

**MacArthur's Population and Reproductive Health
Grantmaking:
A History and Narrative Assessment**

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Abbreviations and Acronyms

ACASAC	Asesoría, Capacitación y Asistencia en Salud, A.C.
AHI	Action Health Incorporated, Nigeria
AMSTAL	Active Management of Third Stage of Labor
ANM	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
CAC	Comprehensive Abortion Care
CCRHS	Centre for Communication and Reproductive Health Services
CEBRAP	Centro Brasileiro de Análise e Planejamento
CEDPA	Center for Development and Population Activities
CHEW	Community Health Extension Worker
CIDHAL	Comunicación, Intercambio y Desarrollo Humano en América Latina
CIMAC	Comunicación e Información de la Mujer
CINI	Child in Need Institute
CNEGSR	Centro Nacional de Equidad de Género y Salud Reproductiva
CONAPO	Consejo Nacional de Población
COPASAH	Community of Practitioners on Accountability & Social Action in Health
CSD	Conservation and Sustainable Development
CSO	Civil Society Organization
DAWN	Development Alternatives for Women for a New Era
DFID	Department for International Development
FCT	Federal Capital Territory
FLD	Fund for Leadership Development
FOGSI	Federation of Obstetric and Gynaecological Societies of India
GEMS	Gender Equity Movement in Schools
GIMTRAP	Grupo de Investigación en Mujer, Trabajo y Pobreza
GIRE	Information Group on Reproductive Choice
GPI	Girls Power Initiative
HBNC	Home-Based Newborn Care
HIMS	Health Information Monitoring Systems
HIP	Hispanics in Philanthropy
HoPE-LVB	Hope of People and Environment in Lake Victoria Basin
IAG	International Advisory Group
ICPD	International Conference on Population and Development
ICRW	International Centre for Research on Women
IDP	Internally Displaced Person
INSAD	Investigación En Salud Y Demografía
IWHC	International Women's Health Coalition

LaQshya	Labour Room Quality Improvement Initiative
LGBTQ	Lesbian, Gay, Bisexual, Trans, and Queer
M&E	Monitoring and Evaluation
MACEI	MacArthur Award for Creative and Effective Institutions
MDG	Millennium Development Goals
MISP	Minimum Initial Service Package
MMM	Maternal Mortality and Morbidity
MMR	Maternal Mortality Ratio
MSI	Management Systems International
NABH	National Accreditation Board for Hospitals and Healthcare Providers
NASG	Non-Pneumatic Anti-Shock Garment
NCCE	National Commission of Colleges of Education
NGO	Non-Governmental Organization
NMSC	National Safe Motherhood Committee, Mexico
PFI	Population Foundation of India
PHC	Primary Health Centre
PHE	Population, Health, and Environment
PMNCH	Partnership for Maternal, Newborn and Child Health
PPH	Postpartum Hemorrhage
PRH	Population and Reproductive Health
RAHI	Recovering and Healing from Incest
RKSK	Rashtriya Kishore Swasthya Karyakram
RMC	Respectful Maternity Care
SISEX	Sistema Nacional de Promoción y Capacitación en Salud Sexual
SEARCH	Society for Education Action Research in Community Health
SIPAM	Salud Integral Para La Mujer
SLIC	Socio-Legal Information Centre
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WLUML	Women Living Under Muslim Laws
WRAI	White Ribbon Alliance for Safe Motherhood India
WRC	Women's Refugee Commission
YARAC	Youth, Adolescent, Reflection & Action Centre
YPSRH	Young People's Sexual and Reproductive Health

Note from Staff

This paper marks the completion of a long and eventful journey for the MacArthur Foundation, a journey that we had the privilege of taking along with hundreds of civil society organizations working toward a world where women's reproductive and sexual rights and health would be fully respected and guaranteed.

As staff and leaders in the MacArthur Foundation's Population and Reproductive Health Program, we want to tell this story. It was a major undertaking for us professionally and personally, and we had the enormous honor of meeting, working with, supporting, and following some of the world's most innovative, audacious, humble, and hard-working leaders in everything from small grassroots organizations to large, multinational networks and agencies. Over thirty years and through thousands of grant proposals, emails, meetings, and reports, we had the privilege of learning from, working alongside, and enabling with financial resources those who were designing and implementing new ways for empowering women to live those rights fully.

This report, like our work, is dedicated to the women of India, Mexico, Nigeria, and Brazil. Women in the 1980s who lived under population control policies and whose claims of forced sterilization were summarily dismissed; women in the 1990s who learned to protect themselves against HIV, lived through the first U.S. Global Gag Rule, and shaped the Cairo and Beijing conferences that made population control a thing of the past and women's rights a thing of the present and future; women in the 2000s who tracked budgets for reproductive health, used sophisticated legal strategies to document reproductive rights violations, borrowed and made their own strategies for holding governments transparent and accountable; and women of the 2010s who took over global leadership for reproductive justice and made louder the voices of women who had been pushed to the margins of healthcare and society, whose voices had been less heard, less recognized.

We also recognize the leadership of our colleagues before us. Of Adele Simmons, MacArthur's President when the program was launched, and the Board members who supported the direction she gave (especially Elizabeth McCormack, Margaret Mahoney, and Shirley Hufstедler). Of Dan Martin, who built from his work in conservation to lead the Population Program in the 1980s. Of Carmen Barroso, who added "Reproductive Health" to our name and always reminded us to "keep your eyes on the prize" and focus our attention on how we, as stewards of philanthropy, could ensure that its resources would better the lives of women in our countries. Of Judith Helzner, who energetically steered the program toward greater focus and purpose and enabled our program to document and share what we learned more broadly, and to learn from our mistakes and our achievements. And of our colleagues who have since moved on: Poonam Muttreja in India, Ana Luisa Liguori and Linda King in Mexico, Bolanle Awe in Nigeria, Cheywa Spindel and Magaly Marques in Brazil, and Elizabeth McGrory, Caren Grown, Stuart Burden, Leni Silverstein, and Anu Kumar from the Chicago office. We also thank the many other colleagues who contributed to the program's success over the years. We list them separately at the end of the report.

We hope that this report—as limited as it may be—will offer insight to some and nostalgia to others, and become a part of the global history of our collective efforts toward a world where women’s rights, especially reproductive and sexual rights, are a reality for all.

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Introduction

MacArthur's Population and Reproductive Health (PRH) area was one of the earliest programs established at the Foundation. Beginning in 1986, the Foundation provided support for research, policy, and programmatic interventions related to PRH. In the 1990s, MacArthur helped strengthen and vitalize a global movement that prepared for, participated in, and followed up on two of the most important international conferences for reproductive health: the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995). MacArthur's support was at the core of the growth of civil society organizing for women's rights and reproductive health, contributing to the paradigm shift from population control to reproductive health and rights in global health. The Foundation's leadership and early investments catalyzed the strong and dynamic movement for reproductive health and rights that has characterized civil society engagement. A hallmark of MacArthur's investments is support for organizations based in Brazil, India, Mexico, and Nigeria. The Foundation established offices in each of these countries in the early 1990s – and something new at the time for US based foundations – trusted local staff and consultants with defining and implementing a strategy for one of the most innovative components of the program: the Fund for Leadership Development. By the early 2000s, the Foundation had built on this momentum and developed a more focused grantmaking approach, prioritizing maternal mortality prevention and the promotion of young people's sexual and reproductive health (YPSRH). These areas of work continued through 2014–15, with an exit phase that was completed in 2019.

From 1986 to 2018, MacArthur's PRH program provided a total of \$372 million in grants and supported 589 organizations and 456 individuals through leadership awards.¹

This paper provides an overview of how and why the Foundation entered this field, how it chose areas of emphasis, and how its grantmaking strategies evolved over time. This document is not a formal evaluation of PRH grantmaking at the Foundation, nor does it describe every grant that was made by the PRH program. Rather, this is a view from the inside by staff responsible for PRH grantmaking and reflects on some of the more significant achievements, disappointments, and lessons learned from this work. Insights are informed by a review of background reports, internal memos, formal external assessments, and interviews with key grantees and former and current staff. The final assessment of the Foundation's [exit strategy in Mexico](#) was completed in February 2019 and a final evaluation of the [India exit strategy](#) was completed in February 2020.

This document has two parts: Part I documents a narrative history of MacArthur's grantmaking in PRH from 1986 through 2018. Part II captures reflections and key lessons learned. An appendix provides a list of individuals interviewed for the preparation of this report. Finally, we offer our heartfelt thanks to the PRH grantees, staff, and advisors, all of whom are listed in the annexes at the end of this document.

¹ The 456 leadership awards represent a total of those directly supported by MacArthur and through intermediary organizations.

Part I: A Narrative History of the MacArthur Foundation's Population and Reproductive Health Grantmaking (1986–2019)

Forging a Field: MacArthur's Early Work on Population and Reproductive Health (1986–2000)

In 1986, the MacArthur Foundation made a set of exploratory grants to eight organizations working in the field of population and reproductive health. Based on those early findings, in May 1988, the Foundation's Board endorsed the establishment of a "World Population Program." The resolution recognized that rapid population growth in developing countries would continue to be a major global concern well into the twenty-first century, exacerbating human problems such as mass poverty, environmental and resource degradation, inequitable economic development, and political instability. The program strategy was informed by a report prepared for the Foundation by Dan Martin, the head of MacArthur's biodiversity conservation work and later also of the Population Program, and Lincoln Chen, director of the Harvard Center for Population and Development Studies. Martin and Chen led an extensive consultative process over two years,² meeting with over 300 people working in six dozen organizations around the world. The Program commissioned several review papers on high-priority topics.

The Board endorsed a new vision for the Foundation's work in the population field, which held that the traditional demographic rationale for addressing "population problems" was no longer adequate. Archival program documents explore the topic in a way that was remarkably different from the prevailing views of that time by prioritizing the health needs of communities, particularly women, based on the demographic trends in countries. The dominant approach of the time often overlooked the rights and agency of individuals' needs within public health, including investments in strengthening Sexual and Reproductive Health and Rights (SRHR). The Foundation's strategy demonstrated that population questions have at least three interrelated dimensions: demographics (or human numbers), human welfare, and human rights. In addition to purely demographic concerns, the strategy linked social, cultural, economic, and political issues related to health, natural resources, urbanization, and human rights as integral dimensions of the population debate.

The World Population Program set out to forge a feminist reproductive health movement through investing in institutions and actors, partnering with other donors, building local capacity, and investing in local leaders. Program staff and leaders from around the world joined to create a theory of change that would enable this movement to improve women's reproductive health; enhance the understanding of population-natural resources, interactions, and the promotion of sustainable use of natural resources; and the use of media and popular education to convey locally appropriate messages about reproductive health and sustainable development. The program also sought to develop leadership dedicated to solving the interrelated problems of population, reproductive health, and natural resource management. These components together constituted a "humanistic" approach to a social

² The John D. and Catherine T. MacArthur Foundation, *Population Program Explorations*, May 11, 1988.

problem related to the most vital and intimate aspects of people's lives.³

The Board approved a strategy focused on four countries from an initial short list of 12: Brazil, India, Mexico, and Nigeria. Although the goal of the Foundation was to influence the population and reproductive health (PRH) landscape as a whole, intensive grantmaking was restricted to four countries for two reasons: a need to strengthen local leadership and build a critical mass that could make a difference at the country level; and the fact that these countries represented the largest populations of their region, with the ability to have influence at the international level. Furthermore, given the Foundation's strategy of supporting civil society organizations with the potential to affect governmental policies, the selected countries needed to have favorable political environments that allowed room for civil society engagement.⁴

The program recruited Dr. Carmen Barroso, a well-known scholar from Sao Paulo, Brazil, to bring in a feminist and developing-country perspective. For a major American foundation to hire a woman from the Global South who was strongly rooted in the international women's health movement to lead one of its programs was a first for its time. This decision helped influence and strengthen the commitment of colleagues at other foundations to support a reproductive health and rights agenda.

Country strategies that reflected the goals articulated by the Board in 1988 were developed in cooperation with panels of experts coming from a wide variety of disciplines and perspectives. This resulted in strategy recommendations that were broadly representative of, and sensitive to, local perceptions. The country strategy papers for Brazil,⁵ Mexico,⁶ Nigeria,⁷ and India⁸ were commissioned and completed by 1992. The resulting strategy included consideration for the activities of other donors, and from the beginning MacArthur partnered with likeminded foundations, particularly those active in this field and these countries such as Ford and Packard. These partnerships enabled MacArthur to build from a common vision of women's rights while also forging new issue areas, such as communication in reproductive health and other areas described later in this paper. The program constituted an International Advisory Group (IAG) to help the staff develop strategies, identify grantees, and develop an evaluation framework. The IAG, which met annually from 1988 through 2001, emerged as a remarkably strong and influential aspect of the program. It was initially composed of four men and one woman (Lincoln Chen from the U.S. as Chair; Ashoka Kosla from India; Oladipo Ladipo from Nigeria; Vijay Variadjava from Thailand; and Carmen Barroso from Brazil), with one-year renewable mandates. As the Program set its roots in the four countries and made its commitment to women's rights stronger, representatives from those countries were enlisted, together with prominent women in global policy, such as Rebecca Cook and Joan Dunlop. The IAG was an innovation in American private philanthropy, creating a new partnership arrangement for creative programming overseas that helped

³ The MacArthur Foundation, *Amendment – Report of the Program Committee of the Whole*, July 14, 1988.

⁴ Nigeria proved to be an exception in this regard in the 1990s.

⁵ MacArthur, *Population in Brazil: Agenda for a Country Strategy*, 1990.

⁶ MacArthur, *Population Issues in Mexico: Guidelines for a National Strategy*, 1992.

⁷ MacArthur, *Country Strategy for the Population Program in Nigeria*, 1992.

⁸ MacArthur, *Population, Health and Women in India: Agenda for a National Strategy*, 1992.

MacArthur avoid a top-down approach.

In the early years, the PRH program was administered by Chicago-based staff. The Foundation added international field offices in Brazil (1991), Mexico (1992), India (1994), and Nigeria (1994). Initially these offices were in charge only of designing and implementing a leadership program.⁹ Grantmaking to support local non-governmental organizations (NGOs) were administered by staff from Chicago, an arrangement that led to some lack of clarity about division of roles and responsibilities, and which later became better integrated. Country office staff reported to the Program Director in Chicago. Over time, staff in Chicago focused on funding international “anchor” institutions for advocacy and networking in the international arena. Having staff in the headquarters and in-country with complementary roles led to synergies that worked both within and outside each country. Over time, the country-level work was documented and disseminated, providing other countries with good practices and global leaders with examples of how to advance the work. Global leadership could encourage and support allies at the country level to prioritize certain issues, strategies, and approaches.

The program decided not to support several types of conventional population work, such as basic research in reproductive physiology, research and development in new contraceptive technology, standard demographic research at universities, and routine provision of family planning services. Given that these types of work were well-funded, it was understood that MacArthur investments in these areas were not likely to make a significant difference.

From the beginning, the program identified two categories of institutional arrangements for its grants. The first was institutional awards to creative organizations working on population and related issues that had developed innovations with broader applicability in other contexts, with a preference for investing in local organizations. The second category was an individual awards program targeted to early or mid-career professionals (aged 25 to 40) from the four priority countries who demonstrated potential for innovative solutions to population problems facing their countries, and those with the potential to assume major leadership positions in the PRH field. This program, called the Fund for Leadership Development (FLD), which gained widespread respect and recognition, was MacArthur’s signature contribution to the PRH field (details about the FLD are provided in the next section of this report).

While the MacArthur Board envisaged that the individual and institutional awards program would be operated by a single intermediary organization working closely with Foundation program staff and the IAG, Foundation staff were eventually responsible for administering program components.

During the first decade of the PRH program, grants were made on a broad range of topics that promoted women’s health, with an emphasis on reproductive health. This included action and research on contraceptive choice; disease prevention, including sexually

⁹ In 1992, the Foundation also opened an office in Russia to support the social sciences in the former Soviet Union; the PRH program did not operate there.

transmitted infections and HIV/AIDS; safe delivery; and safe abortion. The program also made grants for assisting adolescents with making informed choices related to their sexuality, marriage, and reproductive health. Grants also focused attention on the role and status of women as related to women's reproductive health and, in Mexico and Brazil, the needs of Indigenous minorities. While in the early years the program made a few grants that explored the relationship between population and environmental issues, a readjustment of priorities made reproductive health the primary focus of the program. Thus, the program was renamed Population and Reproductive Health (PRH) in 1994.

Between 1986 and 2000, PRH supported 406 organizations: 94 (23 percent) in the United States and 312 (77 percent) outside the United States. It approved 799 grants, totaling \$130 million. The Foundation supported bold strategies that strengthened a movement that has consistently grown and pushed the boundaries for women's full citizenship, beginning with the right to determine one's reproductive and sexual life.

MacArthur's PRH program was at the vanguard of supporting new strategies that may have been considered "risky" by other donors, for example, by providing relatively small grants to new groups that lacked an institutional track record but had strong leadership, good ideas, and solid strategies. By investing in women's rights activists and supporting civil society to advocate for women's reproductive health, it recognized that strengthening local leadership solutions in national contexts was key to developing a sustainable approach to problem-solving within PRH.

A distinctive characteristic of the work during this period of grantmaking was its support for advocacy in women's reproductive health, including support for women's organizations such as Development Alternatives for Women for a New Era (DAWN), the Global Fund for Women, and the International Women's Health Coalition for strengthening and developing networks within countries and internationally. The PRH program supported the development of a conceptual framework wherein reproductive rights were an integral part of human rights, thus facilitating alliances with the human rights community. Yet another approach enabled the media to disseminate information to build public support for new reproductive health policies. It was the support for these multiple advocacy strategies that set MacArthur apart from most other foundations (with the exception of the Ford Foundation) that were active in the population field at the time.¹⁰

When plans for the Population Program were being developed, few appreciated that the HIV epidemic would become a huge health threat. By 1991, the program recognized that with a focus on reproductive health and rights, involvement with HIV prevention was critical, and the Foundation integrated HIV prevention into its broader program of sex education. The following is an excerpt from a 1995 internal review of the program:

"No proposal on prevention was considered too strange or outrageous. As a result, we have supported many innovative efforts to reach various audiences (even though many people in these communities do not consider themselves vulnerable to the disease). We have supported

¹⁰ Carmen Barroso, Stuart Burden, Anu Kumar, and Leni Silverstein, *The Population Program: Continuity and Change in the Last Few Years*, April 1995.

condom distribution campaigns during Carnival in Brazil, magazines and comic books in Mexico, school-based prevention programs in Nigeria, and even a condom art project in Sao Paulo that was subsequently featured in an exhibition in a local museum.”¹¹

The program recognized that different audiences required different strategies and understood HIV to varying degrees. The program was a leader in supporting and advocating for clear materials, targeted to specific audiences and providing accurate information while responding to the values of the communities being addressed.

A milestone for the program was its role in mobilizing civil society for the International Conference on Population and Development (ICPD) in Cairo in 1994. At the ICPD, diverse views on human rights, population, sexual and reproductive health, gender equality, and sustainable development merged into a remarkable global consensus that placed individual dignity and human rights, including the right to plan one’s family, at the heart of development. An external review of the program, conducted in 1995, makes note of the direct and substantial role that the MacArthur PRH program played in the outcome of the ICPD meeting.¹² Many MacArthur grantees from the US and developing countries that were funded by the Foundation to establish coalitions were instrumental in setting the agenda for Cairo and championing the ideas that were ultimately adopted. Global groups such as the International Women’s Health Center played key organizing roles in gathering organizations and movement leaders to prepare for and follow up on the ICPD (and subsequently Beijing) Platforms for Action. The Cairo report espoused many of the ideas that were at the core of the MacArthur PRH program. By virtue of grantees’ expertise in understanding and responding to these topics, they were, along with the Foundation, playing a thought leadership role as other donors, research organizations, and service organizations reoriented their population programs.

Given the power and rise of religious fundamentalism to influence public policy and people’s behavior, the PRH program began to integrate concerns about religious fundamentalism into its grantmaking. It made grants that fostered dialogue among religious leaders, promoted religious groups and perspectives that supported women’s rights and reproductive health, and supported research into the influence of fundamentalism on behavior and policy. Examples include grants to Catholics for Choice; the Columbia University Center for Population and Family Health for a Roundtable on Ethics, Population, and Reproductive Health; and Women Living Under Muslim Laws (WLUML) for work in Nigeria. This area of support was considered essential for expanding access to reproductive health information and services globally.

Another creative stream of grantmaking focused on the role of men in reproductive decision-making. In the mid-1990s this was a neglected area of work, and MacArthur’s support made a critical difference in encouraging new thinking in the population field on men, sexuality, and reproduction. The program made investments to address gender disparities in sexual relations and reproductive health decision-making as fundamental

¹¹ Silverstein et al., *The Population Program...* April 1995.

¹² Allan Rosenfeld, *Review of the Population Program & the Women’s Reproductive Health Grantees*, 1995.

to improving the reproductive health and rights of both women and men. Grants were made to several organizations in this field, including Promundo, the Population Council, India FLD grantees who developed films on masculinity, and the International Union for the Scientific Study of Population for a seminar called “Male Fertility in the Era of Fertility Reduction.” MacArthur’s support of including men and boys in programming for family planning and reproductive health, HIV/AIDS, and gender-based violence is significant, as previous work with men and boys was usually limited to increasing the use of male contraception.

By the beginning of the twenty-first century, the new paradigm that placed women's wellbeing at the center of population policy and focused on the rights of individuals to determine and plan family size according to their own wishes was widely accepted. Women's health advocates were increasingly well informed and well organized, and they exercised a strategic impact on policy decisions.

Several examples of this can be observed in the program’s country investments. Since the 1960s, India’s population programming was guided by contraception targets (number of users) set by central authorities. This system inevitably lent itself to abuse, including forced sterilizations. Targets were dropped in 1996 as the focus shifted to conducting decentralized community-needs assessments, with greater emphasis on maternal health and the prevention of sexually transmitted infections and HIV/AIDS. However, the needs of adolescents were still not addressed, and their SRHR went largely unrecognized.

In Nigeria, Foundation grantees were instrumental in establishing national guidelines for sex education and influencing HIV prevention.¹³ Working with the Federal Ministry of Health, grantees contributed to developing and implementing a reproductive health component of the country’s Adolescent Health Policy. This was particularly important in the Nigerian context, given that the average age at sexual debut among adolescent mothers in Nigeria was 15 years.¹⁴

In Mexico, Foundation grantees had succeeded at influencing government projects and policies on population issues by forging successful partnerships with the national government body (Consejo Nacional de Población, or CONAPO) and government agencies in ten states. In a number of states, grantees worked with officials to design and execute projects related to the implementation of the ICPD plan; topics included sexuality education, public health education, and violence against women.¹⁵

In Brazil, grantees contributed to critical advances in women’s health. For example, a focus on obstetric care, particularly the training of health professionals, contributed to a reduction in hospital-based maternal deaths. The establishment of municipal-level mortality committees to investigate all deaths of women of reproductive age increased the reliability of data on maternal mortality in the country. Significant progress was made in advancing protections against gender-based violence and increasing access to safe abortion services for women who were entitled to a legal pregnancy termination.

¹³ MacArthur, *Population Strategic Review*, 2000.

¹⁴ National Population Commission, Federal Republic of Nigeria, *Nigeria Demographic and Health Survey*, 2003.

¹⁵ MacArthur, *Population Strategic Review*, 2000.

It was clear by the end of the 1990s that the NGO movement in Brazil had matured, even if individual NGOs still suffered from institutional weaknesses. At that time, U.S. Foundations were under pressure to focus their resources to show impact, and in 2000 the MacArthur Board decided to end support for the Brazil program. Under the phase-out plan, the FLD grants were discontinued in 2001, and the Brazil office was closed in December 2002. The Foundation provided transition support as part of its exit strategy, making grants to key NGOs to bolster their organizational capacity and ensure that they would be able to continue their work. MacArthur also made a final grant of \$2 million, plus \$300,000 for administrative costs, to the Centro Brasileiro de Análise e Planejamento (CEBRAP) to seed a continuing source of grants.¹⁶ In 2003, the Foundation published a brief narrative history and lessons learned from the Brazil office that provides a more in-depth rendition of the Brazil years than this document, which prioritizes India, Mexico, and Nigeria whose work had not been documented in a similar fashion.

Investments in People: The Fund for Leadership Development (1991–2013)

MacArthur launched the Fund for Leadership Development (FLD) in Brazil (1991), Mexico (1992), Nigeria (1994), and India (1995). The program was directly implemented by the Foundation's country offices in the first ten years. It was then transitioned to local organizations with expertise on PRH issues: CEBRAP in Brazil (2003–2007); Sociedad Mexicana por Derechos de la Mujer (SEMILLAS, Inc.) in Mexico (2002–2013); Pathfinder International in Nigeria (2004–2008); and the Population Council in India (2004–2008).

The program supported opportunities for individuals to make substantive contributions to the PRH field by promoting innovative solutions and fostering new leadership. It provided broad and flexible support to local leaders working on complex PRH issues that addressed and/or added knowledge to challenges in the field, with an aim to strengthen and diversify leadership within countries and the field itself.

Awardees were selected annually by National Selection Committees or an Advisory Group of five to seven distinguished individuals. The selection process was flexible in searching for applications that allowed for innovation and risk-taking. This flexibility allowed committee members to also look at emerging leaders, not just established leaders within the PRH field. FLD grantees were paired with senior experts from the field who could provide mentorship, problem-solve, and broaden the grantees' perspectives. Training workshops and annual meetings created opportunities for networking. External experts conducted evaluations to monitor grantees' progress in project implementation and professional development activities.

In all countries, the one-to-three-year grants supported activities toward grantees' leadership development plans, including training, networking, and mentoring. Grants supported a wide spectrum of activities: travel, courses, conferences; time away from a job to write, reflect, and plan; the opportunity to pursue research; and seed funds to launch a new institution or project.

The program evolved with influence from each country. Grants covered a range of issues:

¹⁶ MacArthur, [The Population and Reproductive Health Program in Brazil: Lessons Learned](#), 2002.

reproductive healthcare; gender; sexual violence and gender-based violence; environment and sustainable development; access to reproductive healthcare for people living with disabilities; the role of men in reproductive health; HIV/AIDS; maternal mortality and morbidity; young people's sexual and reproductive health (YPSRH); Indigenous women's rights; sexual diversity and lesbian, bisexual, gay, transgender, and queer (LBGTQ) rights; and the role of political, religious, and community leaders in the reproductive health field.

Staff of the Foundation's country offices managed the program for the first 10 years, transitioning oversight after that to partner organizations to reduce staff workload and to enable more effective support to fellows.

A total of 456 individuals received grants as part of the FLD and transitional grants, with 33 percent in Mexico, 32 percent in Nigeria, 18 percent in India, and 17 percent in Brazil. The majority of the grantees (76 percent) were directly managed by the Foundation between 1990 and 2004, while 24 percent were managed by the four partner organizations between 2003 and 2013. MacArthur's investments in the program totaled \$22.8 million, with \$17.1 million granted when the FLD was administered by the Foundation offices, and \$5.7 million granted through partner organizations.

FLD outcomes were observed at multiple levels: individual, organizational, community, national, and international. A retrospective evaluation commissioned by the Foundation and carried out by the Institute of International Education in 2017 surveyed 177 FLD grantees.¹⁷ Data revealed that leadership development occurred in all countries, and that organizations, local communities, and countries benefited from FLD grantees' activities during and after their program participation. Some grantees reported that the FLD's unique approach to leadership development had a considerable effect on their careers: in supporting what other donors would not, FLD was a groundbreaking opportunity for those willing to take initiative. Grantees also influenced the knowledge and practice in and beyond the PRH field and improved the rights and access of marginalized groups to reproductive health services locally, nationally, and internationally.

Alumni also improved and strengthened their management and leadership skills. This was subsequently measured in their ability to start and manage new organizations. About 40 percent of survey respondents reported having created new organizations, most of which implemented activities relating to PRH. Examples include Anis – Instituto de Bioetica in Brazil, which focuses on bioethics from a feminist perspective; the RAHI (Recovering and Healing from Incest) Foundation, an Indian organization that addressed incest and sexual abuse, the first of its kind in the country; and the Center for Women and Adolescent Empowerment in Nigeria.

A significant proportion of grantees worked to influence policy and action in the public-health sector. Grantees went on to participate in legislative action such as drafting laws, working to decriminalize abortion in Mexico, serving as drafting committee members for India's first national mental-health policy, and mobilizing action for Nigeria's National

¹⁷ Institute of International Leadership, *Retrospective Evaluation of the MacArthur Foundation's Fund for Leadership Development*, 2017.

Health Act, which was enacted in 2014.

In developing countries, organizations and individuals often have difficulty accessing funding. Providing funding to individuals made FLD a unique program. When the program changed this element and started providing non-financial resources and training rather than the financial awards, such as with the Emerging Leaders Development Program in Nigeria, key stakeholders noted that the outcomes were not as impactful.

The broader thematic focus and flexibility of the program in its initial years allowed for more applications and innovation. The narrowing of the program to maternal mortality and morbidity, YPSRH, and a subsequent research focus led to a decrease in applications in India and Nigeria.

Periodic efforts were made to bring grantees together to network through workshops, annual seminars, and meetings, but the impact of this dissipated over the years in the absence of a networking platform through which alumni could stay in touch. A significant proportion of alumni conducted collaborative work with peers during the fellowship period and beyond. The evaluation concluded that a mechanism to track alumni could have been implemented to ensure that grantees could connect with one another, both within and across countries.

Managing the FLD program required a large, dedicated team for follow-up, information dissemination, networking facilitation, capacity-building, and day-to-day support.

According to some stakeholders, the FLD day-to-day support was sometimes insufficient. The small number of Foundation staff available to work on the FLD while managing other responsibilities in each of the countries was not enough to fully respond to program requirements. This was one important factor that led to the transfer of the FLD to intermediary organizations.

At its conclusion, the FLD program had successfully contributed to the development of a new generation of PRH leaders in the four countries. Some FLD recipients went on to become institutional grantees of the Foundation.

Phase 2: Focusing on Impact—The PRH Program’s Focus on Maternal Mortality and Morbidity (2001–2015) and Young People’s Sexual and Reproductive Health (2001–2014)

A review of MacArthur’s PRH program in 2000 noted that while in the past it was necessary to focus on work in international and intergovernmental arenas, the program needed to give greater attention to implementation at the country level and advancing select elements of policy and programmatic implementation. As a result, the program narrowed its grantmaking to two themes from 2001: reducing maternal mortality and morbidity (MMM) and promoting young people’s sexual and reproductive health (YPSRH). These were issues most pertinent in India, Mexico, and Nigeria, and influencing both themes would impact the PRH field as whole. Additionally, the eight Millennium Development Goals (MDGs)¹⁸ agreed upon by the United Nations (UN) in 2000 provided a consensus framework for reducing poverty in the developing world. MDG5 had two targets: to reduce the maternal mortality ratio (MMR) by

¹⁸ <https://www.un.org/millenniumgoals/>

75 percent, and to achieve universal access to reproductive health by 2015.¹⁹ The MDG5 goals set the context for the PRH program from 2001 to 2015.

Millennium Development Goal 5 (MDG5)

Target 5.A:

- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Indicators:

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

Target 5.B:

- Achieve, by 2015, universal access to reproductive health.

Indicators:

- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage
- Unmet need for family planning

* Maternal Mortality Ratio represents deaths per 100,000 live births

Maternal mortality was observed as the area with the least progress in the previous decade and where the most dramatic differences existed between richer and poorer countries—underscoring that the majority of maternal deaths are entirely preventable. MacArthur envisioned that support for work on maternal mortality would increase the chances that women would have safer pregnancies and deliveries. These improved outcomes were also an indicator of the availability of services that help women make informed reproductive choices. Reducing maternal mortality requires effective health systems but is also dependent on robust educational and legal systems. For example, besides good care, women need a legal environment that eliminates unsafe abortion, one of the major causes of maternal death and morbidity.

The focus on YPSRH came from the recognition that the sexual and reproductive decisions of young people would have long-term effects on their health and wellbeing and on the future of the planet. By 2000, the world had the largest cohort of young people in history, making this issue even more pressing.

These two streams of programming built on the accumulated experience that MacArthur had gained in the previous decade, while presenting opportunities for timely and targeted grantmaking with the potential to contribute to country-level advances toward MDG5 by 2015.

Under this more focused strategy, from 2000 to 2015, MacArthur approved 798 grants totaling \$212.7 million to support work on the themes of reducing MMM and promoting YPSRH.

¹⁹ <https://www.un.org/millenniumgoals/maternal.shtml>

Reducing Maternal Mortality and Morbidity

In 2000, the three priority countries—India and Nigeria in particular—contributed one-third of the world’s maternal deaths each year. Of the three countries, Mexico had the best possibility of reaching the MDG5 target; Mexico also had an opportunity to provide important lessons that could help other countries lower their maternal mortality ratio (MMR),²⁰ especially others in the region with large Indigenous populations such as Guatemala, Bolivia, or Peru. Within each country, Foundation support was primarily focused on a few states, and furthered government objectives for maternal mortality prevention within the framework of the Millennium Development Goals.

The following table summarizes MDG5 progress in India, Mexico, and Nigeria (2000–2015). The Foundation used national and subnational maternal mortality ratios as top-line indicators for the program’s contribution to national progress; many more intermediate, proxy indicators were tracked throughout the program period. While all three countries made progress during this period, none achieved their MDG5 target.

Millennium Development Goal (MDG5): 2000–2015 ²¹					
	2000		2015		% Change in MMR, 2000–2015
	Maternal Mortality Ratio*	Maternal Deaths	Maternal Mortality Ratio	Maternal Deaths	
Nigeria	1,170	62,000	814	58,000	31
Mexico	77	1,900	38	890	51
India	374	104,000	174	45,000	54

*Maternal Mortality Ratio represents maternal deaths per 100,000 live births.

MacArthur’s strategic approach on maternal mortality reduction can be categorized into three interrelated components: “horizontal” interventions in priority countries that strengthened healthcare systems and promoted the scale-up of civil society organization (CSO) programs; advocacy within focus countries and the global arena; and “vertical” interventions primarily within India and Nigeria.

Within maternal mortality prevention, “vertical interventions” are actions that prioritize financial, human, and other resources on one or more strategies to prevent or remedy a particular cause of maternal mortality (postpartum hemorrhage, eclampsia/preeclampsia, or unsafe abortion), while “horizontal interventions” simultaneously address several issues, including social and cultural aspects of health, health systems, and the broader gender,

²⁰ Maternal Mortality Ratio is defined as the number of maternal deaths over the number of live births. One of the main metrics in the field, it represents the risk associated with each pregnancy.

²¹ Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division, 2015.

political, and policy environments.

Horizontal Interventions

The Foundation supported horizontal approaches to tackle several interrelated health issues by strengthening health systems and developing integrated maternal-health service delivery systems. The Foundation had experience in this area, especially in the three priority countries, through its previous support for testing and scaling CSO interventions and policy advocacy. To have greater impact, the Foundation aligned its strategies with those of the national governments in the three countries.

The Mexico program put horizontal approaches front and center to improve maternal health coverage, especially in rural areas where understaffed clinics must attend to a broad array of health concerns. As a country with a comparatively lower maternal mortality ratio, and a cohort of relatively strong advocacy groups, horizontal rather than vertical strategies would likely yield greater results through improved policy. Horizontal interventions entailed, for example, oversight from civil society to ensure compliance with health-sector protocols and mandatory clinic hours; integration of bilingual health services or translation services for Indigenous non-Spanish speakers; and improved coordination between communities and health centers. The Mexico maternal health grantmaking prioritized states with high levels of maternal mortality – Chiapas, Guerrero, and Oaxaca, where Indigenous women face disproportionately high risks of death during pregnancy and childbirth. Foundation-supported civil society organizations were at the forefront of producing evidence and advocacy for new government policies. For example, Foundation grantees played a critical role in developing the 2008 Federal Ministry of Health guidelines, which replaced a risk-based approach with the more scientifically sound approach of increasing access to emergency obstetric care.

In India, the Foundation supported horizontal approaches to improve access and availability of maternal healthcare. In 2010, the Society for Education Action Research in Community Health (SEARCH) collaborated with the National Health Systems Resource Center, a government agency, to train master trainers for the Indian government's new cadre of Accredited Social Health Activists (ASHAs). This led to almost 860,000 ASHAs across the country being trained by 2012. Through grants to Jhpiego and the Federation of Obstetrics and Gynaecological Societies of India (FOGSI), the Foundation also supported strategies to shift tasks to lower levels, such as from obstetrician-gynecologists to general practitioners in rural areas in India, a strategy that received government support for scale-up across the country. Karuna Trust scaled a model to deliver a government-mandated package of primary healthcare services by improving the capacity of Primary Health Centre (PHC) staff and PHC management in eight states. Yet another example of successful scale-up was SEARCH's scaling of its home-based neonatal and maternal care through the National Health Mission in India.

Following a series of exchange visits to India in 2009, Nigerian maternal health practitioners and champions took inspiration from the Indian maternal health community's use of task-shifting and task-sharing to address the challenge of too-few trained medical professionals to meet the maternal and reproductive health needs of Nigerian women and families. Nigerian

grantees eventually contributed to the creation of a new *Task Shifting and Sharing Policy for Essential Health Services* in 2015. Similarly, the Nigeria PRH program launched a coordinated maternal health social accountability initiative to address a lack of access to services in Nigeria. More details on the country exchanges and subsequent policy initiatives can be found in the “Cross-Country Synergies” section of Part II.

In all three countries, grants facilitated the scale-up of CSO-led models by building significant collaborations with national, state, and local governments, and leveraging public-sector programs. Collaboration was a prerequisite for scaling up—an element that became important for the Foundation’s strategy (see the PRH Program’s International Grantmaking section of Part II for more information on the program’s scaling-up initiative). However, the effectiveness of collaboration and the pace of project implementation were (and continue to be) affected by policy changes, frequent leadership changes in state and district government, and a lack of clear communication between state and district program managers. Inadequate, poorly funded human resources posed a challenge to the entire public health system. The effectiveness of CSOs was also affected by the high turnover of skilled staff for programming in maternal health.

Advocacy within Focus Countries

Technical knowledge, global guidelines, and scientific evidence are of little value if they are not integrated into national policies. Advocacy that could bring about policy change and get good policies implemented was a core component of the PRH program.

Advocacy components were built into the design of most maternal health projects; however, MacArthur also made grants to promote strategic advocacy in each of its three priority countries with the aim of bringing visibility to specific issues and building a collaborative agenda.

In Mexico, the work led by Mexico National Safe Motherhood Committee (NSMC) is an example of how common ground can be established in non-traditional partnerships that can further develop sustainable initiatives at the national and local levels. Originally launched as an interagency group in 1993, the NSMC is an active, 30-member alliance that works closely with decision-makers. Its membership includes governmental organizations and dozens of NGOs; indeed, most of the organizations that received MacArthur grants for maternal health work were part of the Committee at one point of its long history. With its central focus on women and inter-institutional collaboration, the NSMC is credited with shaping national policy in Mexico, raising public awareness about maternal health, garnering commitment to safe motherhood, training health workers and program planners, launching research, and testing pilot programs and interventions. The participation of high-level decision-makers such as the national and some state-level Ministries of Health, and sector-specific public-health systems such as the Mexican Social Security Institute and Centro Nacional de Equidad de Género y Salud Reproductiva (CNEGSR, National Center for Gender Equity and Reproductive Health, a division of the federal Ministry of Health) in its ordinary meetings are key to NSMC’s influence and reach. The NSMC made space for new partners who support safe motherhood through its participation in other networks, such as the Ministry of Health’s Inter-Institutional Groups for Reproductive Health and its Fair Start in Life Program

(Arranque Parejo en la Vida), as well as civil society initiatives such as the Observatory of Maternal Mortality in Mexico (also a MacArthur grantee) and the Committee for the Prevention, Study and Monitoring of Maternal Mortality and Morbidity and of Newborn Health in Mexico City.²²

In India, support for the White Ribbon Alliance for Safe Motherhood India (WRAI) through grants to the Center for Development and Population Activities (CEDPA) and the Centre for Catalyzing Change gave voice to women's and community concerns about maternal health services through community hearings, reports cards on facilities, public campaigns, and media. MacArthur's continuous support for the WRAI Secretariat, beginning in 2002, enabled the alliance to build a network of thousands of individuals and over 2,000 organizational members. At the policy level, WRAI engages respected key influencers, public figures, and celebrities to capture the public's interest and alert politicians and policymakers to the issue. WRAI, with other stakeholders, successfully advocated for the expansion of life-saving skills for birth attendants. More recently, WRAI supported the government in identifying Respectful Maternity Care as an essential component of the Government of India's Labour Room Quality Improvement Initiative ("LaQshya") in public health facilities around the country. LaQshya includes Respectful Maternity Care as one of its program objectives, and trains care providers in observing it in their work. WRAI has strategically used high-profile events to catalyze action; their advocacy efforts resulted in the government-declared "National Safe Motherhood Day" on April 11, 2003, the first of its kind in the world.²³

In Nigeria, the Center for Development and Population Activities (CEDPA) served as the advocacy hub for MacArthur's grantmaking on maternal health. CEDPA partnered with other grantees in the Nigeria portfolio that were introducing accountability mechanisms and community engagement tools to promote knowledge on the issue through seminars and exchange visits to other countries that had implemented successful experiments in this area. CEDPA also worked with grantees and UN agencies to support Nigeria's commitment to the ICPD agenda. Additionally, CEDPA worked with policymakers and health facilities to streamline the ambulance service in Lagos State to serve the needs of pregnant women.

Vertical Interventions

Within maternal mortality prevention, "vertical interventions" are actions that prioritize financial, human, and other resources on one or more strategies to prevent or remedy a particular cause of maternal mortality, such as **postpartum hemorrhage**, **eclampsia/preeclampsia**, or **unsafe abortion**. Because these three problems together contributed to a large proportion of all maternal deaths worldwide and in the priority countries, there was significant value in the Foundation's focus on them within the broader context of strengthening weak health systems.

²² Jill Gay and Deborah Billings, *Evaluation of The MacArthur Foundation's Work in Mexico to Reduce Maternal Mortality, 2002-2008*, 2009.

²³ <https://www.whiteribbonalliance.org/india/>

Postpartum Hemorrhage

Postpartum Hemorrhage is the leading cause of maternal death in many (developing) countries. The paucity of blood banks, the lengthy distances between communities and hospitals make attending hemorrhage once it has onset difficult and render preventing PPH of utmost importance. The Foundation was a principal investor in devising and rolling out PPH prevention strategies.

The Foundation developed and supported a three-part strategy for preventing, identifying, and treating **postpartum hemorrhage (PPH)**: use of misoprostol²⁴ during the third stage of labor as a preventive measure; a blood drape to aid health workers in identifying hemorrhage by measuring blood loss; and use of the Non-Pneumatic Anti-Shock Garment (NASG) to stabilize women experiencing hemorrhage and prevent further blood loss and subsequent shock.

Experience showed some early successes and challenges in this strategy. In India, for example, misoprostol administered following childbirth to prevent PPH was accepted into national policy, while in Nigeria it was approved for use at a facility level only and not at the community level, due to concerns that the drug that can also be used to terminate unwanted pregnancies.²⁵

Research supported through grants to the University of California San Francisco demonstrated that the NASG reduced PPH. A grant Pathfinder International facilitated the rollout of the NASG in Nigeria and India. An evaluation of NASG-related grants indicated that the garment was successfully accepted in Nigeria and demand for it was relatively robust.²⁶ In India, however, the NASG had a slow rollout, in part, because a smaller garment was needed in India to ensure adequate prevention for Indian women. The evaluation found that “while the garment, by itself, can only save the few women who experience severe hemorrhage, using this compelling technology as an entrée into complex health systems and improving the quality of basic obstetrical care in these facilities can significantly reduce the incidence of postpartum hemorrhage. The anti-shock garment is an important clinical and policy tool. At the clinical level, it gives staff extra time to access treatment for women who are hemorrhaging and makes it possible to transport patients who need more advanced care. As a policy tool, it inspires interest and collaboration from governments and other partners and has proven very helpful in leveraging additional resources from both the public and private sectors. But it is the improvements in quality of the obstetrical care, specifically the active management of labor (including access to effective drugs and blood supplies), that appear to be having the biggest impact on outcomes.”

Though the NGO PATH received a separate grant to identify and test alternate manufacturers in China and India, the cost of making, transporting, and maintaining the NASGs was high,

²⁴ Misoprostol is a low-cost, shelf-stable medication that can be used to prevent and treat stomach ulcers, induce abortion, and to prevent and treat post-partum hemorrhage.

²⁵ Public Health Institute, *Community Based Distribution of Misoprostol for the Prevention of Postpartum Hemorrhage: Public and Private Approaches in Nigeria*, 2014.

²⁶ Francine Coeytaux and Elsa Wells, *Anti-Shock Garment for Postpartum Hemorrhage: Technology as a Catalyst for Health Systems Strengthening*, November 2011.

discouraging governments in India, Nigeria, and elsewhere from acquiring the garment in large numbers. Pathfinder International supported large-scale training of providers in Active Management of Third Stage of Labor (AMSTAL) in India and Nigeria.

Additionally, the PRH program supported Pathfinder International and the Women's Refugee Commission (WRC) to test and document use of the garment in refugee camps. In 2012, the World Health Organization (WHO) recommended the NASG as a temporizing device to treat PPH, which opened the possibility of countries and UN agencies procuring the device.²⁷ More recently, the humanitarian community has begun using the garment in refugee and emergency settings.

The grants on the NASG, totaling \$17 million, represented substantial investments for the PRH program. Developing and launching new technologies requires major, long-term investments and a capacity to absorb setbacks, and a dedicated team with specific experience in product development. After this initial investment, the Foundation reduced its funding of interventions such as the NASG while other investors took it on. Today, the NASG is part of the basic equipment at some hospitals and the humanitarian community has adopted it as an approach to care.

Preeclampsia/Eclampsia

Worldwide, **preeclampsia/eclampsia** is an important cause of maternal death, accounting for approximately 12 percent of maternal mortality. Research has shown that eclampsia is best addressed with the drug magnesium sulfate. However, there are challenges that accompany the drug: although it is inexpensive, its availability was not widespread. Many of today's practicing health practitioners and professors in Nigeria and India completed their training before definitive research on magnesium sulfate was carried out and did not know of its effectiveness. Patients who are given magnesium sulfate intravenously need to be monitored to prevent the drug from reaching toxic levels, which can be a challenge in underfunded health systems where healthcare personnel are scarce. Training, information, and advocacy were essential steps to getting magnesium sulfate into clinics.

In Nigeria, the Foundation played a key role in breaking down barriers to accessing magnesium sulfate. One of its strategies was to support pilot projects, carefully document procedures and implementation processes, measure impact, and share the results widely. As observed in the findings of a grant to the Population Council, the results of magnesium sulfate uptake in northern Nigeria in 2008 were encouraging, and the Kano State Ministry of Health scaled the intervention to all 36 hospitals in the state. A grant to the Federal Ministry of Health served a "pump-priming" purpose: the Foundation's \$500,000 led to an expenditure of over \$2 million of the Ministry's own funds, and a commitment to promote the intervention in all 36 states.

The Foundation also explored a new delivery system for magnesium sulfate. The Springfusor pump, used to ensure slow, controlled administration of the drug to prevent toxicity, was tested by Gynuity in India. However, the product did not gain much traction

²⁷ https://www.who.int/medical_devices/innovation/new_emerging_tech_30.pdf

despite its clinical efficacy.

Safe Abortion

Each year, between 5 and 13 percent of maternal deaths are caused by unsafe abortion.²⁸ MacArthur was one of the early donors that supported work on **safe abortion** in the priority countries. Numerous organizations contributed to making safe abortions services more accessible to women through advocacy, research, and pilot interventions.

Mexico

The induced abortion rate of 33 per 1,000 women of reproductive age in Mexico is relatively high by worldwide standards (abortion incidence is estimated to be 29 per 1,000 in developing countries overall). About one in six women in Mexico who had abortions in 2006 were hospitalized for complications resulting from unsafe practices.²⁹ A 2008 evaluation of the Mexico PRH program observed that Foundation grantees contributed to ensuring access to safe abortion services.³⁰

The Information Group on Reproductive Choice (GIRE), Católicas por el Derecho a Decidir, Equidad de Género, and the Mexico offices of Ipas and The Population Council, worked to ensure that women would have access to safe, legal abortion and post-abortion care. In 2001, they formed the Alliance for the Right to Decide, backed by a coalition of international donors, including MacArthur. In coordination with other partners, the Alliance developed an expansive strategy that included research, training, creating youth-activist networks, disseminating information to inform policy and legislative debates, and raising awareness in Mexico about the detrimental impact that unsafe (clandestine) abortion has on the health of women. The evidence, arguments, and approaches that they developed were the backdrop for the historic 2007 decriminalization of abortion in Mexico City and the subsequent 2008 Supreme Court ruling that upheld its constitutionality.

Foundation grantees have been at the forefront of transforming medical education related to abortion. Since 2000, members of the Alliance worked to incorporate abortion-related content and general human rights and reproductive health content into the curricula of medical and nursing schools throughout Mexico. Their early work smoothed the transition from clandestine to legal abortion in Mexico City in 2007, since doctors had been trained in comprehensive abortion care and had acquired the knowledge, sensitivity, and skills needed to support the public health system's roll-out of services and enable women to access them. In 2019, the National Autonomous University of Mexico's School of Nursing finalized course syllabus for providing safe, legal abortion.

²⁸ <https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion>

²⁹ <https://www.guttmacher.org/journals/ipsrh/2008/estimates-induced-abortion-mexico-whats-changed-between-1990-and-2006>

³⁰ Gay and Billings, *Evaluation of The MacArthur Foundation's Work in Mexico...*

India

While abortion has been legal under broad criteria in India since 1971, the availability of safe abortion services remains limited, especially in rural areas. In response to the significant number of unsafe abortions in the country and their resulting deaths and injuries, in 2000, Ipas, with support from MacArthur, started work to bring the concept of comprehensive abortion care (CAC) to India. Beginning in two districts in the state of Maharashtra, Ipas worked to create a pool of qualified abortion providers who offered high-quality services using safe technologies. Today, Ipas's CAC certification training creates 600 legal abortion providers annually, effectively making services available to women who previously had no access to these services. Most of these providers go on to work in rural areas, thereby reaching vulnerable populations. Ipas also provides post-training support, promotes safe technologies, and develops communication strategies designed to reach women with the right information. While MacArthur supported the expansion of Ipas's work into four states, Ipas now provides technical assistance to the Government of India's Ministry of Health and Family Welfare in 12 states. Concentrated efforts to transform abortion services to women-centered services have since gained traction, and the Government of India adopted CAC under the National Health Mission.³¹

Research

MacArthur participated in a consortium of donors to support the Guttmacher Institute to increase the evidence on abortion, unintended pregnancy, and contraception. Guttmacher's 2015 Nigeria factsheet revealed that although abortion is legal in the country only when performed to save a woman's life, abortions are common, and most are unsafe because they are done covertly or by unskilled providers (or both). Unsafe abortion remains a major contributor to the country's high levels of maternal death, ill health, and disability.³² In India, Guttmacher conducted the first study specifically designed to measure the national incidence of abortion in India. The study was done in 2015–16 in six Indian states, where close to half of Indian women of reproductive age live.³³ According to the study, an estimated 15.6 million abortions were performed in India in 2015.³⁴ This translated to an abortion rate of 47 per 1,000 women aged 15–49, which almost doubled the estimates that public health agencies used to design their programs. The study also found that out of India's total 48.1 million pregnancies in 2015, about half were unintended—meaning they were wanted later or not at all. The breadth of the study and the findings can be used to inform policies and programs to expand and improve provision of safe abortion services in the six study states; they may also be relevant for improving services in similar settings in other parts the country. In India, Mexico, and Nigeria, the evidence has been used for advocacy to educate policymakers on strengthening safe abortion services.

³¹ <https://www.ipasdevelopmentfoundation.org/comprehensive-abortion-care.html>

³² <https://www.guttmacher.org/fact-sheet/abortion-nigeria>

³³ Susheela Singh et al., *Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs*, Guttmacher Institute, 2018.

³⁴ *The Lancet Global Health*, "The incidence of abortion and unintended pregnancy in India, 2015," January 2018.

Promoting Young People’s Sexual and Reproductive Health

The PRH program sought to improve young people’s sexual and reproductive health (YPSRH) by investing in initiatives focused on increasing age at marriage and first birth, testing and scaling sexuality education and youth-friendly services, advocacy with government and key influencers, and select research studies. Along with the Packard and Ford Foundations, MacArthur was an early funder of YPSRH.

The Foundation made investments in youth-led organizations advancing YPSRH. While there were programmatic variations among the three countries, advancing the implementation of sexuality education and youth-friendly services were identified as priority interventions. The specific objectives of the program were to: 1) advocate for and extend the delivery of sexuality education at the state level; 2) develop and test models to mainstream YPSRH within a larger framework of health and development; and 3) promote a favorable policy environment for the health and empowerment of young people. From 2000 to 2014, the PRH program made 300 grants, totaling \$65 million, to support YPSRH.

Most PRH grantmaking in this theme supported pilots, but often without adequate monitoring and evaluation, due to lack of funds, limited evaluation capacity, and the inherent difficulties that come with trying to measure the impact of an intervention (e.g., sexuality education) delivered years before the outcome of interest (e.g., first birth). In addition, monitoring and evaluation was not as prevalent in the field at the time as it is today. Furthermore, as the work progressed, there was increased recognition that “young people” are an extremely heterogeneous population (ages 10 to 24, married and unmarried, in and out of school, working and not working, living in urban areas and in rural areas, etc.) and that interventions must be designed by and for particular populations (e.g., newly married couples in an urban slum, unmarried girls in peri-urban communities, etc.). It was not possible to attribute the impact of MacArthur grantmaking to changes in demographic indicators, such as age at marriage and first birth, so changes in knowledge and attitudes, the social mobility of young people, and success in scaling-up priority interventions were used as intermediate measures of success.

In all three countries, the Foundation’s support for work in YPSRH was critical for organizations to establish dialogues to address the discomfort and stigma attached to these issues. Unlike work in maternal mortality prevention, the field of YPSRH internationally has fewer advances to note. Several factors contribute to this relative lack of progress, all of which affect the field at large and are not specific to any of the three countries. Youth sexual and reproductive health remains taboo, especially regarding unmarried youth, creating obstacles to accessing reproductive health information and services. There have been limited investments in documenting what works best for younger adolescents and young people in different contexts. Despite guidelines from international agencies and NGOs (the World Health Organization and Population Council, for example) on what constitutes youth-friendly services, and national protocols outlining the rights and responsibilities of healthcare providers vis-à-vis adolescent patients, discomfort with youth sexuality makes it difficult for service providers to meet these standards. Lack of coordination and ownership among key stakeholders in the health and education sectors also complicate synergistic

advances that could improve access to information and services. Peer-learning programs and youth leadership models require continuous support as their membership and leadership are constantly renewed. Through longer-term grants, organizations were able to develop key capacities that contributed to strengthening and building institutional sustainability over time, and grantees, especially those in India, have continued to flourish.

India

MacArthur's PRH program made YPSRH a grantmaking priority in India as early as 2001, long before the issue of child marriage became the focus of other global, regional, and national agendas. The India program supported a range of approaches to YPSRH, including several out-of-school/residential programs that aimed to provide life skills education. Eventually, the Foundation discontinued its support for out-of-school life skills programs as they demonstrated limited potential for scaling up. Despite strong political and societal opposition, Foundation grantees continued to advocate for the implementation of in-school, age appropriate, and culturally acceptable life skills training, which helped keep the door open for incremental efforts by state governments. This contributed to a greater present-day acceptance of state education departments teaching a life skills curriculum with a stronger focus on gender, preventing gender-based violence, and developing negotiation skills. Grantees such as the International Centre for Research on Women (ICRW), Child in Need Institute (CINI), and Ritinjali successfully partnered with the state governments of Maharashtra, West Bengal, and Rajasthan, respectively, to implement gender and life skills curricula. ICRW's Gender Equity Movement in Schools (GEMS) curriculum, which was piloted in Mumbai schools, received support from another donor for implementation in the state of Jharkhand, as well as other South East Asian countries. Their work was quoted in a 2015 report as one of the more successful gender transformative programs piloted in India.³⁵

The India PRH program's investments in primary research on youth in India have subsequently informed policy and program development in the country. The International Institute for Population Sciences and Population Council, with co-funding from Packard Foundation, conducted the "Youth in India: Situation and Needs" 2006-07 study, the first population-based survey in India dedicated to young people. It was conducted in six states and focused on key issues facing youth, ranging from education and entry into the labor force to sexual life, marriage and childbearing, health, and citizenship.³⁶ In 2012, MacArthur made a grant to the Population Council for a follow-up study with a sample of youth who were previously interviewed in adolescence in 2007.³⁷ The survey results, released in 2014, provide a longitudinal view of the process of moving from adolescence to adulthood and an understanding of the skills and resources young people must have to make a successful transition to adulthood. The results have informed young people's programming by donors and government; convinced of the value of these longitudinal surveys, the Packard and Gates foundations have since commissioned similar surveys in the states where they focus their programming.

³⁵ Muralidharan et al., "Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Findings from a Systematic Review of Gender-integrated Health Programs in Low and Middle Income Countries," *Health Policy Project*, 2015.

³⁶ <https://www.popcouncil.org/research/youth-in-india-situation-and-needs-study>

³⁷ Shireen J. Jejeebhoy and Rajib Acharya, *Adolescents in Rajasthan 2012: Changing Situation and Needs*, 2014.

The India portfolio enjoyed a significant achievement in 2013, when the Ministry of Health and Family Welfare included plans for incorporating adolescent health in the National Health Mission strategy for the first time. The “Reproductive Maternal Newborn Child and Adolescent Health” strategy acknowledged that India’s goals for achieving lower maternal and infant mortality and population stabilization would not be achieved without addressing the needs of adolescents and young people.³⁸ Subsequently, the Ministry partnered with the United Nations Population Fund (UNFPA) to launch Rashtriya Kishore Swasthya Karyakram (RKSK) for adolescents aged 10–19 years to address nutrition, reproductive health, and substance abuse, among other issues.³⁹ Grantees such as the MAMTA Health Institute for Mother and Child, Population Council, Sangath Society, CINI, ICRW, and the YP Foundation contributed heavily to the development of the adolescent health policy and program through their membership on technical committees.

MacArthur’s influence was demonstrated by the inclusion of intervention components piloted by grantees that sought to provide quality reproductive health services to young people, increase age at marriage, and delay the first pregnancy. Grantee efforts that worked at the intersection of mental and reproductive health, delivered sexuality education, and included boys in reproductive health programming also found mention in the RKSK program.

Mexico

The Mexico YPSRH portfolio supported initiatives that sought to improve the delivery of sexuality education and youth-friendly reproductive and sexual health counseling and services. When YPSRH grantmaking started in 2000, its emphasis was on building civil society capacity to leverage change in the public health and education sectors. Because Mexico has few large service-providing CSOs, the program recognized that any grand-scale initiatives must include the public sector. Thus, a unique feature of this portfolio was that nearly all of the grantees had some kind of collaboration with government or intention of improving public education and health services, whether at the municipal, state, or federal level, in the health and education sectors. In 2010, a geographic focus was added to the Mexico YPSRH portfolio to align it with the maternal mortality work in Chiapas, Oaxaca, and Guerrero.

From 2000 to 2006, most of this work focused on the health sector due to ongoing programs by the Ministry of Health and IMSS Oportunidades (the rural health system), that sought to advance young people’s access to reliable information about sexuality and contraceptives. The Foundation also supported some work to promote comprehensive sexuality education by grantees Afluentes and Democracy and Sexuality, which provided technical and strategic input on sexuality education with state and federal Ministries of Education. MacArthur supported a range of initiatives, from policy design to implementation and monitoring. Most of the advocacy and policy work was done at the federal level, with comparatively little at the state level. The Fundación Mexicana para la Planificación Familiar (MEXFAM), Sistema Nacional de Promoción y Capacitación en Salud Sexual (SISEX), Democracy and Sexuality, and

³⁸ https://www.nhp.gov.in/reproductive-maternal-newborn-child-and-adolesc_pg

³⁹ https://www.nhp.gov.in/rashtriya-kishor-swasthya-karyakram-rksk_pg

Afluentes helped secure the integration of youth-friendly services into federal Ministry of Health programs and conducted extensive training of health providers. Ipas Mexico conducted work in medical schools to incorporate the rights and obligations of healthcare providers attending adolescents and young people. As a result, federal programs today recognize the importance of youth-friendly services and have outlined the goal of increasing their availability.

Catholics for the Right to Decide and Equidad de Género created what became Mexico's two largest and most vibrant national networks of youth leaders promoting YPSRH in their states. These networks monitored service delivery in southern Mexico and documented a discrepancy in the number of reported youth-friendly centers. Through field work and using the access to information law, these organizations were able to show that of the hundreds of health centers the government claimed were operating as "youth-friendly centers," only a handful met the Ministry of Health's criteria.

Social mobilization and networking building around YPSRH were essential to getting the voices and needs of young people heard, and their perspectives into youth-friendly policy. The program supported two national networks: Democracy and Sexuality and SISEX. The former received support for work on sexuality education in the schools; the latter for monitoring the youth friendliness of health services. Groups like Catholics for the Right to Decide and Equidad de Género created new national networks that expanded the movement and connected young people who identified with their organizational mission. Elige, an organization composed of activists under the age of 30, coordinated with informal youth groups in Mexico City and other major cities to increase attention to YPSRH. It developed a model with the Mexico City government's Women's Institute that provided sexuality counseling and information in marginalized districts and included a mobile unit that traveled through neighborhoods. SIPAM worked with Mexico City high schools to engage school doctors in creating school-based youth groups, promoting better links between health centers and schools and increasing access to information on sexuality and reproduction; later, it worked to strengthen Indigenous youth participation in YPSRH advocacy at the state, national, and international levels.

In 2010, the portfolio shifted to highlight and deepen its support for local work to improve YPSRH in Indigenous communities, with the goal of strengthening groups in Indigenous states (including Chiapas, Guerrero, and Oaxaca) and to see more community organizing and impact. Lead groups include Asesoría, Capacitación y Asistencia en Salud, A.C. (ACASAC), Marie Stopes Mexico, and Chiltak in Chiapas; Grupo de Estudios sobre la Mujer Rosario Castellanos in Oaxaca; MEXFAM in Oaxaca and Guerrero; and others with no specific target state like Grupo de Investigación en Mujer, Trabajo y Pobreza (GIMTRAP). While most organizations developed local models, some explored scaling up using methodology developed by Management Systems International, a grantee in the PRH International portfolio. With Foundation support, several of these organizations contributed research and leadership to the creation of an Indigenous youth movement mobilized around the most pressing YPSRH issues, as defined by youth in Chiapas, Guerrero, and Oaxaca.

Nigeria

In Nigeria, the program made school-based sexuality education its main priority. Early support to grantees from other donors had supported the National Council on Education's groundbreaking 2002 decision to approve a high-quality curriculum for sexuality education. In response, MacArthur shifted its support to adapt and implement that curriculum. NGOs in six states (Lagos, Cross River, Plateau, Enugu, Kano, and Niger) were selected to work with their respective state ministries of education.

Over time, the six NGOs found different degrees of success, and grantmaking changed accordingly. Unfortunately, despite best efforts in Kano State by Adolescent Health and Information Projects, or AHIP, and in Enugu State by the Global Health Awareness and Research Foundation, or GHARF, it was impossible for the grantees to get permission to talk about any approach to contraception other than abstinence; funding was eventually ended for those programs. The grants to groups in the states of Cross River (Girls Power Initiative, or GPI); Plateau (Youth, Adolescent, Reflection & Action Centre, or YARAC); and Niger (Centre for Communication and Reproductive Health Services, or CCRHS) each tell a different story. Niger State is Muslim; although the original plan was to talk only about abstinence, the teachers themselves made it clear that they knew some of their students were sexually active and they wanted to talk at least about condoms, so this was incorporated into the curriculum. GPI's curriculum was the most overtly gender-sensitive curriculum and was based on a feminist approach that characterized all of the organization's programs. An assessment of the project implemented by Action Health Incorporated (AHI) and the Lagos Ministry of Education in Lagos State showed evidence of knowledge and attitude change, but little evidence of behavior change. Teachers were comfortable with the content and curriculum, and students increasingly developed gender-equitable attitudes and found more reasons to abstain from sex, but overall student knowledge of contraception and contraceptive use remained low.⁴⁰

In 2007, the Nigeria portfolio evolved its grantmaking to focus on a scale-up strategy, incorporating courses on sexuality education into the curriculum in teacher-training colleges both at the state level (by GPI, YARAC, and CCHRS) and the federal level. In Lagos, AHI took the lead in trying to get similar courses into federal teacher-training colleges. Grants to AHI, combined with smaller grants to the quasi-governmental National Commission of Colleges of Education (NCCE), led to the institutionalization of a compulsory two-credit course in all federal and state teacher-training colleges. A shorter version of the program was scaled up with UNICEF support.

In 2012, the Foundation's International portfolio made a grant to the International Women's Health Coalition (IWHC) to conduct a qualitative assessment of Nigeria's in-school youth sexuality education efforts. While there was little evidence of changing health behaviors, there was evidence suggesting that gender-sensitive sexuality education may not only benefit health, but also change attitudes about gender and improve the quality of teaching

⁴⁰ Philliber Research Associates, *The Progress of Comprehensive Sexuality Education in Lagos State: Report from Teachers*, 2004.

and learning outcomes.⁴¹ The Nigeria program also invested in the use of mobile and digital technology approaches to improve youth sexual and reproductive health.

Implemented by OneWorld UK, Mobile4Good was a text message application aimed at sending sexuality education messages. The knowledge gaps, volume of queries, and strong sense of urgency and emotion evident in the messages reflected a substantial unmet need for basic sexual and reproductive health information, a culture of silence around youth sexual and reproductive health, and a need for information free from social taboos.⁴² These findings are valuable for designing health promotion and education interventions targeting young people. The MacArthur-supported “Learning about Living” program was an animated, computerized version of the national sexuality education curriculum customized to Nigerian youth. The availability of this series of lessons and games made it easier for teachers themselves to feel comfortable with the material, proving useful both in classroom settings and online.

PRH Program’s International Grantmaking

To complement the country portfolios, which supported work exclusively on the two priority themes and in the three priority countries, the International portfolio made awards to larger, international NGOs, often headquartered in the United States, to build and sustain the infrastructure of the broader sexual and reproductive health field. In addition, the portfolio supported efforts to reinforce work in priority countries; fund research that responded to gaps in knowledge; fund global maternal, youth, and reproductive health efforts; and promote advocacy, accountability, and resource allocation for sexual and reproductive health. Anchor institutions included the Population Council’s U.S. office (for research on PRH issues); the Center for Reproductive Rights (to promote legal advocacy strategies globally); the International Women’s Health Coalition and International Planned Parenthood Federation Western Hemisphere (for UN-focused advocacy); the Center for Health and Gender Equity (CHANGE) (to promote government-focused PRH advocacy in the United States); and Reproductive Health Matters (to disseminate knowledge on reproductive health through the publication of a journal and to elevate the work of authors from the Global South).

The PRH program supported research to provide evidence for prioritizing strategies or interventions. One such grant to Harvard supported researcher Sue Goldie for mathematical modeling and analyses to guide public-health decision-making related to maternal mortality.⁴³ The Maternal Health Task Force at the Harvard T.H. Chan School of Public Health established a neutral space for convening the maternal health community through conferences, technical meetings, research, education, and a state-of-the-art knowledge management system. The London School of Tropical Medicine and Hygiene

⁴¹ Susan Y. Wood, Deborah Rogow, & Frederica Stines, “Preparing teachers to deliver gender-focused sexuality/HIV education: a case study from Nigeria,” *Sex Education: Sexuality, Society and Learning* 15, no. 6, 671–685, 2015.

⁴² Ann K. Blanc, Kimberly Glazer, Uju Ofomata-Aderemi, and Fadekemi Akinfaderin-Agarau, “Myths and misinformation: an analysis of text messages sent to a sexual and reproductive health Q&A service in Nigeria,” *Studies in Family Planning*, 2016.

⁴³ Sue Goldie et al., “Alternative Strategies to Reduce Maternal Mortality in India: A Cost-Effectiveness Analysis,” *PLOS Medicine*, 2010.

coordinated the preparation of the influential 2016 *Lancet Maternal Health Series*,⁴⁴ and the London School received a grant to disseminate its findings. Grants to Syracuse University supported research in India and Nigeria on political will as a factor in strengthening health systems to reduce MMM.⁴⁵ Grantees such as the White Ribbon Alliance for Safe Motherhood; Global Health Council; CARE; the Partnership for Maternal, Newborn and Child Health (PMNCH); Council on Foreign Relations; and Women Deliver organized for evidence-based change and funding.

The PRH program sought to fund catalytic pilot interventions that, if successful, would be scaled up by the public sector. Yet not enough was known about how, when, and under what circumstances projects would be taken to scale. To address this gap, the International portfolio made a series of grants to Management Sciences International and ExpandNet to advance the science and practice of scaling up. Both organizations produced frameworks to describe the stages of scale-up, created step-by-step tools for practitioners, and provided technical assistance to organizations around the world. Initially, the tools were created for reproductive health programming, but, over time, were effectively used for environmental, water and sanitation, and other international development issues.

Another stream of work focused on extending maternal mortality interventions to crisis and conflict settings to help bridge gaps in services available for internally displaced persons (IDPs) and refugee populations. From 2009 to 2016, the PRH International portfolio recommended ten grants totaling \$3.2 million for this area of work. Pathfinder International received a grant to pilot the incorporation of a postpartum hemorrhage model within the Minimum Initial Service Package (MISP) in Tanzania. MISP activities are designed to be implemented by humanitarian workers operating in health, camp design and management, community services, protection, and other sectors. Grants supported the Women's Refugee Commission (WRC) for a global review of reproductive health among crisis-affected populations and for the WRC to use its advocacy capacity, connections, and experience to address the gaps related to maternal healthcare, comprehensive abortion care, and emergency contraception identified in the global evaluation. Projects to improve the delivery of maternal and reproductive health services in Burma were supported by funding to WRC and Community Partners International. Grant funding secured a medical officer position at WHO headquarters within the Department of Reproductive Health and Research. The medical officer appointed was an obstetrician-gynecologist with emergency training, field-level experience in conflict settings, and global expertise on SRH in humanitarian contexts who was a dedicated presence at the WHO headquarters working to improve coordination, training, and response at the global level. This officer reported that her experience working on the MacArthur-funded projects helped her contribute to planning an effective response during the 2014–2016 Ebola outbreak in West Africa.

Additionally, the PRH program partnered with MacArthur's Conservation and Sustainable Development (CSD) program to make exploratory grants that supported an integrated, community-based approach to population, health, and environment (PHE). This work

⁴⁴ <https://www.thelancet.com/series/maternal-health-2016>

⁴⁵ J. Shiffman and RR Ved, "The state of political priority for safe motherhood in India," *BJOG: An International Journal of Obstetrics & Gynaecology*, 2007; J. Shiffman and FE Okonofua, "The state of political priority for safe motherhood in Nigeria," *BJOG: An International Journal of Obstetrics & Gynaecology*, 2007.

started with a 2010 grant to Blue Ventures Conservation to design and implement a package of community-based maternal, newborn, and child health interventions to meet the needs of the community covered by a Blue Ventures project in southwest Madagascar. This stream of work received a further push in 2011–2017, when MacArthur’s PRH and CSD programs collaborated with the Packard Foundation and the United States Agency for International Development (USAID) Office of Population to make two grants, totaling \$4 million, to Pathfinder International to develop and evaluate a new model for community-based work in the Lake Victoria Basin of Kenya and Uganda. The HoPE-LVB (Hope of People and Environment in Lake Victoria Basin) project worked to reduce threats to biodiversity conservation and ecosystem degradation, while simultaneously increasing access to sexual and reproductive health services to meet women’s and couple’s needs for contraception and improving maternal and child health in project communities.

Results from an internal evaluation showed that the project was ambitious in targeting improvements across multiple sectors, and additionally sought “integration”—related impacts on factors such as gender relations and youth engagement. Notably, achievements were measured in almost every sector. Integration had taken place at the community and policy levels and resulted in positive health and conservation outcomes.⁴⁶ However, it was evident that achieving transformative outcomes in multiple domains requires extraordinarily high interdisciplinary capacity, and that it must be continuous, not interrupted by typical funding cycles of three to four years. Furthermore, evaluating an integrated program is an extremely complex task requiring high levels of resources and interdisciplinary expertise that were in short supply, especially in lower-resource settings. Nevertheless, project findings showed that a PHE strategy could be effectively adapted and refined for different settings.

Historically, the International portfolio supported little work on YPSRH because so much of the overall PRH budget was devoted to the topic at the country level. Grants to Promundo-US supported research, advocacy, and training on increasing men’s role in reproductive and maternal health. The International Women’s Health Coalition was funded for the evaluation of the sexuality education programs in Nigeria. In 2012, the portfolio also made a grant to researchers at Johns Hopkins University to review evidence of effective interventions to increase age at marriage and first birth and decrease sexually transmitted infections. Researchers reviewed both published and unpublished literature and found a dearth of papers on interventions that were both well implemented and well evaluated. Overall, they found the state of evaluation to be poor, contributing to a lack of evidence on “what works” even when interventions appeared to be well implemented.⁴⁷ A grant was made in 2016 to the WHO to conduct secondary data analysis on the most promising projects MacArthur had supported over the years. The purpose of the grant was to support the creation of a tool to allow program implementers and evaluators to do post-hoc analysis of their YPSRH programs in cases where they had not done baseline data collection. The tool was released in 2018.

⁴⁶ *Internal Endline Evaluation: Health of the People and the Environment Lake Victoria Basin Project*, Pathfinder International, December 2017.

⁴⁷ Michelle J. Hinden and Adesegun O. Fatusi, *Exploration of Young People’s Sexual and Reproductive Health Assessment Practices*, Johns Hopkins University, 2014.

Exit Phase of the Population and Reproductive Health Program (2015–2019)

In 2015, after nearly three decades of PRH grantmaking, MacArthur made the decision to end its support to the reproductive health field by 2019. The decision to exit was the result of a renewal process that was happening across the Foundation, through which many programs were being closed to make way for new initiatives and new ways of working. In addition, the environment for PRH grantmaking had changed since the Foundation entered the field in 1986. Reproductive health indicators in the countries where the Foundation worked had improved; new, large donors had entered the field, such as the Gates Foundation, which operates in India, Nigeria, and globally; and the role of national governments in supporting health budgets had grown, all of which necessitated a review of strategy.

By 2014, YPSRH had finally gained much-needed attention from country governments, the UN, and new donors. Increasingly, policymakers and stakeholders were grappling with the “youth bulge” and the demographic, social, economic, and political effects of the largest- ever proportion of young people in the world’s population. At the same time, actors in the field were recognizing the need to generate robust evidence to show what interventions or approaches were effective for changing health behaviors and, ultimately, improving health outcomes among young people. At the time, the Foundation’s leadership did not favor the YPSRH portfolio and raised questions about the level of investment relative to the evidence on effectiveness of interventions. Within the context of the Foundation’s broader changes, Foundation staff and leadership recognized that while there was still much to learn about meeting the needs of young people, the Foundation had been able to position the work of its grantees so that it could serve as a solid base upon which new donors and implementers could build.

The exit plans for the PRH program were implemented in two areas: YPSRH and MMM. The YPSRH exit was implemented from 2014 through 2016, with 22 organizations across the India, Mexico, Nigeria, and International portfolios receiving final tie-off grants. The three-year MMM exits began in 2015 with Mexico and ended in 2019 with India, Nigeria, and the International portfolio. The MMM exits, which took place as the Foundation was going through a reorganization, were more ambitious in terms of goals, budget, and engagement than YPSRH, which was, at the time, viewed more as a programmatic pivot. These narrowly defined, three-year exit strategies were designed to meet gaps and accelerate progress for the work in maternal health in each of the priority countries and for the International portfolio.

The Mexico exit supported a capstone grantmaking strategy to advance the field of professional midwifery as a means to improve access to quality care. India sought to improve the quality of maternal healthcare, and Nigeria supported initiatives to improve the number of trained health workers. In India and Mexico, exit strategies were developed with grantees, and evaluation was built into the initiatives from the outset. Indicators were identified in conjunction with all participating organizations and institutions, and periodic reviews were conducted by external evaluators and used to make midstream adjustments. All exit strategies were built on earlier work the Foundation had supported and were informed by the strategic positioning and expertise of grantees and staff.

India Exit Strategy: Strengthening the Case for Quality of Care

As the number of maternal deaths declined in India, quality of care emerged as one of the most pressing issues in the field. Given that 99 percent of all maternal deaths are preventable, the logical pathway to further progress in preventing maternal deaths in India was to shift from a focus on demand and access to improving the quality of maternal health. The final phase of the India PRH program (2015–2019) focused on initiatives to accelerate the Indian health system’s transition to prioritizing high-quality maternal health services and laid the groundwork to institutionalize quality improvement practices for maternal health in the public and private health sectors. To accomplish this goal, the India program backed three main areas of work: (1) strengthening the supply of quality maternal health services, (2) building the demand for quality services through accountability mechanisms, and (3) fostering a quality of care agenda through building evidence and supporting advocacy for quality maternal health services. The exit strategy was officially launched in June 2015 and led to funding for 20 grantees through 28 grants. In previous years, the India program prioritized work in three states: Gujarat, Maharashtra, and Rajasthan. However, in the final phase of grantmaking, the program worked opportunistically with donors, governments, civil society, and the private sector, where there was the greatest potential for leverage and scale.

Even as MacArthur developed the quality of care strategy, the Ministry of Health and Family Welfare’s programs on maternal health focused on improving quality of intrapartum and immediate postpartum care. The Dakshata initiative of the Ministry of Health and Family Welfare drew upon the experience of Jhpiego’s work in this area under the MacArthur grant. In 2017, the government launched a labor room quality-improvement initiative called LaQshya, which has guided the work of the grantees. According to the midline assessment of the program from March 2018, grantees that were supported to build the capacity of the public and private sector to provide quality maternal health services trained about 34,000 clinical and nonclinical healthcare professionals on quality of care.⁴⁸ Among those trained, a majority of providers who received training reported that their skills improved. Grants resulted in the development of 16 curricula targeting various types of providers, such as nurses, auxiliary nurse midwives (ANMs), and medical officers, as well as nonclinical hospital staff such as primary health center managers. Curricula covered clinical topics such as identifying high-risk pregnancies and emergency management, as well as topics related to managing health facilities such as reporting into health information monitoring systems (HIMS), assessing facility readiness for accreditation or certification, and general capacity building for managers. Over time, new curricula shifted from clinical staff to management staff, such as the curriculum developed by the Population Foundation of India for hospital management committees (Rogi Kalyan Samitis). The White Ribbon Alliance India conducted advocacy to have Respectful Maternity Care (RMC) included into protocols for care; in the last year, the public health system started training its providers in RMC as a component of the LaQshya initiative. With support from MacArthur and the Gates Foundation, WHO assisted the government to develop a roadmap for strengthening midwifery skills for routine deliveries. With technical assistance from WHO, the Indian government released new guidelines for midwifery services in 2018 and is now in the process of introducing midwifery training with the intention of deploying a new cadre of midwives in India.⁴⁹ MacArthur collaborated with MSD for Mothers to enable FOGSI—the professional association of

⁴⁸ *The Maternal Health Quality of Care Strategy in India: Midline Evaluation Report*, Mathematica Policy Research, 2019.

⁴⁹ *Guidelines for Midwifery Services in India*, Ministry of Health and Family Welfare, Government of India, 2018.

obstetricians and gynecologists—to train private-sector providers as per the FOGSI-endorsed quality standards, Manyata, and certify private facilities that provide pregnancy and delivery services. As of early 2020, 2,000 services providers were trained, and 377 facilities certified. About 100 of these facilities applied for third-party accreditation from the National Accreditation Board for Hospitals and Healthcare Providers (NABH), and nine were accredited. FOGSI reported increased demand from its members for the Manyata certification.

During the exit phase, working in collaboration with state Ministries of Health and Family Welfare, grantees working to strengthen quality of care in more than 1,000 health facilities in seven states made progress in a number of areas. They took steps to obtain running water, 24-hour electricity, record management systems, compliant biomedical waste management, provider presence, and quality assurance mechanisms. The structural and process improvements in the ecosystem led to some outcomes that are directly attributable to the maternal health quality of care strategy. For instance, areas where Karuna Trust took over managing and operating defunct or poorly functioning primary health centers directly increased coverage in care for people in Karnataka, Odisha, and northeastern states. It is harder to attribute other outcomes to the strategy. Yet, in an area where progress in reducing maternal mortality has slowed in the past decade, the status quo would not likely produce better outcomes.

Grants seeking to increase demand for quality maternal health services, at midline, have made progress in educating women about their health rights, testing existing community accountability mechanisms, and using legal strategies to promote government accountability for providing high-quality care when other avenues fail. Grantees tested community accountability mechanisms, including community-based monitoring, community-based maternal death reviews, social autopsies to ascertain the social and behavioral determinants of death, grievance redressal mechanisms, and hospital management societies, leading to infrastructure upgrades and additional human resources at facilities. About 20,000 women and 2,200 community leaders received information about healthcare quality and health rights, resulting in moderate increases in knowledge. Networks were developed to address reproductive health rights in the states of Bihar, Jharkhand, Maharashtra, Odisha, Rajasthan, and Uttar Pradesh. The issue of how stakeholders' engagement related to community accountability activities could be sustained remained an area for exploration. The Socio-Legal Information Centre (SLIC), a grantee that implemented legal strategies to address maternal health, trained more than 1,400 legal and allied professionals on maternal health rights. SLIC used high-profile petitions and public-interest litigations related to negligence that had resulted in maternal deaths and banning of sterilization camps to hold the Indian health system accountable. However, because such groups are often perceived as systems challengers, their funding is often limited, making the way forward for these legal strategies uncertain.

Almost all grantees in the exit portfolio contributed some evidence to the field, promoted civil society movements, and/or advanced the sustainability of their work. Grantees participated in community, state, national, and global coalitions and other advocacy activities to promote maternal health quality of care —often using internal resources to remain independent and be perceived as independent from the influences of outside parties.

Publications synthesized existing evidence on respectful maternity care, sex- selective abortion, and other maternal health topics. Advocacy campaigns led to some observable changes, such as adding relevant equipment, supplies, or human resources to state program implementation plans and budgets in Gujarat and Rajasthan. The MacArthur grantees who received funding during the exit phase managed or participated in 11 national or state-level advocacy networks at midline evaluation, including networks in Chhattisgarh, Madhya Pradesh, and Rajasthan.

The work supported under the maternal health quality of care strategy demonstrated potential ways to enhance many systems and processes to achieve positive outcomes. Nevertheless, many of the grantees pointed to areas for further work: reforming health-system financing, developing and implementing actionable information systems, and creating functional referral systems. These types of gaps will require far-reaching policy changes and major efforts to standardize the infrastructure, which could be beyond the reach of any one grant effort in a limited amount of time.

The final assessment of the strategy was published in early 2020. Findings show that the strategy made important gains in strengthening the supply of quality care by, for example, developing standards and guidelines, training large numbers of healthcare providers, and introducing quality improvement approaches to facilities. Findings suggest that scaling up, measuring, and documenting improvements to quality of care on health outcomes would be important next steps. The strategy was successful at sparking action on and interest in accountability mechanisms to improve the availability of quality maternal healthcare. Lessons from the strategy highlighted the need to sustain and deepen community engagement in community accountability; deliver the National Health Mission's stated commitment to encouraging communities to lead health planning and monitoring; document the impact of community accountability on healthcare utilization and health outcomes; and continue to support legal strategies to promote accountability when other methods fall short. Now that the Foundation has exited the field, continued advocacy by communities and coalitions will help keep maternal health quality of care a state and national priority, especially as other goals, such as universal health coverage, gain momentum.

Mexico

By 2015, Mexico reported 890 maternal deaths annually and a maternal mortality ratio (MMR) of 38. The WHO and others have acknowledged the role that skilled, professional midwives play in reducing maternal mortality levels by attending normal births. Yet over a period of about 70 years, the profession of midwifery in Mexico had been slowly extinguished, resulting in the concentration of institutional deliveries by general practitioners and gynecologists. At the same time, in Indigenous regions of Mexico, traditional midwives continue to attend women on the margins of a largely unsupportive health system; their numbers are also quickly decreasing as they attend ever fewer births. Women's choices of with whom and where they might deliver, and the quality of care available in the public health sector, are limited. The program deemed that a new cadre of professional midwives, hired by and integrated into the public health system, would be timely and critically important.

Under the final phase of grantmaking, the Mexico program proposed to contribute to a lasting, systemic, and cultural change that would improve access to quality maternal healthcare in the primary healthcare system, through the training and deployment of a new cadre of professional midwives. These professional midwives would join the estimated 16,000 traditional midwives attending births in Mexico’s rural areas, including many Indigenous communities. The exit strategy built substantially on work previously funded by MacArthur in Mexico that involved traditional and autonomous midwives, and that had led to the creation of both new vocational and university tracks for midwifery training and the opening of Mexico’s first and only public midwifery school, located in a small rural town in Guerrero State. The Foundation’s support for advocacy and promotion of “humanized childbirth” (a movement born in Latin America to counter the high levels of caesarean sections and hospital births) led to new thinking about midwifery as a viable option for Mexico. Foundation funds supported outreach and networking for midwives and nurse-midwives. This led to the creation of the Mexican Midwifery Association, a membership organization that could take the lead in representing midwives and coordinating with health authorities and practitioners.

In 2015, the Mexico program launched a three-year Initiative to Promote Midwifery in Mexico. Guided by a detailed theory of change and extensive consultations with diverse institutional partners, the Initiative invested \$17 million through 50 grants in four thematic areas: 1) promote a more favorable legal and normative environment; 2) strengthen recognition of and demand for midwives; 3) expand educational options; and 4) promote integration of high-quality models of professional midwifery in the public health system. The Initiative sought to create momentum toward a tipping point in which midwifery would eventually become a permanent feature of the maternal healthcare system to help reduce the burden of over-hospitalization for normal, low-risk births; enhance quality of care; and contribute in the long run to reducing high cesarean rates and improving health outcomes. Foundation grantmaking ended in 2018; some projects continued through 2019.

Topline findings from the 2018 evaluation of the three-year initiative indicate that important advances had taken place since the baseline to expand the presence of professional midwives providing high-quality obstetric and neonatal care in Mexico’s public health system.⁵⁰ The number of accredited programs that train midwives to attend births in public health institutions increased by 57 percent in 2018 from baseline data collected in 2015. The number of midwifery students enrolled at the beginning of the 2017–2018 academic year increased threefold compared to the baseline, with the largest increase coming from changes in the curriculum at the National Autonomous University of Mexico that better aligned training of obstetric nurses with midwifery content. Baseline research identified 651 midwifery students. In 2018, there were 2,148 students enrolled in midwifery training programs, an increase of over 300 percent. With additional programs under development, the number of midwifery programs is poised to grow even further.

The potential for midwifery to become a permanent feature of the country’s public health

⁵⁰ Lucille C. Atkin, Kimberli Keith- Brown, Martha W. Rees, and Paola Sesia, *Strengthening Midwifery in Mexico: Evaluation of Progress 2015–2018*, 2019.

system seems greater today because of the growing number of students, midwives, and midwifery sites throughout the country; a larger and more influential community of midwifery proponents or champions; multiple collaborative efforts to disseminate information and sensitize health personnel to midwifery models of care; increased awareness and action by public authorities; and an emerging dialogue among innovative state-level actors about what works. These advances have contributed to momentum around the country, with the most significant progress seen in locations where the Initiative's four thematic areas, and the corresponding efforts of its partners, have converged.

The findings also point to several elements that may enhance success: a few states invested significant effort in preparing the terrain through sensitization of healthcare officials and medical personnel to foster greater acceptance of their midwifery programs. As a result, they encountered fewer difficulties related to referrals and collaboration with other providers. The Initiative recognized the importance of sensitization and supported numerous efforts to enhance acceptance among public officials and health system personnel in targeted states. The best maternal health outcomes are seen in integrated models where midwives are part of a larger team of practice with clear and complementary roles, and they are also best in primary and intermediate levels of care. In addition, the data show that quality of care is highest in midwifery sites where there is an enabling clinical setting, with committed leadership, commitment to evidence-based practices, good training, supportive staff, and continuing education. Much of the Initiative centered on movement-building and increasing the legitimacy of midwifery among women, communities, and the health sector. As such, it did not prioritize a particular model of practice or healthcare level. Rather, it encouraged emerging models through support for learning, information exchange, and recognition of best practices.

The cultural and geographical diversity in Mexico is marked by extreme inequality of income and education linked to ethnicity, gender, and geography. In order for midwifery to be accepted in regions that need it most, this asset of diversity—in the context of inequality—needs to be honored by training diverse midwives who are prepared to work where they are most needed. The Initiative recognized the importance of diversity and fostered this through grants to organizations representing multiple approaches and voices. Extensive information is now available to inform or guide ongoing efforts to advance midwifery in its various forms, and to encourage incoming state and national leaders to embrace midwifery as a key component of strategies to solve the country's maternal health needs. In addition to generating enthusiasm, the information offers roadmaps and lessons learned about what does or does not work in the highly diverse contexts that characterize Mexico.

The importance of locally generated data was underscored by policymakers and health authorities from the start of the Initiative. Midwifery proponents in Mexico now have local evidence showing that professional midwives are capable of providing high-quality, woman-centered obstetric services throughout the continuum of care—including labor and delivery—when they are employed in supportive settings that embrace a midwifery model of practice and ensure prompt and fluid referrals in case of complications. This evidence is critical for overcoming the information gap that, at baseline, was slowing progress. Midwifery is more likely to be viewed today as a potential solution to help satisfy Mexico's

need for high-quality obstetric care—especially in remote and impoverished settings. It appears most promising when certain elements are in place. Of course, if political will is lacking or inconsistent, if there are not enough qualified midwives, if physicians and other personnel are unsupportive, or if women are unaware of midwifery services as an option, midwifery models of care may not realize their full potential. At the conclusion of the Initiative, momentum was apparent, with state-level advances and expressed interest from the government, marking progress toward broader integration of professional midwifery in official maternal health strategies.

Thanks to local and international interventions, the Initiative spurred profound changes in how advocates, health authorities, and international health agencies in Mexico viewed midwifery. Even so, sustained efforts are needed. Pro-midwifery efforts are still relatively isolated on a national scale and in the health system, where traditional midwifery is still not appreciated, and professional midwifery is not yet widely understood; neither are fully recognized as a viable or desirable strategy for improving maternal and neonatal healthcare. Maintaining and expanding the momentum will require even broader communication of current experiences to continue igniting interest, enthusiasm, and experimentation. Multilateral agencies such as UNFPA and PAHO, which continue to be committed to pro-midwifery objectives, can play a key role. While important advances have been made in Mexico in integrating professional midwifery into the public health system, the sustainability of these experiences is by no means guaranteed. Ensuring the sustainability and continuation of the commitment to exploring midwifery models of care at the state and local levels would benefit from a federal mandate, even broader state-level buy-in, and the inclusion of midwifery in maternal healthcare budgets.

Nigeria

During its wind-down phase (2015–2018), the Nigeria PRH program concentrated its resources toward one short-term goal: to improve maternal health in Nigeria by generating momentum in at least three states for state governments, donors, implementers, and policymakers to implement and, eventually, institutionalize the expanded role of the community health extension worker (CHEW), as outlined in the *Task Shifting and Task Sharing Policy for Essential Healthcare Services*.⁵¹ This proposed emphasis was built from the Foundation’s past efforts to reduce maternal mortality, which included successful advocacy leading to the adoption of the task-shifting policy in 2015.⁵² CHEWs represent a strategic focus, since they function as the “first point of call” in high-need communities in Nigeria. An exchange visit to India by Nigerian grantees and representatives from the Ministry of Health to observe how community health workers functioned in NGOs and public-sector programs provided a powerful impetus for action in Nigeria. By helping to successfully launch this policy, the Foundation hoped to assist Nigeria to achieve efficient use of available human resources for health, which, in turn, would lead to improved maternal and reproductive health outcomes.

⁵¹ *Task Shifting and Task Sharing Policy for Essential Healthcare Services in Nigeria*, the Federal Ministry of Health, August 2015.

⁵² The Foundation and its anchor grantee Jhpiego both received special recognition from the Ministry of Health in the preamble to the Task Shifting Policy.

To achieve this goal, the Foundation made grants to two organizations: Jhpiego and Pathfinder International. Jhpiego laid the foundation for implementing the task-shifting policy at the national level and accelerated policy implementation by piloting key aspects of the policy in two high-need states. Pathfinder International supported state-level adoption and implementation in three states. Both grantees worked with the Federal Ministry of Health to craft policy documents, such as updated national training guidelines and job descriptions that supported the new expanded roles of the CHEWs, and to lead them through the advocacy process and implementation of the policy. By the end of 2018, state ownership of the program was clear, which created momentum for scaling the initiative. The states where the grantees were assisting with the implementation became champions of the policy. As of 2019, 27 out of 36 states in Nigeria were working at different levels to implement the CHEW policy.

The PRH team mainly used routine monitoring and evaluation data collected by the two implementing grantees for work in the exit phase. The attitude of nurses who were more reluctant than the doctors to agree to task-shifting remained a challenge; some CHEWs reported that they felt threatened when performing their new tasks. Greater coordination with key stakeholders working with CHEWs in other states was required to ensure that activities were complementary and not duplicative. Despite challenges, grantee partners implementing the project in several high-need states provided catalytic leadership to accelerate momentum for the implementation of the overall policy. This, in turn, should lead to improved access to care and better health outcomes. Support for the CHEW intervention also enabled state ministries of health to connect the task-shifting policy to other projects, such as the World Bank's Saving One Million Lives program. The Nigeria PRH program was successful in getting other donors, such as the Department for International Development (DFID), USAID, and the Gates Foundation to fund task-shifting work.

International Portfolio

In the final exit phase of the International portfolio, the focus of grantmaking shifted from project support for a broad range of organizations to general support to a small number of long-standing grantees that staff considered critical to the infrastructure of the sexual and reproductive health field.

Part II: Lessons Learned

This section of the report offers reflections on key approaches that marked the MacArthur Foundation's PRH grantmaking for over three decades. Now that the PRH program has closed, it is possible to examine how MacArthur's approach to philanthropy in the PRH field evolved, and to describe the successes and limitations of these grantmaking approaches. These observations may be of practical use to the Foundation's programming in other areas, and for donors currently funding or seeking to fund PRH issues.

MacArthur's PRH grantmaking adopted and applied techniques in strategic philanthropy, including theories of change, outcome orientation, impact assessment, and scaling up. Even as grantmaking techniques changed and matured, and the program's thematic focus was redefined, the PRH program continued to be guided by the principles and humanistic vision articulated in the 1988 Board resolution that underscored three interrelated dimensions: demographics, human welfare, and human rights. In addition to purely demographic concerns, the strategy linked social, cultural, economic, and political issues related to health, natural resources, urbanization, and human rights as integral dimensions of the population debate.⁵³

This part of the report is informed by a review of archival documents, strategy memos, internal reviews, external assessments, and more than 50 interviews with representatives of grantee organizations, as well as former and current staff.

Local Leadership and Local Solutions

While the PRH program goals sought to address population problems of global significance, support and development of local leaders and local institutions characterized the program's approach. The program sought to underwrite responses to these problems that were domestically generated, culture-driven, and particular in their application, rather than supporting those that were externally generated, technology-driven, and universal in application.

MacArthur's support for strengthening local leadership is characterized by its support for individuals and local NGOs in the PRH field and its country offices.

There are three ways that MacArthur invested in building local leadership. The first was support for individual leadership through the Fund for Leadership Development (FLD) that was administered in Brazil, India, Nigeria, and Mexico from 1992 through 2013 (details about the functioning of the program and its outcomes are described in the previous section of this report). Providing consistent, long-term support to country-based NGOs, including many that were located outside of the major cities, was the second way that MacArthur supported local leadership and generated local solutions for the PRH field.

⁵³ MacArthur, *Amendment – Report of the Program Committee of the Whole*, July 14, 1988.

i) Fund for Leadership Development (FLD)

It is worth noting that while the PRH program repeatedly clarified that the FLD was not part of the MacArthur Fellows program that has operated with great distinction in the United States since the early 1980s, the program and its awardees benefited from the association with MacArthur and the Fellows Program. This association distinguished the FLD from other fellowships and awards programs.

In many ways, the FLD succeeded in its goal of building leadership in the PRH field in the four countries. The program was successful in building a strong cadre of professionals; individual grantees have assumed leadership roles in local NGOs, government agencies, other private foundations (including Gates, Ford, and Packard), and the World Health Organization, and as academics at universities in their home countries and abroad.

In awarding grants to individuals from multiple backgrounds—theater, film, graphic arts, music, law, and journalism—the FLD program expanded the definition of the population field to attract new talent and build new connections and alliances between population professionals and other sources of political and intellectual capital. The FLD was also intentional in recognizing talent outside of national capitals and major cities by selecting individuals from Indigenous groups in Mexico, Brazil, and remote areas. In general, the FLD encouraged young leaders to broaden their horizons and to stay in their home countries, where their leadership was much needed. The FLD strengthened the programmatic and financial management skills of its grantees, which helped many FLD grantees who went on to start nonprofits.

ii) Support for country-based organizations

Communities were central to the way the Foundation viewed solutions in this field. Social and systemic injustice has deep roots, and local contextual knowledge is better at making concepts such as “community participation” and “local empowerment” a reality in interventions. Within the parameters of its grantmaking mandate, the PRH field recognized that dedicated and embedded local partners are better judges of strategy, good at mobilizing local resources, and responsive to their communities’ needs. The PRH program also understood that when organizations are not externally catalyzed, they are more likely to remain in those communities, working on these issues, long after the Foundation or other actors have left.

In interviews, institutional grantees noted that support for in-country NGOs set MacArthur apart from other donors. Grantees acknowledged the Foundation’s efforts to build the capacity of their grantees. These initiatives included study tours, opportunities to attend country-level and international conferences, and opportunities to learn from international experts. Grantees noted that annual grantee convenings that were organized in each country and technical meetings on a variety of topics provided opportunities for sharing knowledge and experience and allowed for the organic growth of collaboration and partnership among grantees.

Grantees observed that budget allocations for overhead expenses and indirect costs mostly covered the true costs of the project. Allocations for salaries in project budgets helped

NGOs recruit, train, and retain professional talent. They also mentioned that funding for the purchase of assets such as laptops, mobile phones, and other technology, furniture, and vehicles allowed NGOs to be more effective in their work.

Mid-sized and small local grantees often find donor reporting requirements burdensome. Grantees were appreciative that the Foundation's reporting requirements were not unduly onerous; they instead allowed NGOs to use annual reporting for purposes of stock-taking, making mid-course corrections, and future planning. Grantees reported that they could be candid in sharing information about the challenges and disappointments they faced, as they felt secure in knowing they would not be penalized. Such sharing built knowledge in the PRH field, as well as among staff, about what worked and what did not.

Almost all grantees noted the program's openness to revisions to original project proposals if a situation required it. This flexibility reflected that circumstances and context can change within a typical three-year project cycle, and it offered grantees the ability to respond quickly to a changed situation or seize a new opportunity to advance their agenda.

Support for country-based NGOs was usually made through project support grants.⁵⁴ From 2007 to 2014, the Foundation implemented the MacArthur Award for Creative and Effective Institutions (MACEI), a program that made special one-time grants to exceptional grantee organizations that were key contributors to fields that are core to the Foundation's work and help ensure their sustainability long into the future. Of the 102 MACEI grants awarded, 11 were given to local grantees from the India, Mexico, and Nigeria PRH portfolios.⁵⁵ The funds awarded to these 11 NGOs ranged from \$350,000 to \$750,000 depending on the size of each organization. Funds were typically used to purchase real estate for office space or to serve as training centers; owning the needed space reduced an annual cost to the organization, increased its stability, and resulted in expanded programming and reach. Sometimes organizations took a small portion of the grant for strategic planning, investments in technological infrastructure, training, or strengthening an internal function like development or communications. These grants contributed to the organization's infrastructure; brought valuable public attention to the recipients and their work; and signaled the Foundation's confidence in the governance, operations, and programmatic impact of these groups.

Grants to local organizations were typically smaller than those made to international nonprofits. In the early years of PRH, multi-year grants were as small as \$20,000 and as large as \$500,000; most grants ranged from \$150,000 to \$400,000. Providing smaller grants allowed the Foundation to support local grassroots efforts but also required significant time for Foundation staff to process and oversee, as due diligence and reporting requirements were the same for all sizes of grants. Often Indigenous, grassroots, youth-led, or new NGOs needed support to hone clear grant proposals, and staff often provided several rounds of discussion and technical assistance until a proposal was complete. In Mexico, for example,

⁵⁴ The PRH program typically made project support grants, as opposed to general operating grants, due to legal restrictions on providing grants to charitable organizations outside of the United States.

⁵⁵ <https://www.macfound.org/programs/macei/> One grantee from the PRH International portfolio received the MACEI.

the office hired translation services to translate proposals and reports into English, as required by U.S. law for Foundation grants, and to facilitate sharing of the local proposals with non-Spanish-speaking Foundation staff in headquarters and other countries. Especially in the early years, staff from the Foundation's four country offices (including Brazil) reviewed and commented on each country's proposed portfolio. Bilingual staff in all offices also aided in this regard.

However, by the early 2000s, the Foundation had discontinued small grants from \$20,000 to \$40,000 and the emphasis shifted to mid-sized and large local NGOs that were able to document and demonstrate their impact. By this time, some of the smaller CSOs had matured and were still eligible for PRH grants. Larger grantee institutions and intermediaries continued to support field organizations through sub-awards, and grantmaking still prioritized country-based, country-originated organizations.

iii) Establishing in-country offices

Establishing country offices and recruiting local staff in Brazil, India, Mexico, and Nigeria also marked MacArthur's commitment to the principle of priority country leadership. Hiring local professionals to lead the country offices was not without controversies. Inside and outside the Foundation, the prevailing wisdom was that staff needed to be from abroad to avoid favoritism or bias in the choice of individuals and organizations to support. Among U.S. private foundations funding population and reproductive health in the 1990s, only the Ford Foundation had country offices, and their policy at the time required staffing their offices with expatriates. The MacArthur program, instead, made a point of searching for local staff with deep understanding of the philanthropic culture in the country who were in a position to mitigate some of the risks that a foreign donor could have faced. It was possible for country staff to facilitate the exchange of international knowledge and best practices to local organizations, due to their knowledge of and proximity to the work and the local context. The program leveraged the connections that staff had with local nonprofit organizations, academics, media professionals, and other experts to grow the program. It also allowed staff to build relationships with representatives from the government, especially the ministries of health that helped profile grantees' work and advocate for the adoption of relevant policies and the scale-up of grantee interventions. In addition, MacArthur's presence in Brazil, India, Mexico, and Nigeria gave the Foundation better knowledge of and contact bases in those countries, and other donors often sought our advice.

Support for Innovation

Long before "innovation" became a buzzword, it played an essential role in philanthropy. From the time that MacArthur's PRH program was established, it articulated a desire to support innovation in the field, and MacArthur used a small portion of its investments for higher-risk opportunities with the potential for big impact.⁵⁶

The PRH area sourced new and creative ideas in different ways. The FLD program invested in entrepreneurial leaders with breakthrough ideas, and MacArthur built formal and informal networks of advisors that helped staff understand emerging trends and areas.

⁵⁶ Examples of MacArthur-funded innovations are described in the previous section of the report.

Selecting new ideas for funding required staff to balance rigorous analysis—including knowledge of local dynamics and leaderships—with intuition about a project’s potential for transformative change.

In the first decade of grantmaking, as PRH was evolving and less was known about what works and what does not, the program often supported one-off pilots. Over time, staff found a balance between funding innovation and building a strategic portfolio. MacArthur was an early funder of young people’s sexual and reproductive health (YPSRH). When the Foundation ramped up grantmaking on this theme, the issue was not getting the attention it deserved from national governments and international agencies. By the time MacArthur exited this area in 2015, the PRH program’s three priority countries at that time—India, Mexico, and Nigeria—had policies and programs on YPSRH in place, and it was the focus for a growing number of donors. For example, a MacArthur grant to the Partnership for Maternal Newborn and Child Health (PMNCH), an influential alliance of more than 1,000 organizations in 192 countries, contributed to a focus on adolescents in its 2016–2020 strategic plan. The issue of child marriage, a topic first funded by the India program and International portfolio in 2001, began receiving enormous stakeholder attention.

MacArthur’s support for the YP Foundation, a youth-led NGO in India, is an example of how the PRH program legitimized the role of youth as stakeholders in policymaking on YPSRH in India. A 2010 MacArthur grant for a project to deliver comprehensive sexuality education was the first grant that the YP Foundation received from a major donor. The grant supported capacity-building of staff in the NGO on monitoring and evaluation and connected them with experts who served as mentors. This grant and a follow-up grant to the YP Foundation legitimized the role of youth-led organizations to implement and advocate for their sexual and reproductive health and rights. It resulted in the Ministry of Health and Family Welfare inviting the YP Foundation to serve on its drafting committee for developing an adolescent policy (Rashtriya Kishore Swasthya Karyakram, 2014) for the country, and to serve as a member of its committee for work on adolescents. This was the first time a youth-led organization formally served on the reference group for the Ministry. MacArthur’s support for the YP Foundation also signaled trust in the organization to successfully deliver a project, which helped it secure funding from other donors after MacArthur exited the field.

Often, existing approaches prove insufficient for large, complex issues where there is a need to experiment. MacArthur’s contributions in the field of social accountability⁵⁷ for maternal health in India, Mexico, and Nigeria led to widespread acceptance of the idea that citizens’ (especially women’s) engagement with the health system is important for the delivery of quality maternal health services. Few donors have funded social accountability initiatives; holding government and health providers to account is often considered “risky” in some places.

In India, MacArthur funded a spectrum of accountability initiatives: SAHAJ–Society for Health Alternatives (maternal death reviews); Sahayog (maternal death reviews and use of mobile-phone tools for reporting bribes); Center for Catalyzing Change/WRAI (community hearings and community scorecards); the Center for Health and Social Justice (involving men

⁵⁷ “Social accountability” is defined as an approach toward building accountability that relies on civic engagement (World Bank, 2004).

in maternal health issues, social audits, and community scorecards); and the Socio- Legal Information Center (strategic litigation). In Mexico, the program funded NGOs that are members of the Observatory of Maternal Mortality to create a system of indicators that facilitate the analysis, assessment, and systematic monitoring of policies and programs that aim to reduce maternal mortality in the country. The program also made grants to Fundar Centro de Análisis e Investigación in support of its work on budget accountability in Mexico. In Nigeria, MacArthur supported a cohort of seven grantees that focused on four accountability strategies (budget analysis, community mobilization, legal approaches, and maternal death audits) in 12 states, the Federal Capital Territory (FCT), and five geopolitical zones.⁵⁸ These grants, along with support to the Averting Maternal Death and Disability project at Columbia University, have advanced knowledge and practice on accountability for maternal health. MacArthur grantmaking on accountability has also demonstrated the potential for applying this approach to other sectors in development; more recently, MacArthur's Big Bet program on Nigeria began making grants to Nigerian organizations, including some from the PRH portfolio, to focus on issues related to corruption in the country.⁵⁹

Prioritizing Measurement and Impact

MacArthur has embraced the benefits of funding innovation and views innovation as an essential part of philanthropy. As the philanthropy field began to prioritize strategy, measurement, and impact in the 2000s, the PRH program adopted some of these tools as well. The program aligned grantmaking with carefully designed theories of change to produce clear and quantifiable results. This included a stronger focus on monitoring and evaluation and scaling.

i) Monitoring and Evaluation

The PRH program required grantees to use information collected through qualitative and quantitative tools to evaluate project outcomes. Recognizing that many country-based grantees in the PRH portfolio did not have the skills required to monitor effectively, the program made efforts to strengthen skills in each of the priority countries.

The capacity-building effort started with several rounds of training for MacArthur PRH staff on monitoring and evaluation (M&E) methods and tools beginning in 2000. This was soon followed by an effort to identify and build the capacity of in- country organizations to offer M&E technical assistance to grantees. MacArthur supported Investigación En Salud Y Demografía (INSAD) to become the M&E intermediary in Mexico. INSAD reported that its work with Mexican NGOs transformed the sector into a movement that focused on demonstrating results.

In India, where grantees already had significant M&E capabilities, the effort to establish an

⁵⁸ The grantees are Advocacy Nigeria, Community Health Research Initiative, Civil Society Legislative Advocacy Center, Development Communications Network, Society of Gynaecologists and Obstetrics in Nigeria, Women Advocates Research and Documentation Center, and the Women's Health Action Research Center. See also:

<https://www.macfound.org/press/evaluation/evaluation-maternal-health-accountability-nigeria/>

⁵⁹ <https://www.macfound.org/programs/nigeria/>

M&E intermediary was less successful. Instead, the India program built M&E training into grantee budgets. Program staff and grantees selected mutually-agreed-upon indicators for reporting on projects. In some instances, intervention projects were paired with grants to organizations or consultancies specializing in assessments.

Initially, the Nigeria PRH program made a grant to a university department to build its capacity to do M&E; the trained staff were then supposed to support grantees and use their skills as an income generator. However, this experiment did not work out. Subsequently, the Nigeria program engaged external evaluators to assist with M&E. For instance, the Foundation commissioned EnCompass, LLC to refine the portfolio theory of change for the grants focused on accountability, conduct a baseline, and build grantee capacity to monitor their grants.⁶⁰ The learning-focused evaluation over the life of the accountability grants illuminated aspects of the portfolio strategy that were working well and could be improved to strengthen maternal health accountability in Nigeria. In the three countries, some local NGOs institutionalized M&E into their operations, which helped them raise more funds from other donors for reproductive health projects.

The PRH program philosophy on M&E recognized that all projects did not require gold-standard evaluation designs, nor did all grantees have the skills or inclination to execute such designs. Furthermore, the program had to balance its budget allocations between program implementation and evaluation costs. At minimum, the Foundation required grantees to collect baseline and endline data and report regular monitoring data for agreed-upon indicators. Some grantees compared outcomes across interventions and control groups.

In a few cases, where grantees had the capacity to conduct gold-standard evaluations, MacArthur supported the evaluation designs. For example, Sangath Society and the London School of Tropical Hygiene and Medicine, with funding from MacArthur and UNFPA, conducted a cluster-randomized trial to assess the effectiveness of a multi-component whole-school health promotion intervention with integrated economic and process evaluations in grade 9 students (aged 13–14 years) at government-run secondary schools in the Nalanda district of Bihar State, India. The study revealed that the intervention benefitted school climate and health-related outcomes when delivered by lay counselors but had no effect when delivered by teachers. The study was published in the November 2018 issue of *The Lancet*.⁶¹

By 2015, when the PRH program started to work on the exit strategies, the Foundation had developed an approach to evaluation that emphasized context and landscape earlier in the strategy, with more focus on understanding progress, outcomes, and our contribution over time.⁶² In keeping with this approach, the Mexico program commissioned a team of evaluators and the India program commissioned Mathematica Policy Research, a

⁶⁰ Population and Reproductive Health Accountability-related grants in Nigeria: Baseline Report, EnCompass, 2014.

⁶¹ Sachin Shinde et al., “Promoting school climate and health outcomes within the SEHER multi-component secondary school intervention in Bihar, India: a cluster randomized control trial,” *The Lancet*, November 2018.

⁶² MacArthur’s approach to evaluation is available at <https://www.macfound.org/learning/evaluation/>.

consultancy organization, to prepare assessments of the exit strategies.

ii) Progress on approaches to scaling up

Starting in 2003, the PRH program focused on expanding the impact of MacArthur-supported work through a structured approach to scaling up. The PRH International portfolio made grants to two organizations—Management Systems International (MSI) and ExpandNet—to develop a flexible yet analytical process to identify and manage large-scale systemic change.

MSI developed a management framework that offered a practical guide on a three-step, ten-task process for effective scale-up.⁶³ The framework and related tools were field-tested with MacArthur grantee partners in India, Mexico, and Nigeria. In India, MSI provided technical assistance to the Population Foundation of India (PFI), a grantee, to strengthen the organization's capacity to serve as an in-country intermediary on scaling up. MSI and PFI collaborated to assist the Society for Education Action Research in Community Health (SEARCH) to successfully advocate for scaling up its Home-Based Newborn Care (HBNC) intervention through the government's Accredited Social Health Activist (ASHA) workers across the country. PFI, in collaboration with the erstwhile Planning Commission in India, the highest planning body in the Indian government, organized workshops for senior policymakers on the MSI approach to scaling. Grants to ExpandNet allowed it to recruit staff to conduct trainings on scale-up across India and other developing countries and created a cadre of professionals with skills in designing and managing scaled programs. It must be acknowledged that not all efforts at scaling up were successful: in some instances, the policy environment was not favorable for scaling, and in others, NGOs did not have adequate capacity to manage the scaling-up process. Even so, MacArthur grants contributed to wide dissemination of knowledge about scale-up processes in the health sector.

The MSI and ExpandNet tools were also designed to be applicable to sectors other than health. ExpandNet applied its scaling-up tools to strengthen MacArthur grantees from the Girls' Secondary Education portfolio; they have subsequently been used in Water Sanitation and Hygiene (WASH) programs and population, health, and environment interventions. In 2016, MacArthur's 100&Change competition retained MSI director Larry Cooley, who had spearheaded the work with PRH, to provide support to selected projects on scaling up.

Cross-Country Synergies

The PRH program built cross-country collaborations among grantees in India, Mexico, and Nigeria to widen impact beyond geographic boundaries, create longstanding relationships, and place local work in a global context. Cross-country collaboration helped countries with less experience in one area get to a point where impact could be achieved and measured. The South-to-South collaboration was effective since the challenges these countries faced were more similar than those of the Global North; for example, in the case of India and Nigeria, the countries share similar colonial experiences and legal systems. In our

⁶³ Scaling Up – From Vision to Large-Scale Change: A Management Framework for Practitioners, Third Edition, *Management Systems International*, 2016.

experience, cross-country collaborations work best when the scope of the exchange or learning opportunity is well-defined, with a set of expected outcomes, and funding is made available for follow-up, explorations, and pilots.

Two examples illustrate the success of this approach. In 2009, 18 Nigerians were sponsored to travel to India to learn about the country's strategies to reduce maternal mortality. The Nigerians returned to their country feeling challenged and motivated to adapt and implement several of the ideas they saw in action. For example, the Nigerians had not envisioned solutions such as a community insurance plan that covered pregnancy complications, a centralized dispatch center for ambulances, and using the media and health workers to help families plan ahead for possible emergency situations that could arise during a baby's delivery. Colleagues from Nigerian organizations observed how India was addressing the challenge of healthcare human-resource shortages through task-shifting, whereby tasks were moved, when appropriate, to less-specialized health workers. The Nigeria PRH program worked with grantees to implement some of these ideas in forms appropriate to the Nigerian context. The Nigerian House of Representatives also organized and funded its own study tour to India for 20 of its members after getting positive reports from a parliamentarian who participated in the first trip sponsored by MacArthur. The knowledge gained from the learning visits directly contributed to the drafting and adoption of the *Task Shifting and Sharing Policy for Essential Health Services* in 2015 and represented a significant movement toward scaling up access to effective, quality healthcare in maternal and reproductive health. The Nigeria PRH program subsequently made grants to assist with the rollout and implementation of the task-shifting and task-sharing policy in the final exit strategy.

A second cross-country collaboration focused on the topic of accountability in maternal and reproductive health (details on accountability grants are provided in the next section). In 2012, the PRH program organized a meeting in Mexico of accountability grantees in the three countries. The Mexico convening gave grantees the opportunity to share knowledge and start building a community of practice. It also provided the impetus for the Nigeria Office to deepen its grantmaking on accountability. In 2013, the Nigeria program invited proposals from select organizations, and an India grantee provided technical support at a convening of potential grantees. In December 2013, the Nigeria PRH program recommended grants to seven Nigerian organizations focused on four accountability strategies. It is possible to draw a straight line from the 2012 Mexico convening to the growth of the accountability-focused work in Nigeria. In 2011, the Center for Health and Social Justice, a grantee in India, worked with partners in Mexico and Nigeria to establish the Community of Practitioners on Accountability and Social Action in Health (COPASAH), a network of practitioners focused on accountability in health. COPASAH was established to facilitate the exchange of experiences and lessons, the sharing of resources in the production and dissemination of outputs, and networking and capacity-building among member organizations. This network has grown to include membership from other countries in Asia, Africa, and Latin America.

The cross-country collaborative approach, which was tested by the PRH program, had been expanded to other areas of focus for the Foundation. In 2018, the Nigeria and Mexico offices collaborated to build partnerships among institutions and stakeholders in both countries

working on anti-corruption issues.

Making a Responsible Exit

All grantmakers have to deal with exits when they change strategic priorities, leave fields, or leave countries, and they must manage the exits to reduce risks for grantee organizations and the donor. PRH considered several factors in developing its exit plan. First, the program assessed the risks of the exit on its grantee organizations. Grantees received a tie-off grant in cases where funding was required to bring work to a logical conclusion; the project was at a sufficiently mature stage where one more grant could make a difference in achieving goals and objectives; not giving a tie-off grant would result in significant reputational risks for the grantee or the Foundation; or the organization would suffer negative impacts as a result of funding ending abruptly.

The Foundation's exit from YPSRH had consequences in Mexico and Nigeria, where there are few other donors working on the topic. The impact was accentuated by the fact that the Foundation exited this field in a short 12–15 month timeframe, which may not have permitted grantees adequate time and resources to prepare themselves. In some instances, NGOs in Mexico and Nigeria ended their work on youth and received funding for other issues. At least one grantee in Mexico ended operations entirely. Grantees also mentioned that without MacArthur funding, progress in YPSRH could stall in these countries. In India, a country where young people comprise over 30 percent of the population, new donors focusing on YPSRH have entered the field. These include international donors such as the Child Investment Fund, USAID, and Amplify Change, and local donors such as the Piramal Foundation, HCL Foundation, and the Aziz Premji Philanthropic Initiative. India YPSRH grantees, which are considered leaders in the field, have received significant support from other donors and continue to thrive. However, grantees and donors have remarked that MacArthur gave up its leadership mantle in India just as the field was beginning to mature and the issue was gaining traction in national and international agendas.

The maternal health exit plans afforded a longer timeframe to execute the wind-down process. It allowed the PRH program to offer capacity-building opportunities to grantees. For example, a grant was awarded to Dasra, the largest philanthropic intermediary organization in India, to strengthen the capacity of grantees to secure local-donor funding. Dasra offered training and customized support to Indian grantees on areas such as communication, fundraising, and financial planning. Where possible, Dasra has attempted to educate local philanthropic donors and Corporate Social Responsibility initiatives on the critical need to fund maternal health.

The Mexico PRH program made a grant to Hispanics in Philanthropy (HIP), a transnational fundraising and grantmaking organization that seeks to strengthen Latinx leadership, to reach out to private-sector actors, impact investors, and entrepreneurs potentially interested in creating health centers with the midwifery model of care in Mexico. HIP researched, developed, and provided interested parties with information about the financial feasibility of women-centered midwifery models, possible new markets, potential beneficiaries, and successful models from other countries. The project sought to increase both the legitimacy and the recognition of the midwifery model of care, and to create new

formal work opportunities for midwives, with the intention of expanding broad social acceptance needed for the public health sector to embrace this new model and improve quality of care. Despite the Mexico PRH program's efforts to ensure sustainability of NGOs working on midwifery, few donors support reproductive health issues in Mexico, and it is unlikely that organizations will be able to replace the amount and flexibility of the support MacArthur provided.

MacArthur created separate communications plans to support A) legacy grantmaking strategies focused on maternal mortality in each of the countries, and B) the exit plan for the YPSRH portfolio. The communications objectives served to inform past and current grantees of the changes in the grantmaking strategy; ensure that interested parties had access to accurate, up-to-date information about the Foundation's PRH grantmaking via its website; and communicate with grantees and partners in a way that celebrated the accomplishments of work that ended and the partnerships it involved.

While MacArthur was not the only maternal health donor in Nigeria, it was one of the few that prioritized support for national organizations. Larger donors, such as Gates, have favored international groups. Thus, small and national grantee organizations were significantly affected by the Foundation's exit. International NGOs were less affected because they were more likely to receive grants from other donors. In India, where the government has initiated a Universal Health Insurance program and is strengthening primary healthcare, the focus on maternal mortality as a stand-alone issue has become less important as the country takes on a more comprehensive health systems approach; the end of the Millennium Development Goals in 2015 contributed to this as well. Former MacArthur grantees have evolved their programming and expanded the scope of their interventions to include comprehensive women's health or primary health programs. This evolution reflects a maturation of the maternal health field in India. Even so, eight grantees from a portfolio of 20 organizations secured other funding sources for work related to maternal health quality of care, mainly from the Indian government and foreign philanthropies.

Concluding Remarks

When MacArthur entered the population field in the 1980s, its goal was to change the ideas that give the field its direction. In many respects, that goal has been achieved. The Foundation has indisputably played a key role in moving the population discourse toward a rights framework. Its support has seeded new and emerging areas of work, taken on complex and controversial issues such as abortion and youth sexual and reproductive health and rights, and deepened understanding of well-established issues such as maternal health. In the countries where the PRH program invested, significant improvements in reproductive health are evident. There is no question that the complexities of making change in this area are substantial, and the Foundation and its grantees are part of a constellation of forces contributing to our desired change. Still, it bears noting that the Foundation's PRH program was seen as a well-connected, well-informed, trailblazing, and influential player by donors and grantees alike. Even as the PRH program completed its phase-out, staff continued to share insights with other donors and encouraged broader funder engagement with this field. The Foundation is missed not only because of its financial contribution, but for its sustained

long-term investment and championing of the issues. That close engagement is, in many ways, a defining characteristic of MacArthur's PRH program.

In the words of Nigeria Director Kole Shettima, who ran the PRH program in his country from 1999 to 2019, "The PRH program is in the DNA of the Foundation's work in the priority countries and, despite our exit, governments, other donors, practitioners, and policymakers know that the Foundation continues to stand with them and, more importantly, with women."

Appendix: Individuals Interviewed for the Report

India/PRH

Ishita Chaudhry, former Executive Director, YP Foundation
Jasodhara Dasgupta, National Foundation on India
Sharad Iyengar, ARTH
Renu Khanna, SAHAJ
Vinoj Manning, Ipas Development Foundation
Sunil Mehra, MAMTA-Health Institute for Mother and Child
Poonam Muttreja, Population Foundation of India and former Director, India Office, MacArthur Foundation
Vanita Nayak Mukherjee, Ford Foundation
KG Santhya, Population Council
Pankaj Shah, Sewa Rural
Rajani Ved, National Health Systems Resource Center

Mexico/PRH

Hilda Arguello, ACASAC Lina
Berrio, Kinal Antsetik
Daniela Diaz, Fundar
Graciela Freyermuth, CIESAS
Maria Consuela Meija, Catholics for Choice
David Melendez, Comité Promotor
José Luis Palma, Investigación en Salud y Demografía
Gabriela Rodríguez, Afluentes
Rafaela Schiavon, Ipas Mexico
Sebastiana Vázquez, Sakil Nichim

Nigeria/PRH

Segun Adeoue, Society of Gynaecology and Obstetrics of Nigeria (SOGON)
Banke Akinrimisi, FLD, Centre for Women's Health & Information (CEWHIN)
Abiola Akiyode-Afolabi, Women Advocates' Research and Documentation Centre (WARDC)
Sakina Amin-Bello, Pathfinder International
Ndodeye Basse, Girls Power Initiative
Owem Esief, Action Health Incorporated
Nike Esiet, Action Health Incorporated
Kenny Ewulum, Pathfinder International

Aminu Gamawa, FLD

Tor Iorapuu, Youth, Adolescent, Reflection and Action Centre (YARAC)

Stella Iwuagu, FLD, Centre for the Right to Health (CRH)

Akin Jimoh, Development Communications Network (DevComs)

Chioma Kanu, Civil Society Legislative Advocacy Centre

Aminu Magashi, FLD, Community Health and Research Initiative (CHRI) Ugo

Okoli, Jhpiego

Friday Okonofua, Women Health and Action Research Centre (WHARC)

David Olayemi, FLD

Ejike Orji, former Director, Ipas Nigeria

Saudatu Sani, Advocacy Nigeria

International/PRH

Ann Blanc, Population Council; former Program Officer, PRH, MacArthur Foundation, Chicago

Lynn Freedman, Columbia University, Columbia University Mailman School of Public Health

Laura Ghiron, ExpandNet

Anu Kumar, Ipas, former PRH Program Officer, MacArthur Foundation, Chicago

Marta Schaaf, Columbia University, Columbia University Mailman School of Public Health

Lilian Sepulveda, Center for Reproductive Rights

Denise Shannon, Funders for Reproductive Equity

Ruth Simmons, ExpandNet

Serra Sippel, CHANGE

Lisa Thomas, Red Cross Society; former staff at World Health Organization

Current and Former Staff of MacArthur Foundation, PRH

Carmen Barroso, former Director, PRH, Chicago

Sharon Bissell, Director, Mexico Office, MacArthur Foundation, Mexico City

Judith Helzner, former Director, PRH, Chicago

Ana Luisa Liguori, former Director, Mexico Office, MacArthur Foundation, Mexico City

Oladayo Olaide, Deputy Director, Nigeria Office, MacArthur Foundation, Abuja

Kole Shettima, Director, Nigeria Office, MacArthur Foundation, Abuja

Erin Sines, Director, PRH, Chicago

Annex 1: Population and Reproductive Health Grantee Organizations

Abdul Latif Jameel Poverty Action Lab
Abortion Matters Foundation
Academy for Educational Development – Empowerment of Women Research Program
Academy for Nursing Studies
Acción Ciudadana por la Tolerancia
Acción Humana por la Comunidad
Acción Popular de Integración Social
Acoes em Genero, Cidadania Desenvolvimento
Action Canada for Population and Development
Action Health, Incorporated
Action India
Action Research & Training for Health
Actionaid International Foundation Nigeria
ActionAid International USA
Administracao e Financas para o Desenvolvimento Comunitario
Adolescent Health and Information Projects
Advocacy Nigeria
Advocates for Youth
Afluentes
African Centre for Communications & Development
African Population and Health Research Center
African Radio Drama Association
Africare
Ahmadu Bello University Teaching Hospital
Ahmadu Bello University, Center for Social and Economic Research
AIDS Foundation of Chicago
Al-Fataah
Alternativas de Capacitación y Desarrollo Comunitario
Ambulante
American Society of Law & Medicine
American University, School of Public Affairs
Americans for UNFPA
Amigos Contra el SIDA
Amref Health Africa in Uganda
Anglican Diocese of Ibadan – Chaplaincy Family Life Education Unit
Anusandhan Trust, Centre for Enquiry into Health and Allied Themes
Anusandhan Trust, Centre for Studies in Ethics and Rights
Appropriate Health Resources and Technologies Action Group
Article 19 UK
Asesoria, Capacitación y Asistencia en Salud, A.C.
Asian Forum for Human Rights and Development
Asian-Pacific Resource and Research Centre for Women
Asociación Hispano Mexicana
Asociación Mexicana de Educación Sexual, A.C.
Asociación Mexicana de Partería
Asociación Mexicana de Población

Asociación Nacional de Enfermeras Obstétricas y Perinatales
Aspen Institute
Associacao Brasileira de Estudos Populacionais
Associacao Brasileira de Video Popular
Associacao Brasileira Interdisciplinar de AIDS
Associacao de Mulheres de Grajau – Casa da Mulher do Grajau
Associacao Saude Sem Limites
Association for Development Options in Nigeria
Association for Reproductive and Family Health
Association of Reproductive Health Professionals
Bal Rashmi Society
BAOBAB for Women's Human Rights
Bayero University, Kano
BBC World Service Trust
Bhoruka Public Welfare Trust
Bixby Center for Global Reproductive Health – University of California, San Francisco
Boston Women's Health Book Collective
Brown University Population Studies and Training Center
Calabar International Institute for Research, Information and Documentation
California Center for Population Research
Campaign Against Unwanted Pregnancy
Casa da Mulher Lilith
Casa de Cultura da Mulher Negra
Casa de la Mujer – Grupo Factor X
Casa de la Mujer – El Lugar de la Tia Juana, A.C.
Catholics For Choice
Catolicas pelo Direito de Decidir
Católicas por el Derecho a Decidir
Center for Communication and Reproductive Health Services
Center for Health and Gender Equity
Center for Health and Social Policy
Center for Reproductive Rights
Center for the Right to Health
Center for Women Policy Studies
Center on Budget and Policy Priorities
Centre for African Settlement Studies and Development
Centre for Budget and Policy Studies
Centre for Catalyzing Change
Centre for Development and Population Activities
Centre for Development of Instructional Technology
Centre for Development Studies
Centre for Environment, Gender and Development
Centre for Health and Social Justice
Centre for Health Sciences Training, Research and Development
Centre for Population Activities and Education for Development
Centre for Women Studies and Intervention
Centro Brasileiro de Analise e Planejamento
Centro das Mulheres do Cabo
Centro de Colaboración Cívica

Centro de Criacao de Imagem Popular
 Centro de Educacao para a Saude
 Centro de Educacao Sexual
 Centro de Estudos e Pesquisa em Saude Coletiva
 Centro de Investigacion y Estudios Sobre la Sexualidad, A.C.
 Centro de Investigaciones en Salud de Comitán
 Centro de Investigaciones y Estudios Superiores en Antropología Social
 Centro de Orientacion para Adolescentes
 Centro de Partos de San Cristobal
 Centro de Pesquisas e Controle das Doencas Materno – Infantis de Campinas
 Centro de Projetos da Mulher
 Centro de Referencia Integral para Adolescentes
 Centro Feminista de Estudos e Assessoria
 Centro Informacao Mulher
 Centro Luiz Freire
 Centro Mujeres
 Centro para los Adolescentes de San Miguel de Allende
 Centro Regional para la Educacion y Organizacion
 CHETNA Centre for Health Education, Training and Nutrition Awareness – Nehru Foundation for Development
 Child In Need Institute
 Chiltak
 Cidadania, Estudo, Pesquisa, Informacao e Acao
 Civil Resource Development and Documentation Centre
 Civil Society Consultative Group on HIV/AIDS in Nigeria
 Civil Society Legislative Advocacy Centre
 Coalition for Women's Economic Development and Global Equality
 Coalition of Nigerian NGOs on Health Population and Development
 Colectivo de Educacion y Formacion Integral para la Salud
 Colectivo de Hombres por Relaciones Igualitarias
 Colectivo Sol
 Coletivo Feminista Sexualidade Saude
 Columbia University in the City of New York – Earth Institute
 Columbia University in the City of New York, Mailman School of Public Health
 Columbia University Center for Population and Family Health
 Comissao de Cidadania e Reproducao
 Comissao Organizadora do Planeta Femea
 Committee on Women, Population, and the Environment
 Commonwealth Medical Trust
 Communication for Development and Change
 Communications Consortium Media Center
 Community Aid & Sponsorship Programme
 Community Health and Research Initiative
 Community Life Project
 Community Partners International
 Community Women and Development – Nigeria
 Companeros en Ayuda Voluntaria Educativa
 Comunicacao e Cultura
 Comunicación e Información de la Mujer
 Comunicación, Intercambio, Desarrollo Humano America Latina

Comunidad Raíz Zubia
 Confederation of African Medical Associations and Societies
 Confederation of Osun State NGOs Group
 Conference of Nongovernmental Organizations
 Conjunto Universitario Candido Mendes – Centro de Estudos Afro-Asiaticos, Sociedade Brasileira de Instucao
 Consejo De Planificación Familiar Para La Juventud, A.C.
 Consorcio para el Dialogo Parlamentario y la Equidad, Asociación Civil
 Consumer Unity & Trust Society
 Coordinación de la Región Centro, Coordinación Nacional de Mujeres de Organizaciones Civiles por un Milenio Feminista
 Coordinadora Estatal de Productores de Café de Oaxaca, A.C
 Coordination of NGOs from Latin America and the Caribbean
 Corporación Casa de la Mujer
 Council on Foreign Relations
 Creating Resources for Empowerment and Action Inc.
 CRIOLA
 Cultural Action Network
 Cunha – Coletivo Feminista
 Deepam Educational Society for Health
 Democracia y Sexualidad
 Desarrollo, Ambiente y Sociedad
 Deutsche Stiftung Weltbevoelkerung
 Development Alternatives
 Development Alternatives with Women for a New Era
 Development Communications
 Difusión Cultural Feminista, A.C.
 DKT International
 Dreamboat Development Theatre Foundation
 Earth Pledge Foundation
 East-West Center
 ECWA Evangel Hospital
 Edumundo 360
 El Clóset de Sor Juana
 El Colegio De La Frontera Norte – Centro de Estudios Fronterizos del Norte de México
 El Colegio de la Frontera Sur
 El Colegio de México, A.C.
 El Colegio de Sonora
 Elders Foundation
 ELIGE, Red de Jóvenes por los Derechos Sexuales y Reproductivos, A.C.
 Elmhirst Institute of Community Studies
 Empowerment & Action Research Centre
 EngenderHealth Nigeria
 Environment and Population Center of Zambia
 Epikeia
 Equality Now
 Equidad de Género Ciudadanía, Trabajo y Familia
 Equipo Mujeres en Acción Solidaria
 Estudos e Comunicacao em Sexualidade e Reproducao Humana
 European NGOs for Sexual and Reproductive Health and Rights, Population and Development
 Facultad Latinoamericana de Ciencias Sociales

Facultad Latinoamericana de Ciencias Sociales, FLACSO
Fala Preta – Organizacao de Mulheres Negras
Family Care International
Family Health and Population Action Committee
Family Institute of Cambridge Public Conversations Project
Family Violence Prevention Fund
Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo Comunitario, A.C.
Federación Mexicana de Educación Sexual y Sexología
Federación Mexicana de Ginecología y Obstetricia
Federal Ministry of Health
Federation of Female Nurses and Midwives of Nigeria
Federation of Obstetric and Gynecological Societies of India
Formación y Capacitación, Asociación Civil
Foro Nacional de Mujeres y Políticas de Población
Foro Nacional de Mujeres y Políticas de Población Capitulo Distrito Federal
Foro Nacional de Mujeres y Políticas de Población Capitulo Oaxaca
Forum for African Women Educationalists
Forward Africa
Foundation for Education and Development
Foundation for Medical Research
Foundation for Community Health
Foundation for the Global Library of Women's Medicine
Fundacao Carlos Chagas
Fundacao Esperanca
Fundacao Joaquim Nabuco
Fundación de Apoyo Infantil Región Centro, A.C.
Fundación Mexicana Para la Planeación Familiar, A.C.
FUNDAR, Centro de Análisis e Investigación
Fundars for Reproductive Equity
Gabinete de Enfermeras y Centro de Orientación
Geledes Instituto da Mulher Negra
George Washington University Medical Center, Center for Global Health
Georgia Institute of Technology Office of Foundation Relations
GHP Solutions, LLC
Girls Not Brides
Girls' Power Initiative, Nigeria
Global Action Network
Global Committee of Parliamentarians on Population and Development
Global Exchange
Global Fund for Women
Global Health and Awareness Research Foundation
Global Health Council
Global Rights
Gram Bharati Samiti
Grassroots Health Organization of Nigeria
Grupo de Apoio a Prevencao a AIDS
Grupo de Apoio a Prevencao a AIDS – Rio Grande do Sul
Grupo de Educación Popular con Mujeres
Grupo de Información en Reproducción Elegida

Grupo de Mujeres de Pachuca "Cihuatl"
Grupo de Mujeres de San Cristóbal
Grupo de Trabalho e Pesquisa em Orientacao Sexual
Grupo Interdisciplinario sobre Mujer, Trabajo y Pobreza
Grupo Pela Vidda
Grupo Pela Valorizacao, Integracao e Dignidade do Doente de AIDS
Grupo Transas do Corpo Acoes Educativas em Saude e Sexualidade
Gujarat Institute of Development Research
Guttmacher Institute
Halt AIDS Group
Hampshire College Civil Liberties and Public Policy Program
Hampshire College Committee on Women, Population and the Environment
HAQ: Centre for Child Rights
Harvard University, Center for Population and Development Studies
Harvard University, FXB Center for Health and Human Rights
Harvard University, Harvard Institute for International Development
Harvard University, T.H. Chan School of Public Health
Health Management and Research Institute
Health Partners International
HealthWatch
Hesperian Foundation
Hispanics in Philanthropy
Homelands Productions
Human Rights Watch
Hunter College of the City University of New York
Hunter College International Reproductive Rights Research Action Group
Imagine Chicago
Impact Foundation (India)
India Development Service
Indian Institute of Health Management Research
Indian Institute of Management Ahmedabad
Indian Institute of Management Bangalore
Indian School of Business
Indian Society for the Study of Reproduction and Fertility
Información y Diseños Educativos para Acciones Saludables, A. C.
Institute for Democracy Studies
Institute for Human Development
Institute for Social Studies and Action
Institute of Development Studies
Institute of Health Management, Pachod
Institute of Health Systems
Institute of International Education
Institute of Social Studies
Institute of Social Studies Trust
Institute of Women and Ethnic Studies
Institute of Women and Ethnic Studies – Women of Color Reproductive Health Forum
Instituto Antropologia e Meio Ambiente
Instituto Brasileiro de Administracao Municipal
Instituto Brasileiro de Analises Sociais e Economicas

Instituto Brasileiro de Defesa do Consumidor
Instituto de Estudos da Religiao
Instituto de Estudos Economicos, Sociais e Politicos de Sao Paulo
Instituto de Liderazgo Simone de Beauvoir
Instituto de Saude e Desenvolvimento Social
Instituto Mexicano de Estudios Sociales
Instituto Mexicano de Investigación en Familia y Población
Instituto Nacional de Perinatología
Instituto Nacional de Salud Pública
Instituto Nacional de Salud Pública, Centro de Investigaciones en Salud Pública
Instituto Noos
Instituto Promundo
Instituto Sociedade Populacao e Natureza
Inter-African Committee Nigeria
Inter Press Service
Inter-American Development Bank
Inter-European Parliamentary Forum on Population and Development
International AIDS Vaccine Initiative
International Association for Feminist Economics
International Center for Research on Women
International Centre for Diarrhoeal Disease Research, Bangladesh
International Confederation of Midwives
International Council on Management of Population Programmes
International Family Health
International HIV/AIDS Alliance
International Institute for Applied Systems Analysis
International Institute for Population Sciences
International Institute for Sustainable Development
International Planned Parenthood Federation
International Planned Parenthood Federation/Western Hemisphere Region
International Reproductive Rights Research Action Group Nigeria
International Rescue Committee
International Rescue Committee – Women's Refugee Commission
International Society for Research on Civilization Diseases and on Environment – Gujarat AIDS Awareness and Prev. Unit
International Union for the Scientific Study of Population
International Women's Health Coalition
International Women's Human Rights Law Clinic
International Women's Rights Action Watch – University of Minnesota
International Women's Tribune Center
Interventions for Support Healing and Awareness
Inveneo
Investigación en Salud y Demografía
Ipas
Isis International
Isis International – Manila
Jan Madhyam
Jan Swasthya Sahyog
Janani
Jhpiego

Johns Hopkins University, Bloomberg School of Public Health, Department of International Health
Johns Hopkins University, Bloomberg School of Public Health
JSI Research & Training Institute, Inc.
Just Associates
Karmakshetra Educational Foundation
Karmakshetra Educational Foundation – Darpana Academy of Performing Arts
Karuna Trust
Katha
Keshav Gore Smarak Trust
Keystone Center
Kidwai Memorial Institute of Oncology
K'inal Antsetik, A.C.
Lagos University Teaching Hospital Department of Obstetrics and Gynaecology
Latin American Studies Association
Lawyer's Collective
Legal Research and Resource Development Centre
Letra S, Sida, Cultura y Vida Cotidiana
Liverpool School of Tropical Medicine
Local Initiatives Support Corporation
London School of Hygiene and Tropical Medicine
Loto Productions
Longevity Through Operational Arts and Theatrical Organization
Louisiana State University Medical Center Department of Obstetrics and Gynecology
M.S. Swaminathan Research Foundation
Madhyam Communications
Mahila SEWA Trust
Majlis
Mama Cash
Mamta-Health Institute for Mother and Child
Management Sciences for Health
Management Strategies for Africa
Management Systems International
Manta de Mexico
Marie Stopes Mexico
Marketing for International Development
Martha Stuart Communications
Massachusetts Institute of Technology, Office of Sponsored Programs
Masum
Mahila Sarvangeen Utkarsh Mandal
McGill University Centre for Research and Teaching on Women
Metropolitan Group
Mexicanos contra el SIDA Confederación de organismos no gubernamentales, A.C.
Mexico National Safe Motherhood Committee
Miles Por los Derechos Sexuales y Reproductivos
Minerva Picture Company Limited
Monitor Radio
Movimento de Mulheres Trabalhadoras Rurais do Nordeste – Brazil
Movimiento Abrazo
Mujer y Medio Ambiente
Mujer ZModem

Mujeres Aliadas
Mujeres Indigenas en Lucha
Multiple Action Research Group
MUSA Centro de Educacao e Saude da Mulher
Nari Samata Manch
National Academy of Sciences
National Association of Women's Organizations of Uganda
National Black Women's Health Project
National Center for Human Rights Education
National Commission on Colleges of Education
National Council of Applied Economic Research
Rede Nacional Feminista de Saude e Direitos Reprodutivos
National Foundation for India
Nav Bharat Jagriti Kendra
Naz Foundation
Nehru Foundation for Development
New Woman Foundation
New Woman Study and Research Centre
NGO Forum on Women – Beijing '95
Nigerian Institute of Medical Research
Nigerian Institute of Social and Economic Research
Nigerian Medical Association
Nigerian Network on AIDS Prevention, Support, and Care
Nigerian Partnership for Safe Motherhood
Nigerian Popular Theatre Alliance
Northwestern University, Program of African Studies
Nucleo Interdisciplinar de Pesquisa e Acao Social
Nueve Lunas, S.C.
Nuevos Códices Compatía
Observatorio Ciudadano de Políticas de Niñez, Adolescencia y Familias
OneWorld UK
Options for Youth
Organización De Médicos Indígenas del Estado de Chiapas, A.C.
Orissa Voluntary Health Association
Overseas Development Council
Pacific Institute for Women's Health
Pacific Institute for Women's Health Public Health Institute
Pan American Health Organization
Panos Institute
Panos South Asia
Parivar Seva Sanstha
Park Ridge Center for the Study of Health, Faith and Ethics
Parliamentarians for Global Action
Partners in Expanding Health Quality and Access
Partners in Health
PATH
Pathfinder International
Patlatonalli
Patronato de Medicina Social Comunitaria

People and the Planet
Performance Studio Workshop
Plan International USA
Planet Care/Global Health Access Program
Planned Parenthood Federation of Nigeria
Planned Parenthood of Illinois
Population Action International
Population and Community Development Association
Population Association of America
Population Communications International
Population Council
Population Council, Latin America and the Caribbean
Population Council, Regional Office South and East Asia
Population Foundation of India
Population Media Center
Population Reference Bureau
Population Resource Center
Population Services International
PREPARE
Prerana Associate CEDPA
Pro Mulher
Programa de Apoio ao Pai
Programa Latinoamericano de Actividades en Población Instituto de Investigaciones Sociales, UNAM
Pro-Health Foundation
Projeto Roda Viva
Promoción de Servicios de Salud y Educación Popular, A.C.
Promundo-US
Public Health Foundation of India
Public Health Institute
Public Media Center
Public Service Broadcasting Trust
RAHI Foundation (Recovering and Healing from Incest)
Rainbo
Red Ciudadana Feminista de México Región Centro
Red de Mujeres de Baja California
Red de Mujeres Pro Derechos de Educación y Salud
Red de Salud de las Mujeres Latinoamericanas y del Caribe
Religious Consultation on Population, Reproductive Health, and Ethics
Reproductive Health Alliance Europe
Reproductive Health Matters
Res Humanae – The Foundation for Humanitarian Aid
Research Evaluation Resources and Development Consultancy
Research Foundation of the City University of New York
Ritinjali
Rosario Castellanos – Grupo de Estudios Sobre la Mujer
Royal Society of London
Rural Women's Social Education Centre
Rutgers State University of New Jersey – Center for Women's Global Leadership
SAHAJ-Society for Health Alternatives

Sahara House
Sahayog
Sakhi
Sakil Nichim Antsetik
Sakshi
Salud Integral para la Mujer
Salud y Género
Sampada Grameen Mahila Sanstha
Samuha
Sanchetana Community Health and Research Centre
Sangath
Sanskriti Pratishthan
Save the Children
Secretaria Executiva da Articulacao das Mulheres Brasileiras – Beijing 95
Sempreviva Organizacao Feminista
Seva Mandir
Sexuality Information and Education Council of the United States
SHaKTI Productions
Shakti Shalini
Shanthimalai Trust
Shri Bhuvneshwari Mahila Ashram
Sistema Nacional de Promoción y Capacitación en Salud Sexual
SisterLove
Social Action for Rural and Tribal Inhabitants of India
Social Science Research Council
Social Sciences and Reproductive Health Research Network
Sociedad Mexicana de Demografía
Sociedad Mexicana Pro Derechos de la Mujer
Society for AIDS Awareness and Prevention
Society for Education Welfare and Action-Rural
Society for Education, Action & Research in Community Health
Society for Integrated Development of Himalayas
Society for International Development
Society for Women and AIDS in Africa, Nigeria Chapter
Society of Gynecology and Obstetrics of Nigeria
Society of Obstetricians and Gynecologists of Canada
Socio Legal Information Centre
SOS Adolescente
SOS Corpo Genero e Cidadania
SOS Medical and Educational Foundation
South – South Solidarity
Sree Chitra Tirunal Institute for Medical Sciences and Technology
St. John's National Academy of Health Sciences
Stanford University, Morrison Institute for Population and Resource Studies
STOPAIDS Organisation
Survival for Women and Children Foundation
Swaasthya Trust
Syracuse University Maxwell School of Citizenship and Public Affairs, Alan K. Campbell Public Affairs Institute
Talking About Reproductive and Sexual Health Issues

Tata Energy and Resources Institute
 Thais Desarrollo Social
 THEMIS – Assessoria Juridica e Estudos de Género
 Ticime
 Tides Center
 Tides Center, Center for Health and Gender Equity
 Tides Center, Global AIDS Action Network
 Tides Center, Health and Development Policy Project
 Tides Foundation, International Reproductive Rights Research Action Group
 Transnational Family Research Institute
 Turly Pictures, LLC
 UNDP / UNFPA / WHO / World Bank Special Programme of Research, Development
 and Research Training in Human Reproduction
 Uniao de Mulheres do Municipio de Sao Paulo
 Unidad de Atención Sicológica, Sexológica y Educativa para el Crecimiento Personal
 Unión de Comunidades Indígenas de la Zona Norte del Istmo
 Union for African Population Studies, International Development Research Centre
 Unitarian Universalist Service Committee
 United Nations Development Fund for Women
 United Nations Population Division – Department of Economic and Social Affairs
 United Nations Population Fund
 United States Fund for UNICEF
 Universidad de Guadalajara – Instituto Regional de Investigación en Salud Pública
 Universidad Nacional Autónoma de México – Programa Universitario de Estudios de Género
 Universidad Nacional Autónoma de México – Programa Universitario de Estudios de Género, Coordinación de Humanidades
 Universidade de Sao Paulo
 Universidade Estadual de Campinas – Nucleo de Estudos de Populacao
 Universidade Federal da Bahia
 Universidade Federal da Bahia – Instituto de Saude Coletiva
 Universidade Federal do Rio de Janeiro – Nucleo de Estudos de Saude Coletiva
 University Corporation for Atmospheric Research Foundation – The Walter Orr Roberts Institute
 University Court of the University of Aberdeen
 University of California, Irvine, Office of Grants and Contracts
 University of Chicago, Department of Economics
 University of Ibadan, College of Medicine
 University of Ibadan, Department of Sociology
 University of Ibadan, Institute of Education
 University of Michigan
 University of Michigan Center for Afroamerican and African Studies
 University of Michigan School of Public Health
 University of Nigeria, Enugu – Women's Health Unit
 University of Nigeria, Nsukka – Department of Zoology
 University of North Carolina at Chapel Hill – Carolina Population Center
 University of Sussex Institute of Development Studies
 University of Texas at Austin, Population Research Center
 University of the West Indies
 University of the Witwatersrand, Johannesburg, Women's Health Project
 University of Toronto, Faculty of Law
 Urmul Seemant

Usmanu Danfodiyo University Prevention of Maternal Mortality Programme
Vihaan
Vikas Sansthan
Ways of Knowing
WE CARE Solar
White Ribbon Alliance for Safe Motherhood, Global Secretariat
William A. Haseltine Foundation for Medical Sciences and the Arts
WomanHealth Philippines
Women Advocates Research and Documentation Centre
Women and Health Initiative – Harvard School of Public Health
Women Deliver
Women in Nigeria
Women Living Under Muslim Laws
Women, Law and Development Centre
Women's Aid Collective
Women's Environment & Development Organization
Women's Feature Service
Women's Global Network for Reproductive Rights
Women's Health and Action Research Centre
Women's Health Organisation of Nigeria
Women's Health, Education & Development
Women's Media Circle Foundation, Inc.
Women's Refugee Commission
Women's Resource and Research Center
Working Group for Safe Motherhood in Chiapas
World Health Organization
World Health Organization, Special Programme for Research and Training in Tropical Diseases
World Resources Institute
Xi'an Jiaotong University – Institute for Population and Economy Studies
XochiQuetzal
Yale University
Yeshiva University, Albert Einstein College of Medicine – Dept. of Epidemiology & Social Medicine
Youth Coalition
Youth for Action
Youth Pro-File
Youth, Adolescent, Reflection & Action Center
YP Foundation

Annex 2: Fund for Leadership Development Grantees

Safiya Tahir Abdullahi; Joy Abraham; Renu Addlakha; Adeyinka Abideen Aderinto; Joseph Adehitan and Kayode Felix Aiyegbusi Adetoro; Bolanle Akande Adetoun; Victor A. Adetula; Iyabode Adeyefa; Lesley Gene Agams; Martina Oghenevovwero Agberien; Guadalupe Aguilar Madrid; Irma Estela Aguirre Perez; Hajia Asmau Ahmed; Ter Akaa; Dorothy Cesnabmihilo Aken'ova; Adebanke Funsho Akinrimisi; Charlotte O. Akitoye; Bertrand Sampaio de Alencar; Joelzito Almeida de Araujo; Tania Maria de Almeida Franco; Ogoh Alubo; Josephine Nkiru-Edna Alumanah; Elena Alvarez; Francis Taiwo Aminu; Ana Amuchastegui; Dora Isabel do Araujo Andrade; Feruzi Fali Anjirbag; Josefina Aranda; Margaret Olabisi Araoye; Maria de los Angeles Arcos Garcia; Venu Arora; Aida Marina Arvizu Rivas; Shyam Ashtekar; Ruben Edgardo Avila Tena; Jose Ricardo de Carvalho Mesquita Ayres; Marta Maria do Amaral Azevedo; Paramita Banerjee; Sarnath Banerjee; Jummai Bappah; Regina Barba; Abel Jesus Barrera Hernandez; Claudia Isabel Barron Martinez; Marcelina Bautista; Sa'a Abubakar and Yardada Maikano Bayero Bichi; Alberto Becerril; Monisha Behal; Fernando Bejarano Gonzalez; Rufino Benitez Sanchez; Maria Aparecida Silva Bento; Adele Schuartz Benzaken; Dora Lucia de Lima Bertulio; Z.K.A. Bonat; Victor Hugo Borja Aburto; Elaine Reis Brandao; Maria Claudia Brauner; Zenilda Vieira Bruno; Beatriz Bugada Bernal; Samantha Buglione; Sowmini C.V.; Alejandra Caballero; Mark A. Callaghan; Irma Campos Madrigal; Ranulfo Cardoso; Consuelo Yoloxochitl Casas Chousal; Itza Castaneda; Roberto Castro Perez; Mariano Enrique Cebrian Garcia; Venkatesan Chakrapani; Isa Ibrahim Chana; Radhika Chandiramani; Brigida Chautla Ramos; Rodolfo Corona Vazquez; Sonia Onufer Correa; Lester Francis Coutinho; Enrique Cruz Lorenzo; Miguel Angel de los Santos Cruz; Henrique Cunha; Steven Peter Czitrom Baus; Maria Garcia da Costa; Jorge Luiz Cardoso Lyra da Fonseca; Murilo Peixoto da Mota; Joyce Dakun; Maria de los Angeles Diana Damian Palencia; Jashodhara Gupta and Abhijit Das; Bhargavi V. Davar; Iara Cedraz Guimaraes de Carvalho; Maeve Brito de Mello; Jacira Vieira de Melo; Neuza Maria de Oliveira; Silvia Marques Dantas de Oliveira; Aditi Desai; Mara Regia Di Perna; Marcelino Diaz de Jesus; Gilberto Dimenstein; Gloria Maria dos Santos Diogenes; Denise Dourado Dora; Mirna Guadalupe Echavarría Sanchez; Cheche Harold Egbune; Ekanem Efiang Ekanem; Nsikak Etim and Olayinka Jegede Ekpe; Emah Ekpo; Edith Azoma Ekwughu; Aliyu U. El-Nafaty; Rabi Eshak; Anthonia Maurice Essien; Joy Ezeilo; Nkoli Nwakego Ezumah; Adesegun Olayiwola Fatusi; Vera Lucia Fermiano; Maria Eugenia Lemos Fernandes; Bernadette Aparecida Ferreira; Regina Maria MacDowell de Figueiredo; Juan Guillermo Figueroa; Dr. Roseli Fischmann; Marcos Valentin Frigerio; Cristina Galante; Bela and Siddhivinayak Hirve Ganatra; Sanjoy Ganguly; Aminu Magashi Garba; Ibrahim Yohanna Garba; Juana Maria Garcia Ramos; Ajitha Susan George; Patricia Gerez Fernandez; Sumita Ghose; Ranjan Ghosh; Wosilat Olaitan Giwa; Raimunda Montelo Gomes; Amarantha Gomez; Eliane Goncalves; Hauwa Larai Goni; Edgar Antonio Gonzalez Ruiz; Rogelia Gonzalez; Roshmi Goswami; Rosemund Dienye and Blessing Nma Okrigwe Green; Anuja Gupta; Garba Ahmed Gusau; Sule Ahmed and Garba Ibrahim Darna Gusau; Margarita Gutierrez Romero; Sanusi Hashimu; Joseph Hellandendu; Melina Hernandez Sosa; Asavari A. Herwadkar; Maria Guadalupe Huacuz Elias; Omar and Bala Sokoto Gadanga Ibraheem; Grace Foluke Idowu; Andrew Aselokai Igbafe; Uchenna Uzoamaka Igwe; Prasanna Invally; Nnenna Carol and Maria Lucy Auwalu Iorapuu; Tor Iorapuu; Mustapha Hussain Ismail; Valdeci Israel; Felix Amaefule Iwuagwu; Stella Chidinma Iwuagwu; Kirti Iyengar; Nkemdilim Izuako; Sani Gombe and Bara Yusuf Jauro Jibrin; Elsa Alejandra Jimenez Larios; Candida Jimenez Perez; Akinlabi Jimoh; Asma'u Joda; Olubunmi Osarieme Joseph; Muhammed Ibn and Ghadjhaam Von Ardo Junaid; Hadiza Sani Kangiwa; Amar Kanwar; Ima Arit Kashmir; Benno George Alvaro de Keijzer Fokker; Sulaiman and Faruk Dantsoho Khalid; Sujata Khandekar; Berenice Assumpcao Kikuchi; Bernardo Kucinski; Kirtana Kumar; Manish Kumar; Antonio Fernandes Lages; Maureen Lance-Onyeiwu; Yahuya Mohammed Illiya; Maria del Carmen de Lara; Jorge Larson Guerra; Taiwo Olubanke Lawoyin; Raimundo Sergio Barros Leitao; Eclylene Maria da Araujo Leocadio; Theo Lerner; Eduardo Liendro Zingoni; Edmilson Lopes Junior; Francisco Javier Lopez Barcenás; Lizbeth Lopez Carrillo; Ana Flavia Pires Lucas d'Oliveira; Maria das Dores Campos Machado; Abbas Abdullahi Machika; Marucia Irena Madeiros de Amorim; Bene E. 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Gopinath Patil; Roberto Pereira; Camila Alves Peres; Juan Martin Perez Garcia; Victor Perez Grovas Garza; Mayra Perez; Albineiar Plaza Pinto;

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Annex 3: Population & Reproductive Health Staff

Abramson, Kate
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Bauling, Trina
Bissell, Sharon
Blanc, Ann
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Calderon, Edith
Camacho, Alvaro
Casey, Steve
Casillas, Maria Elena
Deogire, Manju
Dutse, Zainab
Egoh, Ana
Garcia, Carmen
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Goldfinger, Marion
Gonzalez, Elizabeth
Grown, Caren
Hanzel, Quinn
Harrison, Helen
Helzner, Judith
Hill, Phillis
Huffstader, Shirley
Kazeem, Hauwa
King, Linda
Kumar, Anu
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Liguori, Ana Luisa
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Mahoney, Margaret
Marques, Magaly
Martin, Dan
McGrory, Elizabeth
Mohammed, Abdullahi
Monroy, Liliana
Muttreja, Poonam
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Navarro, Lisette
Oderinde, Ezra
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Platz, Stephanie
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Usman, Amina
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Williams, Carlene
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Annex 4: International Advisory Group to PRH, 1991–2002

David Bell
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Ela Bhatt
John Bongaarts
Mario Bronfman
Lincoln Chen
Rebecca Cook
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Juan Guillermo Figueroa
Brigida Garcia
Mauricio Hernandez Avila
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David Okali
Friday Okonofua
Babatunde Osotimehin
Saroj Pachauri
Tola-Olu Pearce
Jacqueline Pitanguy
Marta Schteingart
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Mechai Viravaidya
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