11-2020

Translating Evidence Into Meaningful Actions: Annual Report 2019

Population Council

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COLLABORATING AT COMMUNITY, REGIONAL, AND GLOBAL LEVELS

TRANSLATING EVIDENCE INTO MEANINGFUL ACTIONS

IMPROVING LIVES AROUND THE WORLD
LETTER FROM THE PRESIDENT

This report is different from our past annual reports, in part because we are different, the world is different, and the ways in which we think about global health and development are different.

At the time of publication, the world is grappling with the COVID-19 pandemic, a global crisis with more challenges, and fewer resources to overcome them, than we can even imagine. The impact of COVID-19 is being disproportionately felt by the poorest and most marginalized populations in communities around the world. Research, science, and evidence are more important than ever. Too much is at stake to waste time and money on efforts that sound good but have not been shown to be effective or that are not making a real and tangible impact on the policies and programs that affect people’s lives.

Our annual report focuses on what we do best, which is testing ideas to tackle the uncertain challenges that lie ahead, generating evidence to determine what works (and as importantly what doesn’t), and collaborating to ensure that evidence is used to impact lives. We share powerful highlights from 2019 on the impact our research had on critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives.

You’ll read about how we are catalyzing the use of evidence to inform policies and strengthen programs in Guatemala, Tanzania, and other low- and middle-income countries, including:

- How our flagship HIV program has helped change national policy to expand access to HIV services for marginalized populations;
- How a program to empower indigenous adolescent girls has strengthened government programming to enable them to re-enter school;
- How our African-led consortium has influenced national and global efforts to end female genital mutilation/cutting (FGM/C); and
- How our contraceptive research, development, and partnership efforts have helped introduce one of our most effective contraceptive technologies to women in more than 30 countries.
The world’s ability and willingness to protect, let alone advance, the progress made in global health and development over the last 20 years is uncertain. But what we do know is that we have urgent work ahead of us. And now more than ever, we need to invest in evidence to inform and influence policies, programs, practices, and technologies that improve the health and well-being of current and future generations. We simply can’t afford not to.

Julia Bunting
President

RESEARCH UTILIZATION AND IMPACT

In the current environment, it is more important than ever that we ensure evidence is used to improve health, empower women and girls, and alleviate poverty. The Population Council collaborates with program implementers, policymakers, researchers, and funders to advance evidence-based solutions to critical health and development challenges. In the countries where we work, we partner with national governments, regional institutions, and community-based organizations to move evidence into practice and design new research and/or analyses responsive to partners’ needs and priorities.

On the following pages, we invite you to explore recent highlights of our ongoing work to translate social, behavioral, and biomedical research into improved lives around the world.
INTRODUCTION
Globally, female sex workers (FSWs) living with HIV are less likely to be on antiretroviral treatment (ART) than other populations; on average, fewer than 50 percent of FSWs living with HIV are on treatment. Research in Tanzania has documented the challenges FSWs face in accessing HIV care and treatment services, including out-of-pocket costs, reaching distant clinics, lack of awareness and misperceptions of treatment, and dual stigma associated with sex work and HIV status. Studies from sub-Saharan Africa have shown improved HIV treatment outcomes, such as uptake of HIV services, retention in care, and increased dignity and quality of life, by using community-based delivery of HIV services.

Between 2017 and 2019, the Population Council’s Project SOAR (Supporting Operational AIDS Research), funded by the US Agency for International Development, conducted an implementation science study to investigate community-based delivery of ART services to FSWs in Tanzania. This effort was undertaken in close collaboration with the National AIDS Control Program (NACP) of the Government of Tanzania, National Institute of Medical Research Mwanza Research Centre, and Jhpiego’s Sauti Program. The goal of the study was to understand if community-based ART delivery could help FSWs initiate and stay on HIV treatment.

RESEARCH SUMMARY
The project used a quasi-experimental prospective study design to explore the effects of a community-based ART delivery model on three primary outcomes:

- Treatment initiation: Proportion of individuals linked to care and initiating ART treatment
- Retention in care: Proportion of individuals retained in care at 6 and 12 months after enrollment in care
- Adherence to treatment: Proportion of individuals adhering to ART measured by self-reporting and viral suppression at 6 and 12 months

PROJECT SOAR RESEARCH INFORMS NATIONAL POLICY CHANGE IN TANZANIA EXPANDING ACCESS TO HIV SERVICES FOR MARGINALIZED POPULATIONS

A recent Project SOAR study evaluated community-based delivery of antiretroviral treatment to female sex workers (FSWs) in Tanzania, demonstrating the value of this approach to improve HIV care. Informed by these findings, the Government of Tanzania changed national guidance to allow for community-based HIV treatment to better meet the needs of marginalized populations, including FSWs.

A female sex worker receives community-based ART services from a nurse. (Photo: © CSK RESEARCH SOLUTIONS)
The community-based ART service delivery model was built upon Sauti’s existing community-based HIV testing and counseling plus (CBHTC+) intervention that provided additional services to key populations. Sauti operated in all seven study districts and together with the government provided the CBHTC+ package of services. In the intervention arm, ART was delivered through mobile community-based HIV testing and counseling services and home visits in four districts of the Njombe region. The comparison arm of the study was conducted in three districts of the Mbeya region where ART services were available through referrals to government-designated ART care and treatment clinics. A total of 617 FSWs were enrolled in the study.

Research findings demonstrated that FSWs in the community-based ART arm were more likely to initiate treatment than FSWs in the comparison arm. FSWs receiving community-based ART also had higher retention rates, which remained high even after 12 months in the program. Conversely, the study found a significant drop off in participation for the comparison group between 6 and 12 months.

Overall satisfaction with ART services was higher among FSWs receiving the community-based ART services, who spoke positively about client-provider interactions, information they received (adherence counseling, risk reduction), and perceived competence of the providers. However, the intervention had no effect on adherence or viral suppression, which were fairly high across both study arms.

**KEY IMPACTS**

- Informed by Project SOAR, national guidance and job aids updated to include community-based delivery of ART to reach key and vulnerable populations
- Community-based ART services sustained in study sites and continuing to scale across Tanzania with support from multiple partners

In understanding the impacts of community-based ART delivery, health providers offered care in locations where female sex workers felt most comfortable, including in their homes. (Photo: © CSK RESEARCH SOLUTIONS)

- Informed by Project SOAR, national guidance and job aids updated to include community-based delivery of ART to reach key and vulnerable populations
- Community-based ART services sustained in study sites and continuing to scale across Tanzania with support from multiple partners

Informed by the study findings, public facilities across Tanzania now provide community-based delivery of ART to reach key and vulnerable populations, including FSWs. Guidance on ART provision via mobile outreach was first included in the National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23 and is now featured in NACP’s Operational Manual and Job Aids for Comprehensive Differentiated Delivery of HIV and AIDS Services.

In line with Project SOAR’s approach to research utilization, the study was conceptualized and implemented in close collaboration with NACP and other partners to foster use of study results. Research responded to the needs of government officials and other partners to inform forthcoming guidance on decentralized delivery of HIV and AIDS services, specifically mobile outreach for marginalized populations. Throughout the research process, Project SOAR regularly shared data with the NACP, Sauti, the regional, district, and community health management teams, and other partners through interim data workshops and formal presentations. Critically, NACP provided ongoing technical support, recommendations, and buy-in, the Njombe Regional Health Management Team (RHMT) conducted quarterly site visits and provided supervision for delivery of ART services, and facility CTC staff periodically joined Sauti ART delivery teams to observe and supervise patient visits.
Study results, along with data from other partners, reinforced that community-based ART provision was an effective and reliable model for improving initiation and retention in Tanzania, contributing to national policy and guideline changes. Highlighting the sustainability of this endeavor, community ART services remain available in study intervention districts within Njombe region, now managed by facility partners. Notably, these services also continue to scale in all regions across the country with support from USAID and CDC HIV service implementation partners. Beyond the Tanzanian context, this study has been cited in wider analyses of emergent service delivery priorities for global HIV programming.

For more information, please visit projsoar.org, which features additional resources documenting its approach to research utilization employed in Tanzania and more than 20 other countries worldwide.

NOTES

1,4 Community-based HIV treatment service delivery model for female sex workers in Tanzania: Evaluation findings. knowledgecommons. popcouncil.org/departments_sbsr-hiv/363/

2 Barriers and facilitators of retention in HIV care and treatment services in Iringa, Tanzania: The importance of socioeconomic and sociocultural factors. DOI: 10.1080/09540121.2013.861574

3 Project SOAR. projsoar.org/

5 Community-based antiretroviral therapy (ART) delivery for female sex workers in Tanzania: 6-month ART initiation and adherence. DOI: 10.1007/s10461-019-02549-x


8 Job aids for comprehensive differentiated delivery of HIV and AIDS services. nacp.go.tz/download/job-aids-for-comprehensive-differentiated-delivery-of-hiv-and-aids-services/

9 Emerging priorities for HIV service delivery. DOI: 10.1371/journal.pmed.1003028

Project SOAR (Cooperative Agreement AID-OAA-A-14-00060) is made possible by the generous support of the American people through the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID). The contents of this brief are the sole responsibility of Project SOAR and the Population Council and do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.
INTRODUCTION
In Guatemala, indigenous girls are faced with discrimination based on the intersection of gender, economics, and ethnicity. Many live in isolated rural areas with limited access to water, sanitation, passable roads, schooling, and health care. Indigenous girls confront particular barriers that put them at risk of not pursuing secondary education as well as marrying early and having children at a young age. Providing accessible educational opportunities and developing their life skills may delay and even prevent these risks. While conditions are improving across Guatemala, school enrollment remains low overall, and indigenous girls are overrepresented among the out-of-school population.

Research carried out by the Population Council in Guatemala has demonstrated that social programs fail to reach the most marginalized populations when they are not specifically designed to meet the needs of these groups. In response, the Population Council, in collaboration with local and international partners, launched Abriendo Oportunidades (AO) in 2004 to reach indigenous adolescent girls in rural communities across Guatemala. AO makes critical investments in girls ages 8–18 to help them successfully navigate adolescent transitions. The program engages community leaders and establishes community girls’ clubs—safe spaces where girls learn practical skills and assume leadership roles. The program also invests in indigenous female mentors (ages 18–25 years), who run the safe spaces and facilitate regular sessions, receiving tools, trainings, and certifications that enable them to cultivate status as community agents of change. The goals of AO include to strengthen indigenous girls’ social support networks, connect them with role models and mentors, build a base of critical life and leadership skills, and provide hands-on professional training and experience.
female autonomy, freedom to meet with friends, and improved status in the home.

**RESEARCH USE AND IMPACT**

The Population Council and partners have cultivated close relationships with several government ministries in Guatemala, including the Ministry of Education and the Office of the Defense of Indigenous Women (Defensoría de la Mujer Indígena). To date, the Council has piloted multiple programs with the Ministry of Education’s General Directorate for Alternative Education, including Abriendo Oportunidades a la escuela (AO to School) which combines the AO model with existing government efforts to improve school re-entry for adolescents.

Supported by AO’s evidence-based approach and technical assistance from the Population Council, these pilots have strengthened public education programs and reinforced the Council’s role as a valuable partner to the Ministry of Education. Some examples of impact include:

- AO mentors have become tutors certified by the Ministry of Education to provide lower secondary education to out-of-school girls.
- AO also developed curricula now utilized by the Ministry for all secondary students in its alternative education program (Modalidades Flexibles).
- Through AO to School, the Population Council has provided ongoing technical support to the Ministry of Education to assess the challenges continuing education teachers face in delivering high-quality teaching. Assessment findings informed development of a joint teacher training module for all continuing education teachers in the country.
- In addition to now accepting younger adolescents in alternative education programs, the Ministry is exploring avenues to sustain and potentially expand the efforts of AO to School.
Beyond strengthening Ministry of Education-supported programs, the ripple effects of AO are felt in communities throughout Guatemala and beyond.

- Several AO alumni professional networks, including REDMI (Red de Mujeres Indígenas de Abriendo Oportunidades) Aq’ab’al, and Na’leb’ak, now operate independently as registered nongovernmental organizations (NGOs), supporting the participation of indigenous girls and women in civil society, community development, and local governance.

- Due to the reputation of AO mentors as advocates within their communities, program mentors in Chisec have been invited by the Office of the Mayors to participate in the municipal council, advising on gender and youth programs.

- Examples of regional program translation can be seen in similar projects that have emerged in Yucatan, Mexico, and Toledo, Belize to address the unique situations of indigenous girls, employing similar program design, curriculum, and evaluation methods.

LOOKING FORWARD

AO remains committed to investing in the health and well-being of indigenous girls. With an eye toward sustainability, the Council will continue to work with AO mentors on identifying pathways to secure sustainable livelihoods for mentors and girls, including a poultry and vegetable farm in Chisec, Casa Productiva. In addition, the Council is currently providing information about the perspectives and needs of indigenous communities in the context of COVID-19, and in the years to come will continue to expand access to education and pathways for social inclusion for indigenous girls and women.

For more information, please visit https://www.popcouncil.org/research/abriendo-oportunidades-opening-opportunities.

NOTES

2 Pedaling toward the future: Increasing and maintaining the school attendance of adolescent girls in indigenous communities of rural Guatemala. knowledgecommons.popcouncil.org/departments_sbsr-pgy/466/
3 Abriendo Oportunidades (“Opening Opportunities”). https://www.popcouncil.org/research/abriendo-oportunidades-opening-opportunities
4 Creating “safe spaces” for adolescent girls. knowledgecommons.popcouncil.org/departments_sbsr-pgy/837/
5 Abriendo Oportunidades: Integrated Curriculum Guide. knowledgecommons.popcouncil.org/departments_sbsr-pgy/592/
6 Program Modalidades Flexibles: Integrated Curriculum Guide—Segundo semestre. knowledgecommons.popcouncil.org/departments_sbsr-pgy/625/
7 Abriendo Futuros: A program for rural indigenous girls in Yucatan, Mexico. knowledgecommons.popcouncil.org/departments_sbsr-pgy/955/
8 Toledo Adolescent Girl Program. popcouncil.org/uploads/pdfs/Infographic_AdoiGirl2014.pdf
INTRODUCTION
Female genital mutilation/cutting (FGM/C) is a harmful practice that involves cutting, removing, and sometimes sewing up external female genitalia for nonmedical reasons. While considered a social norm in many cultures, FGM/C is a violation of the rights of girls and women and has no health benefits. It is estimated that more than 200 million girls and women have undergone FGM/C around the world, and approximately 3.6 million girls are cut each year.

Despite intensified global efforts to eliminate FGM/C since a 2012 UN General Assembly Resolution, critical evidence gaps have hindered a comprehensive, evidence-based response. To help address these gaps, Evidence to End FGM/C: Research to Help Girls and Women Thrive, an African-led research consortium, was assembled to generate the high-quality data needed to influence strategic investments, policies, and programs. This five-year project worked in eight African countries—Burkina Faso, Egypt, Ethiopia, Kenya, Nigeria, Senegal, Somalia, and Sudan—to dramatically expand the body of research on the most effective approaches to ending FGM/C in different contexts. Research was organized around four themes: 1) building the evidence base of where, when, and why FGM/C is practiced; 2) assessing a range of interventions to address FGM/C abandonment; 3) understanding the wider impacts of FGM/C; and 4) improving research on FGM/C.

RESEARCH SUMMARY
Through the creation of a vibrant South-North research consortium* and 43 studies, the Population Council-led Evidence to End FGM/C program addressed some of the most important challenges in measuring FGM/C and provided critical evidence on effective interventions for abandonment. The project produced new data to support decisions about where to target...
investments; build capacity for utilizing research findings in policies and programs; and strengthen measurement of FGM/C to monitor progress and impacts. Four key lessons are summarized in the box below.

Cross-national, multidisciplinary collaborations brought researchers together to generate high-quality evidence to inform policies and programs. The project also applied innovative research methods to improve FGM/C measurement, including geospatial and social network analysis as well as factorial focus group approaches. The project expanded the cadre of African researchers with capacity to generate rigorous, timely, and policy-relevant results.

**RESEARCH USE AND IMPACT**

Through strategic engagement of decision-makers at all stages of the research process, the Evidence to End FGM/C consortium has gained recognition as an important, credible resource to inform evidence-based FGM/C policies and programming.

The project used innovative multilevel analysis of existing Demographic and Health Survey (DHS) and Multiple Indicator Cluster Surveys (MICS) datasets to determine the prevalence and the changing nature of FGM/C in Kenya, Nigeria, and Senegal. The consortium worked closely with UNFPA to estimate actual survival trends and generate age-specific risks of being cut, allowing for comparisons between countries.

This work has informed UNFPA’s programming decisions at the national level and contributed to UNFPA’s new global estimates of girls at risk for FGM/C.

Strong country-level presence also provided a platform for networking and sustaining relationships with key partners and stakeholders. In Kenya, the project developed and strengthened its partnership and collaboration with the country’s Anti-FGM Board and the United Nations Joint Programme (UNJP) in Nairobi, regularly presenting and discussing the implications of evidence from its work at their meetings. The Anti-FGM Board, the primary government body responsible for implementing the Prohibition of FGM Act, actively sought

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**KEY LESSON 1.** FGM/C prevalence greatly varies between and within countries, thus understanding the local context of where and when FGM/C is practiced is essential for tailoring investments supporting abandonment efforts.

The prevalence of FGM/C varies almost as much within countries as it does between them. The practice tends to be concentrated in certain subregions and locations due to clustering of practicing ethnic groups; therefore, national data may mask important local variations. Subnational analyses can help programs identify “hot spots”—high prevalence areas that would benefit from tailored interventions.

**KEY LESSON 2.** The practice of FGM/C and its social and cultural underpinnings are changing.

The practice of FGM/C is rooted in gender roles, ethnic identity, the power of community influence, and the desire to belong. In 15 countries, the prevalence of FGM/C among girls and women ages 15–19 years is markedly lower than among those ages 45–49 years, providing evidence of a decline in the practice in the younger generation.

**KEY LESSON 3.** The health sector can and should play a central role in preventing and responding to FGM/C.

Across countries where FGM/C is practiced, traditional cutters are the main providers, but medicalization—cutting by a doctor, nurse, or trained midwife—is increasingly common in some places. Many health care systems do not have the policies, resources, capacity, or documentation needed to prevent FGM/C and support women experiencing complications.

**KEY LESSON 4.** Laws are important but require social legitimacy to be effective.

Laws banning FGM/C have existed for decades, but the public may be unaware of them or choose to ignore them, and they may not be enforced. Legal prohibitions of FGM/C may promote abandonment of the practice or may drive it underground. It is critical to address inherent conflicts between formal laws prohibiting FGM/C and religion and customs, which are also recognized as sources of law.
out support from the Council to inform its activities. In addition, the project was invited to contribute to the Joint Evaluation of the UNJP on FGM in Kenya, the UNJP annual FGM/C review and planning meetings, the Board’s capacity assessment, and the Board’s annual strategic planning.

In Nigeria, the consortium’s results highlighting the importance of collecting FGM/C data at community and facility levels, including evidence from recently completed studies such as “Diagnostic assessment of the health systems response to FGM/C management and prevention” and “Understanding medicalisation of FGM/C in Nigeria,” have been referenced in high-level political discussions. The team participated in quarterly meetings with DFID FGM/C implementing partners, the UNJP, the Girl Generation, and government representatives (the Federal Ministry of Health and the Federal Ministry of Women Affairs) to discuss ongoing work and its relationship to local and national abandonment programs and policies. Through these ongoing engagements, in 2019, the consortium was invited to contribute to the development and revision of national policies, including guidelines on ending the practice of FGM/C and addressing gender in health.

LOOKING FORWARD
The Council continues to provide leadership for FGM/C research and evidence uptake, heading the FGM Data Hub as part of DFID’s support to the second phase of the Africa-Led Movement to End Female Genital Mutilation. The FGM Data Hub is a collaborative, target-ed program to improve data use and strengthen monitoring and measurement tools for evidence-based FGM intervention design and implementation. The Council is also working together with UNJP to develop a global research and evidence-based action agenda for the next decade to accelerate progress toward elimination of FGM/C.

For more information, please visit evidencetoendfgmc.org/.

NOTES
1 Female genital mutilation. who.int/en/news-room/fact-sheets/detail/female-genital-mutilation.
2 A state-of-the-art synthesis on female genital mutilation/cutting: What do we know now? knowledgecommons.popcouncil.org/ departments_sbsr-rh/633/
3 Evidence to end FGM/C: Research to help girls and women thrive. popcouncil.org/research/evidence-to-end-fgm-c-research-to-help-girls- and-women-thrive1/.
4 Reference guide for Data Collection: Qualitative social network interviews. knowledgecommons.popcouncil.org/departments_sbsr-rh/720/
5 Reference guide for factorial focus group analysis methods for studying social norm change. knowledgecommons.popcouncil.org/ departments_sbsr-rh/721/
6 A diagnostic assessment of the health system’s response to FGM/C management and prevention in Nigeria. knowledgecommons. popcouncil.org/departments_sbsr-rh/1081/
7 Understanding medicalisation of FGM/C: A qualitative study of parents and health workers in Nigeria. knowledgecommons.popcouncil.org/departments_sbsr-rh/1081/
INTRODUCTION
The Population Council began developing Mirena® in the late 1970s1 with the aim of creating a contraceptive device combining the beneficial features of both hormonal contraceptives and intrauterine devices. Mirena®, approved by the Food and Drug Administration in 2000 and added to the World Health Organization’s Essential Medicines list in 2015, provides up to six years of safe, effective, and continuous contraception for women. Mirena®, produced in Finland by Bayer, is distributed in the private market and is available in more than 120 countries. “LNG IUS” is the version of the product distributed in the public sector outside the United States. However, Mirena® and other branded long-acting reversible contraceptive (LARC) products remain prohibitively expensive2 for many users. Service delivery and demand constraints have also hindered large-scale public sector introductions of the method.

The Council remains committed to continuing to improve access to the LNG IUS and other reproductive health products serving women and men in LMICs. In 2004, the Population Council and Bayer AG joined forces to establish the ICA Foundation, a public-private partnership, as a creative way of enhancing access to this innovative product. The Foundation, through its network of partners across multiple countries, has been engaged in serving women’s needs for expanded long-acting reversible contraceptive options. The Council holds two ex-officio board seats on the Foundation and three positions on the Secretariat that manages the Foundation’s affairs.

RESEARCH SUMMARY
The Council’s development of the LNG IUS/Mirena® with Bayer Oy (formerly Leiras Oy) sought to improve available intrauterine devices with the aim of decreasing menstrual bleeding and preventing anemia with the addition of a progestin (levonorgestrel, hence the generic name). The commercially marketed Mirena® was approved by the FDA for contraception in 2000 and later for the treatment of heavy menstrual bleeding. The LNG IUS is available on a not-for-profit basis through donations by the ICA Foundation to service delivery organizations working in low-resource settings.

The LNG IUS has numerous benefits:3 up to six years of protection, a pregnancy rate of less than 1 percent in the first year of use, a strong safety record comparable to sterilization, rapid return to fertility after removal, the ability to lighten menstrual bleeding and cramping, and the potential reduction in iron-deficiency anemia. Clinical data is available for over 13,000 women-years of product use, demonstrating high efficacy and acceptance.

ICA FOUNDATION SUPPORTS LNG IUS ACCESS IN LOW- AND MIDDLE-INCOME COUNTRIES
The Population Council has developed and introduced several of the world’s most effective and popular contraceptive methods, including the levonorgestrel-releasing intrauterine system (LNG IUS). Through the International Contraceptive Access (ICA) Foundation, a public-private foundation based in Finland, the Council supports LNG IUS distribution to women in over 35 low- and middle-income countries (LMICs) in partnership with international and local organizations. Over 150,000 LNG IUS units have been delivered to date at no cost, laying the groundwork for method introduction in LMICs and further expanding access to safe, long-acting, reversible contraception.
To date, the ICA Foundation has donated over 150,000 LNG IUS devices5 to organizations in 37 LMICs, helping to prevent thousands of unintended pregnancies, unsafe abortions, and maternal deaths.6 These donations support the work of governments and local not-for-profit organizations, hospitals, and global partners that share the Council’s commitment to improving access to quality family planning services and expanding modern contraceptive options.

Across multiple contexts, ICA Foundation donations have responded to growing demand for modern contraception, expanded access to LARCs, and laid the groundwork for LNG IUS introduction in multiple LMICs. In several countries, such as Kenya, Nigeria, and Zambia, donated LNG IUS units have supported demonstration projects that provided a foundation for broader access to the method, institutionalization within national health systems, opportunities for regional replication and encouraging new manufacturing options.

The ICA Foundation has responded to growing demand for LARCs by supporting efforts to expand access to the LNG IUS through the public sector in multiple countries. In Kenya, recent LNG IUS donations contributed to a Jhpiego-coordinated initiative7 to build capacity for increasing access to modern contraception, including LARCs, through public-sector facilities in Kisumu and Migori counties.

In partnership with the Ministry of Health, the LNG IUS was added to the modern contraceptive options offered at select high-volume facilities. Through these collaborative efforts, the LNG IUS is now included in Kenya’s national family planning training curriculum and health information systems. In addition, efforts are underway to transition management of commodity donations from Jhpiego to the Government of Kenya.

Modest donations of LNG IUS product have been catalytic in setting the stage for sustained efforts to increase access to the method within existing health systems by energizing service delivery organizations, harnessing the reach of professional associations, and creating linkages between public and private stakeholders. In Nigeria, LNG IUS donations have supported the efforts of Rotary and several local partners promoting provider skills-building activities; community outreach involving men and religious leaders; and increased availability of modern contraceptives, including LARCs, across multiple states.

The ICA Foundation, in collaboration with these partners and others, has also contributed to recent efforts by Nigeria’s Federal Ministry of Health to sustain and expand access to hormonal IUS through a national plan for coordinated and phased introduction within the country’s health system.

**LOOKING FORWARD**

The ICA Foundation will continue to support increased LNG IUS availability in LMICs through its donation program. Beyond sustained country-level donations, the Foundation also continues to shape global markets, demonstrating the demand for long-acting methods, fostering competition, ensuring a more reliable and greater volume of supply, and stimulating more favorable pricing. In addition, USAID and UNFPA are in the process of adding the hormonal IUS to their procurement catalogs so that interested international buyers can procure the product.

For more information, please visit ica-foundation.org/ica-foundation/our-impact/.

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**NOTES**

1 Advancing long-acting reversible contraception. popcouncil.org/news/advancing-long-acting-reversible-contraception
2 A global learning agenda for the Levonorgestrel Intrauterine System (LNG IUS): Addressing challenges and opportunities to increase access. DOI: 10.9745/GHSP-D-18-00383
3 The hormonal intrauterine system (IUS). iusportal.org/about
4 Contraceptive development. popcouncil.org/research/contraceptive-development
5 ICA Foundation projects. ica-foundation.org/projects/about-the-projects/
6 ICA Foundation impact. ica-foundation.org/ica-foundation/our-impact/
2019 FINANCIAL REPORT

The Population Council delivers solutions that lead to more effective programs, policies, and technologies that improve lives. We closely monitor our financial status and remain committed to the fiscal discipline necessary to maintain the Council’s record of accomplishments.

STATEMENT OF ACTIVITIES (For the year ended December 31, 2019)

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<th>ACTIVITY</th>
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<td>Other</td>
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<tr>
<td>Fund-raising</td>
<td>661,742</td>
<td>-</td>
<td>661,742</td>
</tr>
<tr>
<td>Total supporting services</td>
<td>13,081,542</td>
<td>-</td>
<td>13,081,542</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>70,782,891</td>
<td>-</td>
<td>70,782,891</td>
</tr>
<tr>
<td>Excess of operating revenue over operating expenses</td>
<td>23,370,051</td>
<td>2,718,785</td>
<td>26,088,836</td>
</tr>
<tr>
<td>Other changes in net assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postretirement benefit changes other than net periodic benefit cost</td>
<td>(462,988)</td>
<td>-</td>
<td>(462,988)</td>
</tr>
<tr>
<td>Net periodic benefit costs other than service cost</td>
<td>(314,317)</td>
<td>-</td>
<td>(314,317)</td>
</tr>
<tr>
<td>Transfer from endowments</td>
<td>1,350,052</td>
<td>(1,350,052)</td>
<td>-</td>
</tr>
<tr>
<td>Increase in net assets</td>
<td>23,942,798</td>
<td>1,368,733</td>
<td>25,311,531</td>
</tr>
<tr>
<td>Net assets at beginning of year</td>
<td>89,746,422</td>
<td>16,884,256</td>
<td>106,630,678</td>
</tr>
<tr>
<td>Net assets at end of year</td>
<td>113,689,220</td>
<td>18,252,989</td>
<td>131,942,209</td>
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</tbody>
</table>
**BALANCE SHEET (For the year ended December 31, 2019)**

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>$8,230,102</td>
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<tr>
<td>Grants and contributions receivable, net</td>
<td></td>
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<tr>
<td>U.S. government agencies</td>
<td>3,524,707</td>
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<tr>
<td>Other</td>
<td>5,796,079</td>
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<tr>
<td>Other receivables</td>
<td>1,270,171</td>
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<tr>
<td>Prepaid expenses and other assets</td>
<td>1,074,995</td>
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<tr>
<td>Investments</td>
<td>140,306,710</td>
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<tr>
<td>Fixed assets, net</td>
<td>9,657,118</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>169,859,882</strong></td>
</tr>
</tbody>
</table>

**LIABILITIES AND NET ASSETS**

<table>
<thead>
<tr>
<th>Liabilities:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable, accrued expenses, and other liabilities</td>
<td>$3,556,613</td>
</tr>
<tr>
<td>Awards, contracts, and fellowships payable</td>
<td>2,110,063</td>
</tr>
<tr>
<td>Program advances</td>
<td>16,984,531</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>186,484</td>
</tr>
<tr>
<td>Loans payable</td>
<td>2,792,372</td>
</tr>
<tr>
<td>Deferred rent credit, net</td>
<td>5,072,120</td>
</tr>
<tr>
<td>Accrued lease obligation</td>
<td>25,907</td>
</tr>
<tr>
<td>Postretirement medical benefits payable</td>
<td>7,189,583</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td><strong>37,917,673</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net assets:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Net assets without donor restrictions:</td>
<td></td>
</tr>
<tr>
<td>General undesignated</td>
<td>1,087,081</td>
</tr>
<tr>
<td>The John D. Rockefeller 3rd Memorial Funds</td>
<td>112,602,139</td>
</tr>
<tr>
<td><strong>Total net assets without donor restrictions</strong></td>
<td><strong>113,689,220</strong></td>
</tr>
<tr>
<td>Net assets with donor restrictions:</td>
<td></td>
</tr>
<tr>
<td>Purpose or time restricted</td>
<td>12,767,213</td>
</tr>
<tr>
<td>Restricted by donors in perpetuity</td>
<td>5,485,776</td>
</tr>
<tr>
<td><strong>Total net assets with donor restrictions</strong></td>
<td><strong>18,252,989</strong></td>
</tr>
<tr>
<td><strong>Total net assets</strong></td>
<td><strong>131,942,209</strong></td>
</tr>
</tbody>
</table>

**Total liabilities and net assets**

| Total liabilities and net assets            | $169,859,882 |

A copy of the audited financial statements, prepared in accordance with US generally accepted accounting principles, is available upon request from the Population Council, One Dag Hammarskjold Plaza, New York, New York 10017, and can be accessed online at popcouncil.org.
OUR SUPPORTERS

We are thankful to our supporters who share our vision for improved well-being and reproductive health for current and future generations, and for a humane, equitable, and sustainable balance between people and resources.

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Agency for International Development ( USAID)
Centers for Disease Control and Prevention (CDC)
National Institutes of Health (NIH)
Government of Zambia
National HIV/AIDS/STI/TB Council (NAC)

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CRDF Global Project, funded by Fogarty International Center, NIH
EngenderHealth
Expanded Church Response (ECR)

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Global Health Corps (GHC)
GOAL
Guttman Institute
Harvard T. H. Chan School of Public Health
International Development Research Centre (IDRC)
International Planned Parenthood Federation (IPPF)

Ipas
Jacaranda Health
Johns Hopkins University
JSI Research & Training Institute
London School of Economics & Political Science
Lundquist Institute
Management and Development for Health (MDH)
Marie Stopes International (MSI)
Nossal Institute Limited
Oregon Health & Science University (OHSU)
Overseas Development Institute
Pathfinder International
Program for Appropriate Technology in Health (PATH)
Research Foundation of the City University of New York
Research Triangle Institute (RTI) International
The Sackler Institute for Nutrition Science
Save the Children
Society for Family Health (SFH), Nigeria
SRI International
Stanford University
Swaziland Action Group Against Abuse (SWAGAA)
University of California, San Diego (UCSD)
University of California, San Francisco (UCSF)
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The Boeing Company Gift Match/BPAC Program
Bridgewood Fieldwater Foundation
Caithness Foundation, Inc.
Camber Collective, LLC
The Chicago Community Foundation
The Community Foundation of Eastern Connecticut
The Dawn Hill Fund
The Denver Foundation
The Edward & Rose Donnell Foundation
EcoTrust
Etisalat Foundation
Fidelity Charitable Gift Fund
Financial Decisions, LLC
Fondation des Amis de Médecins du Monde
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Arturo Lanzani
**SPECIAL HONOR GIFT**

**A gift in honor of the remarkable Dr. Elizabeth Price**

The Population Council received a gift in 2019 in honor of Dr. Elizabeth “Betty” Price, a passionate advocate for social and environmental justice, women’s reproductive rights, and equal opportunity for all to reach their potential.

Dr. Price packed a world of experience and service into one lifetime. Born in 1920 in New Jersey, she was driven by an endless passion for knowledge and a drive to make this world a better place. During World War II, Price learned to fly a plane so that she could join Women Airforce Service Pilots (WASP), before going on to become a doctor and a public health practitioner at a time when few women attended medical school.

Price served the field of public health as a doctor in Nepal in the 1950s, and later in a refugee camp in Malaysia for Vietnamese refugees. Price was Director of Community Health for the State of Alaska, making sure that even the most remote villages—reachable only by bush plane much of the year—had basic health services. She traveled extensively and adventurously throughout her life, including a voyage around the world on a “Semester at Sea” program with students a quarter of her age, and earned a master’s degree in storytelling in her eighties.

Price left her savings to support organizations that impact the causes she was so passionate about. Her gift to the Population Council will help our scientists and researchers pursue solutions to critical global health and development challenges, across our biomedical and social and behavioral science portfolios. Price’s life served as an inspiration for all who knew her, and the Population Council is grateful for this contribution that honors her life and her work to make our world a better and more just place.
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Craig Savel and Marion Stein  
Karen and Bob Schaefer  
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Brian Schneidewind  
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Leslie J. Scott  
Perry and Lisa Scott  
Harriet Segal  
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Cynthia L. and Michael D. Sevilla  
Mohammed Shahidullah  
Xixi and Jonathan J. Shakes  
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Mathew Zenkowich  
H. Ziegenfuss  
Rena Zieve and Greg Kuperberg  
Elizabeth and Jaime Zobel de Ayala  
Paul L. and Suzanne C. Zuzelo  
Thomas Zydowsky and Hui Tsou  

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**In Honor of**
Judith Bruce  
Glen M. Feighery  
Andrew Larner  
Don Mordecai  
John E. Morris  
Rebecca Preston  
Sarah Provost  
Whitney Scott

**In Memory of**
McGeorge Bundy  
Ronald Freedman  
Florence Hepner  
Henry King  
Dorothea R. Thorne  
Nuran Turksoy-Marcus  
Josef Karl Voglmayr
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<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Title</th>
<th>Institution/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darcy Bradbury</td>
<td>Chair, Managing Director</td>
<td>The D.E. Shaw Group, New York, New York</td>
</tr>
<tr>
<td>Terry Peigh</td>
<td>Vice Chair, Senior Vice President</td>
<td>Interpublic Group of Companies, New York, New York</td>
</tr>
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<td>Robert Harding Chair in Global Child Health &amp; Policy</td>
<td>Hospital for Sick Children and The Aga Khan University, Toronto, Canada and Karachi, Pakistan</td>
</tr>
<tr>
<td>Peter Brandt</td>
<td>Healthcare Board Director</td>
<td>Stamford, Connecticut</td>
</tr>
<tr>
<td>Julia Bunting</td>
<td>President</td>
<td>Population Council, New York, New York</td>
</tr>
<tr>
<td>Ronald F. Geary</td>
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<td></td>
</tr>
<tr>
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<td>Corporate Partners, New York, New York</td>
</tr>
<tr>
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</tr>
<tr>
<td>Nyovani Madise</td>
<td>Director of Research and Development Policy</td>
<td>African Institute for Development Policy (Malawi), Lilongwe, Malawi</td>
</tr>
<tr>
<td>Wanda Olson</td>
<td>Senior Counsel</td>
<td>Cleary Gottlieb Steen &amp; Hamilton LLP, New York, New York</td>
</tr>
<tr>
<td>Lauren A. Meserve</td>
<td>Chief Investment Officer</td>
<td>Metropolitan Museum of Art, New York, New York</td>
</tr>
<tr>
<td>K. Sujatha Rao</td>
<td>Independent Consultant on Health Systems</td>
<td>Former Union Secretary, Ministry of Health, Government of India, Hyderabad, India</td>
</tr>
<tr>
<td>David Serwadda</td>
<td>Professor, Department of Disease Control and Environmental Health</td>
<td>School of Public Health, Makerere University, Uganda</td>
</tr>
<tr>
<td>Jonathan Shakes</td>
<td>E-Commerce Logistics Consultant</td>
<td>Mercer Island, Washington</td>
</tr>
<tr>
<td>Theo Spencer</td>
<td>New York, New York</td>
<td></td>
</tr>
<tr>
<td>Jeffrey M. Spieler</td>
<td>Consultant in Population and Reproductive Health</td>
<td>Bethesda, Maryland</td>
</tr>
<tr>
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<td>Professor Global Health Education and Founding Director Health[e]</td>
<td>Foundation, University of Amsterdam, Netherlands</td>
</tr>
<tr>
<td>Kaye Wellings</td>
<td>Professor of Sexual and Reproductive Health</td>
<td>London School of Hygiene &amp; Tropical Medicine, London, United Kingdom</td>
</tr>
</tbody>
</table>

### EXECUTIVE TEAM

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julia Bunting</td>
<td>President, Population Council, New York, New York</td>
</tr>
<tr>
<td>Ann K. Blanc</td>
<td>Vice President, Social and Behavioral Science Research</td>
</tr>
<tr>
<td>John Bongaarts</td>
<td>Vice President and Distinguished Scholar</td>
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<tr>
<td>Jackson Ireland</td>
<td>Vice President, Corporate Finance and Administration</td>
</tr>
<tr>
<td>James Sailer</td>
<td>Vice President and Executive Director, Center for Biomedical Research</td>
</tr>
<tr>
<td>Sarah de Tournemire</td>
<td>Vice President, Development and Engagement</td>
</tr>
<tr>
<td>Patricia C. Vaughan</td>
<td>Vice President, General Counsel and Secretary</td>
</tr>
</tbody>
</table>

POPULATION COUNCIL OFFICES

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The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world.

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