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Why Contraception is a Best Buy

Family Planning Saves Lives and Spurs Development

The widespread availability of modern contraceptive methods, along with socioeconomic changes that have made large families less desirable, have contributed to unprecedented declines in childbearing in developing countries. Average fertility has fallen from about six births per woman in the 1960s to about three births per woman today. Social change of this magnitude has occurred in few other spheres of development, and its effects on health have been profound.

Contraceptive use affects the health of women, their sexual partners and children, and society as a whole. Using contraception to delay or stop childbearing allows women to give birth at the healthiest times for them and their children, thereby lowering maternal and child deaths and disabilities. In addition, some contraceptive methods prevent both pregnancy and sexually transmitted infections, including HIV.

Investing in family planning is a cost-effective way to avert births and disease (see table on page 2). The social and environmental benefits of family planning also extend well beyond the health sector and beyond a single generation. Still, increasing contraceptive use among rural and traditional populations in much of sub-Saharan Africa has been slow and difficult.

The Contribution of Family Planning Programs

Organized family planning programs funded by governments and donors are largely responsible for bringing modern contraception to the developing world. Contraceptives offered in such programs range from temporary methods (especially oral contraceptive pills, hormonal injections, and condoms) to permanent methods (female or male sterilization).

Some programs are dedicated to providing only family planning services (known as vertical programs); some work within the health care system and are combined with other reproductive health services; and other programs work independently from health facilities, distributing subsidized contraceptive products through private-sector

outlets. Government and nongovernmental providers, private doctors, and pharmacies often coexist, providing contraceptives to different clientele. Those family planning programs that have reached out to poor communities with information and household delivery of free contraceptives are given credit for rising contraceptive use in some of the poorest countries, such as Bangladesh.

Demand for Contraception and Unmet Need

Despite widespread adoption of family planning in the developing world, contraceptive use is still very low in much of sub-Saharan Africa and in areas in other regions where women are very poor, uneducated, and have limited access to quality family planning services. Women are defined as having an “unmet need” for family planning if they say they prefer to avoid pregnancy but are not currently using a contraceptive method. Sub-Saharan Africa has the highest level of unmet need: About one-fifth of women there do not want to become pregnant, yet use no contraceptive method. Contraceptive use is low, practiced by only one-fifth of married women on average. In contrast, at least 75 percent of married women use contraception in Vietnam, Colombia, and Brazil, and only 6 percent to 7 percent of women in these countries have unmet need.

Why is there so much unmet need in some areas? Women who prefer to avoid pregnancy may not use contraception because of a lack of knowledge, fear of side effects, religious beliefs, or opposition from their spouses or family members. They rarely cite cost as a barrier to use.

Health Consequences of Unintended Births

All pregnancies and births pose health risks, particularly in poor countries. In sub-Saharan Africa, for example, women face a one in 16 lifetime chance of dying due to complications of pregnancy and childbirth. Research has shown that women and their children face a higher likelihood of death and disability when the mothers are under age 17, over age 35, have births spaced too closely together, have too many births,

or have preexisting health conditions. Because pregnancies among women with these characteristics are risky, it is doubly important to prevent pregnancies that are unintended.

Unintended pregnancies, which may end in unsafe abortions or unwanted births, are responsible for between 12 percent and 30 percent of the maternal burden of disease, according to *Disease Control Priorities in Developing Countries*, 2nd edition. However, these figures underestimate the present and future burden of disease that can be prevented through family planning. They exclude the potentially beneficial effects of family planning on children's nutrition and education, and the public savings from reduced incidence of AIDS and other sexually transmitted infections that can be prevented through condom use. Also excluded are the disabling effects of unwanted pregnancies.

The Cost-Effectiveness of Family Planning Programs

The cost-effectiveness of family planning programs is estimated based on the direct health benefits from increasing birth intervals and reducing teenage pregnancies; these estimates ignore the broader benefits to children and families noted above. However, these programs are extremely cost-effective, even excluding the additional health benefits that accrue to multiple generations. Health interventions that cost less than \$100 per disability-adjusted life year (DALY) gained (see table) are considered highly cost-effective by international standards.

Combining family planning with HIV-prevention services would be particularly cost-effective in countries hard hit by the epidemic. One analysis showed that adding family planning to the more common services that prevent mother-to-child transmission of HIV significantly lowered prevention costs. Helping HIV-positive women avoid unintended pregnancies by integrating family planning services also reduces the number of maternal deaths and the number of children orphaned by HIV. Averting an AIDS-related maternal death

costs an estimated \$1,824.

Governments and donors have plenty of evidence to justify funding for family planning programs, but program managers often lack information on how best to spend funds within their programs. Many program managers need guidance when deciding the most cost-effective ways to deliver contraceptives in various settings, how to direct subsidies to the poorest people, and how best to combine related services.

Research Needed

Research priorities for improving the effectiveness of family planning include:

- Operational research on the most cost-effective programs and delivery systems in specific developing-country settings;
- Developing new contraceptive methods that prevent both pregnancy and HIV, and that women and men want to use;
- Finding better ways to integrate family planning and HIV programs in countries with high levels of HIV prevalence, thereby gaining greater efficiencies in service delivery, saving more women's and children's lives, and preventing further spread of HIV.

For More Information

Levine, R., A. Langer, N. Birdsall, G. Matheny, M. Wright, and A. Bayer, 2006. "Contraception." In *Disease Control Priorities in Developing Countries*, 2nd ed., ed. D.T. Jamison, J.G. Breman, A.R. Measham, G. Alleyne, M. Claeson, D.B. Evans, P. Jha, A. Mills, and P. Musgrove, 1193-1209. New York: Oxford University Press.

Average Costs per Benefit of Family Planning (in 2001 U.S. Dollars)				
Region	Birth averted	Infant death averted	Maternal death averted	Disability-adjusted life year gained
East Asia and the Pacific	\$163	\$4,907	\$12,880	\$60
Latin America and the Caribbean	\$87	\$2,316	\$34,564	\$53
Middle East/North Africa	\$97	\$1,989	\$18,917	\$49
South Asia	\$113	\$1,577	\$5,172	\$30
Sub-Saharan Africa	\$131	\$1,367	\$10,231	\$34

Note: A disability-adjusted life year measures a year of life free of disease or disability.

Source: Ruth Levine et al, 2006, *Disease Control Priorities in Developing Countries*