

FAMILY PLANNING SAVES LIVES

Fourth Edition



P O P U L A T I O N R E F E R E N C E B U R E A U

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Population Reference Bureau

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PREVIOUS EDITIONS OF FAMILY PLANNING SAVES LIVES

The 1st edition of *Family Planning Saves Lives*, published in 1986, provided valuable information to policymakers, program planners, and journalists on the health benefits of family planning. In response to the overwhelming demand for the subsequent editions (published in 1991 and 1997), PRB is pleased to present the 4th edition. While the message has not changed, this new edition provides data from the latest research on maternal and child health in developing countries. It also includes new information on how family planning reduces the rate of new HIV infections and deaths from AIDS as well as a Special Focus section on repositioning family planning in sub-Saharan Africa.

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FAMILY PLANNING SAVES LIVES

Table of Contents

Overview.....	3
<i>Box 1. The Health Benefits of Family Planning</i>	4
Saving Women’s Lives	5
<i>Table 1. Women’s Risk of Death From Pregnancy and Childbirth</i>	5
The Need for Family Planning.....	5
<i>Figure 1. Total Potential Demand for Family Planning in Selected Countries</i>	6
Reducing Unintended Pregnancies.....	6
<i>Figure 2. Modern Contraceptive Use and Abortion</i>	7
Family Planning Methods	7
<i>Box 2. Adolescents and Reproductive Health</i>	8
Saving Children’s Lives	10
The Benefits of Birth Spacing	10
<i>Figure 3. Infant Mortality by Birth Interval</i>	10
<i>Box 3. Breastfeeding Protects Babies and Saves Lives</i>	11
Preventing HIV/AIDS	11
<i>Box 4. Integrating Family Planning and HIV/AIDS Services</i>	12
Special Focus: Repositioning Family Planning in sub-Saharan Africa	13
Investing in the Health of Mothers and Children	16
The Cost of Family Planning Services	16
<i>Table 2. Costs to Meet Family Planning Needs and Resulting Savings, Selected Countries</i>	16
The Need to Reach the Poor.....	18
<i>Figure 4. Contraceptive Use Is Lowest Among the Poor and Highest Among the Rich</i>	18
<i>Box 5. Reasons to Invest in Family Planning: Benefits Beyond Health</i>	19
Priority Actions	20
References	22

Overview

The widespread adoption of family planning represents one of the most dramatic changes of the 20th century.¹ The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has had tremendous lifesaving benefits. Yet despite these impressive gains, contraceptive use is still low and the need for contraception high in some of the world's poorest and most populous places.

Recent research is shedding light on how family planning increases survival, improves the health of millions of people, and helps achieve national goals. Considered a “best buy” among health investments, family planning is one of the most cost-effective, high-yield interventions that exists today. Countries that invest in family planning can reap immediate health benefits, investment savings in the health and education sectors, and social and environmental benefits that extend well beyond a single generation.

Family planning could prevent many more deaths—particularly in the poorest countries—if we put current knowledge into practice:

- **Family planning saves women's lives.** Family planning could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size.²
- **Family planning saves children's lives.** After giving birth, family planning can help women wait at least two years before trying to become pregnant again, thereby reducing newborn, infant, and child deaths significantly.³
- **Family planning saves adolescents' lives.** Teen pregnancies pose health risks not only for the babies but also for the young mothers, particularly those under age 18. Family planning can help young women avoid having children during this high-risk time and also avoid the social and economic consequences of early childbearing.
- **Family planning reduces deaths from AIDS.** The consistent and correct use of condoms can significantly reduce the rate of new HIV infections. Many HIV-positive women and couples want to avoid becoming pregnant and many effective methods are available to assist them. By averting unintended and high-risk pregnancies, family planning reduces mother-to-child transmission of HIV and the number of AIDS orphans, whose life chances are seriously diminished because they have lost a parent, particularly the mother.
- **Family planning helps governments achieve national and international development goals.** Governments around the world are focused on combating poverty and achieving a range of health and development goals, such as those outlined in the United Nations' Millennium Development Goals (MDGs). Family planning can contribute to nearly all of these goals,

including reducing poverty and hunger, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, and ensuring environmental sustainability.⁴

There is a safe and effective family planning method for every woman that can enable her to protect her health and that of her children. More than half of all couples in the developing world are using family planning to delay, space, or limit future pregnancies, yet the need for family planning keeps increasing as the number of women of reproductive age continues to grow. An estimated 137 million women worldwide have an unmet need for family planning—they are not using any method and report that they want to avoid a pregnancy.⁵

To reach these women, and save additional lives, governments and donors need to focus more attention and commit more resources to family planning programs. Over the last decade, however, family planning in many countries has lost focus amid shifts in international health and development priorities. Policymakers have turned their attention to other issues such as HIV/AIDS, infectious diseases, and alleviating persistent poverty. As a result, family planning programs are struggling at a time when universal access to family planning could contribute to solving these issues.

Overcoming these challenges is important for the health and welfare of mothers, children and families (see Box 1). At an average supply cost of US\$1.55 per user annually, family planning offers a safe, affordable, and effective way to avoid maternal and child deaths.⁶ Governments and donors need to work together to increase investment in and commitment to strengthening family planning programs. Committing additional resources and allocating existing resources more effectively will help governments invest in programs that: (1) improve access to family planning services, especially for women in rural areas, youth, and the urban poor; (2) ensure a steady supply of contraceptive methods; (3) provide high quality services; and (4) support communication activities and behavior change interventions to increase knowledge and use of family planning methods. By taking these actions, the lives of many more women, children, and adolescents can be saved.

Box 1: The Health Benefits of Family Planning

Family planning has numerous health benefits for women, their sexual partners, and their children. Family planning helps to:

Prevent unintended pregnancies and the number of unsafely performed abortions, thereby reducing:

- Maternal deaths and disabilities.
- Infertility.

Prevent high-risk pregnancies among:

- Adolescents under age 18.
- Women over age 35.
- Women who have had many births or births spaced too closely together.

- Women with HIV/AIDS and other health conditions such as malaria and tuberculosis.

Space births, resulting in:

- Lower rates of newborn, infant, and child mortality.
- More time to breastfeed, improving infant health.
- More time for women to recover physically and nutritionally between births.

Adapted from: Susheela Singh et al., *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care* (New York: Guttmacher Institute and UNFPA, 2003): 24.

Saving Women's Lives

Most women welcome pregnancy and childbirth, yet the risks of illness and death associated with these events are very high in some parts of the world. In developing countries, a woman's lifetime risk of dying due to pregnancy and childbirth is 1 in 75, or almost 100 times higher than the 1 in 7,300 risk in developed countries (see Table 1). In sub-Saharan Africa, the risks are the highest in the world; a woman's lifetime chance of dying from pregnancy or childbirth-related causes is 1 in 22. Of all health indicators, maternal mortality shows the greatest disparity between rich and poor nations. Of the estimated 536,000 maternal deaths that occur annually worldwide, more than 99 percent occur in developing countries—86 percent in sub-Saharan Africa and South Asia alone.⁷

THE NEED FOR FAMILY PLANNING

If women had only the number of pregnancies they wanted, at the intervals they wanted, maternal mortality would drop by about one-third.⁸ Women with birth-to-pregnancy intervals of less than five months experienced a risk of maternal death that was 2.5 times higher than women with birth-to-pregnancy intervals of 18 to 23 months.⁹

In the developing world, an estimated 137 million women who want to avoid a pregnancy are not using a family planning method.¹⁰ These women have an “unmet need” for family planning. Women with unmet need fall into two groups: women who wish to wait at least two years until their next pregnancy, and those who want to stop childbearing altogether. Globally, an estimated 55 percent of those with unmet need for family planning have a need for spacing and 45 percent for limiting.¹¹

Figure 1 (page 6) presents the total potential demand for family planning in selected countries, which is made up of current contraceptive users and women with unmet need. There is substantial unmet need for family planning in sub-Saharan Africa (see Special Focus: Repositioning Family Planning in Sub-Saharan Africa, page 13). In other regions of the world, unmet need is generally lower because more women in those regions are using family planning. Nevertheless, unmet need remains an important component of the total potential demand for family planning.

Women may have an unmet need for family planning for a variety of reasons: lack of knowledge about the risk of becoming pregnant; fear of side effects of contraceptives; perceptions



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Pregnant women wait to see the nurse at a health center in Sierra Leone.

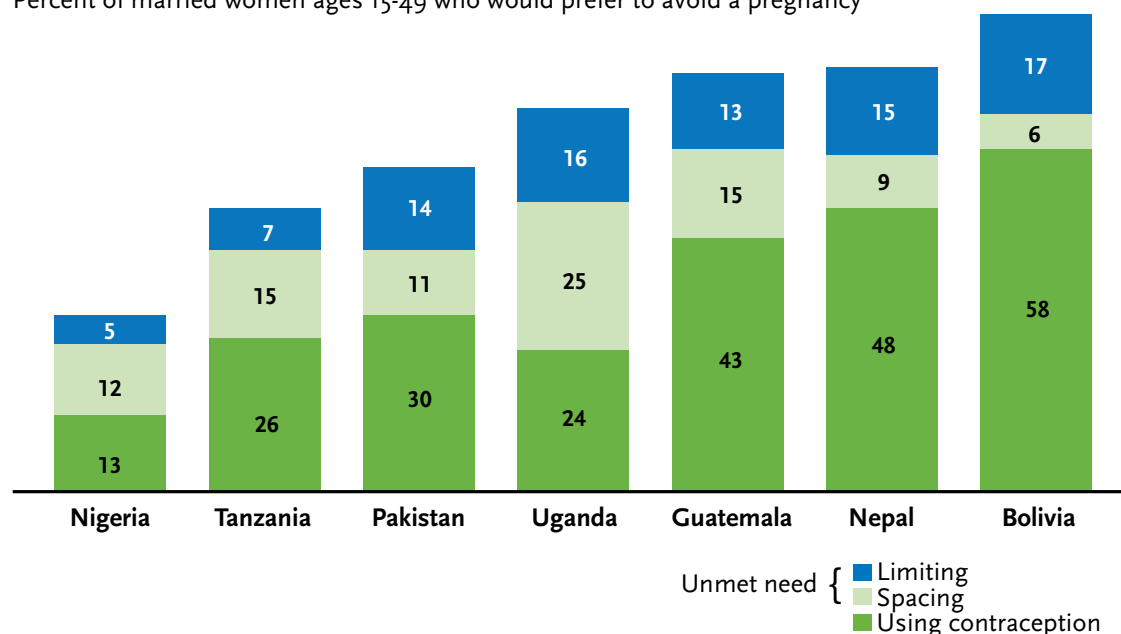
Table 1: Women's Risk of Death From Pregnancy and Childbirth

Region	Lifetime risk of maternal death
World	1 in 92
Developed countries	1 in 7,300
Developing countries	1 in 75
Sub-Saharan Africa	1 in 22
Asia	1 in 120
Latin America & Caribbean	1 in 290

Source: World Health Organization (WHO), *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank* (Geneva: WHO, 2007).

Figure 1: Total Potential Demand for Family Planning in Selected Countries

Percent of married women ages 15-49 who would prefer to avoid a pregnancy



Sources: Macro International Inc., Demographic and Health Surveys, various years; and Ministerio de Salud Publica y Asistencia Social, Guatemala, *Encuesta Nacional de Salud Materno Infantil de 2002: Mujeres* (2003).

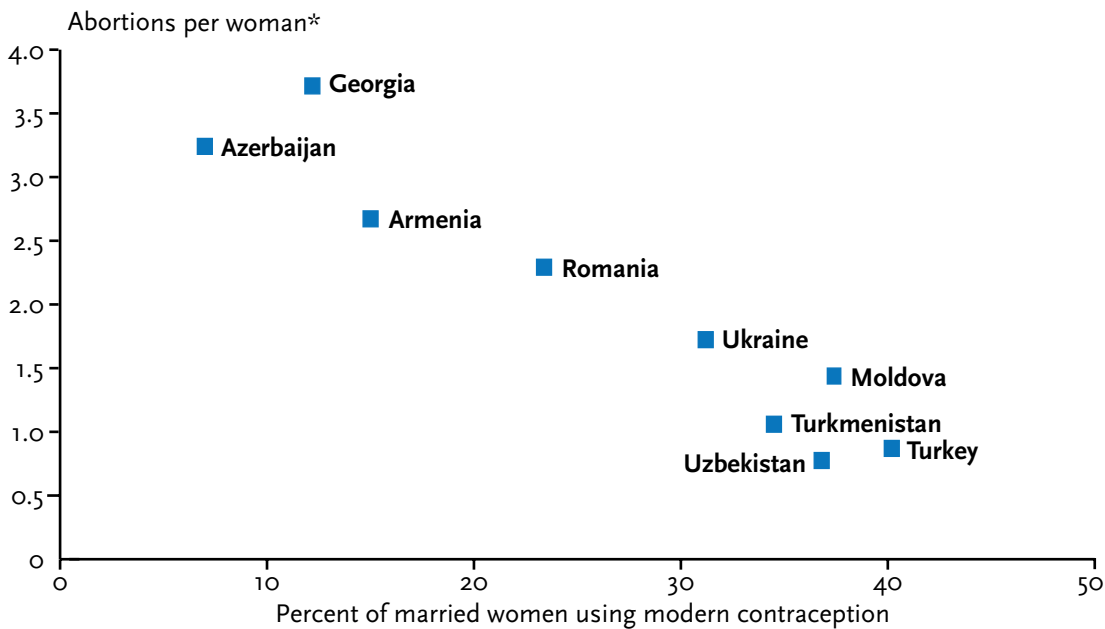
that their husbands, other family members, or their religion opposes family planning; or lack of access to family planning services.¹² Many of these barriers could be overcome through better information and counseling for both women and men.

REDUCING UNINTENDED PREGNANCIES

One of the outcomes of high unmet need is unintended pregnancies. Of the 210 million pregnancies occurring each year, nearly 80 million are unintended.¹³ Unintended pregnancy is a primary reason for abortion. Each year, approximately 42 million women decide they cannot continue their pregnancies and seek abortions. An estimated 20 million of those abortions are performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both—resulting in nearly 67,000 deaths annually.¹⁴ Millions more women suffer long-term, often life-altering, injuries from complications of abortions not carried out in a safe way.

Access to safe and voluntary family planning counseling and services significantly reduces unintended pregnancies and abortions and saves women's lives. Figure 2 shows the relationship between contraceptive prevalence and abortion rates in nine countries in Eastern Europe and Central Asia. The lowest use of modern contraception is in Azerbaijan, Georgia, and Armenia, which also show the highest abortion rates.¹⁵ This relationship is also demonstrated in resource-poor countries. A study from Bangladesh on the impact of family planning services on women's reproductive health needs in the Matlab area revealed that where high quality services were available, demand for abortion declined.¹⁶ Moreover, studies have demonstrated that in countries where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises.¹⁷

Figure 2: Modern Contraceptive Use and Abortion



* Total abortion rate: the number of abortions per 1,000 women ages 15-44 or 15-49.
Source: Charles F. Westoff, *Recent Trends in Abortion and Contraception in 12 Countries* (Calverton, MD: ORC Macro, 2005).

FAMILY PLANNING METHODS

Advances in medical technology over the last 35 years have made it possible for all women and men to plan their childbearing. Family planning methods include oral contraceptives (the “Pill”); hormonal injectables; subdermal implants; intrauterine devices (IUDs); male and female sterilization; and barrier methods such as male and female condoms, diaphragms, and spermicides. Other modern methods include the Lactational Amenorrhea Method (LAM) (described in Box 3, page 11); fertility awareness methods such as methods that involve keeping track of when the fertile time of the menstrual cycle starts and ends (the Standard Days Method); and symptoms-based methods, which depend on observing signs of fertility (cervical secretions, basal body temperature).¹⁸

Emergency contraception can keep a woman from getting pregnant after she has had unprotected sex. Emergency contraceptive pills contain the same hormones used in oral contraceptives; they can be obtained by using higher doses of regular packets of pills or by buying pills designed for that purpose.¹⁹ They are not intended to be used as a regular family planning method, but can help a woman avoid a pregnancy if used up to five days after having unprotected sex.

While there is no “ideal method” of family planning, there is a safe and effective method for every woman. Family planning methods vary according to their convenience, cost, effectiveness, side effects, risks, and benefits for the individual. Family planning users are best able to evaluate the relative importance of these factors based on their preferences; their desired family size; stage of life; goals of delaying, spacing, or limiting future pregnancies; health status; relationship status; and living conditions.

Box 2: Adolescents and Reproductive Health

Today, there are 1.2 billion young people ages 10 to 19, almost one-fifth of the world's population. Most of these young people are adolescents, a period of life that starts at puberty and ends at the culturally determined entrance to adulthood (social maturity and economic independence). While adolescence is generally a healthy period of life, many young people face a number of reproductive health challenges.

EARLY MARRIAGE AND CHILDBEARING

Early marriage can pressure young brides to begin having children early. Early childbearing poses serious health risks. Maternal death rates for young women ages 15 to 19 are twice as high as for older women, and research suggests that girls ages 10 to 14 are five times more likely to die of maternal causes than women ages 20 to 24.¹ Early childbearing is particularly common in sub-Saharan Africa, where surveys show that 28 percent of women ages 20 to 24 had given birth by age 18.² In Niger, the percentage reaches as high as 51 percent. Having a baby by age 18 is also common in other parts of the world, such as in Bangladesh (46 percent) and Nicaragua (28 percent).³

Many adolescent women under 18, especially in poorer countries, are physically immature, which increases their risk of suffering from obstetric complications. For example, malnourished young women may not have developed sufficiently for the baby's

head to be able to pass safely through the birth canal. This complication can lead to death and disability. One tragic outcome of this complication is obstetric fistula, caused by obstructed labor.⁴

In addition, children born to adolescent mothers face higher risks of illness and death than those born to mothers in their 20s. The mortality rate among infants of mothers under age 20 is at least 35 percent higher than among infants of mothers ages 20 to 29.⁵

FAMILY PLANNING INFORMATION AND SERVICES

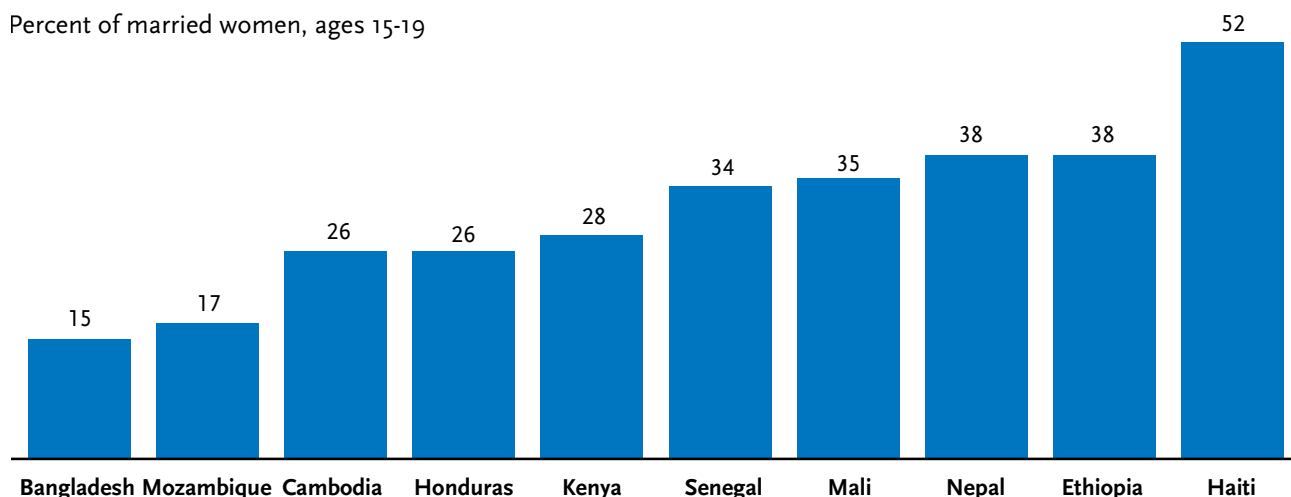
Around the world, adolescents are less likely than women just a few years older to use family planning. In Bolivia, for example, only 19 percent of single, sexually active women ages 15 to 19 use a modern method of contraception, compared with 45 percent of those ages 20 to 24.⁶ Lack of information, fear of side effects, and other barriers—geographic, social, and economic—prevent young people from obtaining and using family planning methods.

Surveys indicate that many married teenage women prefer to delay, space, or limit their births and are not using contraception. These women are referred to as having “unmet need” for family planning (see figure). Improving access to family planning information and services is vital for adolescents to protect their reproductive health.

continued

Unmet Need for Family Planning Among Married Women, Ages 15-19

Percent of married women, ages 15-19



Source: Macro International, Inc., Demographic and Health Surveys, 2003-2006.

UNINTENDED PREGNANCIES

Each year, 2.5 million teenagers in developing countries choose to end unintended pregnancies by undergoing abortions that are performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.⁷ In Africa, about one-fourth of all abortions performed in these circumstances are among young women ages 15 to 19—the highest proportion of any world region—and represent one of the leading causes of death among teenage women.⁸ Providing family planning information, counseling and services to young people could significantly reduce the number of abortions and associated risks of death and disability among the world's youth.

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4. During prolonged or obstructed labor, undue extended pressure in the birth canal can lead to tissue damage. If untreated, this tissue damage results in a fistula—an abnormal opening between a woman's vagina and bladder or rectum (or both).
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A couple visits a family planning clinic in the Philippines.

Saving Children's Lives

Child survival has improved greatly because of childhood immunizations, improvements in nutrition, and use of oral rehydration salts to reduce deaths from diarrhea. Still, each year, more than 9 million children in developing countries die before their fifth birthday.

THE BENEFITS OF BIRTH SPACING

Family planning is an important part of efforts to improve infant and child survival. Delaying and spacing births helps women bear children during their healthiest years and enables them to have their desired number of children.

International health experts now believe that the healthiest interval between a woman's previous birth and her new pregnancy is at least two years. By preventing closely spaced births, family planning could save the lives of more than 2 million infants and children annually.²⁰ To reduce infants' health risks, health experts recommend the following:²¹

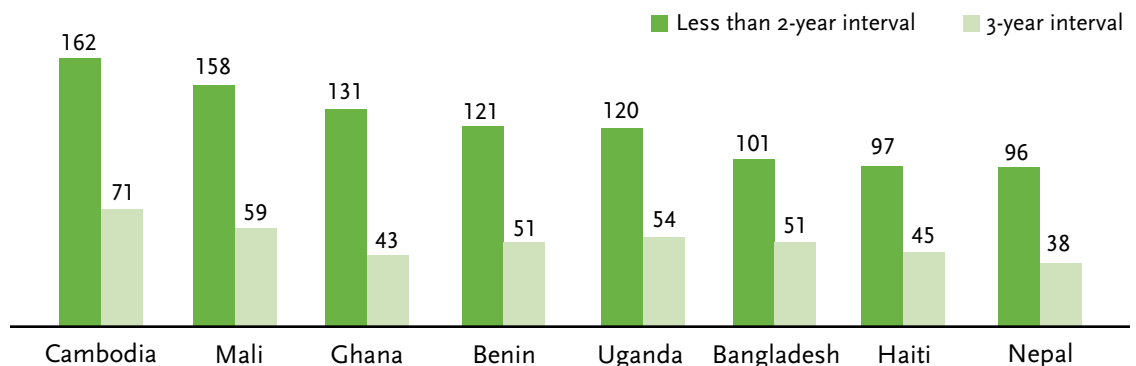
- After a live birth, women should wait at least two years, but not more than five years, before trying to become pregnant again.
- After a miscarriage or induced abortion, women should wait at least six months before trying to become pregnant again.

These recommendations are also consistent with WHO's and UNICEF's recommendation to breastfeed for at least two years (see Box 3).

Research also has shown that babies born less than two years after the next oldest sibling are more than twice as likely to die in the first year as those born after an interval of three years (see Figure 3).

Figure 3: Infant Mortality by Birth Interval

Deaths per 1,000 infants under age 1



Source: Macro International Inc., Demographic and Health Surveys, various years.

Box 3: Breastfeeding Protects Babies and Saves Lives

Research has shown for many years that breastfeeding plays an important part in child survival. Breastfeeding is nature's way to nourish and protect young infants from childhood illnesses. Any form of breastfeeding reduces by one-half a baby's chance of dying before age 1, compared with no breastfeeding. However, initiating breastfeeding immediately after birth, breastfeeding exclusively for the first six months, and introducing nutritious complementary feeding after six months while continuing to breastfeed, are even more powerful tools for improving infant health. This optimal form of breastfeeding could save an estimated 1.5 million infant lives each year that otherwise would be lost to diarrhea and acute respiratory infections.¹ Exclusive breastfeeding for the first four to six months also has been found to reduce the transmission of HIV from mother to child among HIV-positive women who do not have access to recommended antiretroviral drugs during pregnancy and childbirth.²

In addition, breastfeeding can serve as a form of contraception. If a woman's menstrual cycle has not resumed (referred to as amenorrhea), exclusive breastfeeding for six months is more than 98 percent effective in preventing a pregnancy and is promoted as the Lactational Amenorrhea Method of contracep-

tion.³ As long as menstruation has not returned, and the woman is fully breastfeeding, the contraceptive effect can last considerably longer than six months, although effectiveness is not as reliable after the six months period. A breastfeeding woman may also want to use another family planning method at the same time such as progestin-only pills, progestin-only injectables, subdermal implants, intrauterine devices (IUDs), or condoms.⁴

Promoting breastfeeding is a cost-effective way to improve infant and child health. Breast milk is the best and least expensive infant food. By preventing infant and child illnesses and deaths, and by enabling women to space pregnancies, breastfeeding also reduces health costs.

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Family planning can also improve infant survival by delaying the age at which a woman has her first pregnancy. Babies born to young mothers under age 18 are more likely to be premature, have low birth weights, and suffer from complications of delivery.

PREVENTING HIV/AIDS

Family planning saves lives and promotes reproductive health by reducing the spread of HIV/AIDS and other sexually transmitted infections (STIs). Worldwide, 33 million people were living with HIV in 2007. Of those with HIV infection, an estimated 15.5 million were women.²² Currently, about 7,400 adults and children become infected with HIV every day, and more than 5,500 die of the disease.²³

Family planning is important to women and men with HIV/AIDS and other STIs who do not want to risk infecting their partners. Aside from abstinence and having sex with only one, uninfected partner, condoms offer the best protection against both pregnancy and HIV. Latex condoms, if used correctly and consistently, are the most effective way to prevent sexual transmission of HIV, although are less effective than some other methods in preventing pregnancy.

Other family planning methods, such as hormonal pills, injections, and intrauterine devices, offer no protection against HIV. Couples who want the most effective protection from both infection and pregnancy may need to use two methods—condoms for infection prevention and another method to prevent an unintended pregnancy. The risks and benefits of each method, in

relation to both pregnancy and infection, depend on each individual and should be evaluated based on individual needs and goals.

A cornerstone in the prevention of mother-to-child transmission of HIV (PMTCT), contraception reduces unintended pregnancy among women with HIV/AIDS. Many HIV-positive women (who know they have the virus) do not want to become pregnant, yet unintended pregnancies are high among these women.²⁴ According to an expert review, ensuring access to family planning in PMTCT centers “can save the lives of thousands of women and children and significantly reduce the number of orphans.”²⁵

Another recent study suggests that women may be at increased risk of acquiring HIV during pregnancy.²⁶ Thus, by averting unintended pregnancies, family planning can play a significant role in reducing the number of women and children infected with HIV. Family planning is also an effective approach to reducing costs associated with HIV/AIDS. Researchers found a potential savings of almost US\$25 for every dollar spent on family planning at HIV/AIDS care and treatment facilities funded under the U.S. PEPFAR program.²⁷

Women can become better informed about contraception, HIV, and other STIs through integrated family planning and HIV/AIDS programs. These integrated programs can offer prevention education and counseling, condom promotion, STI screening, contraceptive supplies, HIV/AIDS treatment, or referral to these services. Where appropriate, these programs can also provide voluntary and confidential HIV counseling and testing. Integrated HIV and family planning programs may have greater potential to meet women’s overall reproductive health needs than stand-alone programs (see Box 4).

Box 4: Integrating Family Planning and HIV/AIDS Services

The benefits of integrated family planning and HIV/AIDS services include improved access to information and services, enhanced quality of care, better use of resources, and reduced stigma. Family planning is currently being integrated into a variety of HIV/AIDS programs, including:

- Treatment programs.
- Voluntary counseling and testing (VCT).
- Prevention of mother-to-child transmission (PMTCT).
- Home-based care.
- PMTCT-Plus programs, which in addition to protecting the infant from HIV transmission either during pregnancy and childbirth or through breastfeeding, also provide comprehensive and continuous care to HIV-positive mothers and their families.

Integrated programs generally offer counseling on the prevention of both unintended pregnancy and HIV, and either provide contraceptives or refer women to facilities where the products and services are available.

In integrated programs, promoting condoms can have a beneficial effect, possibly lowering the stigma associated with condom use. Recent research indi-

cates that by strengthening counseling on the use of condoms to prevent HIV and pregnancy, use of condoms and use of condoms with another contraceptive method both increased significantly.¹

There are many approaches to integrating family planning and HIV. In countries where the HIV epidemic has spread to the general population, integration efforts may occur across a range of interventions, with family planning integrated into HIV activities and vice versa. On the other hand, where both contraceptive use and HIV prevalence are low, stand-alone family planning programs might be most effective, alongside HIV activities that focus on higher-risk populations. Program managers should pay close attention to the country context and look for synergies among programs so that good opportunities are not missed.²

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Special Focus:

Repositioning Family Planning in sub-Saharan Africa

Every hour of every day, at least 30 women die from complications of pregnancy and childbirth in sub-Saharan Africa—about 270,000 deaths every year. Every minute of every day, nine children under age 5 die in Africa—4.8 million children annually. Family planning could prevent many of these deaths by enabling women to bear children during the healthiest times for themselves and their children.

Over the last decade, attention and resources for family planning programs have been diverted in many countries in sub-Saharan Africa, even though the need remains high. HIV/AIDS and poverty have become high priorities. Health sector reforms have created new management challenges, including the decentralization of authority to lower administrative levels, where family planning may not be seen as a priority. New financial mechanisms from donors and lenders, such as sector-wide approaches (SWAp) and Poverty Reduction Strategy Papers (PRSPs), often omit family planning. These and other factors have given family planning a lower priority in recent years.

To reinvigorate interest, countries throughout the region are engaging in an important initiative to reposition family planning higher on national and local agendas. “Repositioning Family Planning” is a multi-lateral initiative to ensure that access to quality family planning services remains a priority for policymakers and health providers. The goal is to mobilize political commitment and resources to strengthen family planning services, which will lead to expanded access to safe, effective contraceptive methods to help women and couples have the number of children they want, when they want them.

WHY FOCUS ON AFRICA?

Sub-Saharan Africa has the highest fertility of any world region—5.4 births per woman on average—double that of Asia (excluding China) and more than three times that of Europe.¹ Birth rates in the region are so high that even in the face of high AIDS mortality in some countries, the region’s 2008 population of 809 million is projected to increase to 1.2 billion by 2025.²

A major factor underlying high birth rates is low family planning use: Only 18 percent of married

women in sub-Saharan Africa use modern methods of family planning. This figure, however, masks important sub-regional differences—modern contraceptive use is 58 percent in Southern Africa, 22 percent in Eastern Africa, and only 7 percent and 9 percent in Central and Western Africa, respectively.³

An estimated 35 million women in sub-Saharan Africa have an unmet need for family planning—they want to delay or stop childbearing but are not using any contraceptive method. In 28 of 31 countries where this indicator is measured, at least one-fifth of married women ages 15 to 49 have an unmet need. In six African countries (Comoros, Ethiopia, Ghana,



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A couple with their two children in Nairobi.

Lesotho, Mauritania, and Senegal), about one-third of women have an unmet need for family planning. In three countries (Rwanda, Togo, and Uganda), an estimated 40 percent or more of women have an unmet need.⁴

THE COSTS OF UNINTENDED PREGNANCIES

As a consequence of unmet need, millions of unintended pregnancies occur each year in sub-Saharan Africa. In three countries in the region with recent survey data available (Lesotho, Namibia, and Swaziland), 50 percent or more of pregnancies are unintended—either unplanned or mistimed. In other countries, from 45 percent (Kenya) and 46 percent (Uganda) to 40 percent of pregnancies (Ghana, Malawi, and Rwanda) are unintended. About one in

every three births is unintended in Congo, Democratic Republic of Congo, Ethiopia, Senegal, and Zimbabwe.⁵

These high levels of unintended pregnancies can pose serious health risks to mothers and their infants. About half of maternal deaths worldwide occur in sub-Saharan Africa, where one of every 22 women risks dying from complications of pregnancy and childbirth during her lifetime.⁶ Every pregnancy poses some health risk, but in particular, women who are young (under age 18), older (over age 35), have babies too close together, or who have had many births face greater risk of complications and death as well as higher risks for their babies.

Another consequence of unintended pregnancies is abortions. In sub-Saharan Africa, an estimated 4.7 million abortions occur each year.⁷ Of these abortions, about 98 percent are performed either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both, accounting for 17 percent of all maternal deaths in Eastern Africa, 13 percent in Western Africa, 10 percent in Central Africa, and 9 percent in Southern Africa.⁸ Additionally, these unsafely performed abortions occur more frequently among poor, rural, and young women.

REDUCING UNMET NEED

Reducing unmet need would significantly reduce unintended pregnancies, abortions, and maternal and child deaths. For example, current projections for Ethiopia estimate 56 million pregnancies from 2005 to 2015, of which nearly 24 million would be unintended. By meeting unmet need in Ethiopia, there would be almost 6 million fewer unintended pregnancies, which would lead to nearly 2 million fewer abortions (see table).⁹ In addition, more than 1 million infant and child deaths (under age 5) would be averted, and

nearly 13,000 maternal deaths would be averted over the 10-year period.

HIV/AIDS

As of 2007, more than two-thirds of all people who are HIV positive live in sub-Saharan Africa—22 million. More than 5,200 adults and children become infected with HIV in the region every day.¹⁰ Throughout the region, HIV is mainly transmitted through heterosexual contact, and women make up a higher share of new HIV cases than men because they are physically more susceptible to contracting the virus. In sub-Saharan Africa, 59 percent of adults living with HIV or AIDS are women.¹¹ In South Africa, young women ages 15 to 24 are four times more likely to be HIV-infected than are young men.¹²

At least 2 million children are living with HIV/AIDS in the region. Mother-to-child transmission of HIV during pregnancy, birth, or breastfeeding accounts for more than 90 percent of all infections in children. In the absence of any intervention, an estimated 15 percent to 30 percent of HIV-positive mothers will transmit HIV during pregnancy and delivery, and 10 percent to 20 percent through breast milk.¹³

Family planning may be one of the best-kept secrets in HIV prevention.¹⁴ Improving the availability of family planning could prevent tens of thousands of infections more reliably and less expensively than anti-retroviral drugs. Use of contraception prevents more than 577,200 unintended pregnancies to HIV-infected women each year in sub-Saharan Africa. If all women in the region who did not wish to get pregnant used contraception, more than 533,000 (additional) unintended pregnancies to HIV-positive women could be averted annually.¹⁵ In Rwanda, including family planning in a voluntary counseling and testing program

Saving Lives by Meeting Unmet Need for Contraception, 2005 to 2015

	Cumulative unintended pregnancies (2005-2015)	Unintended pregnancies averted if unmet need for contraception were met	Abortions averted	Cumulative child deaths (under age 5) averted	Cumulative maternal deaths averted
Nigeria	29 million	3.5 million	1.2 million	1.0 million	18,849
Ethiopia	24 million	5.8 million	2 million	1.1 million	12,782
Kenya	15 million	3.9 million	1.2 million	0.4 million	14,040
Uganda	14 million	4.6 million	1.2 million	0.8 million	16,877
Tanzania	14 million	2.9 million	1.1 million	0.5 million	18,688
Ghana	8 million	1.4 million	0.4 million	0.2 million	3,962

Source: Scott Moreland and Sandra Talbird, *Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning* (Washington, DC and Chapel Hill, NC: Constella Futures and RTI International, 2007).

showed that pregnancies among women with HIV decreased dramatically, from 22 percent to 9 percent one year after hormonal contraceptives were added to the program.¹⁶

LOOKING AHEAD

Helping couples throughout sub-Saharan Africa choose the number and timing of their children would vastly improve the health and lives of millions of women, girls, infants, and families. The Repositioning Family Planning initiative hopes to raise awareness and educate new generations of policymakers, program staff, and providers about the lifesaving benefits of family planning and its role in national development. The success of this initiative—to make access to family planning a priority once again—depends on increased political commitment for financial and human resources for family planning; greater participation and coordination among national leaders, donors, and other partners, including the private sector; and more effective allocation of resources toward technically sound programs.

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Investing in the Health of Mothers and Children

THE COST OF FAMILY PLANNING SERVICES

Each dollar invested in family planning brings multiple benefits in terms of births averted and lives saved, making family planning an extremely cost-effective health intervention.²⁸ International studies have repeatedly confirmed that family planning ranks among the most cost-effective of all health services, along with other basic and preventive health measures such as vaccinating children and preventing HIV/AIDS.²⁹

The average cost per year for contraceptive supplies is estimated to be about US\$1.55, based on the existing mix of contraceptive methods used in developing countries.³⁰ Program costs are higher, however, because they include health personnel and the cost of running facilities and outreach programs. Program costs vary across regions and range on average from \$2 to \$35 per year of protection per person, depending on the mode of service delivery, such as social marketing, clinics, or community-based distribution.³¹ Costs in Africa tend to be higher, regardless of the service delivery mode. However, because many existing programs are underutilized, researchers believe that the average cost for an additional contraceptive user may be closer to the average cost of the commodity—an average of US\$1.55 per new user. Dramatically reducing the cost per user over the long term requires that governments successfully boost clinic attendance, increase the availability of and information on long-acting contraceptive methods, and partner with the private sector to provide services.

Investing in family planning can result in large savings to the health and education sectors, and help countries achieve development goals. Simply stated, by averting unintended births, countries are better positioned to meet the Millennium Development Goals. They will reap health, education, and economic advantages because there are fewer children to educate and immunize, fewer people in need of water and sanitation services, and fewer women in need of maternal health services. Table 2 illustrates the savings that governments can reap from investing in family planning, and Box 5 (page 19) highlights broader benefits to individuals and societies.

Table 2: Costs to Meet Family Planning Needs and Resulting Savings, Selected Countries

	Cost to meet need for family planning (in US\$ millions)	Savings incurred by category (in US\$ millions)					Total	Savings per \$ invested in family planning
		Education	Immuni- zation	Water & sanitation	Maternal health	Malaria		
Bolivia	5	21	0.1	10	14	–	45	9.0
Guatemala	19	73	1	25	29	–	128	6.7
Madagascar	26	20	13	11	29	3	76	2.9
Zambia	27	37	17	17	37	4	112	4.1
Bangladesh	50	153	4	68	102	–	327	6.5
Indonesia	67	338	5	78	125	9	555	8.3
Ethiopia	103	23	44	26	105	10	208	2.0

Source: Constella Futures, POLICY Project and Health Policy Initiative, 2005-2007.

Family planning programs can be particularly cost-effective when offered in the following circumstances:

- **Providing family planning to HIV-positive women who use HIV services.** One study investigated the costs of providing family planning to women in HIV care and treatment centers, and the savings that would accrue from not needing treatment for the prevention of mother-to-child transmission of HIV or support for orphans. Among 14 countries studied, the average cost of providing family planning was \$4 million, while the savings averaged \$72 million (a savings to cost ratio of 18 to 1).³²
- **Providing family planning as part of maternity care.** A study of 27 countries found that two-thirds of women had an unmet need for contraception within one year of their last childbirth.³³ This need could be satisfied by greater integration of family planning with maternal and child health services, particularly during prenatal visits, delivery care, and postpartum visits.
- **Incorporating family planning services into post-abortion care.** Few clinics and hospitals that treat women with abortion complications offer contraceptive counseling and services as part of their post-abortion care, yet these services are effective in increasing contraceptive use.
- **Providing family planning along with child immunization services.** Women who attend clinic services for their infants' immunizations are also in the postpartum period, which is a critical time for providing family planning advice and services. Integrating family planning services within immunization programs, or just integrating counseling and referral services alone, has been shown to be an effective strategy, leading to increases in contraceptive users.³⁴
- **Offering long-acting and permanent methods (LAPMs) to women and couples who want to space or stop childbearing.** These methods include IUDs, implants, and male and female sterilization; they are cost-effective choices because of the many years of protection they provide. They are also convenient because users do not need to make frequent return visits for their contraceptive supplies. In a recent study of 14 countries in sub-Saharan Africa, only 17 percent of contraceptive users who stated that they wanted to stop childbearing were using LAPMs.³⁵



A young family in Cairo, Egypt.

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THE NEED TO REACH THE POOR

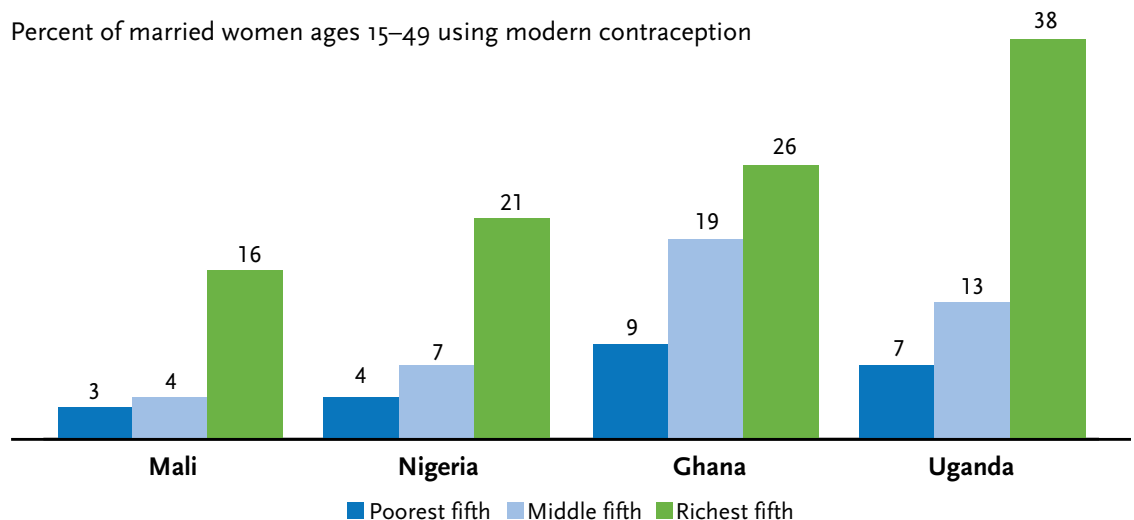
In most societies, the poorest women are least likely to use contraception (see Figure 4). These women are also the least likely to be able to pay for family planning services. Thus, public funds are most wisely spent on providing family planning to the poorest population groups. All too often, however, the subsidies that governments provide for family planning are “captured” by the wealthiest people, because wealthier couples typically want smaller families and seek out and use available services.

In a study of 10 countries, 45 percent of oral pills and 56 percent of condoms that were either supplied directly or subsidized by the government were found to be distributed to individuals who lived above the poverty line and were financially able to buy contraceptives from a commercial source.³⁶ The study suggested that the rising use of these methods in the future would lead to unsustainable resource requirements for governments and donor agencies. Thus, governments should target resources to the poor and near-poor groups who do not use commercial sources for contraceptive supplies, while encouraging the private sector to serve the demand of better-off people. Successful targeting of resources toward the poor is typically based on identifying specific individual characteristics or providing services to people living in a determined geographic area.

A variety of program strategies can be pursued to bring more program benefits to the neediest groups. Examples of strategies to reach the poor include: making family planning part of universal primary health care, bringing services closer to the community, and partnering with the private sector to make services more widely available.

Figure 4: Contraceptive Use Is Lowest Among the Poor and Highest Among the Rich

Percent of married women ages 15–49 using modern contraception



Note: Using the DHS survey data, researchers divided the population into five groups of equal size (or quintiles) based on an index of household assets. The first, third, and fifth quintiles are shown here.

Source: Macro International, Demographic and Health Surveys, 2003–2006.

Box 5: Reasons to Invest in Family Planning: Benefits Beyond Health

Family planning contributes to individual, family, and social well-being and therefore multiplies the return on governments' investments. Examples of nonmedical family planning benefits include:

For individuals:

- Less worry about unplanned pregnancies.
- Greater self-esteem and decisionmaking power, especially for women.
- More time with children.
- Greater educational and employment opportunities, especially for girls and women.
- Greater ability to participate in civil society.

For families and households:

- More attention and parental care for each child.
- Higher health, nutrition, and educational expenditures per child.
- Fewer orphaned children.

For communities and societies:

- Higher productivity.
- Less societal burden of caring for neglected children.
- Reduced public expenditures in education, health care, and other social services.
- Higher savings and investment.

Adapted from: Susheela Singh et al., *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care* (New York: Guttmacher Institute and UNFPA, 2003): 26.

Priority Actions

Today, increasing numbers of women and men want to decide the number and spacing of their children and adopt voluntary family planning. For policymakers and program planners who are trying to meet this growing demand, the current environment is challenging. Past experiences



A couple in Solola, Guatemala, receives a family planning consultation.

demonstrate, however, that successful family planning programs can be developed even under difficult circumstances. A recent study of Ghana, Malawi, and Zambia shows how steady increases in contraceptive use can occur despite weak infrastructure, limited resources, and a growing focus on HIV/AIDS.³⁷ Staying the course—and recognizing that change requires continuous support—makes a difference.

Family planning efforts can be reinvigorated by advocating for renewed commitments at the highest levels of government, increasing access to and quality of services, maintaining a steady supply of contraceptives, and encouraging people who need and want family planning to seek

services. Implementing these actions and committing the necessary resources can save millions of lives and help people achieve their childbearing goals.

Priority actions include the following:

- **Advocate for family planning at all levels** of government and with donor agencies to ensure that family planning is included in budgeting and planning.
 - Provide evidence to persuade decisionmakers to include family planning in poverty-reduction strategies, sector-wide approaches, country strategic plans, and national health budgets.
 - Work to ensure that family planning is included as an essential health service in national and district-level plans for primary health care.
 - Identify and support champions for family planning among leaders who are willing to influence their peers. These champions include parliamentarians, and leaders in ministries of health, nongovernmental organizations, donor agencies, health facilities, and communities.
 - Emphasize that family planning saves lives, helps in the fight against HIV/AIDS, and helps achieve many other development goals.

- **Reform service delivery** to ensure that the health systems supporting family planning function well and provide quality care:

- Ensure that sufficient contraceptive supplies are procured and delivered to service sites where and when they are needed.
- Integrate services in cost-effective ways to provide women and families with the care they need. Integrating family planning with postpartum care, post-abortion care, immunization services, and HIV/AIDS services is particularly critical.
- Improve contraceptive counseling to ensure that women, men, and young people are able to make informed, voluntary choices.
- Ensure adequate training and supervision of providers so that they provide technically correct information about contraception and are responsive to clients' needs.
- Eliminate barriers to contraceptive use, such as age, marital status requirements, and spousal consent, and ensure that those providing services understand and eliminate these barriers.
- Make long-acting and permanent methods available to couples who wish to stop childbearing.



Women listen to a talk on contraception given by a counselor from a reproductive health NGO in Pakistan.

- **Create demand for family planning services** through information, education, and behavior change communication programs. These programs increase the understanding and acceptability of family planning and dispel myths about contraceptive methods. Messages about the health benefits of pregnancy spacing are especially important in sub-Saharan Africa, where there is high unmet need for delaying, spacing, and limiting births.
- **Involve communities and community leaders**, particularly in rural areas where the majority of the population lives. Use existing community structures to inform people about family planning and make services and supplies easily accessible, such as through community-based distribution and social marketing.
- **Reach out to underserved groups**, especially adolescents, men, and the poorest segments of society. Governments should look beyond average contraceptive use and focus on reducing disparities in use among population sub-groups.
- **Partner with the private sector** to increase the reach of family planning services and foster long-term sustainability. The for-profit and nonprofit sectors can reach important segments of the population and can sometimes deliver services more efficiently than governments.
- **Use evidence to replicate and scale up successful programs.** There is a continuing need for rigorous evaluations and operations research on family planning programs to identify successful approaches and how they can be applied elsewhere and expanded.

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