately, the conflict stems from the different definitions of pregnancy: the U.S. government defines pregnancy as beginning at implantation, whereas many Catholics, evangelicals, and others define pregnancy as beginning at conception. Therefore what might be a contraceptive under a federal definition could be considered as an abortifacient by others.

even though these were aimed primarily at HIV outcomes.³⁴ The first draft of the bill also embraced the idea that contraception for the prevention of unintended pregnancies in women with HIV is an important and cost-effective HIV-prevention strategy.³⁵

The Republicans declined reported offers by the Democrats to participate in the drafting of the reauthorization bill. As a result, when the draft first appeared, it created a fire-storm among Republican conservatives and the White House. Representative Mike Pence (R-IN) claimed that the draft would “hijack” PEPFAR’s strategy and “mandate the integration of reproductive health services into PEPFAR,” thus turning the program into “a mega-funding pool for organizations with an abortion agenda.”³⁶ The global AIDS coordinator, Ambassador Mark Dybul, and the White House also pushed back on the “FP as an effective HIV-prevention” argument.³⁷

As the conservative attacks against the draft bill increased, the new chairman of the House Committee on Foreign Affairs, Representative Howard Berman (D-CA), and his staff realized that

³⁴ The vast discrepancies in funding levels between HIV/AIDS and FP have contributed to these tensions. See PAI, “U.S. HIV/AIDS and Family Planning/Reproductive Health Assistance: A Growing Disparity in PEPFAR Focus Countries,” January 2008, http://www.populationaction.org/Issues/U.S._Policies_and_Funding/FPRH/Summary.shtml. There was certainly a strong case to be made, based on increasing reports from the field indicating high levels of unintended pregnancies among HIV-positive women. These women needed accurate information about either how to prevent pregnancy or how to have the baby as safely as possible. Indeed, FP services for people living with HIV was already acknowledged by PEPFAR to be an important component of “prevention with positives” initiatives.

³⁵ This proved to be a very contentious point with those who questioned the underlying ethics of what they saw as a policy of preventing pregnancies among all HIV-positive women simply because some of their babies would have been born HIV positive. The proponents argued that the policy was aimed only at women who did not wish to become pregnant and that this approach was far more cost effective than utilizing nevirapine and other services in prevention of mother-to-child transmission (PMTCT) programs, thus reducing the number of infections—and orphans—with the same amount of resources. They also emphasized that some 70 percent of pregnant women in sub-Saharan Africa still do not access PMTCT services. See H.W. Reynolds et al., “Contraception to Prevent HIV-Positive Births: Current Contribution and Potential Cost Savings in PEPFAR Countries,” *Sexually Transmitted Infections* 84, suppl. 2 (2008): 49–53.

³⁶ Pence Statement on HIV/AIDS Relief for Africa, February 11, 2008, <http://mikepence.house.gov/news/DocumentSingle.aspx?DocumentID=83349>.

³⁷ In a February 2008 letter to the late Representative Tom Lantos (D-CA), then chairman of the House Committee on Foreign Affairs, an assistant secretary of state wrote: “We strongly oppose the [PEPFAR] draft’s introduction and endorsement of family planning as an aspect of PEPFAR and as a means of prevention of mother-to-child transmission of HIV. Such language does not appear in current law and wrongly suggests it is necessary to prevent children from being born in order to prevent them from being born with HIV, when in fact PEPFAR currently supports highly effective methods of avoiding mother-to-child transmission. This language is contrary to PEPFAR’s life-saving principles and should be struck from the bill.” Letter from Jeffrey T. Bergner, assistant secretary of state for legislative affairs, to Representative Tom Lantos, chairman of the Committee on Foreign Affairs, House of Representatives, February 7, 2008.

they would have to change course if there was to be any hope of finding an acceptable compromise. Ultimately, the Republicans made two major concessions—accept a \$50-billion authorization level for AIDS, TB, and malaria, even though the president had originally requested just \$30 billion; and accept an “abstinence compromise” relating to the highly controversial “abstinence earmark”³⁸ in the original law. In return, the Democrats would agree to the same “compromise”—the elimination of the “earmark” in favor of new reporting requirements relating to prevention spending on abstinence and fidelity-related programs; add back a controversial provision requiring U.S. contractors to pledge to oppose prostitution;³⁹ and drop most of the controversial language promoting linkages between HIV/AIDS and FP/RH services.⁴⁰

In addition, the “conscience clause”⁴¹ was strengthened, due to fears by conservatives that it was not protective enough for faith-based organization to be excused from participating in programs against which they had a religious or moral objection, and despite concerns by the FP community that it would undercut evidence-based programming. Finally, the Mexico City debate also played out in the reauthorization process, since many antiabortion groups feared that nongovernmental organizations (NGOs) known to advocate for legalization of abortion might be eligible for

³⁸ The original legislation required that one-third of all HIV-prevention funds be spent on “abstinence until marriage” programs. Since there was no accepted definition of the term, nor any scientific evidence that such a requirement would achieve desired results, the term was informally modified to include all program activities involving sexual abstinence, partner reduction, and fidelity to a spouse. Nonetheless, independent studies showed that even in its modified form, the “abstinence earmark” created problems in the field with a negative impact on the program’s effectiveness.

³⁹ In 2003, Congress required that NGOs seeking U.S. HIV/AIDS funds must adopt a formal policy that they do not support “prostitution and sex trafficking.” The provision was initially not enforced against U.S. NGOs because of constitutional concerns. But in 2005, the Justice Department reversed course and extended the requirement to U.S. NGOs. Two lawsuits were filed challenging the requirement; both District Courts found the provision unconstitutional on first amendment grounds because it forced groups to take the government position and restricted the use of private funds. The DKT International case lost on appeal. The second case—joined by the two largest humanitarian and development coalitions, InterAction and the Global Health Council—is on appeal. A preliminary injunction now protects all members of the coalitions, except DKT. It remains to be seen whether the Obama administration will take the same view as the Bush administration in the litigation. The Obama administration will also have the opportunity to revise regulations issued by USAID and HHS that apply to both foreign and domestic NGOs.

⁴⁰ Some prominent FP/RH advocates considered the compromise bill to be unacceptable. Having been so close to what they saw as an important victory that suddenly disappeared, they felt betrayed by those in Congress who they considered to be allies. Their efforts to convince other House allies to restore the controversial provisions were not successful. Speaker Nancy Pelosi (D-CA) decided to back her new chairman, who reportedly persuaded her that this compromise was the best they could do with the White House and that the many good things in the bill made it worthy of support.

⁴¹ The conscience clause in PEPFAR states that groups receiving HIV/AIDS funding do not have to take an approach to prevention, treatment, and care that they find morally objectionable, and preference in funding decisions cannot be given (or taken) based on these objections.

PEPFAR funding for their HIV/AIDS work.⁴² Some observers believe that this possibility, more than any real concern that the United States would begin funding overseas abortions, was the major factor in the aggressive opposition to the FP/RH language.

Abortion Debate

It would be impossible to overstate the role that domestic abortion politics increasingly plays in discussions about the U.S. role internationally in FP programs. The emotional debate in the United States over abortion has led to deep suspicions on both sides. Even the vocabulary used has become a bone of contention. Many members of the pro-life community, for example, consider the term “reproductive health” to include and be code for abortion, since certain international definitions of reproductive health include language about access to safe and legal abortion. During the PEPFAR reauthorization discussions in the Senate, the term “structural prevention” was removed due to concerns by some that it meant abortion.⁴³

Similarly, the argument that money is fungible is frequently used by pro-life groups to prevent U.S. funding to pro-choice groups. They argue that pro-choice groups should have no access to U.S. funding for fear that it will help subsidize a pro-choice agenda and ultimately abortion services. Since some of the organizations working effectively in the field providing FP/RH services also promote legalization of abortion, like the affiliates of the International Planned Parenthood Federation (IPPF) or Marie Stopes International, a priority for pro-life groups is to prevent them from receiving any U.S. funds for any purpose.⁴⁴

⁴² See Presidential Documents, “Assistance for Voluntary Population Planning: Memorandum for the Secretary of State [August 29, 2003],” *Federal Register* 68, no. 170 (September 3, 2003): 52323, http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2003_register&page=52323&position=all.

⁴³ Structural prevention refers to AIDS interventions that seek to change broader societal structures in order to facilitate individual behavior change, including addressing legal reform and other inequities that increase vulnerability to HIV/AIDS. Structural factors affecting HIV include physical, social, cultural, organizational, community, economic, or legal considerations that can both help and harm efforts to prevent HIV infections. See G. Rao Gupta et al., “Understanding and Addressing Structural Factors in HIV Prevention,” *The Lancet* 372, no. 9640 (August 2008): 764–775.

⁴⁴ This fungibility argument has also been applied to providing contraceptive commodities to such groups. This matter emerged in June 2007, when Representative Nita Lowey (D-NY), chair of the House Appropriations Subcommittee that oversees foreign assistance, proposed to modify Mexico City policy to “allow for the provision of contraceptives, not direct funding, to foreign NGOs to help reduce abortion, unintended pregnancy, and the spread of HIV/AIDS.” Lowey stressed the negative impact of Mexico City in many developing countries, noting that U.S. shipments of contraceptives had ceased to 20 countries, including in Africa, which had led to an increase in unintended pregnancy and in women seeking postabortion care. Her proposal was strongly opposed by pro-life members, led by Representative Chris Smith (R-NJ), who saw it as a legislative loophole to Mexico City. Although Lowey prevailed in a 223-201

Abortion politics have also colored the debates on emergency contraception (EC) and the intrauterine device (IUD), due to some controversy as to how they impact a pregnancy. In the past, some medical schools taught that these methods interrupted pregnancy rather than preventing conception, leaving parts of the U.S. population with the erroneous view that these methods are abortifacients. Some pro-life advocates continue to view these methods as abortifacient, meaning that they may stop a pregnancy by interfering with an embryo not yet attached to the uterus. However, the existing evidence does not support these claims. EC is essentially high doses of oral contraceptives, which affect ovulation and prevent fertilization but do not interfere with implantation.⁴⁵ Pro-life advocates question this evidence and argue that this debate will continue in the absence of definitive research studies that are unlikely to be conducted for ethical reasons. Regarding the intrauterine device, scientific studies have shown that it is unlikely that the effectiveness of the IUD results primarily from its capacity to interfere with implantation.⁴⁶ The American College of Obstetricians and Gynecologists also concluded that the IUD is not an abortifacient.⁴⁷

An emerging force in the Congress on the subject of abortion is pro-life Democrats, whose numbers grew in the 2008 elections. Many pro-life Democrats are also pro-contraception as a way to prevent/reduce abortions. As Representative Tim Ryan (D-OH) put it: “The abortion debate in the 21st century needs to be about prevention...prevention and family planning does reduce the number of abortions.”⁴⁸ Ryan is cosponsor of the Reducing the Need for Abortions and Supporting Parents Act (“Ryan-DeLauro”), a bill intended to enable pro-life and pro-choice advocates to find common ground by reducing the number of abortions while protecting personal liberties.

The Language Challenge

The deep suspicion on both sides of the FP debate is strikingly evident in the terminology that is considered to be acceptable. The issue of what words to use and how exactly to define them will require attention from anyone seeking to make a contribution to this contentious issue, including

vote, the matter was dropped in conference with the Senate. See *Congressional Record* 153, no. 101–part II (June 21, 2007), H 6892.

⁴⁵ Family Health International (FHI), “Mechanisms of the Contraceptive Action of Hormonal Methods and Intrauterine Devices (IUDs),” <http://www.fhi.org/en/RH/Pubs/factsheets/mechact.htm>.

⁴⁶ According to a WHO Scientific Group: “It is more probable that they exert their antifertility effects beyond the uterus and interfere with steps in the reproductive process that take place before the ova reach the uterine cavity” (WHO, *Mechanism of Action, Safety and Efficacy of Intrauterine Devices*, Technical Report Series Number 753 [Geneva: WHO, 1987]), as cited in FHI, “Mechanisms of the Contraceptive Action of Hormonal Methods and Intrauterine Devices (IUDs).”

⁴⁷ American College of Obstetricians and Gynecologists (ACOG), *The Intrauterine Device*, ACOG Technical Bulletin Number 104 (Washington, D.C.: ACOG, May 1987).

⁴⁸ *Congressional Record* 153, no. 101 (June 21, 2007), H 6883.

the Obama administration, since it may impact how the new policy is received. Overall, the term “family planning” seems to enjoy wide acceptance, but it is essential to be very specific about what services are included and to be just as specific that current U.S. law prohibits any foreign assistance funds from paying for abortion.

As stated earlier, some pro-life advocates equate “reproductive health” with abortion. Other terms can also raise suspicions. It was noted earlier that the Senate insisted on dropping the term “structural prevention” from the PEPFAR bill. During that time, House staff members were very surprised to discover that some offices believed that “behavior change” meant masturbation training, so they removed that term from the bill. These examples are cited as a caution to anyone seeking to find common ground.

Many public health experts argue for the importance of “reclaiming” any words or terms that are in general use around the world, despite the problems associated with some international definitions. For example, in international discussions about family planning and maternal and child health, the term “reproductive health” is commonly used in both documents and debate. There are undeniably some benefits in being able to use the term, but there are potential costs as well, relating to being able to engage those who might be willing to consider compromise.

One term that has largely lost credibility is “population control,” since it is associated with programs of the past that had a primary objective of lowering birthrates. “Birth control” suffers from some of the same concerns. The problem for both stems in part from evidence that U.S.-funded programs in the past sometimes crossed an ethical line and encouraged coercion of individuals to achieve particular outcomes. These tactics, and the explicit objectives that contributed to them, have been widely discredited in the United States and in the developing countries, where they engendered deep resentment about the United States’ true motives.⁴⁹ But even this area is complicated, since population growth (rather than “control”) is a serious issue for many countries, and an important issue for U.S. policy, with real consequences for health and development programs.⁵⁰ One way to address population growth is indirectly, through expanded access to voluntary FP services. A number of countries continue to use FP for population control within their own health plans, including Nigeria, India, and Bangladesh.

⁴⁹ See Helen Epstein, “The Strange History of Birth Control,” *New York Review of Books*, August 14, 2008.

⁵⁰ Demographic projections predict that the world population, currently 6.7 billion, will rise to 9.2 billion by 2050, assuming declines in fertility and increased access to contraception; otherwise, it is estimated that the population may rise to 12 billion. Most of this population growth is occurring in developing countries, which are already struggling to support their populations. For many of these countries, the consequences of rapid population growth will involve serious strains on health care, education, housing, employment, and natural resources. See PAI, “International Population & Family Planning Programs: An Agenda for the Obama Administration,” November 2008, http://otrans.3cdn.net/ec9bea74765238dadb_v2m6ix0qe.pdf.

“Birth spacing,” with its emphasis on timing births to provide health protection for the mother, infant, and older child, is actually seen favorably in cultures with a high value on children, even as it generally decreases the total number of children born per mother.

Recommendations—the “Common Ground”

Success in expanding U.S. leadership on family planning will require the active involvement of President Obama, top administration officials, and the Congress. If the administration is to accomplish its stated objective of finding common ground on expanding family planning services and reducing the number of unintended pregnancies, without provoking the wrath of either end of this polarized debate, it will have to navigate numerous minefields and carefully separate the issues linked to the abortion debate from the discussions of international FP programs. This delicate task will require keeping a sharp focus on the areas of broad agreement, while making clear that U.S. law prohibits funds from paying for abortion services. All stakeholders will not necessarily embrace every one of these recommendations, but the authors believe that they would enjoy broad support when viewed as a package.

Recommendation 1: Commit to Universal Access to Voluntary FP Services

The U.S. government should commit itself to universal access to voluntary FP services as quickly as possible. The policy is based on indisputable benefits: Women (and couples) control decisions on whether and when to have children; millions of maternal, newborn, and early childhood deaths avoided; millions of abortions avoided; healthier mothers and children; economically stronger families and communities; and key element toward achieving MDGs 1-8.

Recommendation 2: Double U.S. Spending on FP to \$1 Billion

The U.S. government should commit to double U.S. spending for FP to \$1 billion per year as quickly as possible. Develop specific targets and a mechanism to monitor progress.

Recommendation 3: Link FP to Other Global Health Programs

The U.S. government should create appropriate linkages between FP and other government programs, including maternal and child health, HIV/AIDS, RH, food and nutrition, clean water, other infectious diseases, health system strengthening, etc.

Recommendation 4: Develop Partnerships with Community Leaders

The U.S. government should embrace local partnerships and ensure the involvement of community leaders, including women’s groups. Local practices and preferences must be incorporated in program design consistent with the utilization of “best practices.”

Recommendation 5: Encourage Global Embrace of New FP Policy

The U.S. government should take the lead in encouraging international partners to endorse goals of universal access, increased financial support (including dedicated funding mechanisms), and improved program coordination on the ground. The United States should also initiate a global consultation to explore alternative multilateral funding mechanisms for FP.

Related Action Steps for the Administration

If the Obama administration were to embrace the Common Ground policy described, it would benefit from an “action plan” to unveil and implement it. Here are some ideas for such a plan:

- *Announce the “new” comprehensive FP policy in a major speech.* In a public address, announce a new, comprehensive vision for a reinvigorated U.S. approach to family planning based on the “common ground.” The address could be made in connection with the commemoration of the 15th anniversary of the 1995 ICPD in October 2009. The address should reaffirm the consensus benefits of universal access to FP.
- *Engage congressional support.* Recruit four or more members of Congress to constitute a bipartisan, bicameral “Leadership Team” to support the common-ground policy. The team should include persons representing pro-life and pro-choice positions. Encourage the Leadership Team to develop a concurrent resolution in support of the president’s policy.
- *Develop a plan for funding scale-up to \$1 billion.* Develop a timeline and define specific objectives over a period of time. For example, indicate what percentage of the estimated 200 million women in need of FP services will receive access to them as a result of U.S. efforts over the next 5 to 10 years. Identify specific countries, and a programmatic timetable, to develop a fully integrated global health initiative with comprehensive FP services. Develop appropriate indicators to monitor progress and mechanisms to track funding. This includes using evidence and sharing best practices to inform replication and scale-up.
- *Align FP programs with other U.S. health programs.* Use executive powers, and propose legislation as necessary, to link FP services to other U.S. programs including maternal and child health (MCH), PEPFAR, the President’s Malaria Initiative (PMI), as well as those focusing on clean water, and food and nutrition. Alignment in field should include local partnerships.
- *Build bridges among interested parties in the United States.* The outreach plan would include those known to be supportive of FP, as well as conservative and religious leaders willing to publicly support an expanded, “common-ground” U.S. policy on FP.
- *Build international support for universal access on FP and encourage international partners to increase financial support and ensure coordination.*