



## POTENTIAL IMPACT OF INCREASED FAMILY PLANNING FUNDING ON THE LIVES OF WOMEN & THEIR FAMILIES OVERSEAS

As part of his FY 2001 budget request, the President urged Congress last February to appropriate an additional \$169 million above current levels for international population and family planning programs, which would restore funding for the program to the FY 1995 level. Approval of the funding increase proposed by the President would have a measurable impact on the health and well-being of women and their families in the countries receiving financial and technical assistance from the U.S. Agency for International Development (USAID) as summarized below.

### ESTIMATED IMPACT OF THE PROPOSED FUNDING INCREASE

Leading researchers estimate that if the \$169 million increase for USAID population assistance were allocated among the countries receiving USAID funding in the same manner that past expenditures have been distributed, and if the cost per public sector family planning user in each country remains constant, the following would occur:

**11.7 million more couples in developing countries receiving USAID population assistance will have access to and use a modern method of contraception.**

**As a result, 4.3 million women will be able to avoid an unintended pregnancy each year, leading to:**

- **1.5 million fewer unintended births;**
- **2.2 million fewer abortions; and**
- **0.5 million fewer miscarriages each year.**

**By preventing these unintended pregnancies, 15,000 fewer women will die each year:**

- **7,000 fewer from pregnancy-related causes other than induced abortion; and**
- **8,000 fewer from unsafe abortions.**

**In addition, there will be 92,000 fewer infant deaths.**

### RECENT POPULATION ASSISTANCE FUNDING TRENDS

Beginning in 1993, President Clinton requested and Congress approved significant increases in U.S. support for international family planning programs, bringing bilateral spending to an all-time high of \$541.6 million in FY 1995. But in 1995, a newly-elected Congress dramatically reduced overseas development aid. Funding for international family planning assistance was cut disproportionately, declining by 35 percent to \$356 million. These cuts—together with months-long delays and restrictions on the release of population assistance funds—caused severe disruptions to the program.

In the four subsequent fiscal years, international population assistance funding levels have remained stagnant, capped at \$385 million. (In FY 2000, available funding declined an additional \$12.5 million to

\$372.5 million when the President chose to partially waive new restrictions on the ability of overseas family planning providers to engage in abortion-related advocacy activities in their own countries using non-U.S. funds.)

## **DIMENSIONS OF REPRODUCTIVE HEALTH PROBLEMS**

Because of early and frequent childbearing and poor access to health care and contraception, nearly 600,000 women die each year in pregnancy and childbirth. Virtually all maternal deaths occur in developing countries and account for one-quarter to one-half of all deaths to women of childbearing age in these countries. Included in that toll are an estimated 77,000 deaths annually from unsafe abortion.

Better access to voluntary family planning and related health care would prevent many of these deaths, abortions, and injuries. Family planning helps people avoid high-risk pregnancies, prevent unwanted childbearing, and reduce infections, such as HIV/AIDS and other sexually transmitted diseases, that could lead to death, disability, and infertility, and helps to improve women's health in general.

Worldwide 150 million couples in the developing world say they would prefer to plan their births but are not using family planning. Although there are many reasons for this gap, lack of access to high quality information and services is a key problem in many countries. In addition, one billion young people are entering their reproductive years and will also require services. The amount of funding for these vital programs falls far short of the need.

## **CALCULATING THE IMPACT OF A \$169 MILLION INCREASE**

The potential impact of an additional \$169 million is estimated by gathering and reconciling information from a wide variety of sources. These sources range from United Nations estimates of annual births to USAID population funding trends to country-specific surveys of women of reproductive age to special studies of contraceptive use and of pregnancy outcomes.

In general, an increase in the USAID budget for international population assistance would improve the quality of life of many families around the world by providing more financial and technical resources for the family planning programs in the countries where USAID operates. These additional resources would lead to an increase in the number of users of modern methods of contraception as a result of improved availability and quality of family planning services and enhanced programs for training, information, education and communications, policy development, and research. The estimates provided above probably underestimate the long-term impact of USAID investments, as USAID assistance helps build countries' capacity to provide services on into the future.

The first step in calculating specific impacts is determining how many new family planning users would be assisted by U.S.-funded programs. The number of new users that would be associated with an increase in USAID population assistance of \$169 million depends on how and where the funds are used. The most logical and conservative approach to estimating this impact is to assume that the new funds are distributed functionally and geographically in a manner similar to current USAID funding trends. The second step is estimating the positive benefits that will result from an increased number of new users of U.S.-funded family planning programs in terms of the health and well-being of women and their families in those countries.

*The analysis summarized above reflects the combined knowledge and expertise of the following organizations: The Alan Guttmacher Institute, The Futures Group International, Population Action International and the Population Reference Bureau, in consultation with the Population Council. Detailed methodologies and references are available on request.*

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## **ESTIMATING THE IMPACT OF A \$169 MILLION INCREASE IN USAID POPULATION BUDGET: CALCULATION NOTES AND SOURCES**

In his FY 2001 budget request, President Clinton proposed to appropriate \$169 million above the current levels of international population and family planning assistance, thus restoring funding to its FY 1995 level. Approval of this proposed increase would improve the availability and quality of family planning services in the 68 developing countries receiving financial and technical assistance from the United States Agency for International Development (USAID). This would help improve the health and wellbeing of women and their families.

These additional funds, which would support the public sector in developing countries, would improve the availability and quality of family planning services and enhance programs for training; information, education, and communications; policy development; and research. In turn, these enhanced activities would lead to an increase in the number of users of public sector family planning services and to a related decrease in unintended pregnancies, abortions, unintended births, maternal deaths and infant deaths.<sup>1</sup>

Following is a description of the methodology for a quantitative analysis of the potential impacts of the proposed increase in international family planning funding. The analysis probably underestimates the long-term impact of USAID investments, as USAID assistance helps build countries' capacity to provide services into the future.

### **NUMBER OF ADDITIONAL USERS OF PUBLIC SECTOR FAMILY PLANNING SERVICES**

The first step in this exercise was to estimate the number of new users of the contraceptive services provided with the additional funding. The calculations assumed that the \$169 million would be allocated across countries and spent in a manner similar to USAID's population assistance expenditure patterns between 1994 and 1998 in each of the 68 USAID-supported countries.

Therefore, for each country, the share of the additional funds was calculated by applying that country's proportional share of total 1994-1998 USAID assistance to \$169 million.<sup>2</sup>

These additional funds were then divided by country-level estimates of current cost per user (public sector expenditures per public sector user) to arrive at the number of additional public sector users the new money would support in each country.<sup>3,4</sup>

**In total, 11.71 million additional new users of public sector family planning services would be expected to result from an additional \$169 million in funding.**

## NUMBER OF UNPLANNED PREGNANCIES PREVENTED

It was assumed that the additional 11.71 million women who would use USAID-supported services would be obtaining modern contraceptive methods. Formerly they would have been using no method, a traditional method or a modern method from a private sector source. Thus, these new users of public sector services would reduce or maintain their exposure to the risk of unplanned pregnancy depending upon which of these three categories they had been in before the \$169 million was allocated. The risk of unplanned pregnancy would decrease significantly for those formerly using no method or a traditional method while the risk was assumed to remain unchanged for modern method users who switched their source of services from the private to the public sector.<sup>5</sup>

The distribution of new users by their former method was assumed to be the same as the current distribution of women 15-44 in each of the 68 countries who are at risk of unintended pregnancy because they are not using a method but say they would prefer to space or limit childbearing, or are using a traditional or a modern reversible contraceptive method. Excluded from the at-risk group were women who were not in union, infecund, relying on contraceptive sterilization of themselves or their partner, postpartum amenorrheic, intentionally pregnant or trying to get pregnant.<sup>6</sup>

This distribution of potential users was further refined by excluding modern method users who are already relying on the public sector for their services and supplies.<sup>7</sup>

Next, the percent distribution of women using no method but say they would prefer to space or limit childbearing, using a traditional method or using a modern reversible contraceptive from private sources was applied to the number of additional public sector users to estimate the number of additional public sector users by their former method for each country. For all 68 USAID-funded countries combined, the distribution of the 11.71 million additional users of public sector services was as follows: 60 percent (6.97 million) would formerly have been using no method, 24 percent (2.84 million) a traditional method, and 16 percent (1.90 million) a modern method from the private sector.

To determine the magnitude of the decrease in the risk of unintended pregnancy for these additional public sector users, the difference in pregnancy rates prior to and after use of the new services was calculated. The annual pregnancy rates associated with each of the former risk categories were compared with the risk of pregnancy after all these women receive modern methods from the newly provided public sector services.

The annual pregnancy rates used in the analysis were as follows: 13 percent for modern users, 30 percent for traditional method users, and 68 percent for no method users.<sup>8</sup> Since all the 11.71 million additional users were assumed to be adopting modern contraceptive methods, they would have a pregnancy rate of 13 percent. Therefore, the pregnancy rate of those who switch from no method would decrease from 68 to 13 percent (by 55 percentage points), and for traditional method users from 30 to 13 percent (by 17 percentage points). The risk of unplanned pregnancy was assumed not to change for modern method users switching from private to public sector services.<sup>9</sup>

The number of unplanned pregnancies that could be averted as a result of women using the newly provided modern methods of family planning from public sector sources was calculated by applying the difference in pregnancy rates to the relevant number of new users in each country. **It was estimated that a total of 4.31 million unwanted pregnancies could be prevented in the 68 USAID-funded countries where additional population assistance funds would make services available to women who need them.**

Preventing unplanned pregnancies would reduce unplanned births, abortions, miscarriages, and maternal and infant deaths. Following is an estimation of the number of these events prevented as a result of additional resources.

#### **UNPLANNED BIRTHS PREVENTED**

In estimating the number of unplanned births, abortions and miscarriages prevented, the regional distribution of unplanned pregnancies by these three outcomes were used due to lack of country-level data.

To determine the number of unplanned births that could be averted, the regional percentages of unintended pregnancies that result in births were applied to country-level estimates of the number of unplanned pregnancies that could be averted.<sup>10</sup> **This calculation yielded an estimated 1.54 million unplanned births that could be prevented in all USAID-funded countries.**

#### **ABORTIONS PREVENTED**

The number of abortions that could be averted was estimated in a way similar to that of unplanned births prevented; regional percentages of unplanned pregnancies that end in abortion were applied to country-level estimates of the number of unplanned pregnancies averted.<sup>11</sup> **The additional \$169 million could prevent 2.24 million abortions in the 68 USAID-funded countries.**

**Out of the total 4.31 million unplanned pregnancies that could be prevented, it was estimated that 530,000 would have ended in a miscarriage.<sup>12</sup>**

#### **MATERNAL DEATHS PREVENTED**

Use of more effective family planning methods and improved public sector reproductive health services would directly and indirectly lead to a decrease in the number of maternal and infant deaths. Direct benefits stem from a reduction in the exposure to the risk of death associated with ectopic pregnancies, pregnancies resulting in a live birth or miscarriage, or pregnancies ending in an abortion. Additional benefits stem indirectly from improved maternal and child health resulting from better child spacing, lower parity and the reduction in the number of risky births to very young and older women. Although these indirect benefits may be extensive, these estimates take into account only those maternal and infant deaths that could be prevented directly, that is, related to avoiding an unplanned pregnancy.

The decrease in maternal mortality resulting from a decrease in the number of unplanned pregnancies resulting in live births, miscarriages and ectopic pregnancies was calculated by taking the product of country-level maternal mortality ratios from causes other than abortion, expressed as the number of maternal deaths per 100,000 live births, and country-level estimates of unplanned births averted.<sup>13</sup> This totaled 6,670 maternal deaths that could be prevented.

The number of maternal deaths due to a decrease in pregnancies ending in abortion was calculated by taking the product of the regional abortion mortality ratios, expressed as the number of deaths per 100,000 abortions, and country-level estimates of abortions averted.<sup>14</sup> This totaled 8,270 maternal deaths prevented. **In all, nearly 15,000 maternal deaths could be prevented annually in USAID-supported countries due to decreases in the number of women exposed to the risks associated with unintended pregnancies, births and abortions.**

## INFANT DEATHS PREVENTED

To estimate the number of infant deaths that could be prevented in each country, infant mortality rates, expressed as the number of infant deaths per 1,000 live births, were applied to the estimated number of unplanned births prevented.<sup>15</sup> As with maternal deaths, this estimate did not take into account infant deaths averted indirectly through improved maternal and infant health. **Nearly 92,000 infant deaths could be prevented if international population and family planning expenditures increase by \$169 million.**

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<sup>1</sup> The increase in funds is expected to cause a general increase in demand for family planning across all sectors and for all methods. Therefore, the demand for private sector services as well as traditional methods is also expected to increase as a result.

<sup>2</sup> USAID. *Overview of USAID Population Assistance, FY 1998*. Arlington, VA: Family Planning Logistics Management for USAID, 1999.

<sup>3</sup> It would be more accurate to use marginal cost per new user, but there is very little information available on marginal costs. If funding were to increase by a large amount, then marginal costs would be higher than average costs, since the program would be able to concentrate more on recruiting less committed users. However, since the additional \$169 million examined here represents only a small increase in total funding for family planning from all sources and since there are also potential increasing returns to scale, we assumed that the average expenditure per user is an acceptable alternative to marginal expenditures.

<sup>4</sup> Population Action International. *Family Planning Expenditures in 79 Countries: A Current Assessment*. Washington, DC: Population Action International, 1995. Expenditure Figures are for 1994; USAID. *Overview of USAID Population Assistance, FY 1998*. Arlington, VA: Family Planning Logistics Management for USAID, 1999.

<sup>5</sup> We conservatively estimated that modern method users switching from private to public sector services would not change their pregnancy risk. However, private sector modern method users switching to public sector services would likely choose more effective methods (e.g., IUDs and sterilization).

<sup>6</sup> Country-specific distributions of women aged 15-44 by risk for unintended pregnancy (not at risk because they were not having sex, were intentionally pregnant, postpartum amenorrheic, infecund or they or their partner were contraceptively sterilized; traditional method users; modern reversible contraceptive method users; and other nonusers) were taken from tabulations of Demographic and Health Surveys in The Alan Guttmacher Institute. *Hopes and Realities: Closing the Gap between Women's Aspirations and Their Reproductive Experiences*. New York: The Alan Guttmacher Institute, 1995, and from special tabulations of the Demographic and Health Surveys for India and Bangladesh. The distribution for countries with no available data was estimated from countries in its subregion, weighting the countries by the 2000 population of women aged 15-44 from United Nations. *World Population Prospects: The 1998 Revision*. Electronic Version. New York: United Nations, 1998. Nonusers were segmented into those not currently at risk of pregnancy because they were currently pregnant or postpartum amenorrheic and those nonpregnant users who say they would prefer to have children later or no more children, based on this distribution among currently married women in Demographic and Health Surveys. *Comparative Studies 5: Unmet Need and the Demand for Family Planning*. Columbia, MD: Institute for Resource Development and Macro International, 1991. Subregional distributions were used where country-specific information was unavailable.

<sup>7</sup> Mauldin, W. Parker and Vincent C. Miller. *Contraceptive Use and Commodity Costs in Developing Countries: 1994-2005. Technical Report Number 18*. New York: United Nations Population Fund, 1994.

<sup>8</sup> Annual contraceptive failure rates were based on first-year method failure rates including only births as outcomes from Moreno, Lorenzo. "Differences by Residence and Education in Contraceptive Failure Rates in Developing Countries." *International Family Planning Perspectives* 19, No. 2, June 1993, adjusted to include all pregnancy outcomes (births, abortions and miscarriages) based on Alan Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York: The Alan Guttmacher Institute, 1999 and detailed source tabulations, and combining rates for barrier and other modern methods using the distribution reported for developing countries in United Nations Department of Economic and Social Affairs. *World Contraceptive Use 1998*. New York: United Nations, 1999. The first-year pregnancy rate for no method was taken from Trussell, James, Robert A. Hatcher, Willard Cates, Jr., Felicia Hance Stewart and Kathryn Kost, "Contraceptive Failure in the United States: An

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Update," *Studies in Family Planning* Vol. 21, No. 1, 1990. Annual rates were estimated by deflating the first-year rates by 20% based on Trussell, James and Barbara Vaughan. "Contraceptive Failure, Method-related Discontinuation and Resumption of Use: Results from the 1995 National Survey of Family Growth." *Family Planning Perspectives* 31, No.2, March/April, 1999 and Ranjit, Nalini, Akinrinola Bankole, Jacqueline E. Darroch, and Susheela Singh. "Socioeconomic Differentials in Contraceptive Failure Rates in the United States: Estimates from the 1988 and 1995 NSFG," *Family Planning Perspectives*, forthcoming.

<sup>9</sup> It is likely that the pregnancy rate of former modern reversible methods would also decrease on moving from private sources to the public sector, both because of the greater availability of highly effective long-term contraceptive methods, including voluntary sterilization, as well as additional counseling and education services regarding contraceptive method choice and use.

<sup>10</sup> The Alan Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York: The Alan Guttmacher Institute, 1999 and detailed source tabulations.

<sup>11</sup> The Alan Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York: The Alan Guttmacher Institute, 1999 and detailed source tabulations.

<sup>12</sup> The Alan Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York: The Alan Guttmacher Institute, 1999 and detailed source tabulations.

<sup>13</sup> WHO and UNICEF, *Revised 1990 Estimates of Maternal Mortality. A New Approach by WHO and UNICEF*. Geneva: WHO, 1996; WHO Division of Reproductive Health. *Unsafe Abortion. Global and Regional Estimates of Incidence of and Mortality Due to Unsafe Abortion with a Listing of Available Country Data*. Third Edition. Geneva: WHO, 1998.

<sup>14</sup> WHO Division of Reproductive Health. *Unsafe Abortion. Global and Regional Estimates of Incidence of and Mortality Due to Unsafe Abortion with a Listing of Available Country Data*. Third Edition. Geneva: WHO, 1998.

<sup>15</sup> UNICEF. *The State of the World's Children 2000*. New York: UNICEF, 2000.