WHY DOES POPULATION GROWTH MATTER?

**AGING:**
In the least-developed countries, one in 20 people is now over age 60; by 2050, one in nine will be. By 2050, the number of working-age people available to support each person 65 or older will decline by half worldwide, straining government social support and retirement financing.

Source: Population Reference Bureau

**WATER SCARCITY:**
About 508 million people lived in 31 water-stressed or water-scarce countries in 2000. By 2025, 3 billion people will be living in 48 such countries. The number of people living in conditions of water scarcity will double and those living in water stress will increase sixfold.

Source: UNFPA

**URBANIZATION:**
Over the past 10 years, the share of the urban population living in slums in the developing world has declined significantly: from 39 percent in 2000 to 33 percent in 2010. However, in absolute terms, the number of slum dwellers in the developing world is actually growing, and will continue to rise in the near future.

Source: United Nations Population Division

**ENVIRONMENT:**
About one-sixth of the world’s population – close to 1.1 billion people – lives in ecological “hotspots” – lands that are richest in biodiversity and most threatened by human activity. The hotspot-based population is growing nearly 40 percent faster than that of the world as a whole.

Source: Population Action International

**POLITICAL INSTABILITY:**
Countries in which young adults made up a large proportion of the adult population – 40 percent or more – were more than twice as likely to experience an outbreak of civil conflict during the 1990s as those below this benchmark. These youth-bulge countries are in the developing world, which is where more than 90 percent of the world’s population growth is taking place.

Source: Population Action International

**CARBON EMISSIONS:**
The UN Population Division’s medium population growth scenario – a little more than 9 billion people by 2050 – might result in 1 billion to 2 billion more tons of carbon emissions than the low-growth scenario – about 8 billion people by 2050.

Source: National Center for Atmospheric Research

---

7 BILLION WORLD POPULATION IS PROJECTED TO REACH 7 BILLION ON 31 OCTOBER 2011, according to the United Nations Population Division of the Department of Economic and Social Affairs. By 2100, the world population is projected to reach 10.1 billion. PSI recognizes that women’s unmet demand for modern contraceptives is an important contributing factor to high population growth. The map on the right highlights the impact of some of PSI’s family planning interventions that address this unmet demand.

PSI’S 2010 Continued to Modern Cont
Modern methods of contraception include oral contraceptive pills, intrauterine devices, male condoms, female condoms, contraceptive injectables, hormonal implants, vaginal barrier methods, emergency contraception, female and male sterilization, and fertility awareness.

Percentage of women using any modern method of contraception among those aged 15-49 who are married or in a union. The most recent data available is used.

Couple years of protection (CYPs) is the estimated protection provided by contraceptive methods to a couple for one year.

Source: United Nations Population Division

Source: United States Agency for International Development

Professor Babatunde Osotimehin is only the fourth Executive Director of United Nations Population Fund (UNFPA) since the organization became operational in 1969. He brings extensive knowledge and understanding of the global and national frameworks and processes that are critical to UNFPA’s work. He was Professor of Medicine at the University of Ibadan, Nigeria, and the African Spokesperson for the Partnership for Maternal, Newborn and Child Health. Having previously served as Nigeria’s Minister for Health, Prof. Osotimehin was also Director-General of the country’s National Agency for the Control of HIV and AIDS, which coordinates all HIV/AIDS activities in the country. In addition, he was a Visiting Fellow at the Harvard Center for Population and Development Studies. He speaks with PSI President and CEO Karl Hofmann.

KH Where do young people fit into this 7 billion milestone?

BO The momentum of the population growth will depend on how we engage young people globally. Out of the 7 billion we’re talking about, 1.8 billion will be young people (aged 10 to 24) — young people who will determine the growth momentum of the next billions. Ninety percent of them are in the developing world. So, we should ensure that they have access to education and family planning information and services to ensure that they can make decisions about their futures.

KH Demography can be a key to progress with the right policy environment in place, but it can also be a burden when we don’t have the right framework in place to take advantage of growing populations. Some have described this as the demographic dividend — growing populations as a potent driver of economic growth and development. Give us your perspective on that.
In many parts of the world, family planning issues can be very divisive. How do we meet the needs of the 215 million women in the developing world who lack access to modern contraception?

I like the way you framed the question because we’re talking about 215 million women, so the need is there. We in the field need to raise the visibility of this issue globally so donor countries understand that this is urgent and will invest necessary resources. We also need to raise the visibility of this issue in countries where these women live, so that governments can implement programs that reach out to the women. If you break it down to the average community leader in Africa or South Asia that family planning means saving the lives of young women and ensuring that they have healthy children, I don’t think that there is opposition to that.

There are lots of conversations going on in global health circles these days around the synergy of integration. From your perspective, what are the barriers to this integration?

I think it’s bipolar. Some countries are satisfied with vertical programs. Others are resistant to changing their system at the request of a donor. One argument for integration is that you can have the one-stop shop situation where one, two, three trained providers can deliver services at the same time. These include integration of HIV counseling, testing and treatment with family planning, with health education for non-communicable diseases, with immunization for children or with maternity services.

The private sector is responsible for so much of the health that is available, particularly to poor and vulnerable populations. So where does the private sector fit into this conversation?

Private sector organizations could participate in this very actively. I welcome the development of health financing schemes around the world that respond to patients, so they can access health services from any provider, whether it is public or private, as long as the quality of services is good.

I also believe that the private sector is a very strong ally in the delivery system and the strengthening of delivery systems – making sure that they work with the government on commodity supplies and ensuring that economies of scale kick in so that you can actually begin to see reduction in the cost of drugs, condoms or other family planning commodities. Once you have a system that is established and working, it gives the private sector a handle on how to work in a more strategic way with governments.

You know PSI well, particularly through the Society for Family Health, our affiliate in Nigeria. Throughout our 40 years, we have been working to address family planning needs. What can organizations like PSI do better, faster or more efficiently in the years ahead?

What you’ve done well in the past is social marketing. Going forward, you might want to get involved with member states and governments to advocate for appropriate policies and programs that would provide better policy environments for your programs. Often, the knowledge of these issues within government circles is not great, and the turnover with governments is rapid. So, some consistent way of dealing and engaging with governments and policymakers would be a good thing. Working with parliaments is also very important, as they make resource decisions. We can work with you in selected countries to make sure that not only do they have policies and programs in place, but also local resources to provide sustainable support to reproductive health.
Population is on the world’s radar as we near the October 31 milestone of a planet with 7 billion people.

Experts and agencies like the United Nations, World Bank and Population Reference Bureau (PRB) cite startling statistics on future trends in population growth. Developing countries are adding more than 80 million to the population every year, according to PRB. Data from the UN Population Division of the Department of Economic and Social Affairs show that 39 high-fertility countries in Africa, nine in Asia, six in Oceania and four in Latin America are driving this projected increase.

Population has reappeared as a topic in the media and in blogs. National Geographic devoted its January cover to “Population 7 Billion” and is running a series on the issue this year. The U.K.-based Guardian’s environment blog has hosted a series with experts on population and its effects on the environment.

Science Magazine featured a special section, titled “Population,” in its July 29th issue. In his Science article, David E. Bloom, professor of Economics and Demography at the Harvard School of Public Health and PSI board member, writes, “Although the issues immediately confronting developing countries are different from those facing the rich countries, in a globalized world demographic challenges anywhere are demographic challenges everywhere.”

Development organizations and governments are talking population as it relates to their respective priorities: climate change, poverty alleviation, family planning, food scarcity, women and gender equality—all of which we discuss in this issue of Impact.

The world’s population at 7 billion presents complex challenges. Actions taken now will have serious implications on societies and ecosystems for generations to come. As an organization that provides reproductive health services to women in developing countries, PSI sees family planning interventions as a central response to the population question.

The United Nations Population Fund (UNFPA) estimates that some 215 million women in the developing world want to avoid pregnancy but lack access to effective family planning.

“Behind the numbers are the faces of women, and their families, who want nothing more basic than to live a better life by being able to decide when to have children. By failing to listen to them, we are condemning them—women, their partners and their children—to lives of greater misery and poverty,” says PSI President and CEO Karl Hofmann. “Whether and when you consider the range of challenges facing the planet, it is a mistake not to start the response with family planning.”
Faridah is a young mother of five from Uganda. She is raising her children alone, and works hard as a day laborer to provide them with food and clothing. One day, Faridah brought one of her children for immunizations at a local clinic that was a part of ProFam—a branded network of reproductive health providers run by PACE, PSI's affiliate in Uganda.

There, she met Grace, a ProFam midwife, who talked with Faridah about her family planning needs. Faridah explained that, as a single mother, she couldn't afford to have any more children right now. Grace presented her family planning options, and Faridah decided to get an intrauterine device. Faridah chose not to get pregnant, but 215 million women in the developing world do not have that option, as they do not have access to modern methods of family planning.

PSI implements reproductive health programs in 37 developing countries worldwide, supporting women and couples throughout their reproductive life cycles. The programs focus on expanding access to comprehensive contraceptive choices, maternal health products and services, and STI prevention and treatment, while creating strong linkages to other health areas.

Throughout the past three decades, PSI has expanded its portfolio to include a wide range of short- and long-acting family planning products and maternal health interventions. In 2010, PSI’s reproductive health programs prevented approximately 4.2 million unintended pregnancies, averted 23,700 maternal deaths and provided 18.6 million couples with protection against unintended pregnancy for a one-year period.
SMALL INVESTMENTS IN FAMILY PLANNING
CAN PAY BIG DIVIDENDS

According to World Bank statistics, there are currently seven countries – all in the less developed world – with fertility rates of six children per woman or greater; that number jumps to 25 when taking into account all countries with fertility rates of five children or greater. High fertility rates in the developing world are a leading contributor to global population growth. For every 100 people added to the planet, 97 are from less developed countries.1

The UN projects fertility rates in high, medium and low projection variants. For long-term trends the medium variant is considered most likely. According to the medium variant, it will take 13 years to reach 8 billion and 40 years to reach the 10 billion.

Under the high projection variant – which is half a child more than the medium – the world would add a billion people every 10 or 11 years for the rest of the century. While the low variant – which is half a child less than the medium variant – produces a population that reaches 8.1 billion in 2050 and declines towards the second half of this century.4 [See chart on page 9.]

Relatively modest investments in family planning can produce significant differences in the size of populations over time. A study from the Guttmacher Institute calculated the cost of meeting total needs would amount to US$6.7 billion annually – US$3.1 billion for current services and US$3.6 billion for extending those services to all women with unmet need for effective contraceptives.5

Family planning resources have failed to increase relative to the need in developing countries. UN estimates show that foreign aid for family planning and reproductive health has stagnated in the last 10 years. The U.S. has traditionally been the biggest donor, contributing US$668 million in FY2010. But a budget compromise in Congress earlier this year cut international family planning and reproductive health programs by 5 percent for FY2011, according to the Population Institute.

That "unmet need" for family planning is expected to grow by 40 percent in the next 15 years, according to UNFPA. In 2010, the Futures Group analyzed the demographic impact of meeting the unmet need for contraceptive services in 99 developing countries (excluding China) and the U.S., whose combined population in 2005 was 4.3 billion. According to the model, if unmet need were fully met, the average fertility rate would drop to just below the replacement level by 2050.6

POLICY DECISIONS WORTH BILLIONS

UNFPA kicked off its global "7 Billion Actions" campaign in May. At the launch, Executive Director Babatunde Osotimehin said, "Whether we can live together on a healthy planet will depend on the decisions we make now. The date we reach the next billion – and the ones after that – depends on policy and funding decisions made now about maternal and child health care, access to voluntary family planning, girls' education, and expanded opportunities for women and young people."7

A number of experts like Joel Cohen, professor of Population at Rockefeller University, write that universal secondary education, particularly for girls, can play a significant role in influencing population growth.8 One PRB report on women's education and family size found that women in many developing countries who completed secondary school averaged as much as one child fewer per lifetime than those who completed only primary school.8

In Niger in 1998, for example, women who completed secondary education had 32 percent fewer children (on average, 4.6 per lifetime) than those who completed only primary education (6.7), as measured by the total fertility rate.9

India has seen similar trends. Although fertility rates are still high by Western standards, they are on a steady decline. "From 1966 to 2009, contraceptive usage more than tripled and fertility rate declined by more than half," says Deputy Executive Director and Assistant-Secretary-General of UN Women Lakshmi Puri. "A good part of the fertility decline occurred in the southern states, which generally have higher rates of literacy and education along with greater equality for women."

Political stability and the right comprehensive government strategies also play a role in population growth. The world's least developed countries, which currently make up 12 percent of the global population, tend to be the most economically, socially, environmentally and politically fragile countries of the world, Bloom writes in Science.

Throughout the past several decades, the governments of some less developed countries have invested in family planning as part of their national economic development strategies. Through a comprehensive and non-coercive approach to family planning, governments have been able to significantly reduce fertility rates. Indonesia is one good example. In 1960, the fertility rate in Indonesia was 5.7 births per woman, which is about the same as Nigeria today.10

From 1966 onward, the fertility rate began a steady decline as the Indonesian government implemented a national family planning program. The program has evolved over time, but at no point was it compulsory. Through building village-level clinics, training field workers and creating demand through what now might be considered social marketing campaigns, Indonesia was able to sharply reduce its fertility rate. Today, Indonesia's fertility rate stands at 2.1, which is considered long-range replacement level (absent of migration).

Lowering fertility rates required a generation-long commitment on the part of policy makers, NGOs and donors around the world. This shows that even in places where population growth is stubbornly high, non-coercive public policy interventions can markedly lower a country's fertility rate. For countries struggling with their own demographic transitions today, the experience of countries like Indonesia should offer reason for hope.

"Lowering growth paths where the population is growing fastest is possible, and doing so is the difference between the planet having 8 billion people and 10 billion people before it stabilizes," says Hofmann. "That is a huge difference."11

Authors: Mark Goldberg, freelance writer, Washington, D.C., and Mandy McAnally, Associate Manager, Communications, Washington, D.C.
VARIATIONS IN POPULATION GROWTH PROJECTIONS:

Small variations in fertility can produce major differences in the size of populations over time. The high projection variant, whose fertility is just half a child above that of the medium variant, produces a world population of 9.8 billion in 2100. The low variant, whose fertility remains half a child below that of the medium variant, produces a population that reaches 6.2 billion in 2100.

Source: United Nations
With the birth of the 7 billionth human being just around the corner, it’s a good time to pause and reflect on the evolution of global thinking about population and where things stand today. Few subjects have aroused more debate among more diverse actors around the world than this one. And it all began 213 years ago with an essay by the English philosopher and economist, the Rev. Thomas Malthus.

Debates about whether population growth is a good or a bad thing and what can or should be done about it have been raging ever since Malthus first published his Essay on the Principle of Population. As everyone knows, Malthus predicted that the rapid population growth England was experiencing during the Industrial Revolution would inevitably outstrip food production, leading to widespread starvation and rising mortality. He was, of course, wrong, and Malthusian thinking has been suspect ever since. Nonetheless, it has persisted, rising to the level of near consensus among Western thinkers by the mid-20th century in the face of an apparent population explosion, first observed in post-World War II Asia and then throughout the developing world.

As Earth’s population rose from 1 billion around 1800, to 2 billion in 1930, ballooning to 6 billion by 1999, and now, merely 12 years later, reaching 7 billion, alarm about the consequences has been widespread among a diverse array of thinkers: agronomists, climate scientists, ecologists, environmentalists, national security experts and many others. The prospect of further growth to 10 billion by 2100, now projected by the United Nations, only causes additional alarm.

But in the face of the concern that arose in the 1950s and 1960s, perhaps best exemplified by biologist Paul Ehrlich’s 1968 publication, The Population Bomb, an equally vociferous group arose to contest what it saw as the excessive alarmism of these neo-Malthusians, as they were called. Perhaps foremost among them was the late economist Julian Simon, whose book, The Ultimate Resource, reflected the thinking of many other economists, as well as most of the conservative political movement in this country and elsewhere. Simon and his allies held that human ingenuity and technological change have always enabled us to adapt to rising human
numbers and, indeed, to advance and thrive as a consequence of, not despite, population growth. Throughout most of the 1970s and 1980s, and well into the 1990s, the neo-Malthusian view tended to prevail, with the result that many governments in the global south, as well as most donor governments and international agencies, built and sustained strong policies aimed at achieving slower population growth rates and eventual population stabilization. These efforts achieved varying degrees of success in different parts of the world but resulted in an overall decline in total fertility rates in the developing world, from around six children in the mid-1960s to fewer than three today. Perhaps as a consequence of this success, which was reached during the 1990s, and because of a rising tide of anti-Malthusian thinking, attention shifted away from population growth as a global problem in the latter part of the 1990s.

Parallel to the debate about whether population growth should be a cause for alarm has been an equally sharp divide about how to address it. Generally speaking, the two sides have been divided over the question of whether intensified efforts to promote and provide contraceptive use should receive priority, or whether a broader approach that addresses the underlying causes of high fertility should predominate. At issue was the question of whether and to what extent couples are already motivated to limit family size. Everyone could agree that improvement in living standards, and the donors preferring the more limited family planning option.

The UN’s first World Population Conference in Bucharest in 1974, was bitterly divided on the issue, with many developing countries calling for massive infusions of aid to raise overall living standards, and the donors preferring the more limited family planning option.

Over time, a great majority of developing countries did adopt a family planning approach to population policy alongside parallel efforts to, inter alia, raise school enrollment rates for girls, reduce under-five mortality and improve employment opportunities for women. But the strong focus on contraception provoked a reaction from the Roman Catholic Church, which, in its campaigns against family planning programs increasingly conflated family planning services with abortion, thus muddying the waters and creating controversy about family planning where little had previously existed. First the Reagan and then both Bush administrations in the United States, which were by far the largest donors to family planning programs, joined forces with the Vatican in its anti-family planning, anti-abortion crusade.

At the same time as conservative religious and political forces were attacking family planning, the organized international women’s health and rights movement used the International Conference on Population and Development, the third global UN population conference, held in Cairo in 1994, as a platform to launch its attack on the “family planning approach” to population policy, arguing that family planning programs were too narrowly constructed and that their focus on fertility control was, at best, disrespectful of women’s rights and needs and, at worst, coercive. The history of coercive contraception in some Asian countries gave credence to this charge. Cairo produced a worldwide shift away from the emphasis on family planning and toward a broader and somewhat more amorphous “reproductive health approach.”

Where has all this left us? First of all, the evolution in global thinking and policy just outlined has resulted in a major shift of resources away from contraceptive services. Much of this money has, since the 1990s, been devoted to HIV/AIDS treatment and care. The result has been a flattening out of the decline in fertility and a plateau in the use of modern contraception. The momentum that was achieved during the last quarter of the 20th century has pretty much come to an end.

Getting it going again will take considerable political will and commitment of resources. Fortunately, there is some evidence that opinion leaders in various countries are once again becoming persuaded of the need to intensify the provision of family planning services as a means toward both reducing unsustainable rates of population growth and achieving several of the Millennium Development Goals, particularly those aimed at reducing maternal, infant and young child deaths. While renewed interest in family planning and somewhat bigger investments in reproductive health programs are still quite tenuous, there is unmistakable movement in this direction, spurred by rising concerns about the impact of population growth on rapidly rising food prices and greenhouse gases, among other problems. Hopefully, the world has reached a stage of maturity in its discussion about population that nations can avoid being distracted by extreme versions of either the debate about whether population growth is a problem – neo-Malthusian vs. anti-Malthusian hyperbole or the debate about how best to resolve it. That means giving appropriate attention to family planning without entangling it in the abortion controversy, while ensuring that it is embedded in a broader development and reproductive health context.

**Steven Sinding, Ph.D.** retired after serving from 2002 to 2006 as Director-General of the International Planned Parenthood Federation (IPPF), which he is credited with rejuvenating and revitalizing during his tenure. Following a 20-year career at the United States Agency for International Development (USAID), he served as Population Advisor to the World Bank, Director of Population Sciences for the Rockefeller Foundation and Professor of Population and Family Health at Columbia University. He has written extensively on international population matters and is frequently called upon to speak to both academic and general audiences.
Lakshmi Puri joins UN Women following a distinguished career of more than 37 years in economic and development policy-making as well as in political, peace and security, humanitarian and human rights-related diplomacy. More than 20 years of these have been in relation to the UN system. Prior to joining UN Women she held posts at the UN Conference on Trade and Development (UNCTAD) and the UN Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS), and served in the Indian Foreign Service.

**IMPACT:** UN Women is a young organization and you will play an important role in setting its agenda in these early years. What would you like to see the organization accomplish in its first five years?

➤ **LAKSHMI PURI**: UN Women – United Nations Entity for Gender Equality and the Empowerment of Women – is charged with advancing gender equality. By establishing UN Women through a General Assembly resolution, countries have strongly committed to support gender equality and to invest in it. In the next few years, we would like to see the widespread support that established UN Women – from member states, women’s movements, UN system, partners and donors – come together and transform its priorities and mandates into concrete advancement for gender equality at the international and national levels.

**IMPACT:** This year the world’s population reaches 7 billion, with much of that population growth happening in low- and middle-income countries. How has such rapid growth in those countries affected gender equality?

➤ **LP**: Gender inequalities are both a cause and an effect of population growth. For instance, high fertility rates often lead to larger families, reduced opportunities for women to join the labor force, and shorter birth intervals, which can have devastating effects on both maternal and child health.

Interlinked and very important to point out is that gender inequality fuels population growth. Where women are denied full legal, social and economic rights, such as education, secure livelihoods, property ownership and credit, they are forced to rely on childbearing for survival, status and security.

At societal levels, higher population growth increases the pressure on natural resources, food productivity and the need for investments in social services. Women and girls have less access to education and productive resources than men, and with increased competition, they lose out even more. I am particularly concerned about the least developed countries since they are experiencing the fastest growth rate, in spite of high levels of mortality.

**IMPACT:** India’s fertility rate – while still high by Western standards – is on the decline. What can countries with very high fertility rates learn from India’s experience, specifically in regard to its management of gender issues and the promotion of gender equality?

➤ **LP**: In India, better education and family planning have been important priorities for the government. From 1965 to 2009, contraceptive usage more than tripled and fertility rates more than halved. A good part of the fertility decline occurred in the southern states, which generally have higher rates of literacy and education, along with greater equality for women.

Mounting evidence shows that in the context of developing countries like India, the decision on contraceptive acceptance is often shaped at the community level; therefore, it’s necessary to tap into the power of the community to attain social change while continuing to build individual or household capacity. This is true not only in the case of contraceptive acceptance but also in several other developmental issues. Globally, a combination of international family planning programs, growing prosperity and better education of women is widely credited with reducing fertility rates worldwide.

**IMPACT:** Peacebuilding in conflict zones is a core priority of UN Women. Tell us about UN Women’s strategy behind stabilizing conflict zones. What is the link between empowering women and stabilizing these areas?

➤ **LP**: From Nepal to Afghanistan to Sudan, war harms women in multiple ways – from mass rapes to mass displacements. Women are on the frontlines of wars. In the aftermath, it is, however, women who bring families, homes and communities back together. Yet their roles and rights continue to be overlooked at peace talks. Since 1992, less than 10 percent of peace nego-
One of every four newborn deaths around the world is an Indian child, according to new numbers released this week by the World Health Organization (WHO), Save the Children and partners.

In India in the year 2009, more than 900,000 babies died during their first four weeks of life – but this risk of dying is not equal. The poorest families are more than twice as likely to mourn the loss of their newborn baby compared to the wealthiest families. If all of India’s newborns had the same risk of death as the richest fifth of the population, 900 fewer newborns would die each day, reducing newborn deaths by one third. A rural family has a 30 percent higher risk of newborn death than an urban one, despite the increasing challenge of urban poverty in India.

A woman’s chance of her baby dying varies dramatically between the different Indian states. A baby born to a family in the small western state of Goa has a risk of newborn death similar to a baby born in Argentina (9 per 1000 births). A baby born in Chhattisgarh state in central India has a risk similar to an Afghani baby (55 per 1000 births). This is a six-fold difference within one country.

Overall, India ranks highest in the world for the number of newborn deaths, and 166 out of 193 countries for newborn mortality risk. While India is not currently on track to achieve its Millennium Development Goal (MDG) 4 target, to reduce child mortality, by the year 2015, the nation has made progress in reducing child deaths and that pace has increased in recent years.

Progress in reducing deaths for children under five years of age is good news. The bad news, however, is that due to slower progress in reducing newborn deaths, a staggering 52 percent of deaths of children under age five in India are in newborns.

Accelerating progress to reach MDG 4 requires concerted action to reduce these deaths. India has reduced the national neonatal death rate by one-third since 1990 while other countries, such as Nepal and Bangladesh, have more than halved this rate in the same time period.

Reduction in newborn deaths in the 1950s and 1960s in Europe and North America was achieved prior to the introduction of hi-tech, expensive and intensive care. Progress is possible, even in the most challenging circumstances.

Three “killers” account for more than three-quarters of newborn deaths: childbirth complications, preterm birth and infections. For each of these there are highly effective interventions that work as long as there are frontline health workers available with information, simple medicines and basic equipment.

The strategies to reduce newborn deaths vary in different settings, but involve community empowerment, demand creation and bringing care closer to homes, improving care at health facilities, and engaging civil society and policy makers to ensure effective implementation.

India’s poorest families have the highest risk of newborn deaths; yet, these deaths are due to the most preventable causes, such as neonatal tetanus and infections. Paradoxically these are the deaths that can be reduced most quickly with even basic care at birth and newborn care that should be the right of every citizen.

As Gandhi once advised, we should prioritize our next step based on the effect it will have for the “most vulnerable human being we ever saw.” Who can be more vulnerable and voiceless than a newborn baby?

Authors: Joy Lawn and Kate Kerber, Save the Children’s Saving Newborn Lives program

This post originally appears on the Gates Foundation’s new Impatient Optimists blog. It is the second post in a multi-week series that focuses on what the foundation’s partners – including the Healthy Newborn Network, supported by Save the Children’s Saving Newborn Lives program – are doing to address the health needs for women and newborns in India.
For as long as Ramkeshari could remember, it would start, like clockwork, every June. Then, a few years ago, she had to wait until August. Last year, August came and went. She was still waiting.

“Everyone here waits for the rainfall,” Ramkeshari says. “Everyone has his eyes on the sky.”

In Nepal, the very concept of a “rainy season” has become outdated as the climate has changed and weather patterns have become increasingly erratic. Without regular rainfall, the crops ripen differently, and often fail. Ramkeshari, 42, remembers being pulled out of school for weeks as a child because rice paddies had to be planted. Now, many of the farms on the outskirts of Kathmandu are gone, replaced by roads and buildings. Those that still exist are struggling. People are looking elsewhere for work and income.

“We can’t grow and eat from our farms like we used to do before,” Ramkeshari says. “People have to face hunger and other problems relating to health and education. We don’t get to have a quality life.”

As harvests suffer, husbands move to the cities to find work and families are separated. Women must walk farther to fetch water and firewood and find ways to get by with less as they cook and care for children. “They start working right after they wake up and continue on until it is time for them to sleep,” Ramkeshari says.

Dealing with changes beyond their control, women in Ramkeshari’s community are taking control of what they can: their own childbearing. “If people start using contraceptives, then many problems will get condensed,” she explains. “Women are eager. They realize that it is for their own health.”

Family planning is just one tool to help families adapt, together with education, sustainable agriculture and environmental conservation. When their reproductive health needs are met, women are healthier and have healthier children. Being able to choose to delay pregnancy also increases their prospects for completing school and accessing greater economic opportunities.

Ramkeshari sees these positive outcomes in her own daughter, Renu, a college student who hopes to pursue a career in the family planning field. “Times have changed,” Renu says, explaining that many women now want fewer children so that “the resources from the environment are adequate for everyone.”

She and her mother are optimistic, but know things could get harder. The world’s growing population, which will surpass 7 billion people in October, will only increase demands on natural resources and magnify climate challenges.

“I hope that her future will be good,” Ramkeshari says, smiling at her daughter. “But I don’t know for sure what tomorrow is going to bring.”

**CONSEQUENCES OF CLIMATE CHANGE** — floods, droughts, extreme weather, declining agricultural production — affect everyone. But in many developing countries, shifting temperature and precipitation patterns are making life especially hard for women and families. “Weathering Change,” a new documentary from Population Action International, tells the stories of women around the world who are shouldering a disproportionate share of the burden of climate change. One such story follows Ramkeshari Shrethsa.

To watch the trailer for Weathering Change, visit www.weatheringchange.org. The full film will be released September 22.
Mandy McAnally: Nathan, tell us what PAI's new film “Weathering Change” is about.

Nathan Golan: The film is specifically about how women are dealing with climate change now. The reason we're focusing on women is because women tend to be the ones who are most affected. They're the ones gathering firewood, they're the ones gathering water, and largely, they're the ones doing the agricultural work. So, any change in rain patterns and temperature usually tends to affect them more so than anyone else.

Mandy McAnally: Did you know a lot about this subject before you started?

Nathan Golan: I'd seen headlines and I had read articles, but our goal was really just to go and see what we would find. And it wasn't hard finding the story. The communities where we filmed had a story to tell about climate change. It wasn't hard to see it beyond the anecdotal evidence. For example, we filmed in Peru during the winter, but you can literally see the heat waves over the mountains where the snow is receding. So, when you have people telling stories like the ones you hear in the film and you can literally see what it is they're telling you, I think that made for a very powerful final presentation.

Mandy McAnally: Michael, do you find that the stories really hit home more than the data?

Michael Khoo: It's a great contrast to the ways things are talked about, say, in Washington, D.C., or even in American politics. The climate change issue is debated back and forth. It's very contentious, people question all aspects of the facts. But when you go to somebody like Radhika, the first woman who's interviewed in the film, there's just no argument to be had. She's experiencing this and that's all that matters. What people really connect with is just the look on her face, the struggle that you see she goes through every day, and you think of how you can help.

Mandy McAnally: What are the main messages you want audiences to walk away with?

Nathan Golan: Well, the main message that I walked away with after working on this project is that climate change isn't theoretical; it's something that people are dealing with. While we debate and have conversations about climate change, there are a lot of people on this planet right now who are having to face the reality of it, and it's significantly changing their lives.

Michael Khoo: The line that Nathan liked most from all filming and that ended up being the final line was by Aragash, the woman interviewed in Ethiopia. She says, “Life is hard for a woman; climate change is making it harder.” And that really became the whole coalescing purpose of the film. Although women are making some progress at some levels, climate change threatens to stop all that progress.

Mandy McAnally: How do you make delicately the link to climate change and population, since it is a sensitive connection to make?

Nathan Golan: Before we turned the camera on, we talked to the women about the issues that were affecting their lives. Climate was one of them, education was one of them, obviously poverty was one of them, and they also talked openly about family planning. Like you said, it is a delicate subject in some places, but we didn't find that at all. These women were very open about family planning. In fact when we found Aragash and Radhika, we thought they were really great women to tell the story because they're so passionate, open and sincere. Later, we found out they provided education about family planning as volunteers.

Michael Khoo: And family planning is one of the critical tools for women's empowerment, which is broadly what the film is about – how the empowerment of women is being threatened by climate. They're policy connections if you break it down to those of us doing lobbying on U.S. government policy. For these women, it's just a very direct, visceral, daily connection on what it takes to empower them so that they can take care of their families, which is something that everybody can agree on.

Listen to the complete interview on e-Impact, www.psi.org/impact7

About PAI

Population Action International advocates for women and families to have access to contraception in order to improve their health, reduce poverty and protect their environment. PAI's research and advocacy strengthen U.S. and international assistance for family planning. The organization works with local and national leaders in developing countries to improve their reproductive health-care programs and policies. PAI shows how these programs are critical to global concerns, such as preventing HIV, combating the effects of environmental degradation and climate change, and strengthening national security.
There are now an estimated 925 million undernourished people in the world.

Source: Food and Agriculture Organization of the United Nations (FAO)

The rate of growth in agricultural production is expected to fall to 1.5% between now and 2030 and further to 0.9% between 2030 and 2050, as compared with 2.3% per year since 1961.

Throughout the next 41 years, agricultural production would need to grow globally by 70%, and more specifically by almost 100% in developing countries, to feed the growing population.

Source: FAO

By 2050 the world’s population will be 34% higher than today, and about 70% of the world’s population will be urban (compared with 49% percent today). Income levels will be many multiples of what they are now. In order to feed this larger, more urban and richer population:

• Food production must increase by 70%;
• Annual cereal production will need to rise to about 3 billion tons from 2.1 billion today; and
• Annual meat production will need to rise by more than 200 million tons to reach 470 million tons.

Source: FAO

About one in four children under the age of five are underweight, mainly due to lack of food and quality food, inadequate water, sanitation and health services, and poor care and feeding practices.

Source: United Nations
The Domino Effect: Food Security

Dr. David Nabarro

Special Representative of the UN Secretary-General for Food Security and Nutrition

Dr. David Nabarro was appointed Special Representative of the UN Secretary-General for Food Security and Nutrition in 2009. Throughout his career, Dr. Nabarro has promoted greater equity in health and development by encouraging the implementation of evidence-based strategies, combined work of intergovernmental bodies and political leadership from community-centered actors. He joined the office of the UN Secretary-General as Senior Coordinator for Avian and Pandemic Influenza in 2005. In the past, he led WHO’s Roll Back Malaria and Department for Health Action in Crises, coordinating worldwide support for health aspects of crises preparedness, response and recovery. Dr. Nabarro speaks with PSI’s Chief Liaison Officer and Senior Vice President Sally Cowal.

Sally Cowal: Can you set the scene for us? What is the scale and the nature of the global nutrition problem?

Dr. David Nabarro: We start from the reality that the world’s food systems are not working as well as they should. So although there is enough food to go around at the moment, there are about 1 billion people chronically hungry. This means they don’t get enough food in their homes to feed their families at least two good meals a day. Most of these 1 billion are also at risk of undernutrition.

As the world population approaches 7 billion people, what links do you see between population growth and food security?

Dr. David Nabarro: Demand is rising for two reasons in our modern world: one is population growth. It’s not going to go on growing forever, but it’s certainly going to grow until 2050. It might stabilize then between 9, 10, 11 billion. The second reason why demand is increasing is that there are certain parts of society that are moving into a more affluent lifestyle with diets that include more meat. Meat, in return, requires cereal, because domestic livestock are typically fed on cereal. People are consuming food that is more demanding in terms of what is needed to make it, to develop it. So both the increase in population and the growing affluence in population are factors in that demand.

Tell me, as a physician, what effect does undernutrition have on a person’s health and development?

Dr. David Nabarro: To speak as a medic, the simple language that I use is that you need adequate nutrients in your body for growth, for work, for repair and, of course, for maintaining body functions. Our bodies are quite efficient in that they tend not to need too much in the way of energy or nutrients for body functions, but if they’re deficient in a key nutrient, like vitamin A or zinc or iron, the function can get impaired very quickly. Micronutrient deficiency is a very pernicious and unpleasant determinant of the function. We pay a lot of attention to that and recently have been looking for ways to deal with micronutrient deficiency.

What kinds of nutritional interventions are working best to address the macro food security and an individual’s undernutrition?

Dr. David Nabarro: The combination of direct nutritional interventions and nutrition-sensitive policies in a range of different sectors are better for nutrition. Food security may be complex, but in summary it’s about ensuring that sufficient food is produced, ensuring that all households can access that food, ensuring they can use that food to get adequately nourished and ensuring stability of supply and access. But to get there, we need a combination of many different actions – and it is easy to work them out if we consider food security from the perspective of the individual and the household.

So are these then the objectives of the Scale Up Nutrition (SUN) movement?

Dr. David Nabarro: The Scale Up Nutrition movement is an attempt to build a more concerted and coordinated approach to addressing nutrition. The idea is to get a unified policy framework in which stakeholders from a variety of sectors can work together on the issue. There is something interesting here for all – stakeholders can plug themselves into six task forces and two focus groups to scale up nutrition.

PSI is convinced by your argument and those of The Lancet and others that nutrition is an enormous challenge and one that we should all get behind. We are beginning to look at ways in which we could bring what we have to offer to this movement. So we’ll be looking for your guidance.

PSI is a very important organization, and I’m happy that you’re prepared to think about coming on board. We are counting on you to work in it. The three things I like about PSI are firstly, you are fearless and go to places where others aren’t set to go. Secondly, you are marketeers and you believe in the power of markets. And thirdly, you believe in, and are good at, social marketing and franchising which are approaches that sure have an application in the worldwide effort to combat under-nutrition.

I have confidence in your ability to move this forward on a world scale. So it gives me hope.

Although there is enough food to go around at the moment, there are about 1 billion people chronically hungry.

psi.org | impact 17
The sustained increase in the number of young people in the least developed countries represents a difficult challenge for the labor market, considering that the working-age population of the least developed countries (LDCs) is expected to increase by more than 200 million people from 2010 to 2025.

Source: UNFPA and UN Population Division

Increase in poverty is often an indirect effect of population growth. An estimated 20-25 percent of the world's population lives in absolute poverty, defined as per capita income of less than US$370 a year. More than 90 percent of those people live in developing countries, which are experiencing more than 90 percent of the world's population growth.

Source: United Nations Centre for Human Settlements

In 56 developing countries, the poorest one-fifth of women still average six births, compared with 3.2 in the wealthiest quintile.

Source: UNFPA
In a few years’ time, the workforce population in India will outnumber the Chinese workforce. How do you see this shift affecting the global economy, if at all?

ROBERT GREENHILL: It depends whether the growth in the number of people becomes reflected in the number of attendees in primary schools, high schools and eventually universities. If India ends up having the same number of high school graduates as China, it could have a tremendous impact in terms of the economic growth of India as a major source of consumption, production and innovation. If there isn’t the increase in education, China will continue to outstrip India well into the foreseeable future. The challenge up until recently has been that it’s a two-speed development where urban areas have had increasing levels of education but significant rural areas still lag behind many other countries.

KATE ROBERTS: In these states it’s so important for families to get access and options for family planning.

ROBERT GREENHILL: Sure. The empowerment of women and families – choices of how many children to have and when to have them – and the full support for those children to get the pre- and postnatal care and education they deserve is fundamental to the economic growth of these countries.

What can a platform like the World Economic Forum do to raise awareness around issues relating to population growth and family planning?

ROBERT GREENHILL: Our role is to be a convener so different stakeholders can hear important issues and debate their consequences. We have a very active global agenda council focused on the issue of population growth that shares its views within the Forum community and more broadly as well. We also deal in many of our regional summits specifically on the issue of demographics. There’s no doubt there can be sensitivity around this issue but those are there around many other issues that we try to address, such as sustainability and climate change. In these cases our role is to provide a platform for these critical issues to be debated.

Governments are increasingly calling on the private sector to help solve public health issues. What role can the corporate world play in addressing global challenges related to population growth?

ROBERT GREENHILL: Accelerating economic opportunity and education are ways to both encourage reduced fertility and produce economic growth. Corporations have a very important role to play there by helping to accelerate the development of many of these poor communities.

“HIGH FERTILITY MAKES IT VERY DIFFICULT FOR THESE COUNTRIES TO ENJOY THE ECONOMIC GROWTH THAT WOULD COME FROM THE DEMOGRAPHIC DIVIDEND OF A YOUTHFUL POPULATION WITH FEWER CHILDREN PER FAMILY.”
COMPLEX PROBLEMS, SIMPLE SOLUTIONS

In October 1999, the seventh Secretary-General of the UN, Kofi Annan, traveled to Sarajevo to welcome the world’s 6 billionth person amid widespread nervousness around the new millennium about the world’s future. A public relations success, to be sure, but ultimately the event marked the beginning of nearly 10 years of what the United Nations recently labeled as failure in increasing funding for family planning programs in the developing world. By 2008, donor support for family planning programs remained below 2000 levels, despite unintended pregnancies adding an astonishing 75 million people per year.
At PSI, it is a bit hard to argue that funding for family planning during this period was inadequate or led to failure in our efforts to increase access and demand for modern methods of contraception. After all, PSI managed to increase the number of couples we serve with contraceptives in the decade starting in 2000 from about 8 million to more than 18 million, a 10-year growth rate of approximately 11 percent at a cost of about US$15 per couple. We publish these results monthly and annually in our health impact and cost-effectiveness reports at <www.psi.org>.

Undoubtedly, unintended pregnancies and unmet need for contraception are too high and the consequences for women, their families and communities are enormous. PSI and many other organizations could have done more with more resources.

Yet, in the midst of the public events and stirring calls for further support for family planning surrounding the birth of the 7 billionth person, it is worth reflecting for a moment on the conclusions of a simple case study recently published in the journal Contraception by our colleagues Josselyn Neukom, Jully Chilambwe, Joseph Mkandawire and their partners at the Zambian Ministry of Health and Family Health International. Their study shows the fresh approaches happening today on the frontline of family planning service delivery within PSI and how efforts to reduce unmet need for contraception are succeeding despite funding and other constraints.

The case study describes Zambia as typifying family planning programs in many sub-Saharan African countries. Just more than 20 percent of reproductive-aged women use modern methods of contraception, a rate increasing at about 1 percent per year. The most popular methods are condoms and oral and injectable contraceptives, whose high levels of effectiveness can be compromised by supply shortages or inconvenience, among other things. Intrauterine devices (IUDs) and hormonal implants, “long-acting, reversible contraception,” overcome those problems, but use rates for these were very low in Zambia, like elsewhere in sub-Saharan Africa, despite multiple pilot scale efforts throughout the past 30 years. Neukom and colleagues asked why.

Neukom and her colleagues steered clear of debate about the relative importance of demand or supply side barriers to family planning uptake. Instead they went to public health facilities where women were waiting for family planning and other maternal and child health services and spoke to them and the providers there about obstacles to getting the family planning method the women wanted. Those conversations led to a “dedicated provider” program to overcome barriers to adopting long-acting, reversible contraception. Their plan was to employ midwives to answer a litany of personal questions from women waiting for health services about long-acting, reversible methods and then to use these dedicated staff to deliver the services “on demand.” Nothing fancy. Just a personal service that all of us appreciate.

As Samuel Johnson said, the applause of a single human being is of great consequence. In 14 months, at a cost of about US$13 per couple year of protection, the dedicated provider program served more than 30,000 clients, with about half shifting from the short-acting to the more effective long-acting methods and the remainder shifting from not using to using contraception. Implant users were markedly younger and had fewer children than the average long-acting method user, demonstrating that new populations were being reached. By these and other metrics, the dedicated provider program met the criteria of high performance – a large-scale intervention, serving low-income and needy clients, cost effectively, with an ability to become a national effort.

The authors concluded that “although many elements of the program came together to make it successful, the role of the provider is perhaps most important.”

“We hired enthusiastic providers committed to contraceptive choice and gave them excellent supervision and support to do their work.”

Yes, the arrival of the 7 billionth person and the likely consequences of the tens of millions of additional human beings arriving each year is startling. Yes, the tens of millions of unintended pregnancies and women with unmet need for contraception point to the need for millions in additional resources for family planning in the developing world.

Yet, amid these large numbers, the lesson here for family planning at PSI is not demographic in scale. It is the individual, and her or his specific needs, as a client or a provider, who counts the most.
Amid the technical discussions on global population growth, it is possible to forget how these issues directly impact women. Rose, Ingrid and Samina are three women who have made informed decisions on how to create and raise a family in a way that protects the health of their bodies, households and communities.
**ROSE**

**ROSE MSAMBALA COMES FROM A FAMILY OF FIVE CHILDREN.** When she was very young, her father left her mother. Since Rose’s mother didn’t have much money, she couldn’t afford to send her children to school. Once Rose finished primary school, which is free in Tanzania, her education came to an end.

Rose, now a 30-year-old mother of two daughters, wants more for her children: “I want them to receive a proper education. I don’t want to have a large family I can’t afford to take care of,” she says.

About 10 minutes from where Rose lives in Magomeni, Dar es Salaam, is a private health center. One day, she heard that people were coming to the clinic to talk about family planning.

“At first, I was a bit scared. I had heard so many rumors about bad side effects from family planning methods,” says Rose. “But I went to the clinic anyway. There were a lot of women there.”

The staff at the clinic talked to the women about family planning and eased their concerns about side effects. Afterwards, they provided counseling sessions to the women who were interested in a long-acting and reversible contraceptive method, such as an IUD or implant.

That day, Rose chose to have an IUD inserted. “At first, I didn’t tell my husband because I thought he would want more kids. He just found out about it recently, and he was okay with my decision.”

Rose wants to keep using family planning for a few more years. Then she wants to have a third child.

“I feel better when I’m using family planning. I look at my daughters, and all I want is for them to be healthy and educated. I want them to grow up and have a better life,” she says. “I have hope.”

---

**THE AVERAGE TANZANIAN WOMAN HAS 5.4 CHILDREN** during her lifetime (Demographic and Health Surveys 2010).

With its 9 million women of reproductive age, Tanzania is expected to have one of the highest fertility rates in the world by 2050.

However, about 50 percent of mothers in Tanzania deliver at home – most of them without access to skilled birth care.

As a result, the maternal mortality ratio for Tanzania is 454 deaths per 100,000 live births; that’s more than 21 deaths per day (DHS 2010). The government of Tanzania is committed to reducing the maternal and child death rates in Tanzania. PSI/Tanzania works with the Tanzanian government to train private sector providers to offer long-acting reversible contraceptive methods (LARCs) for family planning, specifically IUDs and implants.

In addition, they help equip private health facilities with the supplies necessary to provide LARC insertion services and create demand for family planning services through mass media and interpersonal communications activities.

In 2010 alone, PSI was able to provide a LARC method to 13,626 women like Rose.

---

**PSI Authors:** Jyoti Kulangara, Corporate Marketing & Communication, Washington, D.C., Dr. Mashafi, Medical Advisor, Reproductive Health team, PSI/Tanzania, Tanzania, and Gaston Shayo, Corporate Affairs, PSI/Tanzania, Tanzania
INGRID

INGRID IDALIA MONTES ALVARADO, a 44-year-old mother of seven from a poor neighborhood in Guatemala City, had tried just about every family planning method.

She used condoms and different forms of hormonal short-term contraceptives, but she experienced side effects each time. And each time, Ingrid got pregnant.

“Each child is beautiful. They are all so beautiful,” says Ingrid. “But when one gets sick, sometimes you don’t have what you need to take care of them. Sometimes there’s not even enough bread or water to give them.”

After their sixth child was born, Ingrid and her husband decided they couldn’t afford to have any more children; she didn’t work and her husband was a day laborer. But they were confronted with a lack of access to information and effective contraceptive options. That’s when Ingrid got pregnant with her seventh child.

Ingrid and her husband aren’t alone. In Guatemala, 20.8 percent of married women who want to use a contraceptive method are unable to access it.

One day, Ingrid saw a flyer for a health clinic day about family planning methods organized by the Pan-American Social Marketing Organization (PASMO), PSI’s affiliate in Central America. Ingrid went to learn about her family planning options, especially long-term methods, such as implants and the intrauterine device (IUD).

She had heard about the IUD, called “Copper T” because of its shape, but had many misconceptions about it—one in particular claimed that babies would be born with the IUD in their forehead.

At the health clinic day, PASMO counselors informed Ingrid about all of her family planning options, including hormonal and short-term methods, such as injectable and oral contraceptives, and addressed the myths. Ingrid chose to get an IUD inserted. Since then, she hasn’t been pregnant and hasn’t had any side effects.

Now, three of her children are married. Ingrid educates all of them about using contraception.

“I told my daughter to have two children,” says Ingrid. “Have two until they’re 10 or a certain age, and then you can decide if you’re going to have more.”

One of Ingrid’s daughters now uses the IUD and her daughter-in-law uses a contraceptive implant.

PSI Authors: Jyoti Kulangara, Coordinator, Corporate Marketing and Communications, Washington, D.C., and PASMO team, Guatemala

INGRID’S STORY IS NOT UNCOMMON IN GUATEMALA, a country characterized by a high unintended pregnancy rate of 43 percent. This trend is driven in part by the low proportion of Guatemalan women using contraception. The country’s modern contraceptive prevalence rate (CPR) of 29.3 percent is one of the lowest in the Western hemisphere.

In order to meet the contraceptive needs of women in Guatemala, PASMO provides a supply of low-cost IUDs and implants through the private sector. The PASMO staff also train health professionals to provide balanced, high-quality family planning counseling and services, including for long-acting reversible contraceptive methods (LARCs), in public, private and NGO clinics.

Last year, PASMO in Guatemala delivered 12,683 LARCs, with more than 80 percent of women choosing IUDs.

PSI Authors: Jyoti Kulangara, Coordinator, Corporate Marketing and Communications, Washington, D.C., and PASMO team, Guatemala

It was late in the evening when Samina started feeling labor pains from her first pregnancy. Samina lives with her parents in the Dera Ghazi Khan district of Pakistan. Since the women in her neighborhood delivered at home, she prepared to do the same.

By the following morning, the baby was still not born. As Samina’s condition worsened, her mother telephoned Nagma, the area’s female health worker. As she waited for Nagma to arrive, Samina’s mother felt helpless.

More than three-quarters of births in Pakistan take place at home. Maternal mortality is estimated to be 279 per 100,000 live births and infant mortality is 78 per 1,000 live births (Pakistan Demographic and Health Survey 2006-07).

These health indicators, coupled with Pakistan’s large and fast-growing population, which is expected to double by mid-century, do not bode well for its women.

To help reduce maternal and infant mortality, Greenstar Social Marketing, PSI’s local affiliate in Pakistan, along with the Pakistan Initiative for Mothers and Newborns (PAIMAN – a USAID-funded, John Snow International-led project), began implementing a pilot voucher program.

Women, like Samina, from resource-poor communities purchase the Sehat (Urdu for “health”) vouchers at a highly subsidized price, entitling them to reproductive health services from private health providers that are part of Greenstar Social Marketing’s provider network.

When a woman uses the voucher at the clinic, the health-care provider gives her money to pay for transport costs. The woman pays nothing out of pocket for the health services. Greenstar reimburses the provider for the transportation costs and pays for the services provided.

The Dera Ghazi Khan district, where Samina lived, was selected as the pilot for the Sehat voucher scheme. It was a low-income district with the highest unmet need in Pakistan.

Samina was one of the women who had purchased this voucher. When Nagma saw the Greenstar voucher, she called the staff, who instructed her to take Samina to the hospital immediately. The Greenstar staff also contacted Dr. Numera, the physician who was assigned to Samina.

At the hospital, Dr. Numera found Samina in severe pain, lethargic, dehydrated and very anemic. Complications continued to develop. Samina had obstructed labor and her baby was in severe distress. Dr. Numera performed an episiotomy, allowing for a normal delivery. However, the baby, who was unconscious and didn’t cry, had to be revived with CPR and oxygen. Samina then had postpartum hemorrhage, or severe bleeding after the birth, and was given emergency treatment. Greenstar staff found someone in the hospital willing to donate blood. In the end, both mother and baby survived.

Samina was one of the 1,968 women who had purchased the vouchers and gave birth in a health facility during the pilot.
INVESTING IN GLOBAL HEALTH

Given the current fiscal challenges facing the United States, it is more important than ever that we invest in proven-effective global health programs, which, beyond their global impact, are also cost-effective and critical to national security. Even with limited funding, global health programs have and continue to make a significant difference in the lives of millions of individuals throughout the world. As such, it's vital that robust funding for global health programs remain a key priority during the FY2012 appropriations cycle.

Today, there are still approximately 215 million women in developing countries who want contraception but lack access to family planning services—a demand that is projected to rise 40 percent by 2050. It is critical that the U.S. make a real investment in family planning programs. Providing access to family planning services strengthens our efforts to decrease maternal and child mortality, reduce mother-to-child transmission of HIV and combat gender-based violence. It also supports our broader development goals, including slowing population growth, easing pressure on natural resources and helping to create a healthier, more sustainable environment. Our nation’s investment in international family planning has had a significant and sustained impact. U.S. assistance in 2011 will help prevent 11.7 million unintended pregnancies, 140,000 children from losing their mothers and 32,000 women from dying. And these investments are highly cost-effective.

The U.S. must also continue to support the critical role of UNFPA, which is the largest multilateral provider of family planning and reproductive health services. UNFPA works in more than 150 countries to prevent maternal mortality, expand access to contraceptives and improve the status of women.

At the same time, nearly 900 million individuals throughout the world do not have access to safe drinking water, which, together with inadequate sanitation and hygiene is an overwhelming contributor to the 1.5 million child deaths each year from diarrheal disease alone. Investment in water, sanitation and hygiene (WASH) programs is extremely cost-effective, and with every US$1 spent, there is a return of $8 in economic productivity and savings in healthcare costs.

Robust funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria is also imperative to addressing the global burden of infectious diseases.

We must also remember that non-communicable diseases (NCDs) account for 63 percent of all deaths globally. NCDs, including diabetes, cardiovascular disease, cancer and lung disease, resulted in the deaths of more than 36 million people in 2008 alone, with nearly 80 percent of these deaths occurring in low- and middle-income countries. Funding for health services is crucial to addressing the scale of this problem.

PSI directly implements programs that target malaria, child survival, HIV, Tuberculosis, reproductive health, water sanitation and non-communicable diseases. Through evidence-based interventions, many PSI platforms engage in advocacy efforts that help to improve the health and well-being of vulnerable populations around the world. Our experience of being involved in successful and lifesaving initiatives for more than 40 years tells us that with adequate funding, we can achieve substantial progress in global health. In 2010 alone, PSI prevented approximately 29 million episodes of malaria, 4 million cases of diarrhea and roughly 180,000 HIV infections. As such, we must continue our efforts to bring attention to the importance of investing in global health programs.

While resources are limited, smart investments in effective and sustainable global health programs are cost-effective, and bring about significant results both internationally and nationally.

PSI Author: Scott Thompson, Associate Manager, Communications, Washington, D.C.
**LOCAL PROVIDERS TO FILL THE GAP IN FAMILY PLANNING SERVICES**

Current estimates show an unmet need for family planning that reaches 215 million women in the developing world today. To respond to this need, the U.S. Agency for International Development (USAID) has launched a centrally funded project, called Support for International Family Planning Organizations (SIFPO).

The project will provide support to PSI and Marie Stopes International (MSI) to build their capacity in family planning services and programming.

The purpose of the project is to increase the use of family planning services globally through strengthening selected international family planning organizations that have a global reach and an extensive, multicountry network of family planning clinics. PSI’s vision under SIFPO is to enhance scale-up of high-quality family planning service delivery. Working through its 21 social franchise clinic networks, PSI will expand contraceptive choice to include long-acting and permanent methods. SIFPO core funds as well as field-based funding will support efforts to develop local leaders who will scale up family planning services through social franchising and gender-sensitive programming.

One of these leaders is Dr. Milly Kaggwa from PACE, PSI’s affiliate in Uganda. Dr. Kaggwa provides support to PACE’s large family planning program that delivered an estimated 14,200 intrauterine devices (IUDs) and 7,800 contraceptive implants in 2010. According to UNICEF data, the total fertility rate in Uganda in 2009 was 6.3 children per woman, down slightly from 7.1 in 1990. The PACE family planning program team helped to avert approximately 45,600 unintended pregnancies and provided 153,000 couple years of protection (CYP) through its family planning program in 2010. A CYP is the estimated protection provided by contraceptive methods for one year to a couple.

In March, Dr. Kaggwa was one of six PSI reproductive health specialists who attended a SIFPO-funded training in Washington, D.C., on techniques for coaching and mentoring local staff in quality assurance and quality improvement of family planning programs. In the past, PSI has used outside experts (mainly from the U.S. and Europe) to provide quality assurance audits and quality improvement planning to field programs. The training program greatly increased PSI’s internal capacity in quality assurance auditing.

Referring to the PSI quality assurance audit training, Dr. Kaggwa said, “It was a great opportunity to learn from other PSI staff and to build my skills in providing quality assurance support to not only my program but also other PSI programs.” Dr. Kaggwa also noted the importance of service delivery programs. “Family planning service delivery programs fill a gap by providing long-acting and reversible methods such as IUDs and implants, which increases contraceptive options available to women and the likelihood that they will choose a method that they can easily adhere to.”

**PSI Author:** Christine Bixiones, Senior Associate Technical Advisor, Sexual, Reproductive Health & TB, Washington, D.C.
The economic downturn exhibited across many European states has people concerned that Europe’s overall development support will contract dramatically. While some countries have indeed had to initiate austerity measures, overall foreign aid spending among the European states remains vigorous, but with more emphasis on results and transparency.

A couple of recent public events support this premise. In a surprisingly upbeat speech given by United Kingdom’s Secretary of State for International Development Andrew Mitchell earlier this summer, he detailed his government’s commitment to international development, stressing how it was going to be “smarter about how we spend money, sharper in our focus, tougher in our approach and more inclusive in our partnerships.” The Secretary also highlighted transparency measures that will allow British taxpayers as well as the recipients of British aid open access to program evaluations, with results that can be easily interpreted and commented on by all.

The second event was the United States-European Union (U.S.-EU) High Level Consultative Group Meeting held in June. EU Commissioner for Development Andris Piebalgs and United States Agency for International Development Administrator Dr. Rajiv Shah stated in a joint press release: “At a time of economic constraints, we are determined to deepen our cooperation to increase the impact of our aid and to ensure measurable results on the ground.”

The press release also detailed the new U.S.-EU joint work plan on Division of Labor, Transparency and Accountability. Like the U.K. Department for International Development, the U.S. and EU “will make user-friendly information about our development assistance available to all and promote transparency in multilateral institutions. We will strengthen evaluations of our development activities and we will rationalize who does what in agreement with our developing country partners.”

During these lean times, politicians have had to become more attuned to the demands of their increasingly sensitive constituents, positively affecting what hopefully will be a significant new era of development.

**PSI Author:** Michael Chommie, Director, PSI/Europe, Amsterdam

In 2008, PSI received funding from the Dutch government’s Strategic Alliances with International NGOs (SALIN) initiative to support reproductive health programming in 12 countries. SALIN has allowed thousands of women in these countries to make informed choices about their health and their families. One of these women was 35-year-old Mariam Sangare; she has already had 13 pregnancies. Mariam was able to learn about her options and eventually chose a free implant.

The three-year SALIN initiative, combined with additional donor support, enabled PSI and its partners to avert more than 1 million unintended pregnancies and prevent thousands of deaths.
The challenge of providing basic services in countries across Africa, like Ethiopia, Kenya, Malawi, Niger and Uganda – where the populations will at least double, sometimes triple and, in Niger, quadruple – will be immense.

Globally, around one-third of pregnancies are unintended. Some 215 million women in the developing world say that they would like to delay or avoid pregnancy, but do not have access to modern family planning methods.

Meeting the unmet demand for family planning is not only integral to reducing the global fertility rate and the rapid growth of the world’s population, but it is also one of the most effective ways we can tackle the scandal of maternal mortality in the world’s poorest countries.

Last year, on a visit to a health clinic in Rwanda, I watched women queue for pregnancy tests and cheer when the results were negative – when they realized they would not have to risk their life by having a baby.

The reality is that, among the poorest women, high fertility is inextricably linked to high maternal mortality. Our shared mission is to start to change that reality.

The U.K. government is putting women and girls at the heart of its international development efforts. Our strategy — Choices for Women — sets out a vision for the developing world where all women are able to exercise choice regarding the size and timing of their families, where no woman dies giving birth and where all newborns survive and thrive.

We are doubling our efforts for women’s and newborn’s health in order to save the lives of at least 50,000 women in pregnancy and childbirth, and 250,000 newborn babies, by 2015.

Working with partners like PSI, British aid will enable at least 10 million more women to use modern methods of family planning by 2015, contributing to a wider global goal of 100 million.

Family planning is cost effective and saves women’s lives. Globally, meeting the unmet need for family planning could avoid around one-third of maternal deaths and one-fifth of newborn deaths, and save an estimated US$5.1 billion.

There is also overwhelming evidence of the wider benefits of family planning. For example, if a woman is able to wait three years between giving birth, the chances of her baby dying in its first year are greatly reduced.

Improving reproductive and maternal health is the linchpin of poverty eradication. It is only through giving women greater choice and access to family planning and safer births that we will lift communities from desperate poverty.

I am proud that the U.K. government is working with PSI and a range of other donors and organizations to give women in the developing world the same choices that they have in the U.K.
HOW DOES POPULATION GROWTH AFFECT GENDER INEQUALITY?

BY DONNA HICKS

On the other hand, in areas where women continue to be de-valued, in spite of commitments by countries to close gender inequality gaps, there will continue to be higher population growth, which will perpetuate the poverty and second-class status of women.

Although some countries have made progress in closing the inequality gap, other countries continue treating women in an inhumane manner, with little to no access to adequate health care, education or even basic needs. However, eliminating gender inequality can slow population growth. In “A Sad Worldwide Gender Gap,” Cesar Chelela states that “smaller families mean slower population growth, which in turn diminishes competition for natural resources.” Indeed, if we commit to urgent action to end gender inequality worldwide, women would be empowered and countries would benefit from slower population growth and faster economic development.

population growth has a staggering effect on gender inequality, which in turn affects economies and national development. Population growth will continue to have a significant effect on gender inequality until the global community takes urgent measures to eliminate it. Therefore, it is imperative to understand the relationship between the two.

The second-class citizenship of women carries with it high consequences. Women are overwhelmingly poor, particularly in developing countries, and are subjected to inhumane treatment, including forced child-marriages, human trafficking, domestic violence, and the denial of property and inheritance rights. It is in these areas that the effects of population growth and the resulting gender inequality cause greatest suffering.

Rapid population growth is both a cause and effect of poverty and inequality, with population growth rates being highest in high-poverty areas. Denied basic human rights, women in many high-poverty areas rely on childbearing for “survival, status and security.” Already suffering from extreme poverty, unwanted pregnancies and the responsibility of raising multiple children, opportunities for women are further restricted.

Areas with the cycle of high fertility rates – females bearing children at younger ages and having more children because of high adolescent fertility rates and high child mortality rates in their area – fail to achieve bonuses of lower fertility rates and higher per capita income.

The large family sizes in these areas with high fertility rates affect education, which in turn affects economic growth and development. Girls may end up leaving school very early to help at home or because of pregnancy once they reach puberty. An estimated two-thirds of the 350 million children without access to education are girls. In countries where girls are permitted an education, with better health care, including family planning resources, the gender inequality gap may begin to close.

ABOUT THE WRITING CONTEST PARTNERS:

➤ The Pulitzer Center on Crisis Reporting promotes in-depth engagement with global affairs through its sponsorship of quality international journalism across all media platforms and an innovative program of outreach and education.

<www.pulitzercenter.org>

➤ Helium is a knowledge co-operative where writers are also editors who read and rate every article on the site.

<www.helium.com>

DONNA HICKS HAS BEEN A WRITER FOR MORE THAN 25 YEARS. She particularly enjoys writing about criminal justice, international politics and global issues, among many other topics. She recently enjoyed serving in a 13-month assignment as a member of various Helium writers’ groups – Distance Learning Criminal Justice, Distance Learning Culture & Arts, Distance Learning Social Sciences, Distance Learning Nursing, and Doctoral and Distance Learning Sciences. She was also the winner of the 2008 Paul Laurence Dunbar Memorial Poetry Prize in the adult category, which had more than 1,000 entries.

In the past 20 years, child mortality has dropped dramatically, thanks to increased immunization, vitamin A supplementation, the use of insecticide-treated nets to prevent malaria and many other interventions. At the same time, however, maternal mortality at the global level has hardly changed at all. Every day, almost 1,000 girls and women die in pregnancy or during or after childbirth, and for every death, at least 20 more suffer from infection or injury. The tragedy is that the deaths and disability are mostly preventable. If all women had access to antenatal care, skilled birth attendance, a hospital for emergencies and postnatal care, maternal mortality would plummet around the world.

Another important consideration in the reduction of maternal mortality is family planning. More than 225 million women globally do not want to become pregnant but are not using a modern contraceptive method, often because they have no access to it or have limited choices. Nearly 75 million women become pregnant unintentionally in developing countries every year.1

One of the fundamentals of family planning is choice: Women should have options when it comes to choosing which contraceptive method is right for them. Even where women have access to modern contraceptives, their choice may be limited to short-term methods, such as oral contraceptives or condoms. One of the biggest advantages of long-acting methods is that they last longer. As well, they are highly effective, more convenient for the user and more economical over time. Implants can last for three to five years, and the intrauterine device (IUD) can last up to 12 years. This is particularly important in low-income countries, where access to contraceptives may be irregular due to frequent stock-outs in clinics, or where rural women may find clinics difficult to reach. Also, long-acting methods have lower failure rates because once they are in place, there is nothing more for the woman to do.

PSI began as a family planning organization in the early 1970s, and today about 37 of 67 PSI countries have family planning programs. In 2008, PSI received funding to expand the range of family planning methods available by increasing access to long-acting reversible contraceptive methods. In the past 2.5 years, PSI has launched or scaled up programs in 17 countries. Service delivery channels through which PSI offers long-acting reversible contraceptives vary by country and may include franchised private provider networks, specially trained and dedicated providers in public and private sector clinics, or “event days” in which women and couples go to a one-time, clinic-based event for family planning counseling and services. In addition, PSI uses radio, television, billboards, community dramas, printed materials, and community- and clinic-based outreach to raise awareness of family planning methods and services.

Over two years (2009-2010), PSI provided 1.4 million IUDs and 233,200 implants. In 2009, PSI prevented an estimated 3.7 million pregnancies, and this number increased to 4.2 million in 2010.

With the establishment of long-acting methods as a part of a comprehensive family planning method mix, PSI is now moving to a greater emphasis on sustainability. This means improving access in the private sector, changing healthcare providers’ beliefs and attitudes about IUDs, and advocating with medical schools and health ministries to integrate IUDs into medical education and routine clinical services.


PSI Author: Julie Archer, Associate Researcher, Research & Metrics, Washington, D.C.
At this conference, the UN’s latest planetary demographic projections were the background to the discussion: are we headed to 9 billion by century’s end, or 10 billion, or even more? Despite disagreements on projections, one thing was clear – the answer depends on what happens to women’s fertility among the less than 20 percent of the world’s population living in countries where the demographic curve shows no sign of peaking throughout this century (areas of the world like Afghanistan, Niger, Pakistan, Yemen and countries of the Sahel).

PSI is helping women and families plan their pregnancies and reduce unintended pregnancy in some of these places, though not all. And it is sobering that this “demographic driver” geography includes some of the toughest-to-govern parts of the planet.

From Malthus well more than 200 years ago to our more modern efforts to grapple with the planet’s capacity, our responses to the population challenge have veered between the extremes of “population control” with its whiff of coercion and violations of rights, and at times a general unwillingness to talk about the issue at all. No effective policies come from either extreme.

Instead, the practical reality of dealing with population pressures finds its best approach in a dignified and simple strategy: help women who want to limit their fertility with modern contraception to do so.

There are at least 215 million of them, WHO tells us. PSI’s experience in countries such as the Democratic Republic of Congo, where for decades the unmet need for family planning has left women with a sixth, seventh or eighth pregnancy, or a dangerous and unsafe abortion, provides countless individual examples of women who want only to take care of the children they already have. Nothing more. Yet, the world cannot yet organize itself to meet this fundamental need, which would have so many positive results for women, families, countries and the planet as a whole.

Seven billion humans on the planet. Many of them will be born into a global economy where they will live better lives than their parents; many will emerge from poverty. In this sense, we can take joy from the fulfillment of so many aspirations. But leaving so many of our mothers, wives, sisters and partners behind in a high-fertility cycle they want desperately to escape is unworthy of us. ■
FEMIPLAN
MALE CONDOMS
strawberry scented

6 condoms @Kshs.40/-