ASSISTANCE TO INTERNATIONAL FAMILY PLANNING PROGRAMS

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I. INTRODUCTION

The main reasons for establishing family planning programs in the 1960s were to improve couples' abilities to plan their families, decrease unwanted pregnancies, decrease abortions and reduce high rates of fertility. Accomplishing these objectives would lead towards better overall standards of living in the world by significantly improving women's health and slowing population growth. Despite the progress made to date, the human rights, health, and demographic rationales behind the main reasons to provide family planning services are still valid.

Family planning programs take on a special importance in developing countries. These countries host most of the "world's poor." They have the greatest unmet need for family planning.[1] The estimated requirements for contraceptives will continue to grow as new cohorts of young women enter their fertile age.[2] Meanwhile, donor support is far from reaching the estimated needs of family planning programs.[3] Factors that interfere with family planning as a priority program in most of the poor countries include controversies surrounding the programs, changes in donor priorities, and narrow views of women's reproductive rights by the Bush administration.[4]

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[1] Women who want to delay the next pregnancy, or stop childbearing, but are not practicing contraception.

[2] *See* Malcolm Potts, *The Unmet Need for Family Planning*, SCIENTIFIC AMERICAN, 2000, 89-93.

[3] *Id.*

[4] President George W. Bush reinstated the global GAG rule in January 2001 (which will probably be in place until the end of his second term in 2008). Officially termed the Mexico City Policy, these restrictions mandate that U.S. family planning assistance cannot be provided

The expansion of the population program's (known only as "family planning programs") mandate to include all aspects of reproductive health, without increasing its funds accordingly, has hindered family planning programs as well.

II. ASSISTANCE TO FAMILY PLANNING PROGRAMS

Historically, major donors for family planning have been the U.S. Agency for International Development (USAID), the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF).[5] Overall, total funding for population and family planning increased from $13.6 million in 1965 to $3.2 billion in 2002.[6] It is estimated that developing countries have contributed around 75% of the total funding for population activities in the 1990s.[7] Since early 2001, the overall contribution of USAID has decreased.[8] When adjusted for donor countries' level of Gross National Product (GNP), the United States ranks ninth in the level of population assistance, despite it being the world's largest economy.[9]

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to organizations that use funding (even from any other source) to perform abortions, to provide counseling and referral for abortion or to lobby to make abortion legal or more available in their country. This policy has forced many organizations that reject the policy to lose vital U.S. funds, contraceptive supplies and technical assistance. *See* http://www.globalgagrule.org.

[5] *See* JUDITH R. SELTZER, THE ORIGINS AND EVOLUTION OF FAMILY PLANNING PROGRAMS IN DEVELOPING COUNTRIES 36 (2002), *available at* http://www.rand.org/pubs/monograph_reports/MR1276/MR1276.chap2.pdf.

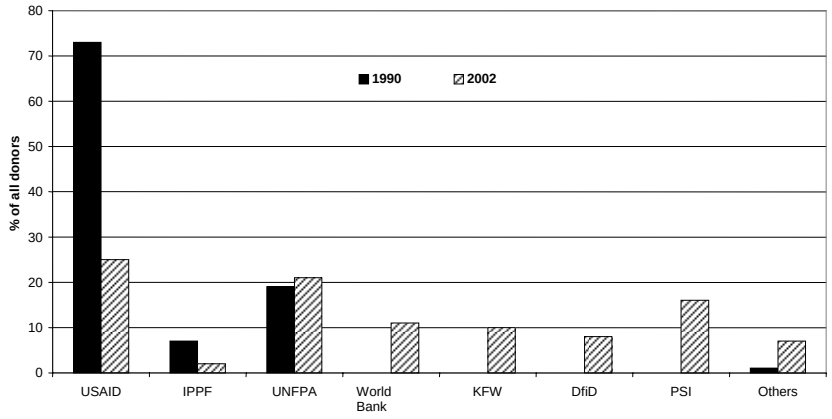
[6] *See id.* at 37.

[7] *See id.* at 36. Following the ICPD (International Conference on Population and Development) in 1994, population assistance includes all reproductive health components, thus funding comparison between earlier and recent years should be made with caution.

[8] *See* Figure 1.

[9] Total foreign aid is 0.1% of the U.S. GDP, the lowest of the rich countries. The Millennium Project, commissioned by the UN Secretary General and supported by the UN Development Group, calls for rich countries' commitment to devote 0.7% of their GDP for development assistance. First pledged 35 years ago in a 1970 General Assembly Resolution, the 0.7% target has been affirmed in many international agreements over the years, including the March 2002 International Conference on Financing for Development in Monterrey, Mexico and at the World Summit on Sustainable Development held in Johannesburg later that year. *See* United Nations Millennium Project, The 0.7% Target: An In-Depth Look (2006), http://www.unmillenniumproject.org/involved/action07.htm.

Figure 1: Major donor support for family planning, 1990 and 2003



Source: UNFPA,

The ICPD (International Conference on Population and Development) program of action called upon the international community to:

> achieve an adequate level of resource mobilization and allocation, at the community, national and international levels, for population [programs] and for other related [programs], all of which seek to promote and accelerate social and economic development, improve the quality of life for all, foster equity and full respect for the individual rights and, by so doing, contribute to sustainable development. [10]

In 1994, the ICPD program of action estimated that the required need for population programs would be $5.7 billion.[11] Current resources fall short of the pledged amount from the international community, especially for

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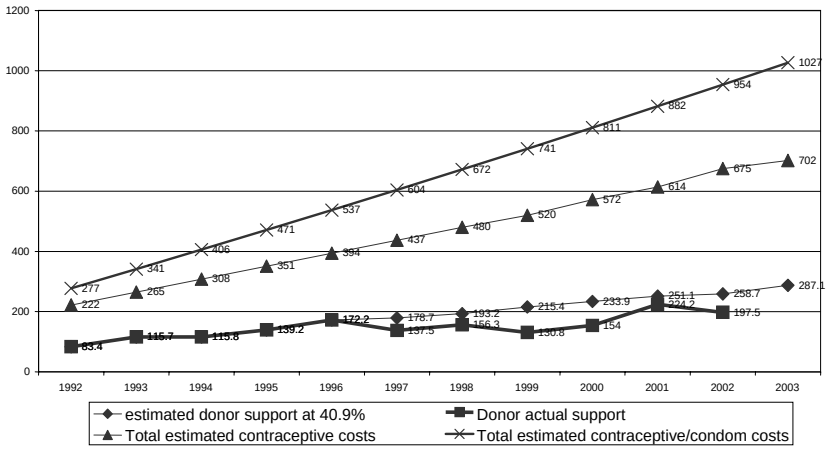
[10] International Conference on Population and Development [hereinafter ICPD], Cairo, Egypt, September 5-13, 2004, *Programme of Action* 13.21, *available at* http://www.unfpa.org/ icpd/icpd_poa.htm.

[11] *See* United Nations Population Fund, *Annual Report 2004*, U.N. Doc. E/2004/25, E/CN.9/2004/9 (2005) [hereinafter UNFPA, *Annual Report*], *available at* http://www.unfpa.org/upload/ lib_pub_file/434_filename_annual_report_04.pdf.; *see also* U.N ESCOR, 37th Sess. at 10, *Flow of financial resources for assisting in the implementation of thePprogramme of Action of the International Conference on Population and Development: a ten-year review*. Report of the Secretary-General, U.N. Doc. E/CN.9/2004/4 (2004), *available at* http://daccessdds.un.org/ doc/UNDOC/GEN/N04/ 206/10/PDF/N0420610.pdf.

family planning programs.[12] This poses a great deal of concern since funding for all four ICPD population categories should increase.[13] Since the early 1990s, donor support for contraceptives has been consistently below the required needs, and the gap between available funds and estimated requirements continues to grow.[14]

Figure 2: Reported donor support for contraceptives compared with estimated requirements, 1992 - 2003 (in millions of dollars).



Source: UNFPA, 2004.

Of all the ICPD categories, the percentage of total expenditures for family planning has decreased the most.[15] This decrease in funding has prohibited countries from reducing the unmet need for contraception.[16] The increase in HIV funding resulted from the international community's response to a crisis significantly worse than anticipated.[17] The issue of funding programs for diseases, such as HIV/AIDS, is far less controversial. Evidence indicates that both HIV/AIDS and family planning programs should be integrated.[18] Generally, this has not happened because of

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[12] *See* UNFPA, *Annual Report, supra* note 11, at 16.

[13] The four ICPD categories are family planning services, basic reproductive health services, STD/HIV activities and basic research.

[14] *See* Figure 2.

[15] *See* Figure 3.

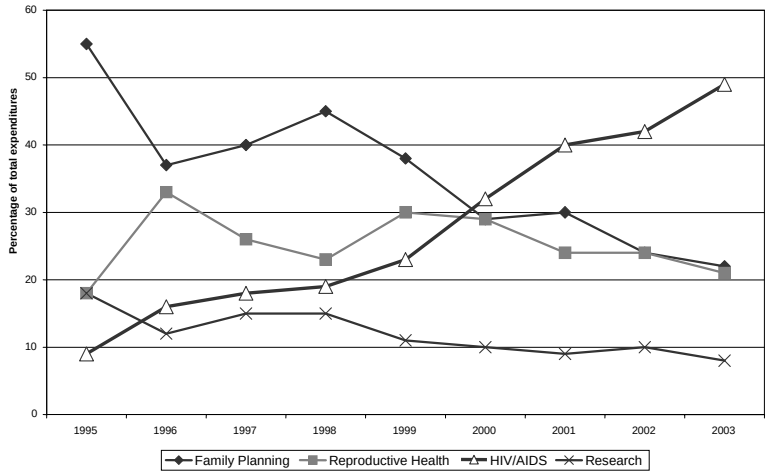
[16] *See* Figure 4.

[17] *See* Declaration of Commitment on HIV/AIDS: "Global crisis – Global Action", G.A. Res. S-26/2, at 3 U.N. Doc. A/RES/S-26/2 (June 27, 2001), *available at* http://www.un.org/ga/aids/docs/aress262.pdf.

[18] *See* Molly Strachan et al., An Analysis of Family Planning Content in HIV/AIDS, VCT, and PMTCT Policies in 16 Countries 1-2 (POLICY Project, Working Paper Series No.

budgetary constraints attached to donor funds.[19]

Figure 3: Trends in donor funding by ICPD category 1994 - 2003



A 2005 analysis of global assistance for health and population done by Landis MacKellar concluded that HIV/AIDS accounted for 25.9% of total development assistance for health and population in 2003, while maternal and perinatal health accounted for 16%.[20] MacKellar also notes that HIV/AIDS accounted for 5.8% of the burden of disease in 2001, compared to 8.3% due to maternal and perinatal conditions.[21]

III. IMPORTANCE FOR CONTINUING FUNDING

More than half a million women die from pregnancy and childbirth around the globe every year.[22] Less than one percent of these deaths occur in developed countries where adequate resources and services are available.[23] Women in sub-Saharan Africa have a 250 times greater risk of

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9, 2004), *available at* http://www.policyproject.com/pubs/workingpapers/wps-09.pdf.

[19] *See* UNFPA, *Annual Report*, *supra* note 11, at 25-30.

[20] *See* Landis MacKellar, *Priorities in Global Assistance for Health, AIDS, and Population*, 31 POPUL. & DEV. REV. 293, 300 tbl.3 (2005). http://www.blackwell-synergy.com/doi/abs/10.1111/j.1728-4457.2005.00066.x.

[21] Maternal and perinatal conditions category includes "reproductive health care." *See id.*

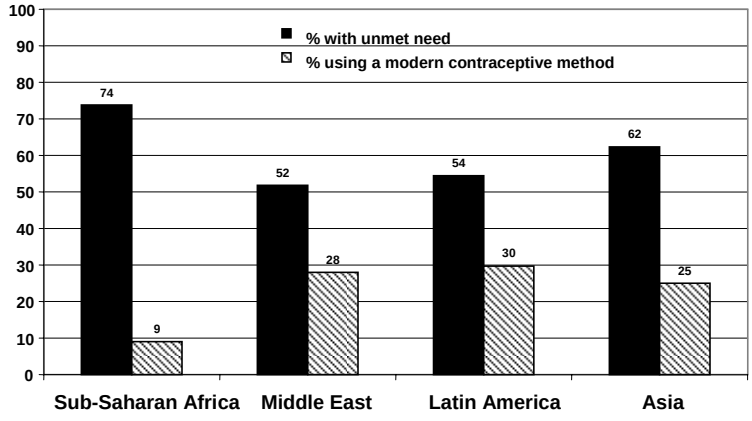
[22] *See* UNFPA, *Annual Report*, *supra* note 11, at 3.

[23] *See* World Health Organization et al., *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA*, at 1 (2004) [hereinafter WHO], *available at* http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf.

dying during pregnancy or childbirth than their counterparts in industrialized countries.[24] All countries that have a low maternal mortality rate have consistently high rates of contraceptive use.[25] Family planning programs are the most rapid and efficient way of achieving high contraceptive use.[26]

About 150 million married women in developing countries want to delay their next pregnancy or stop childbearing.[27] The vast majority of these women live in sub-Saharan Africa which has the lowest use of modern contraceptive methods.[28]

Figure 4: Unmet need and use of family planning among married women



Source: Data computed by author from demographic and Health Surveys (DHS) for the last 5

Failure to use contraceptives results in unwanted pregnancies.[29] There were 80 million unwanted pregnancies worldwide in the late 1990's, estimated to be around 27% of total pregnancies.[30] Most abortions are

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[24] *See id.* at 27, tbl.1.

[25] *See* Population Reference Bureau, *2005 World Population Data Sheet* at 1 (2005) [hereinafter PRB, *2005 World Population*], *available at* http://www.prb.org/pdf05/05WorldDataSheet_Eng.pdf.

[26] *See* Robert J. Laphan & W. Parker Mauldin, *Contraceptive Prevalence: The Influence of Organized Family Planning Programs*, STUD. FAM. PLAN., May-June 1985 at 132.

[27] *See* BARBARA SHANE, FAMILY PLANNING SAVES LIVES 3 (3d ed. 1996), *available at* http://www.prb.org/pdf/FamPlanSavesLives_Eng.pdf.

[28] *See* Figure 4.

[29] Data is from mother's attitudes toward recent births; recent births (last 3 years) were categorized by mothers as unwanted pregnancies. These include pregnancies that were wanted later and those who were not wanted at all.

[30] *See* PRB, *Family Planning Worldwide 2002 Data Sheet*, at 1 (2002), *available at* http://www.prb.org/pdf/FamPlanWorldwide_Eng.pdf.

performed as a result of unwanted pregnancies.[31] Of the estimated 80 million unwanted pregnancies in the late 1990's, more than 19 million of these pregnancies result in unsafe abortions, comprising 13% - 25% of all maternal deaths.[32] Most of the developing world prohibits abortion.[33] Women have to resort to clandestine procedures. The vast majority of these procedures are unsafe.[34] Access to safe abortion in developing countries is also a matter of equity.[35] Rich women, regardless of the abortion law in their countries, have access to safe abortion procedures.[36] Poor women have to resort to unsafe abortions that can result in death.[37] The poorest 20% of the population also has the most pronounced need for family planning services. They hold the highest total fertility rate (TFR)[38], the lowest contraceptive prevalence rate (CPR)[39] and the highest unmet need for family planning services.[40]

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[31] *See* CICELY MARSTON & JOHN CLELAND, THE EFFECTS OF CONTRACEPTION ON OBSTETRIC OUTCOMES 5 (2004) [hereinafter MARSTON & CLELAND, EFFECTS OF CONTRACEPTION], *available at* http://www.who.int/reproductive-health/publications/2004/effects_contraception/text.pdf.

[32] *See* WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000* 13, 1 (4th ed. 2004) [hereinafter WHO, *Unsafe Abortion*], *available at* http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/ estimates.pdf.

[33] *See* HEATHER BOONSTRA ET AL., ABORTION IN WOMEN'S LIVES at 10 (2006), *available at* http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf.

[34] *See id.* at 14.

[35] South Africa for example, has since 1996 one of the most liberal abortion laws in Africa. Before 1996, abortion was widely practiced but only white women and the rich had access to safe abortions. *See* United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies: A Global Review*, at 99, U.N. Doc. POP/830 (June 17, 2002), *available at* http://www.un.org/esa/population/publications/abortion/doc/southafrica.doc.

[36] *See* WHO, *Unsafe Abortion*, *supra* note 32, at 4.

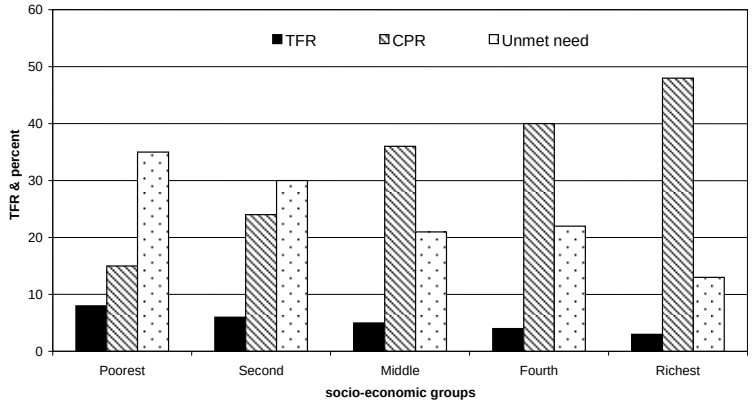
[37] *See* WHO, *Unsafe Abortion*, *supra* note 32, at 14.

[38] The total fertility rate (TFR) represents the average number of children a women would have by the end of her reproductive live.

[39] The contraceptive prevalence rate (CPR) represents the percentage of women using contraceptives at a specific point in time.

[40] *See* Figure 5.

Figure 5: Reproductive health differences across socio-economic groups. Kenya 2003.



Notes: TFR: Total Fertility Rate
Source: Kenya 2003 Demographic and health Survey (DHS)
CPR: Contraceptive Prevalence Rate

Since there has been a decline in donor support for population programs, some experts have suggested increasing user fees for family planning services for pre-existing consumers and requiring payment from those who have not been paying for contraceptives.[41] Initially, most researchers, policy makers and program planners agreed with this concept.[42] Some countries even started to implement it.[43] However, further research of countries' poverty levels and their health care systems raised questions about this plan of action.[44] A review of the literature by Prata et al. shows that the poor are more sensitive to price changes.[45] Small fee increases for family planning services could result in a significant decline in contraceptive use.[46]

A close relationship exists between a family's annual income and

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[41] Russell Green, *Empty Pockets: Estimating Ability to Pay for Family Planning* at 2 (Bay Area International Group 2002), *available at* http://big.berkeley.edu/research.workingpapers.atp.pdf.

[42] *See id.*

[43] *See* JACK MOLYNEAUX, THE EVOLUTION OF CONTRACEPTIVE PRICING IN INDONESIA: A FINAL REPORT TO THE POLICY PROJECT at 25 (2000), *available at* http://www.policyproject.com/pubs/commissionedresearch/rand2-final.pdf.

[44] *See* Ndola Prata et al., *How Much Are Consumers Willing to Pay for Family Planning?* 24 (Bay Area International Group, 2001), *available at* http://big.berkeley.edu/research.workingpapers.consumers.pdf.

[45] *See id.* at 22.

[46] *See* Prata et al., *supra* note 44, at 22.

contraceptive use.[47] One percent of per capita GNP for a year's supply of condoms appears to be the highest price feasible for programs designed to maximize condom use and prevalence.[48] When the cost of contraceptives represents more than 1% of a household annual income, there is a significant drop in use.[49] This "One Percent Income Rule" also applies to contraceptive use in general.[50] The threshold has been widely used when measuring access to contraceptives[51] Evidence shows that beyond the "One Percent Rule," contraceptive use drops significantly.[52] Research on the "One Percent Income Rule" shows that most people in the developing world cannot afford contraception.[53] The worst case is in sub-Saharan Africa where 98% of the population cannot pay full price for family planning.[54] In poor countries, where per capita expenditures of total health care costs amounts to less than $20 a year,[55] contraceptive cost is a barrier to use.[56] In these countries, dependence on donor support will remain high.[57]

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[47] *See* Prata et al., *supra* note 44, at 4.

[48] *See* Philip D. Harvey, *The Impact of Condom Prices on Sales in Social Marketing Programs*, STUD. FAM. PLAN., Jan.- Feb. 1994, at 52, 56-57.

[49] *See id.*

[50] *See* Green, *supra* note 41, at 3.

[51] *See* Green, *supra* note 41, at 3.

[52] *See* PHILIP D. HARVEY, LET EVERY CHILD BE WANTED: HOW SOCIAL MARKETING IS REVOLUTIONIZING CONTRACEPTIVE USE AROUND THE WORLD 135 (1999).

[53] *See* Green, *supra* note 41, at 13.

[54] *See* Table 1.

[55] *See* David H. Peters et al., *Health Expenditures, Services, and Outcomes in Africa: Basic Data and Cross-National Comparisons, 1990-1996*, HUMAN DEV. NETWORK, at 23 (World Bank, Health, Nutrition, and Population Series No. 19578, 1999), *available at* http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2000/04/19/000094946_99093005584165/Rendered/PDF/multi_page.pdf. There are many countries in sub-Saharan Africa where the per capita health expenditures amount to only $4-$10. For comparison, per capita health expenditures in the U.S. are over $3000 annually.

[56] *See* Prata et al., *supra* note 44, at 24-25.

[57] *See* Peters et al., *supra* note 55, at 27-28.

Table 1:

Percent of the population who cannot afford family planning
(population weighted averages assuming 1% income rule)

	full cost	3/4 cost	half cost	only commodities
Sub-Saharan Africa	98	96	93	77
Arab States/E.Europe	65	51	33	10
Latin America	54	44	30	9
Asia	89	82	71	30
all aid-dependent nations	84	76	66	34

Source: Green, R. 2002. Empty pockects: Estimating ability to pay for family planning. Bay Area International Group, University of California, Berkeley. http://big.berkeley.edu/research.workingpapers.atp.pdf

IV. BENEFITS OF FAMILY PLANNING

Research results and worldwide experience attest to the health benefits of family planning for women and children.[58] Improved access to family planning could avert 100,000 maternal deaths worldwide by decreasing the odds of pregnancy.[59] In addition, improved access will help decrease births from adolescents and older age women.[60] It will also help reduce high-parity[61] births and short birth intervals. These types of pregnancies present significant risk factors for maternal mortality.[62]

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[58] *See generally* PATRICIA DONOVAN & DEIRDRE WULF, ISSUES IN BRIEF: FAMILY PLANNING CAN REDUCE HIGH INFANT MORTALITY RATES (2002) [hereinafter DONOVAN & WULF], *available at* http://www.guttmacher.org/pubs/ib_2-02.pdf.; Diana Green Foster et al., *Expanded State-Funded Family Planning Services: Estimating Pregnancies Averted by the Family PACT Program in California, 1997-1998*, 94 AM. J. PUB. HEALTH 1341 (2004), *available at* http://www.ajph.org/cgi/reprint/94/8/1341.pdf.

[59] *See* WHO et al., *Reduction of Maternal Mortality: A Joint WHO/ UNFPA/UNICEF/ World Bank Statement*, at 10 (1999), *available at* http://www.who.int/ reproductive-health/ publications/reduction_of_maternal_mortality/e_rmm.pdf.

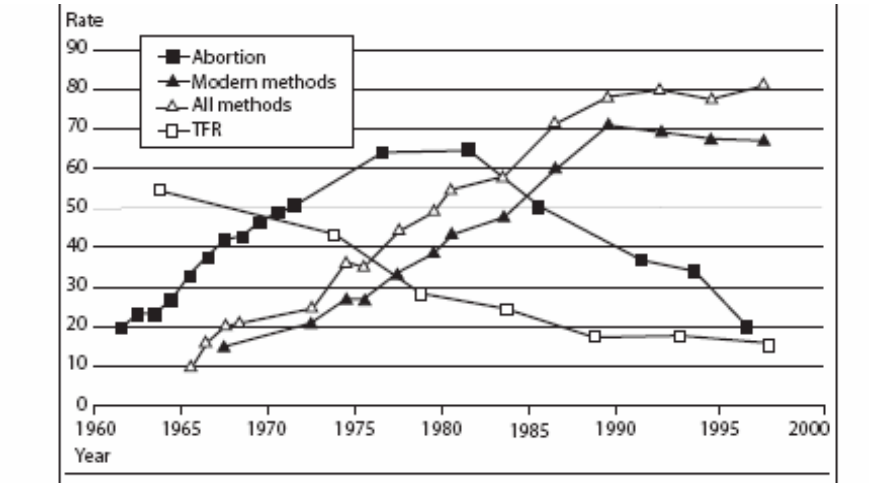
[60] *See* MARSTON & CLELAND, EFFECTS OF CONTRACEPTION, *supra* note 31, at 13-14.

[61] Women who have borne many children, usually more than 4.

[62] *See id.* at 13-15.

Family planning services would also decrease abortion rates.[63] High levels of contraceptive use leads to a reduction in abortions.[64] The rise in contraceptive use alone, however, is not sufficient to meet the growing need for smaller families.[65] To avoid an increase in abortion rates, unrestricted access to contraception should be granted to all sexually-active women and men.[66]

Figure 6: Relationship between abortion, total fertility rate, and contraceptive use of Korea 1960 - 2000.



Source: Marston and Cleland, 2003.

Contraception may also be used to prevent mother-to-child transmission (PMTCT) of HIV. The number of women living with HIV in the world is increasing.[67] In 2005, 17.5 million women were living with HIV, an increase of one million from just two years prior.[68] An estimated 25% of

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[63] *See* Cicely Marston & John Cleland, *Relationship Between Contraception and Abortion: A Review of the Evidence*, INT'L FAM. PLAN. PERSP., Mar. 2003, at 6, 6-7, 11 [hereinafter Marston & Cleland, *Relationship Between Contraception*], *available at* http://www.guttmacher.org/pubs/journals/2900603.pdf.

[64] *See* Figure 6.

[65] *See* Marston & Cleland, *Relationship Between Contraception*, *supra* note 63, at 6.

[66] *See* MARSTON & CLELAND, THE EFFECTS OF CONTRACEPTION ON OBSTETRIC OUTCOMES, *supra* note 31, at 15.

[67] *See* Joint United Nations Programme on HIV/AIDS [hereinafter UNAIDS & WHO], *AIDS Epidemic Update: December 2005*, UNAIDS/05.19E, at 2 (2005) *available at* http://data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf.

[68] *See id.*

those HIV-positive women need contraception.[69] Family planning is one of the most cost-effective ways to prevent HIV vertical transmission.[70] Unavailability of family planning to HIV-positive women results in an increased number of HIV-positive children. These children are then unlikely to receive HIV drugs.[71] HIV-positive pregnant women also face the possibility of deteriorating health status.[72]

Family planning also impacts infant and child mortality.[73] A systematic review and meta-analysis of the relationship between births intervals and infant and child mortality shows that the smaller the birth interval between pregnancies, the higher the odds of the preceding child dying.[74] In general, newborn health is affected by the timing and frequency of pregnancy.[75] Women who give birth when they are too young, too old, or have babies too closely-spaced, place themselves and their newborns at an increased risk of complications.[76] A child born less than 24 months younger than the next oldest sibling is 2.2 times more likely to die than a child that arrives after 36 months.[77] Effective use of family planning methods can contribute to improved maternal and newborn health by helping women avoid high-risk pregnancies.

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[69] *See* UNFPA, *Annual Report*, *supra* note 11, at 10.

[70] *See* Heidi W. Reynolds et al., *The Value of Contraception to Prevent Perinatal HIV Transmission*, 33 SEXUALLY TRANSMITTED DISEASES 350, 5 (2006). *See also* Kim Best, *Family Planning and the Prevention of Mother-to-Child Transmission of HIV: A Review of the Literature*, at 2 (Family Health International, Working Paper Series No. WP04-01, 2004), *available at* http://www.fhi.org/NR/rdonlyres/ehm4ci7qpkw422j3rhj6n6rht3xmbtidtr6pyq4csmeg2363rad5yewukfbac4xifmhqoas4usfbzl/FPPMTCT.pdf.

[71] *See* UNAIDS & WHO, *supra* note 67, at 13.

[72] *See* UNAIDS & WHO, *supra* note 67, at 13.

[73] *See* Shea Rutstein et al., Systematic Literature Review and Meta-Analysis of the Relationship Between Interpregnancy or Interbirth Intervals and Infant and Child Mortality at 1, also reproduced in Figure 7 of this manuscript. (Oct. 2004) (report submitted to the CATALYST Consortium Available at http://www.maqweb.org/techbriefs/tb15birthspacing.shtml

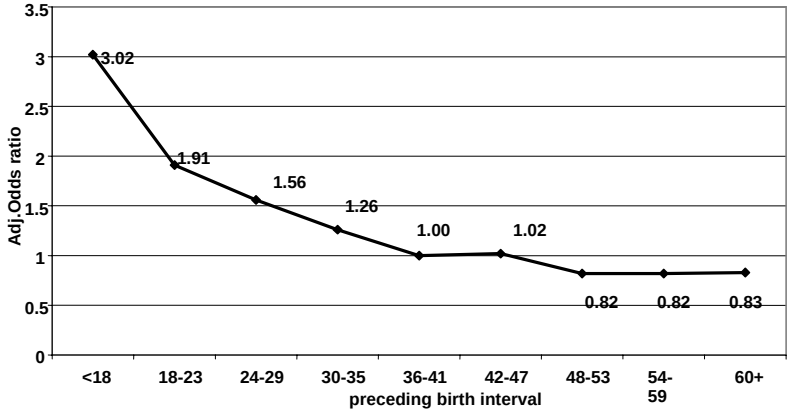
[74] *See* Figure 7.

[75] *See* DONOVAN & WULF, *supra* note 58, at 1-2 .

[76] *See* Ruth C. Fretts et al., *Increased Maternal Age and the Risk of Fetal Death*, 333 NEW ENG. J. MED. 953 (1995); Agustin Conde-Agudelo & José M. Belizan, *Maternal Morbidity and Mortality Associated with Interpregnancy Interval:Cross Sectional Study*, 321 BRIT. MED. J. 1255 (2000).

[77] *See* Figure 7.

Figure 7: Child mortality and birth spacing



Source: Rutstein, S et al, 2004. Systematic literature review and meta-analysis of the relationship between interpregnancy or interbirth intervals and infant and child mortality. Report submitted to the CATALYST Consortium. www.USAID.gog/birth_spacing_brief.html

Family planning helps families stay manageable in size. This affects the participation of females in the labor force.[78] In developing countries, children from large families suffer from poorer living conditions and are more likely to be deprived higher education and quality health care.[79]

One of the goals of the current generation is environmental protection for the benefit of future generations. Support for family planning can help achieve this goal by decreasing fertility, which results in a slower growth rate of population. This decreased rate will relieve the pressure on many natural resources and averts conflict over them. In addition, it will ease environmental pressures by decreasing the demand for water, limiting pollution, and preserving arable land.[80] Family planning will also contribute

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[78] *See* Siv S. Gustafsson et al., *Women's Labour Force Transition in Connection with Childbirth: A Panel Data Comparison Between Germany, Sweden and Great Britain*. 9 J. POPUL. ECON. 223 (1996).

[79] *See* John Knodel & Malinee Wongsith, *Family Size and Children's Education in Thailand: Evidence from a National Sample*, 28 DEMOGRAPHY 119, at 130 (1991); Pragai Jirojanakul et al., *Predicting Young Children's Quality of Life*. 57 SOC. SCI. MED. 1277 (2003).

[80] *See* Ushma D. Upadhyay & Bryant Robey, *Why Family Planning Matters*, POPUL. REP., July 1999, at 1, *available at* http://www.infoforhealth.org/ pr/j49/j49.pdf.

to progress in poverty and hunger, which is also hindered by high fertility rates.

> The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And this means stronger efforts to promote women's rights and greater investment in education and health, including reproductive health and family planning.
>
> —United Nations Secretary-General Kofi Annan.

V. CONCLUSION

International assistance to family planning programs has decreased over time.[81] From 1992-1996, the donor support met 41% of the total contraceptive requirements.[82] In 2002 this support covered only 20% of the contraceptive requirements.[83] The gap between the actual dollar amount received and dollar amounts needed to satisfy the demand for contraception is widening.

Family planning has long been acknowledged as an effective public health intervention.[84] The use of modern contraceptive methods and the desire for smaller families has been increasing globally. However, large disparities between rich and poor still exist.[85] Limited availability and limited access are major reasons for the lack of contraception use. Fifty-nine percent of the less developed nations' citizens live on less than two dollars a day.[86] The vast majority of these citizens in need of assistance from international planning programs live in rural areas.[87] These programs provide couples with tools to reach their desired family size. The programs have a significant impact on lowering maternal and child mortality by decreasing fertility and optimizing child spacing. In developing countries, smaller families are associated with relatively greater family wealth.[88]

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[81] *See* UNFPA, *Annual Report*, *supra* note 11, at 16.

[82] *See id*.

[83] *See id*.

[84] *See* World Bank, *World Development Report 1993: Investing in Health*, at 64, June 30, 1993, *available at* http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1993/06/01/000009265_3970716142319/Rendered/PDF/multi0page.pdf.

[85] *See* DARA CARR, IMPROVING THE HEALTH OF THE WORLD'S POOREST PEOPLE (2004), *available at* http://www.prb.org/pdf04/ImprovingtheHealthbrief_Eng.pdf.

[86] See PRB, *2005 World Population*, *supra* note 25, at 1.

[87] *See id.*

[88] *See* Jirojanakul et al., *supra* note 79, at 1277.

Evidence shows that HIV programs are, and will continue to be, better funded than family planning programs.[89] The response to the HIV epidemic has changed personnel and logistical funding priorities. Furthermore, restrictions imposed by the gag rule make it difficult for family planning programs to be integrated with HIV programs in countries where the US is a major donor.

The financial resources of the less developed countries are inadequate to cover all of the problems affecting their health systems. These countries lack the required capacity to mobilize commitment in the international arena. It is incumbent upon us to advocate for the meeting of family planning financial targets set out at ICPD-Cairo in 1994. We must denounce the injustice of making motherhood unsafe. The donor community should immediately reassume the role of assisting the world's poor with family planning services.

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[89] *See* UNFPA, *Annual Report*, *supra* note 11, at 10.