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Family Planning and the MDGs: *Saving Lives, Saving Resources*

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Achieving the MDGs

The contribution of family planning

Ethiopia

In 2000, members of the United Nations pledged their commitment to the Millennium Declaration. The declaration, adopted by more than 190 nations, calls for achieving the Millennium Development Goals (MDGs)—a set of eight vital, time-bound goals, ranging from reducing poverty by half to improving maternal health. The goals are delineated as 21 targets with 60 measureable indicators. With a target year of 2015, the MDGs are an important framework for monitoring countries' progress, ensuring accountability, and advocating for stepping up efforts to meet the health and development needs of the world's poorest populations.

While the global consensus on and commitment for the MDGs represent significant steps forward, periodic progress reports show that many countries are not "on track" for reaching the goals by 2015. In many developing countries, continued rapid population growth is a major challenge to meeting the MDGs. At the societal level, rapid population growth adds to the number of people in need of healthcare, education, livable wages, and other social services—which, in turn, requires additional human, financial, material, and natural resources. At the household level, high fertility affects the health of women, their children, and families, thereby increasing the risk of maternal, child, and infant mortality.

Development efforts to achieve the MDGs must recognize the benefits of slowing population growth. One way to slow population growth is to satisfy the current unmet need for family planning (FP). Many married women report having mistimed or unintended pregnancies or a desire to space or limit future pregnancies, but are not using modern contraceptive methods. Satisfying existing

Children sift powdered cassava in Nyegina Village, Tanzania. © 2001 Njamburi/Cabak ELS, Courtesy of Photoshare.

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Figure 1. Social Sector Cost Savings and Family Planning Costs in El Salvador, 2005–2015

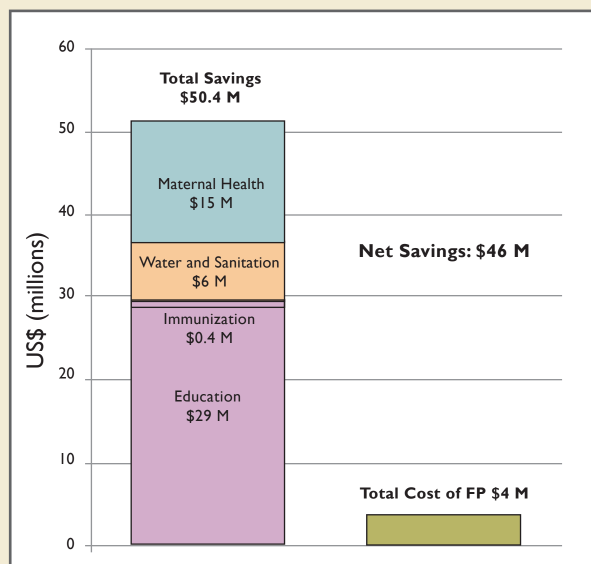
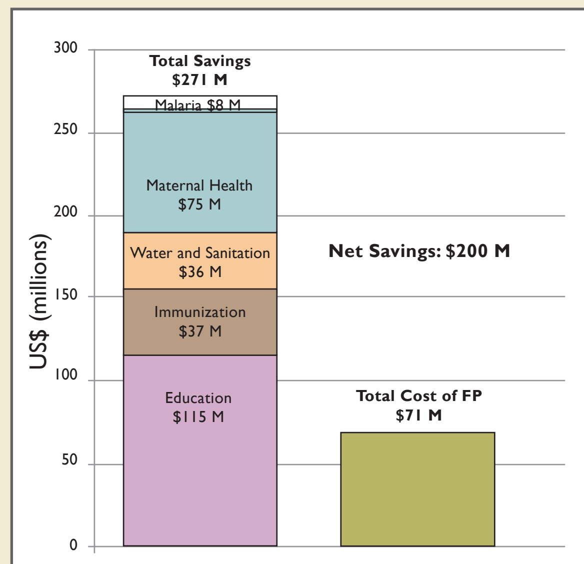


Figure 2. Social Sector Cost Savings and Family Planning Costs in Kenya, 2005–2015



Family Planning Is a Good Investment

The FP–MDG analyses make clear that family planning saves lives and resources. Family planning can delay the onset of first pregnancy, prevent unintended pregnancies, and promote birth spacing—thereby reducing abortions, giving women time to recover between pregnancies, and limiting women's lifetime risk of maternal death. Further, family planning can reduce the number of infant and child deaths by reducing the proportion of high-risk births. Healthier mothers are also better able to provide for the nutrition and care of their babies after delivery.

These facts are supported by the FP–MDG analyses. In 2005, 11 countries accounted for 65 percent of all maternal deaths.[2] The Health Policy Initiative has completed analyses for nine of these countries: Bangladesh, Democratic Republic of Congo, Ethiopia, India, Indonesia, Niger, Nigeria, Pakistan, and Tanzania.[3] Gradually satisfying unmet need for family planning by 2020 in these nine countries would save the lives of more than 225,000 women and avert about 10.6 million child deaths. Thus, family planning helps countries reduce child mortality (MDG 4) and improve maternal health (MDG 5).

What key decisionmakers might not realize is that family planning also plays a valuable complementary role in reaching the other MDGs. Helping couples achieve their desired family size by promoting contraceptive use helps to reduce total fertility and, ultimately, slows rapid population growth. A smaller population means fewer people in need of education (MDG 2) and health services (MDGs 4–6), and less strain on the environment and natural resources (MDG 7). Thus, full achievement of the MDG targets costs less and is more manageable logistically.

Countries across the spectrum of demographic situations and development needs can realize significant returns on their investment in family planning. A comparison of countries as diverse as Kenya and El Salvador illustrates this point. In Kenya, women still have, on average, about 5 children each, and surveys show that the unmet need for FP services is high (about 25 percent of married women of reproductive age want to space or limit births but are not currently using any method of family planning).[4] In El Salvador, women have, on average, 2.9 children each and unmet need for family planning among married women is only about 9 percent.[5]

The FP–MDG analyses, presented in Figures 1 and 2, consider the costs for satisfying unmet need for family planning and for achieving selected indicators for the MDG targets—such as net enrollment ratio in primary education, proportion of children age one immunized against measles, and proportion of the population with access to an improved water source/sanitation.

For El Salvador, cost savings in meeting the selected MDG indicators outweigh the additional costs for family planning by a factor of 13 to 1. In Kenya, the benefit-cost ratio is lower (4 to 1) due to the costs associated with satisfying a higher current level of unmet FP need and other factors. However, by investing in family planning, Kenya would realize a significant net savings of about US$200 million from 2005–2015.

If costs were to be projected for additional indicators of the MDG targets and beyond the year 2015, countries' potential savings from investing in family planning would be even greater.

Uses of the FP–MDG Analyses

The FP–MDG analyses are integrated into the Health Policy Initiative's country-based policy and advocacy programs. Moreover, the briefs have been disseminated to diverse partners and are available online. As shown in the examples below, in-country partners typically use the FP–MDG analyses as part of a package of evidence-based advocacy and policy dialogue strategies for various FP/RH issues, leading to results.

Promote gender equality and empower women and girls

Two young Guatemalan girls take a break from helping their mother sell items to tourists on the street of Antigua. © 2001 Virginia Lamprecht, Courtesy of Photoshare.

MALI | Linking Family Planning and Poverty Reduction

In 2001, Mali had a total fertility rate of 6.8 births per woman. Among currently married women, nearly one-third had an unmet need for family planning (29%) and only 6 percent were using modern contraceptive methods (with 8% using any method).[6] In 2006, the country had an estimated population of about 12 million people and an annual population growth rate of 3 percent.[7] A majority of the country's population lives in rural areas and below the national poverty line.

These indicators suggested that Mali's national development efforts could benefit from strategies that link family planning and poverty reduction. In September 2006, the Health Policy Initiative presented the FP–MDG analysis to the Secretary-General of the Presidency, a representative of the Office of the Presidency (and now the current Prime Minister). The presentation emphasized the need to incorporate family planning into the country's second-generation Poverty Reduction Strategy Paper (PRSP). Throughout the more than year-long preparation of the PRSP-II, the project also supported an NGO network and a civil society policy champion to participate in the PRSP-II drafting sessions and advocate for inclusion of FP programs.

The country's first PRSP made no mention of family planning. However, the PRSP-II, finalized in April 2008, lists reducing health expenses for the poor, including for FP services, under the priority interventions for the health and social development sector. It also calls for FP information and sensitization programs under strategies to address gender and health issues. Moreover, population issues are listed

Reduce child mortality

EPI Team Leader Dr. Brandao of UNICEF immunizing a missed child in Gayari village, Gummi local government area, Zamfara State, Nigeria; Sub-National Immunization Day (SNIDS) 2002. © 2002 CCP, Courtesy of Photoshare.

as a crosscutting concern. As such, the PRSP-II urges development efforts to appreciate the interrelationships among the social, economic, and demographic sectors. The language on family planning in the PRSP-II will provide FP champions a mechanism to encourage funding and additional support for FP programs in Mali.

MALAWI | Expanding FP Access through Community-based Distribution

Malawi, like many sub-Saharan African countries, faces a shortage of doctors, nurses, and midwives. This shortage comes at a time when demand for family planning is increasing. Particularly in rural areas, modern contraceptives are often scarce, and few trained professionals are available to provide FP services. Married women of reproductive age in Malawi report a high unmet need for family planning (28%) and a clear preference for injectable contraceptives among those who intend to use family planning in the future (59%).[8]

Providing injectable contraceptives through community-based distribution (CBD) is one way to meet the FP demand. In Malawi, health surveillance assistants (HSAs) are responsible for providing basic preventive care at the community level, including the administration of immunizations for children under five and tetanus shots for pregnant women. They are frequently the first point of contact for Malawians when seeking healthcare services.

In March 2008, Malawi's Ministry of Health (MOH) decided to allow HSAs to administer injectable contraceptives at the community level, a decision it had been debating for more than 10 years. The decision came about, in part, due to information, analyses, and advocacy support provided by the Health Policy Initiative. The project worked with Malawi's Reproductive Health Unit (under the MOH) and other partners to carry out evidence-based advocacy, including an operational barriers analysis, mapping of community-level services, reviews of other CBD projects, and stakeholder forums. As part of this effort, the FP–MDG analysis was one of the key arguments for expanding access to family planning at the community level.

Moreover, based on the analysis, the MOH has prepared a "Minister's Brief on Microeconomics of Maternal Health in Malawi." The brief is being used to help advocate to other policymakers for additional resources to satisfy unmet need for family planning as a way to improve maternal health.

Improve maternal health

A family in Trecer Lotificacion, a peri-urban community near Santa Elena in El Peten, the northern region of Guatemala. © 2002 Aimee Centivany, Courtesy of Photoshare.

LAC REGION | Ensuring Contraceptive Security

Many countries in the Latin America and Caribbean (LAC) region are planning for the gradual phaseout of donor support for contraceptive procurement. Thus, governments must take the necessary steps to ensure contraceptive security (CS). In response, as part of USAID's LAC Contraceptive Security Initiative, the Health Policy Initiative has helped to create in-country, multisectoral CS committees to foster evidence-based advocacy, planning, and policymaking.

The FP–MDG analyses are one component of the CS committees' multifaceted advocacy and policy dialogue strategies. The Health Policy Initiative has completed analyses for Bolivia, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Peru. The findings have been shared through advocacy training

Combat malaria, HIV/AIDS, and other diseases

A mother with her infant children sleeping under an insecticide-treated net to prevent malaria in Tanzania. © 2007 Bonnie Gillespie, Courtesy of Photoshare.

workshops for CS committees and stakeholders throughout the region, which included guidance on how the evidence could be incorporated into the committees' CS advocacy plans.

The CS committees have achieved several successes in advancing contraceptive security throughout the region.[9] For example, in July 2007, the Dominican Republic's President issued a decree to formally establish the National CS Committee and mandated that participating institutions allocate resources for contraceptive procurement. Before this decree, no legal document had established the requirement for institutions to allocate resources for FP programs, specifically for contraceptive procurement. The Health Policy Initiative assisted the Dominican Republic's CS committee to design a CS advocacy strategy, including linking family planning with the country's MDG targets. The FP–MDG analysis and other information shared in CS meetings were an important input leading to the presidential decree. The mandated allocation of funds for contraceptive procurement will contribute to the sustainability of FP programs as contraceptive donations phase out.

UNITED STATES | Renewing U.S. Global Leadership for Reproductive Health

"Repositioning" family planning is a key concern for reproductive and maternal health champions. Donor support for family planning has declined over the past decade with the emergence of other health priorities, namely the HIV epidemic. In January 2009, to encourage renewed U.S. global leadership for reproductive health, five former directors of USAID's Office of Population and Reproductive Health released the report *Making the Case for U.S. International Family Planning Assistance*.[10] The document uses findings from the FP–MDG analyses to make the argument that investments in family planning will lead to significant returns in terms of family well-being, health, and national development. The report also includes a graph from the Zambia MDG Brief and notes that every dollar the country spends on family planning will save four dollars in other health and development programs.

Summary

Emerging and persistent issues—from economic recessions to food insecurity—call on national leaders to devise innovative strategies to bolster socioeconomic development and meet the needs of their citizens. At the same time, changes in government and donor priorities and funding mechanisms (e.g., phaseouts, basket funding, sector-wide approaches) require FP champions to come up with new strategies to mobilize commitment and resources for FP programs.

The FP–MDG analyses are influential advocacy tools because they use country-specific goals, data, and trends; provide evidence-based analyses to complement advocacy efforts; and can be tailored to various issues of interest (as shown by the country examples). Most important, the analyses bolster appeals to both economic and public health concerns, which helps broaden support for family planning among a wider range of decisionmakers.

MDG Briefs are available for the following countries:

AFRICA

Burkina Faso
Cameroon
Chad
Democratic Republic of Congo
Ethiopia
Ghana
Guinea
Kenya
Madagascar
Malawi
Mali
Niger
Nigeria
Rwanda
Senegal
Tanzania
Uganda
Zambia

ASIA & THE MIDDLE EAST

Bangladesh
India
Indonesia
Jordan
Nepal
Pakistan
Yemen

LATIN AMERICA & THE CARIBBEAN

Bolivia
Dominican Republic
El Salvador
Guatemala
Honduras
Nicaragua
Peru

The MDG Briefs are available to download online. Please visit **www.healthpolicyinitiative.com**. Click on the Resources tab to find the Publications Page and then select **"MDG Briefs"** as the document type.

Ensure environmental sustainability

Children in Indonesia enjoy fresh water from a water well newly installed in their village. © 2003 Project Concern International, Courtesy of Photoshare.

ENDNOTES

[1] The USAID-funded POLICY Project (1995–2006) is the predecessor to the Health Policy Initiative, which has updated the original MDG analyses and completed additional country analyses. To learn more about the methodology, please see: Moreland, S., and S. Talbird. 2006. *Achieving the Millennium Development Goals: The Contribution of Fulfilling Unmet Need for Family Planning*. Washington, DC: Futures Group International, POLICY Project. Available at http://www.healthpolicyinitiative.com/Publications/Documents/MDGMaster%209%2012%2006%20FINAL.pdf [accessed April 27, 2009].

[2] WHO, UNICEF, UNFPA, and World Bank. 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and World Bank*. Geneva: WHO.

[3] FP–MDG analyses have not been done for Afghanistan and Angola.

[4] 2003 Kenya Demographic and Health Survey.

[5] 2002/03 El Salvador Reproductive Health Survey.

[6] 2001 Mali Demographic and Health Survey.

[7] See World Bank, Key Development Data & Statistics, Country Profile for Mali. Available at http://worldbank.org [accessed June 10, 2009].

[8] 2004 Malawi Demographic and Health Survey.

[9] Health Policy Initiative, Task Order 1. 2008. "Safeguarding Contraceptive Security in Latin America and the Caribbean." Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1. Available at http://www.healthpolicyinitiative.com/Publications/Documents/604_1_604_1_Safeguarding_CS_in_LAC_FINAL_11_19_2008_acc.pdf [accessed April 27, 2009].

[10] Speidel, J.J., S. Sinding, D. Gillespie, E. Maguire, and M. Neuse. 2009. *Making the Case for U.S. International Family Planning Assistance*. Baltimore, MD: Bill and Melinda Gates Institute for Population and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University. Available at http://www.jhsph.edu/gatesinstitute/_pdf/policy_practice/Papers/MakingtheCase.pdf [accessed March 5, 2009].

FOR MORE INFORMATION

Project Director
Health Policy Initiative, Task Order 1
Futures Group International
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: 1-202-775-9680
Web: www.healthpolicyinitiative.com
Email: policyinfo@futuresgroup.com

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