



# The Unmet Need for Family Planning: Handbook of Advocacy Tools for Stating the Case for Meeting the Need

2012



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## About Countdown 2015 Europe

**Countdown 2015 Europe** is a consortium of 16 leading European non-governmental organizations working to address the unmet need for family planning in developing countries. The consortium raises awareness and promotes increased European donor support in terms of policies and funding to ensure universal access to reproductive health and family planning worldwide.

For more information, please contact the Countdown 2015 Europe lead partner, the International Planned Parenthood Federation European Network (IPPF EN), at [countdown2015europe@ippfen.org](mailto:countdown2015europe@ippfen.org) or visit [www.countdown2015europe.org](http://www.countdown2015europe.org).



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## Toolkit introduction

Sixteen European non-governmental organizations (NGOs) working in the field of sexual and reproductive health and rights (SRHR) have joined forces under the banner of **Countdown 2015 Europe**. The group's aim is to ensure universal access to reproductive health and family planning.

Countdown 2015 Europe's current project is entitled '**The Unmet Need: Building a more effective dialogue in Europe on the role of family planning in poverty alleviation**', which is funded by the European Commission. One of the main strategies of the project is to provide practical tools to NGOs to help them advocate for support for family planning among European donors and institutions, and other NGOs and organizations. This **Advocacy Toolkit for Addressing the Unmet Need for Family Planning** is the main project tool.

### Who the toolkit is for

The toolkit is designed for advocates in Europe to promote increased European donor support for addressing the need for family planning in developing countries. It may be useful for advocacy with a wide range of target audiences, including:

- national government ministries, including ministers of finance, health, development, labour and other sectors;
- politicians and Members of Parliament (MPs);
- civil servants;
- Members of the European Parliament (MEPs);
- European Commission leaders and staff;
- EU institutions; and
- broader civil society, including NGOs working on issues such as health and health reform, financial reform, human rights, environment and population issues.

### How to use the toolkit

This toolkit is organized into ten chapters, each comprising evidence, statements, statistics, quotes, case studies and visual elements that can be used to support advocacy campaigns. All content can be 'cut and pasted' directly into your own organization's documents and other materials. It can be adapted to fit your needs; however, direct quotes should be used verbatim.

Use the [Category map](#) to locate all of the content in the toolkit related to a specific category. The categories include:

- Background: *general information about unmet need*
- Universal: *overall reasons to support family planning*
- Health: *individual health benefits of family planning*
- Poverty: *how family planning contributes to poverty eradication and economic growth*
- Fiscal: *how family planning can lead to fiscal savings for governments*
- Empowerment: *how family planning contributes to women's empowerment*
- Climate change: *how family planning can help to slow population growth and address environmental and natural resource pressures*
- Human rights: *family planning as a human right*
- Strategies: *best practices and strategies for addressing unmet need*

Each category is a platform from which to argue for more investment in family planning. For example, if you plan to discuss the need to invest in family planning with a policymaker or other stakeholder whose primary interest is fiscal spending (e.g., the Minister of Finance), the [Category map](#) tells you where to find all the information in the toolkit that supports the Fiscal Savings argument.

Chapter 8 provides cut-and-paste charts, graphs, tables and other graphics to help you get your points across with less text.

Chapter 9 provides links to external sources for:

- creating customizable data tables on reproductive health and unmet need, downloadable to Excel and other software;
- online tools for building charts, graphs, tables and maps (even interactive maps) using a huge range of indicators;
- free (high- and low-resolution) photos relevant to development issues; and
- videos about the need for investment in family planning.

Chapter 10 gives you four facts sheets on key topics, which you can adapt for your own use.

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## CATEGORY MAP (INDEX)

Use this map to locate all of the text in the toolkit related to a particular category or topic. As a general guide:

- **Overview** sections give you detailed narrative text about a topic.
- **Quick Facts** are boxes which provide brief summaries of the topic.
- **Facts and statistics** are a collection of the quantifiable facts related to a topic (i.e., the numbers rather than just ideas or concepts).
- **Quotes** are direct quotes from people working in developing countries on family planning issues; they can add a personal voice to your documents and campaigns.
- **Q&A (Q)** are questions you might get from stakeholders, and suggestions for how you might respond to them.
- **1-minute talking points** are short statements you can make during meetings or presentations to quickly and concisely state the case for urgently addressing unmet need.
- **Country names** are brief case studies of good practice in meeting unmet need.
- **Charts, tables, graphs etc.** enable you to get your point across visually rather than with words.

**Tip:** If you are viewing this in Microsoft Word, the Category map will allow you to 'jump' to a section of interest within this toolkit. You can easily find your way back here by navigating with Microsoft Word's Document Map function. Here's how:

1. On the **View** menu, click **Navigation Pane**. (The map should appear as a column on your left.)
2. Click a heading in the Navigation Pane you want to navigate to. The insertion point in the document will move to the selected heading.
3. When you no longer want to view the Document Map, click **Navigation Pane** on the **View** menu to close the pane.

### CATEGORY

#### Sections of the toolkit which support this argument

(click on the links below to be redirected to the related text)

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**Q** Why should we continue to invest in family planning?

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Quote: family planning is a matter of justice

Graph: Funding has not kept pace with demand

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Clip-art graphic: \$1 spent on FP saves \$4

Table: Selected benefits of family planning across sectors

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Q In a nutshell, what needs to be done?

Q Family planning is only one aspect of women's rights. Shouldn't we focus more generally on improving equality for women, for example, through micro-credit schemes or educational programmes for girls?

Q I understand that the largest generation of young people are coming of age and becoming sexually active. Can't young people get contraceptives in the same places that adults get them?

Graph: Funding has not kept pace with demand

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# 1 OVERVIEW: UNMET NEED FOR FAMILY PLANNING

## 1.1 Levels of unmet need

One in four people in developing countries are women of reproductive age (15-49). Among these women, 867 million of them want to avoid a pregnancy completely or space or limit future pregnancies (Singh, Darroch et al. 2012; USAID 2009). Despite these desires, 222 million of them are not using any form of *modern contraceptive*.

These 222 million women have an unmet need for modern contraception (Singh, Darroch et al. 2012). They are women who are using either *traditional methods of family planning*, which have been shown to have high failure rates (Singh, Darroch et al. 2009) or no method at all.

### Quick Facts: what is unmet need?

Women and girls have an unmet need for family planning when they are sexually active and wish to avoid a pregnancy completely, or space or limit future pregnancies, but are not using a modern form of contraception.

- 867 million women in developing countries want to avoid pregnancy
- 645 million are using modern contraceptives
- 222 million are not using any form of modern contraceptive

These 222 million women have an unmet need for modern contraception. This is due in part to the fact that many do not have access to an effective, affordable family planning programme.

Source: (RHSC 2009; Singh, Darroch et al. 2012)

## 1.2 Reasons for unmet need

There are individual reasons why women do not use modern methods of contraception. These can be influenced by social, cultural or political factors, such as a lack of support for family planning in a woman's family or social or religious community, or a lack of family planning policies and, therefore, limited access to information, supplies and services.

According to data reported by the Guttmacher Institute (Sedgh, Hussain et al. 2007), unmet need for family planning at the individual, family or community level is largely attributed to the following:

- **Low perception of risk** – Woman perceive that they are at low risk of getting pregnant – for example, due to infrequent sexual activity or because they have recently given birth or are breastfeeding and believe this will adequately protect them from pregnancy.
- **Inadequate access to supplies and services** – Inadequate availability of contraceptive supplies and/or health services, including lack of knowledge about contraceptive methods; problems accessing contraception (including cost, not knowing a source and not being able to get to a care facility); and problems related to side-effects, health concerns, and difficulties or inconvenience in using methods.
- **Opposition** – Refusal of family planning, either on the woman's part or on the part of her partner or another influential person, including opposition on religious grounds (Sedgh, Hussain et al. 2007)

An analysis of 13 developing countries found that a significant number of women do not have adequate knowledge about contraception, have health concerns about using modern contraception or could not afford or easily obtain contraceptive supplies or services (Sedgh, Hussain et al. 2007).

At the broader political level, the lack of access to supplies and services could be associated with reductions in political commitment and funding for family planning in recent decades. For example, restrictions on funding for reproductive health by the US government during the presidency of George W. Bush (i.e., the Mexico City Policy or 'Global Gag Rule') led to dramatic cuts in money available for family planning for a number of years. While these restrictions are no longer in place, they led to cuts in services in many countries, which is likely to have contributed to increasing unmet need for family planning (Lancet/UCL 2009).

In addition, reductions in funding may have come about due to the belief by donors that family planning is already fully funded. In part, the success of family planning programmes has led to this false belief. Also, while there have been large increases in funding to 'population' budget lines, much of this has gone towards HIV/AIDS (Lancet/UCL 2009) rather than family planning. The lack of transparency in budget lines and the lack of a dedicated budget line specifically for family planning have led to a false confidence that family planning has received adequate funds.



## 1.3 Consequences of unmet need

Not meeting the need for family planning in developing countries has widespread impact, affecting families, communities and economies, not to mention individual health and well-being.

For example, unmet need:

- increases maternal and child morbidity and mortality, particularly when births cannot be adequately spaced (Ashford 2003; Mackenzie, Drahota et al. 2010);
- leads to an increase in unsafe abortions (Ashford 2003; Mackenzie, Drahota et al. 2010);
- contributes to the incidence of HIV and sexually transmitted infections (STIs) (WHO 2010);
- compromises women's abilities to be productive in their communities and national economies (Mackenzie, Drahota et al. 2010);
- forces girls and young women to drop out of school due to unplanned pregnancies (Barot 2008);
- exacerbates women's lower social status and gender inequality (FHI);
- increases poverty and slows economic growth (RHSC 2009; Speidel, Sinding et al. 2009); and
- contributes to unsustainable population growth (Ashford 2003).

### Quick Facts: some consequences of unmet need

#### *Economic*

Maternal and newborn deaths slow growth and lead to global productivity losses of US\$15 billion each year (UK All Party Parliamentary Group on Population, Development and Reproductive Health 2009; Vlassoff, Sundaram et al. 2009; UN Secretary General 2010).

#### *Educational*

Approximately 8–25% of young women in some sub-Saharan African countries drop out of school because of unintended pregnancy. Among unmarried 15–17-year-olds, those in school were more likely to use contraceptives than those out of school (Barot 2008; Guttmacher/IPPF 2010).

#### *Health*

Termination of unintended pregnancies in unsafe conditions is the third main cause of maternal death worldwide (WHO 2011). While risks associated with childbirth cannot be completely eliminated, only deaths due to unsafe abortion are entirely preventable (Speidel, Sinding et al. 2009; WHO 2011).

## 1.4 Progress and set-backs in addressing unmet need

Over the past two decades, the use of contraceptives increased among women in almost every region. By 2007, approximately 60% of married women of reproductive age were using some form of contraception (UN-DESA 2011). It is important to note, however, that data about contraceptive use among unmarried women (Sedgh, Hussain et al. 2007) and adolescent girls in developing countries are limited compared to data on married women, particularly in Asia, so global levels of unmet need may be higher than statistics suggest.

However, there has been a considerable slowdown in meeting the unmet need in the past decade and a widening gap among regions. According to the United Nations, the annual rate of increase in contraceptive prevalence in almost all regions was lower from 2000 to 2007 than it was during the 1990s. And contraceptive prevalence in some regions, such as sub-Saharan Africa, continues to be low (UN-DESA 2011; UN 2011). In some

countries, such as Ghana and Benin, there have even been reversals in contraceptive prevalence (UN 2011).

The increase in unmet need for family planning is linked to reductions in political commitment and funding. For example, restrictions on funding for reproductive health by the US government during the presidency of George W. Bush (i.e., the Mexico City Policy or 'Global Gag Rule') led to cuts in family planning services in many countries, which is likely to have contributed to increasing unmet need (Lancet/UCL 2009). In addition, while there have been large increases in funding to 'population' budget lines, much of this has gone towards HIV/AIDS (Lancet/UCL 2009) rather than family planning. The lack of transparency in budget lines and the lack of a dedicated budget line specifically for family planning have led to a false confidence that family planning has received adequate funds, when in fact it has not, and the result is an increase in unmet need.

## 1.5 Future projections of unmet need

According to projections by the United Nations, the number of women of reproductive age (15–49) will grow by almost 33% in the next decade (Ross and Stover 2009). Between 2008 and 2015, demand for family planning in the developing world will likely increase from the current 867 million to 933 million women, and the number of family planning users will increase from 645 million to 709 million users, a projected increase of 106 million users. This is equivalent to almost half the current level of unmet need. The projected increase in demand between now and 2015

would leave around 224 million women with an unmet need for modern contraception, compared to today's 222 million (RHSC).

The impact of failing to meet the contraceptive needs and desires of 222 million women is devastating for women, young people, families and societies, and the situation will only intensify as the largest cohort of young people ever becomes sexually active: 1.5 billion adolescents are now entering their sexual and reproductive years (IPPF 2008; UN 2009).

## 2. BENEFITS OF INVESTING IN FAMILY PLANNING

Decades of programmes and research show that family planning is one of the best investments donors and governments can make with respect to human and economic development (RHSC; UN Secretary General 2010).

By meeting women's unmet need for family planning, benefits can be seen not only in terms of women's health, but with many other human and development indicators, including poverty reduction and economic growth, children's health and development, women's empowerment, and addressing environmental challenges (UN Secretary General 2010). Most importantly, family planning is essential to promoting the fundamental human rights of women, men and young people: the ability of women and couples to decide on the number and spacing of their children is a fundamental human right interlinked with many other rights (Barot 2008; Singh, Darroch et al. 2009).

In general, addressing the unmet need for family planning means that women and couples have the number of children they want, when they want, and are able to space births safely, all of which are in line with international commitments to upholding human rights. The benefits, however, go much further, for example:

- better health for women and children (Singh, Darroch et al. 2009; UN Secretary General 2010);
- more life options for women in terms of education and economic opportunities (Center for Global Development; Singh, Darroch et al. 2009) (e.g., fewer girls forced to drop out of school due to pregnancy);
- women's abilities to work more productively and earn more throughout their lives (Singh, Darroch et al. 2009; UN Secretary General 2010), thus families are better off;
- existing children are more likely to get better education, health care and nutrition (Singh, Darroch et al. 2009; UN Secretary General 2010);

### Quick Facts: benefits of investing in family planning

#### Family planning:

- enables women and couples to decide on the number and spacing of their children, which is a fundamental human right;
- prevents unintended pregnancies, which can save women's lives and protect their health and the health of their children;
- promotes equality between men and women and raises women's status in society;
- provides cost savings in the health-care sector; and
- fosters social and economic development and is, therefore, a key component of reducing poverty.

Source: (Barot 2008; Singh, Darroch et al. 2009; Vlassoff, Sundaram et al. 2009)

- reduced burden on schools by reducing the proportion of school-age children relative to the working-age population (Center for Global Development);
- less pressure on public services and natural resources, including housing, employment, health care, and resources such as safe water (Center for Global Development; Singh, Darroch et al. 2009);
- greater gender equality and empowerment (Center for Global Development); and
- higher economic growth and GDP (Center for Global Development).

### Quote: family planning is an easy win for governments

"I think apart from the diminished funding, family planning would be the easiest thing to do if we had adequate resources. I also think there's a lot of opportunity to integrate family planning more fully into existing programmes, such as HIV and maternal mortality reduction."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

### 2.1 Benefits: fulfil international commitments

The right to family planning and reproductive health services has been enshrined in a number of international agreements and strategies; therefore, governments are obligated to ensure these aims are met.

Many of these agreements recognize the need to prioritize sexual and reproductive health and rights in international development and national-level policies in order to meet international development goals, such as reducing poverty. Key agreements include:

**The International Conference on Population and Development (ICPD) Programme of Action (1994)** – Rooted in a rights-based approach, it recognized, for the first time in an international consensus document, that reproductive rights are human rights.

**UN Women's Conference in Beijing (1995)** – Reinforced many of the commitments made at the ICPD, including the need to enhance women's sexual and reproductive health, remove legal, regulatory and social barriers to sexual and reproductive health education, and to recognize that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

**The Millennium Summit's Millennium Development Goals (MDGs) (2000)** – Set forth key targets for the reduction of maternal mortality and other health-related issues which contribute to poverty. Several international agreements and programmes focus on ensuring that donor and developing countries commit the funds needed to achieve the MDGs.

**Paris Declaration on Aid Effectiveness and the Accra Agenda for Action (2005)** – Agreed by 100 donor and recipient governments and international organizations including the International Monetary Fund, World Bank and a number of regional development banks, these documents represent comprehensive attempts to improve the way donor and recipient countries cooperate to achieve the MDGs.

**Maputo Plan of Action (2006)** – Regional agreement by African Union countries, which aims to ensure universal access to sexual and reproductive health in Africa.

**The Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) (2009)** – Also an initiative driven by the African Union in connection with the Maputo Plan of Action, CARMMA aims to improve the health of mothers in countries with high rates of maternal mortality.

**The UN Global Strategy for Women's and Children's Health (2010)** – An aid-based strategy that includes strong support for reproductive health.

## 2.2 Benefits: Health

Use of modern contraceptives helps to prevent unintended pregnancies. This plays a key role in reducing maternal mortality and morbidity (reflected in MDG 5); reducing recourse to unsafe abortion; and reducing newborn deaths and improving child health and survival (MDG 4) (WHO 2009).

Approximately 40% of pregnancies worldwide are unintended, posing serious risks to women's health (Singh, Wulf et al. 2009). Contraceptive use can reduce unintended pregnancies, thereby averting unsafe abortions, which is one of the main causes of maternal death, especially among young women (WHO 2010). Contraceptive use can also reduce risks of unsafe delivery in low-resource settings, where there are high risks of maternal mortality and morbidity (WHO 2010).

Latest figures from the World Health Organization (WHO) show that approximately 356,000 pregnancy-related deaths occur annually in developing countries (WHO 2010). While maternal mortality declined by one-third between 1990 and 2008, this figure still remains high and is still the MDG which has progressed the least. According to the World Bank, maternal mortality would drop by 25–35% if the unmet need for modern contraceptives were fulfilled (Barot 2008).

For every woman who dies of pregnancy and childbirth complications, at least 20 more women suffer long-term illness related to unintended pregnancy or recent childbirth. Complications from unsafe abortion are a leading cause of maternal morbidity in developing countries (UK APPG on Population, Development and Reproductive Health 2009).

### Quote: family planning is a matter of justice

"We need to understand that one of the priorities in family planning programmes should be access without shame or guilt. This is missing from most programmes. In general, there are very high levels of stigma and discrimination in health services such as family planning. And the needs of HIV-positive people are not addressed. There has been a narrow, myopic view of providing services, but this needs to be widened: we need to see it through a justice lens."

– Sarita Barpanda, Country Programme Advisor, Interact Worldwide, India

**The Muskoka Initiative on Maternal, Newborn and Child Health (2010)** – A funding initiative agreed by G8 countries to help realize MDGs 4 (reduce child mortality) and 5 (improve maternal health), and which includes as one of its key goals "sexual and reproductive health care and services, including voluntary family planning".

### Quick Facts: health benefits

A recent study suggests that meeting the unmet need for contraceptives in developing countries would:

- reduce the number of unintended pregnancies by two thirds, from 80 million to 26 million per year;
- reduce unplanned births from 30 million to 9 million, with the greatest percentage reduction happening in low-income countries; and
- avert 54 million unintended pregnancies annually, which would result in 21 million fewer unplanned births, 26 million fewer induced abortions and 7 million fewer miscarriages.

The health benefits would be tremendous: an additional 150,000 women's lives would be saved, and there would be 640,000 fewer newborn deaths. The benefit to families would be substantial, with more than half a million fewer children losing their mothers.

Sources (FHI ; Singh, Darroch et al. 2012; Vlassoff, Sundaram et al. 2009; Guttmacher/IPPF 2010)

In short, meeting the unmet need for family planning:

- improves maternal and child health by reducing unintended pregnancies and maternal mortality and morbidity;
- reduces the rate of unsafe abortion and associated mortality and morbidity; and
- allows women to space or limit pregnancies, thereby reducing high-risk pregnancies and births.

Delaying childbearing and wider spacing of births alone is a benefit of family planning. Research suggests that infants born close together are at a considerably higher risk of dying in their first year than children who are spaced wider apart. If women had the means to space their births three years apart, infant and under-five mortality rates would drop by 24% and 35%, respectively. In addition, if there were at least two years between a birth and a subsequent pregnancy, deaths of children under-five would fall by 13%; if the gap were three years, such deaths would decrease by 25% (Rutstein 2008). There would also be improvements in other child health and nutrition indicators, such as malnutrition (Barot 2008).

## 2.2.1 For girls and young women

The benefits of addressing the unmet need for family planning are particularly striking for girls and young women. Complications of pregnancy or early childbirth are highest among adolescents, and children born to adolescent mothers have double the risk of dying in their first year than children born to mothers aged 20 and older (Barot 2008).

## 2.2.2 Reducing child and infant mortality

While there are many causes of child and infant mortality, family planning is arguably one of the two most powerful interventions for decreasing child mortality, the other being education of women (IPPF 2008). The current level of modern contraceptive use results in 1.1 million fewer newborn deaths annually. If the unmet need for modern contraceptives were fully met, 53 million unintended pregnancies could be prevented each year, averting well over an additional half a million (590,000) newborn deaths annually (Guttmacher/IPPF 2010).

## 2.2.3 Non-pregnancy-related benefits

Family planning in the form of male and female condoms reduces the transmission of sexually transmitted infections (STIs), including HIV. And when family planning and HIV services are integrated, it can reduce the overall cost of service provision. By preventing unintended pregnancies and childbirth, all contraceptives play a critical role in preventing vertical transmission by HIV-positive women. Prevention of such unintended pregnancies is three times more effective as a prevention strategy than providing antiretroviral treatment to women during pregnancy, birth and breastfeeding (WHO 2010).

In terms of health services, family planning is a key entry point for accessing a wider range of primary health care services. This includes services for HIV and AIDS care (WHO 2009) and counselling and other services for women and girls who have experienced gender-based violence (UN Women).

Therefore, reducing unintended pregnancies among girls and young women, by ensuring access to modern contraceptives and other services, saves lives. In addition, the ability to delay births is even more pressing for the millions of girls who are subject to early marriage, which is a common practice across many regions including in Eastern Europe and Central Asia (Barot 2008).

### Quick Facts: links between family planning, poverty reduction and economic growth

Family planning is one of the most cost-effective ways to reduce poverty, because it:

- enables women and couples to choose to have smaller families, which are usually better-off families, where children often have better nutrition and education;
- enables women to work and be productive, which contributes to household, family and national economic well-being;
- improves the ratio of dependents to wage earners and, therefore, reduces the burden on state funds and services;
- reduces the economic shocks on the household due to maternal death or morbidity;
- contributes to higher gross domestic product (GDP); and
- will greatly assist countries that want to evolve from low-income to middle-income country status by 2030.

Source: (RHSC 2009; WHO 2010)

### Quote: family planning is essential for poverty reduction

"...the eradication of extreme poverty and hunger cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."

– Former UN Secretary General, Kofi Annan, Fifth Asian and Pacific Population Conference. UN Economic and Social Commission for Asia and the Pacific (ESCAP), Bangkok, 16 December 2004

## 2.3 Benefits: poverty eradication and economic growth

Family planning plays a catalytic role in improving the health and well-being of women and children, and it is a fundamental goal in itself. It also has broader positive effects, including stimulating economic development and raising the standard of living, which contribute to reducing poverty (RHSC 2009; Speidel, Sinding et al. 2009).

Countries with lower fertility and slower population growth have experienced higher productivity, more savings and more effective investments (UNFPA 2002). In many countries, a reduction in fertility at the household level has translated into potential economic growth at the macro level in the space of just one generation. This is attributed to the 'demographic dividend': the concept that lowered fertility results in a larger group of working-age people, who support relatively fewer older and younger dependents. Countries in Asia, in particular, have benefited from the demographic dividend, watching their economies grow and levels of poverty decrease as families have become smaller.

Data suggest that:

- globally, maternal and newborn deaths are linked to global productivity losses of US\$15 billion each year (UN Secretary General 2010); and
- between 30% and 50% of Asia's economic growth from 1965 to 1990 has been attributed to changes in population dynamics, which are strongly influenced by access to family planning (Bloom and Williamson 1998).

There are even global-level data which show a correlation between the prevalence of modern contraceptive methods and per capita gross national product (GNP) (WHO 2010) – an important indicator of economic growth and well-being.



While reduction in fertility alone is not sufficient to improve economic development, it is a necessary component, and an estimated 25–40% of economic growth in developing countries has been attributed to lower fertility according to some studies (Barot 2008).

At the household level, complications from pregnancy and birth threaten the health and lives of women and children, and can also have economic consequences for families. In many countries, maternal health care is not free and can be extremely expensive for poor households. For example, in Burkina Faso, delivery costs are estimated to be 43% of the per capita income in the poorest households and as much as 138% for a caesarean section (UK APPG on Population, Development and Reproductive Health 2009).

On the other hand, when family planning services are accessible and affordable, they can have positive, long-term effects on the lives of women, girls and families. Women and couples who can decide on the number, spacing and timing of their children are better able to save resources, increase their household income and better plan their lives. In this way, family planning allows families to invest in existing children, providing adequate education, nutrition and fulfilling other needs (Barot 2008).

In the longer term, the economic and social benefits of family planning are not only relevant to developing countries. Donor countries also benefit, as family planning can increase the

economic strength and stability of potential trading partners, while at the same time improving people's quality of life in line with humanitarian goals (Center for Global Development). Moreover, the private, for-profit sector may find that providing employees with family planning services can lower medical costs of pregnancy and maternity leave, lower employee turnover and increase productivity and profit (USAID/WHO Regional Office for Africa 2008).

#### Quick Facts: fiscal savings and family planning

For every dollar spent on family planning, US\$4 can be saved.

If modern contraceptive services were provided to all women in developing countries who need them:

- the total costs of services would **increase** by US\$3.6 billion per year.

However...

- the total costs of providing newborn and maternal health services would **decrease** by US\$5.1 billion per year; and
- the total costs of providing post-abortion care would **decrease** by approximately US\$140 million per year.

Source: (Singh, Darroch et al. 2009; Speidel, Sinding et al. 2009; UN Secretary General 2010)

## 2.4 Benefits: fiscal savings

In many countries, every US dollar spent on family planning saves at least US\$4 that would otherwise have been spent on treating complications from unintended pregnancies (Speidel, Sinding et al. 2009; UN Secretary General 2010).

Of course, **there are costs involved in ensuring access to family planning; but they are outweighed by the savings in every country** for which data are available.

For example, the costs of providing contraceptive services to all women in developing countries who need them would be, on average, just over one US dollar (US\$1.2) each year. The total costs of services would increase from US\$3.1 billion to US\$6.7 billion if the unmet need for family planning were met. This is an increase of US\$3.6 billion (Singh, Darroch et al. 2009; Guttmacher 2010).

However, **it would lower the cost of providing newborn and maternal health services by US\$5.1 billion** – a significant cost savings. If all women at risk of unintended pregnancy used modern contraceptive methods, the declines in unintended pregnancy and unsafe abortion alone would reduce the cost of post-abortion care by approximately US\$140 million every year (Singh, Darroch et al. 2009; Guttmacher 2010).

An analysis of 16 sub-Saharan countries reports that **satisfying the unmet need for family planning can produce cost savings in meeting five of the MDGs – across different sectors, not just in health care** (Health Policy Institute).

Some specific country cost savings include the following:

- Fulfilling the unmet need of women in **Ethiopia** wanting to avoid pregnancy would result in annual savings of US\$34 million from the amount that would otherwise be spent on medical costs related to unintended pregnancies, unsafe abortion and other consequences (Guttmacher/Ethiopian-Society-of-Obstetricians-and-Gynecologists 2010).
- **Egypt** is one of the few countries on track to achieve MDG 5, which exemplifies the tremendous cost savings that can be realized by investing in family planning. Spending of approximately US\$400 million<sup>1</sup> (EGP2.4 billion) spent on family planning between 1980 and 2005 saved around US\$8 billion<sup>2</sup> (EGP45.8 billion at 2005 currency rates) in child health, education and food subsidies (RHSC 2009).
- By investing more in family planning, **Kenya** would have realized a significant net savings of about US\$200 million between 2005 and 2015.
- In **Kazakhstan**, contraceptives are almost 3.2 times more cost-effective than abortion in terms of births averted. Since abortion services accounted for almost 1% of total public health expenditures in Kazakhstan in 2004 (Lule, Singh et al. 2007), ensuring universal access to contraception could result in substantial cost savings.
- In **Nigeria**, the annual cost of post-abortion care is estimated at US\$19 million, which is 3.4% of total national health expenditure. The annual cost is four times the cost of contraceptive services, estimated at US\$4.5 million (Lule, Singh et al. 2007).

<sup>1</sup> 2005 currency rates

<sup>2</sup> *Ibid.*

## 2.5 Benefits: women's empowerment

Meeting the unmet need for contraception empowers women – socially, economically and politically – by enabling them to decide the number, spacing and timing of their children (Center for Reproductive Rights/UNFPA 2010). Empowering women, including in their ability to achieve their desired family size, has been recognized as one of the most important drivers of modern development (WHO 2010).

**Modern contraceptive use by women and girls increases their access to education.** Pregnant adolescents are often forced to abandon their studies, and, according to the Millennium Project:

- approximately 8–25% of young women in some sub-Saharan African countries drop out of school because of unintended pregnancy; and
- among unmarried 15–17-year-old girls, those in school were more likely to use contraceptives than those not in school (Barot 2008).

Not having an education often means that a woman cannot be fully involved in economic, social and political aspects of their communities, and this is directly linked to increased poverty (IPPF 2006). On the other hand, educated women are more likely to have educated children, particularly daughters (Barot 2008; Singh, Wulf et al. 2009). This suggests that meeting family planning needs of women today has a multi-generational impact.

**Women who use contraceptives are more likely to be active and productive in the workforce,** which means they have increased earning power that allows them to improve their own and their family's economic security (FHI). For example:

- In Egypt, women who use contraception are more likely to be employed than those who don't.
- In Brazil and Indonesia women who use long-acting or permanent contraception have a greater likelihood of working for pay than those who do not (WHO 2010).

In addition, women's increased ability to control their own fertility has implications for efforts to improve gender equality. In general, reproductive health services improve women's and girls' health,

### Quick Facts: benefits in terms of women's empowerment

Women's use of family planning, and particularly modern contraception:

- means that they can decide the number, spacing and timing of their children, in line with international human rights agreements;
- enables women and girls to spend more time in education, training and employment;
- has been shown to increase the likelihood that women will be involved in education and the labour force; and
- ultimately enables women to better support their families, contribute to their communities, and be involved in the political and economic life of their countries.

Source: Barot 2008; Center for Reproductive Rights/UNFPA 2010; WHO 2010

so that they can be productive in their families, communities and economy (UNFPA 2005). For example, when women have access to family planning, they can plan the timing of their children and the size of their families with their need and desire to earn a wage (Birdsall, Ibrahim et al. 2004). In addition, one of the key indicators of women's empowerment at the household level is the ability to make childbearing decisions and use contraception (Grown, Gupta et al. 2003).

**Empowering women and girls – in part through ensuring their access to voluntary family planning – is a crucial step towards more widespread gender equality** in communities, societies and states.

Gender inequality has many causes, but it is rooted in socio-cultural norms and myths about what is permissible behaviour for women and men, girls and boys. This includes beliefs related to sexual health and family planning. For example, norms related to women being passive and men being assertive or aggressive can lead to men making the decisions about sex in a relationship or marriage. Other norms support the notion that family planning, including contraception, is the sole responsibility of women and girls.

The informed participation of men and boys in reproductive health programmes and decision-making can help to challenge harmful gender norms. It also recognizes that men and boys have reproductive health needs and responsibilities.

### Quotes: women's empowerment

"In terms of family planning among African women, I think for a long time there were a lot of assumptions, especially about women in rural areas. For example, there were assumptions that they don't know or want or are against family planning because of tradition. Those were mostly myths started by people from the West. I worked in communities and we reached around 500,000 women over four years, and in every case there was curiosity about family planning, and not community resistance."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"At community level, even religious leaders understand the need for family planning because they are close to the issues. Catholic hospitals council women about child spacing and then tell them where to access contraception, because the service providers themselves don't care about the politics at higher levels."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"I used to blush in these sessions with women – old women talking about sexual positions and clapping and laughing, and talking about how men don't know how to please us and sometimes you don't even realize that they are done! They looked like my grandmothers! This sort of talk is something I've found working and living in those communities."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

## 2.6 Benefits: helping developing countries adapt to climate change

Climate change is mainly due to consumption and greenhouse gas emissions in more-developed countries. However, less-developed countries are and will continue to be most affected by climate change, despite having contributed the least to the problem (Bryant, Carver et al. 2009; Lancet/UCL 2009; UNDP 2010).

Many developing-country governments and civil society organizations have identified rapid population growth as one of the factors which hinders their adaptation to climate change (Bryant, Carver et al. 2009). Voluntary, rights-based family planning programmes can help them to achieve a sustainable population and, in part, mitigate the effects of changes in climate patterns (Lancet/UCL 2009).

Investments in family planning must be part of a comprehensive policy which also includes, for example, investments in food security, safe water supply, improved buildings, reforestation, and other strategies (Lancet/UCL 2009). This requires a multisectoral approach, which extends the responsibility for climate change adaptation beyond ministries of the environment and ensures that issues such as health, including family planning, are integral to national plans (Bryant, Carver et al. 2009).

Reproductive health and women's organizations have decades of experience delivering voluntary, rights-based family planning services, which meet the needs of women, men and young people (Lancet/UCL 2009), while avoiding the coercive and ineffective practices which characterized 'population control' programmes of the past. This knowledge and experience in providing rights-based family planning programmes has been one of the greatest contributors to the reduction in fertility levels in many countries in the past 40 years, and must be the basis for addressing population growth issues today.

### Quick Facts: benefits in helping developing countries adapt to climate change

- Developed countries are most responsible for climate change, but developing countries bear the greatest burden of its effects (Bryant, Carver et al. 2009; Lancet/UCL 2009; UNDP 2010), particularly women and girls in rural areas (UNDP 2010).
- Some developing countries have identified rapid population growth as an obstacle to their abilities to adapt to climate change (Bryant, Carver et al. 2009).
- Voluntary, rights-based family planning programmes are a key strategy in helping developing countries to achieve a sustainable population and, in part, mitigate the effects of changes in climate patterns (Lancet/UCL 2009).
- Meeting the unmet need for family planning is an essential strategy for empowering women, in particular, to cope with the effects of climate change by enabling them to control their own fertility (UNDP 2010).
- Rights-based family planning programmes have been one of the greatest contributors to the reduction in fertility levels in many countries in the past 40 years, and must be a fundamental strategy for addressing population growth issues today.

Source: Bryant, Carver et al. 2009; Lancet/UCL 2009; UNDP 2010

It is also important to recognize that climate change is not gender-neutral: women and girls, especially in rural areas, are often dependent on natural resources and their natural environment for their livelihoods and their family's survival. Therefore, climate change adaptation strategies should be gender-sensitive and inclusive of women's knowledge and experience of their environment (UNDP 2010).

Investing in voluntary family planning programmes and meeting the unmet need for family planning is an essential strategy for empowering **women** to cope with the effects of climate change by enabling them to control their own fertility (UNDP 2010).

## 3. STRATEGIES FOR ADDRESSING THE PROBLEM

### 3.1 Strategies: increase and improve contraceptive services and supplies

The success of family planning policies and programmes depends on a strong supply chain. This ensures that users have a choice of methods which are:

- supplied in the right quantities;
- available in the appropriate places, when they are needed;
- affordable, including the cost of contraception and also costs such as transportation, loss of income and general health care service costs.

It is also vital that contraceptives be stored and shipped appropriately to ensure their quality and effectiveness (European Commission 2007).

The right mix of contraceptives will differ among different populations, but usually includes: male and female condoms, oral contraceptives, intrauterine devices (IUDs), injectables, implants, and emergency contraception. This mix of methods is unavailable to women in many developing countries (RHSC 2009).

**Stock-outs** of contraceptives occur regularly in developing countries due to forecasting problems, inadequate systems of supply and logistics management, and limited funding due to lack of national budget lines and a dependence on international donors. In addition, contraceptives – and the budget, equipment, and supplies needed to provide them – are not always included in the list of national essential medicines (WHO 2010). This is despite their inclusion on the WHO list of essential medicines, which recommends that countries make contraceptives, including emergency contraception, accessible and affordable for all.<sup>3</sup>

#### Quick Facts: what can governments and donors do to realize the benefits of family planning?

- Increase political will
- Create budget lines for reproductive health
- Ensure low prices for contraceptives
- Increase supplies
- Ensure there are adequate local clinics
- Implement comprehensive, evidence-based sex education in schools
- Sponsor national campaigns, such as Family Planning week
- Work with religious and community leaders to encourage acceptance of family planning as a health and social priority
- Integrate family planning into other health and non-health interventions and services

Increased collaboration among multiple funders of family planning can improve the delivery of commodities and reduce stock shortages, including systems to assess demand and track contraceptive pipelines. In addition, creative financing schemes, such as social marketing, franchising systems, and other public-private partnerships have functioned with reliable supplies, multi-tier pricing linked to clients' ability to pay, and guidance for consumers on quality (WHO 2010).

#### Quote: Need for supplies

"Trying to run sexual and reproductive health programmes without contraceptives... and other reproductive health commodities is like trying to eradicate smallpox without vaccines. It simply cannot be done."

– Steven Sindig,

Former Director-General, International Planned Parenthood Federation, 2003

### 3.2 Strategies: increase information, education and communication

In the 1980s, the main reason women gave for not using contraceptives was a lack of information and knowledge. This is no longer the case, suggesting that family planning programmes have had a significant impact on raising awareness (Sedgh, Hussain et al. 2007; Guttmacher/IPPF 2010). However, the problem still exists, and levels of knowledge differ by region.

The most common reason cited for non-use of contraception today is infrequent sex. The second most common reason, cited by 19–36% of married women with an unmet need across developing regions, is the perceived or actual side-effects or health risks believed to be associated with modern contraception. This is a significant increase from the 1980s, and may be due to women either being exposed to side-effects and not having information on

how to manage them; a lack of choice of methods, so that a woman may use a method that is not suited to her needs or health; or simply to misinformation (Guttmacher/IPPF 2010).

Increasing dissemination of information about family planning to women, men, young people and health care providers is vital to meeting the unmet need for contraception. Comprehensive, evidence-based family planning programmes are the primary strategy for correcting misinformation that exists about contraception, and ensuring that women can manage any side-effects of a chosen method. This goes hand in hand with ensuring a good mix of methods are available, enabling women and their health care providers to make informed choices that support the woman's health and meet her fertility needs and desires.

### 3.3 Strategies: increase political commitment

Political leaders are often unaware that family planning is a strong complement to efforts to reduce poverty and spur development. As a result, health systems do not devote sufficient resources to family planning, and political leaders do not make public pronouncements

that give government officials and other politicians the space they need to implement such programmes (RHSC 2009).

Many countries fall dismally short in budgeting the necessary allocations to reproductive health care services and family planning.

<sup>3</sup> The health and social benefits incurred with ensuring access to affordable contraceptives is reflected in the WHO model list of essential medicines, which lists the minimum medicine needs for a basic healthcare system. Contraceptives are included on the 'core list' of essential drugs, which means that the WHO considers contraceptives to be a minimum need in a basic health care system that should be accessible and affordable to all.



In some countries, for example, family planning services are not covered as part of a national health insurance scheme, forcing women to pay a fee for family planning services, even if they are receiving antenatal and delivery care (PPAG 2009). The need for

political will by both national governments and donor agencies has never been greater (UK APPG on Population, Development and Reproductive Health 2009).

### 3.4 Strategies: promote Gender Equality

Lack of political commitment to family planning can be linked to a number of causes, including gender inequality and the low status of women. Both of these factors underpin the low level of priority given to ensuring women's reproductive health and rights. Inequality can also be rooted in religion and culture. For example, studies suggest that religious opposition to contraception is one of the most significant obstacles to securing political commitment both at the national and international levels (IPPF 2008; UK APPG on Population,

Development and Reproductive Health 2009). In addition, lack of male involvement and promotion of traditional gender roles at the individual and societal level are significant barriers to gender equality. Steps need to be taken to improve the status of and priority given to women in policies and health budgeting. In addition, there need to be contraceptive and family planning services aimed at men as well as women (WHO 2010).

### 3.5 Quotes: strategies for addressing the problem

#### Ensure quality of contraceptives

"I think what is really required is an increase in choices related to family planning. This requires a lot more funding, outlets for distributing it, and quality control in relation to the contraceptives themselves. I think people are sceptical of generic brands including condoms. They think it's not as good as the one that's branded."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"Young Filipinos are really brand-conscious and look for a specific brand of pills or other products that really work for them. So it's important not only to ensure adequate stock of contraceptives, but to be consistent with the brand that is provided."

– Bryant Gonzales,  
*Youth Coordinator, Family Planning Association of the Philippines*

#### Partner with governments

"If we strategically support the Government through policy, it will help to scale up reproductive health services and commodities. I think over time we make a bigger impact by supporting them to develop policies and strategies, creating guidelines, than we would if we were in the streets holding placards. That's an important strategy, but not for us to do."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"I think sometimes you can be more effective with the First Lady approach, where the Government is the husband and president, and we are the First Lady, making issues understandable and going beyond figures and putting faces to these issues. We are not only advocates who condemn, but we are partners who give solutions."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

#### Ensure youth-friendly services

"We sometimes meet a young client who tells us that he or she is really glad there is a service for young people. In areas where the Catholic Church really enforces its doctrine, such as in the villages, young people tell us they are really glad there is a service for them."

– Bryant Gonzales,  
*Youth Coordinator, Family Planning Association of the Philippines*

"Youth centres are not necessarily the best model for providing services to young people, because it means extra costs for personnel and infrastructure. Instead, we trained our service providers to become youth-friendly. At some clinics we even changed the façade and the name to 'Community Health Care Centre', so that young people would be more comfortable going to that clinic. A young person would think twice if it said 'family planning', because he or she may be single and not interested in planning a family, even though they are sexually active. These centres also have indoor games, for example, which makes it more inviting. This is one potential model for providing services to young people. Another is to have a system of peer educators, or a peer motivator who would motivate his or her friends to go to a clinic. There are pilot projects of this model now, and we have seen a rise in the number of services that we provide to young people and the number of them who attend the clinic."

– Bryant Gonzales,  
*Youth Coordinator, Family Planning Association of the Philippines*

#### Look to communities to find their own solutions

"We need to have a more empowering and positive approach to promote the family planning agenda. It's the same with a lot of development issues on equality and gender. There are positive things happening in many communities, and we should capture those. For example, there is an area in northwest Zambia where the Chief has declared that any husband whose wife doesn't deliver through the hospital will be fined. Since then, maternal mortality went way down and attended births went up, and that Chief is a man! This is an example of finding people who are willing to be the flag-bearers and engaging with them in a positive way."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"Some of the communities we have worked with are showing great willingness and initiative to contribute to family planning programmes. For instance, the Chief in one community told us they had a three-bed dwelling and they wanted to use it as a clinic. They asked for help to complete the building, and asked the Government to support them, so they could staff it at least once per week. The whole community, even the men, were aware of the need for a reproductive health facility and were willing to get behind the initiative."

– Nana Amma Oforiwa Sam, *Advocacy Officer, Planned Parenthood Association of Ghana*

## 4. CUT-AND-PASTE FACTS, STATISTICS AND QUOTES

### 4.1 Quotes: reasons for unmet need

#### Family planning has not been a priority for governments

"In Mexico, population growth was slowing, but now that trend is stalled. The recent census found that there were five million more people than was projected, and academics and others concluded that this was because the Government has made so little effort to promote family planning."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

"We are an emerging economy, but that does not mean you can step back from efforts to ensure family planning. Family planning has to be a priority, and it has to be based on choice, not coercion. Mexico's family planning efforts were a response to a very legitimate demand from women in Mexico – that's how we achieved the success we did in terms of slowing population growth. But today many women are still having more children than they want because of a lack of access to contraceptives."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

#### Lack of information

"Sexual and reproductive health issues are real, and as a doctor I saw them on a daily basis. What shocked me was the stress girls would have, coming in with many questions, but very few answers."

– Dr. Moses Muwonge, M.D., Health Logistics Consultant, Uganda

"Sexuality education is not part of the school curriculum. UNFPA tried to introduce sexuality education in the Philippines, but it was opposed by the Catholic bishops. The Minister of Education was in favour of continuing the integration of sexuality education into the curriculum, but the government changed in the past year and, once again, sexuality education has been banished. Based on a recent survey, many young people don't have much information – for example, they believe that HIV is curable. The only sexuality education that goes on in schools relates to anatomy, and there is no discussion of HIV and AIDS. Age-appropriate sexuality education would go a long way towards reducing unwanted pregnancies, but also it would teach basic things, like preventing HIV and also safety with regard to gender-based violence."

– Bryant Gonzales,  
Youth Coordinator, Family Planning Association of the Philippines

"Government providers are reluctant to talk about or give out anything except oral pills. In the past year they have started providing emergency contraception, but they don't appear to have adequate information about how to use it."

– Sarita Barpanda,  
Country Programme Advisor, Interact Worldwide, India

#### Lack of choice of contraceptive methods

"The choice of contraceptive method is crucial. Some people have problems with their husbands not supporting them, so they prefer injectables, while other women cannot visit the clinic every three months, so they prefer implants."

– Nana Amma Oforiwa Sam,  
Advocacy Officer, Planned Parenthood Association of Ghana

"One girl came after she had a good sexual experience, but the condom broke and she didn't know if she was pregnant. You can do a pregnancy test but it doesn't always work, so this girl needed emergency contraception."

– Dr. Moses Muwonge, M.D.,  
Health Logistics Consultant, Uganda

"Often, the national medical storage does not have a choice of contraceptives for the public sector. There is a supplier for the private sector, but it is faith-based, which limits choice."

– Dr. Moses Muwonge, M.D.,  
Health Logistics Consultant, Uganda

"Choice of method is very, very important. If a young person is not regularly having sex, and has a sexual contact, she does not need daily pills. She may need emergency contraception, but then she goes back to her normal life. If I'm a woman and I have eight kids, and I want to limit this, I need a different method than that young person. Women present to you with different needs. Some are medical, such as being unable to take certain pills. Some just want to limit births, and you can't tell them to go on pills for three years. We have to help a woman make the right choice for her. Some will say 'give me pills'; others say 'I just want to have something that I can use once and come back in three years.' Some women react badly, for example, to injectables, so they need another method. Other women cannot use hormonal methods at all, so they need an IUD. For doctors like me, it is not right to say we have no other methods. We should be aware that women react differently to different contraceptives. If you don't offer choice you are not doing a service to the women."

– Dr. Moses Muwonge, M.D.,  
Health Logistics Consultant, Uganda

## Limited access to services and supplies

"In Zambia people want the contraceptives but can't get them, particularly in rural areas. The pill is the easiest to get, some can access implants but only at level 2 or 3 hospitals (where they can do minor surgeries)."

– Holo Hochanda, *Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia*

"In 2010 when we were producing a video documentary about family planning in the Kwahu South District in Ghana, we arrived in one of the communities on the first day, and people said 'Oh! Now we have people to talk to about this problem, which we can't talk about with anyone else.' Our organization was recognized by the community as the only family planning service provider, the only entity that reached out to them. This was a result of faced by the public health care system, including logistics, the Government can't reach everyone, so we try to fill the gap. For five years people had no services in some of these communities, due to funding withdrawal from our organization. They had no clinic in the community, and had to travel long distances to get reproductive health care."

– Nana Amma Oforiwa Sam,  
*Advocacy Officer, Planned Parenthood Association of Ghana*

"Most of our work has been with young people, and it's clear that they simply don't have access to contraceptives. There isn't even adequate information about reproductive health. For example, we've been running projects for young people in three states, focusing on meeting demand for contraception. It's very difficult to link them up with services because, at community level, family planning and contraception are not priorities. All these people can get are oral contraceptive pills. And, not only are there no condoms, but the service providers are not trained to inform young people how to use a condom correctly. It's a vicious cycle to create a demand but then not have supplies to cater to that demand."

– Sarita Barpanda,  
*Country Programme Advisor, Interact Worldwide, India*

"Getting access to transport is a challenge for many people. Commercial vehicles only travel on market days. And what's the guarantee that on that day you will have the money for the services or supplies you need? So the cost is not just the product, but the transport."

– Nana Amma Oforiwa Sam,  
*Advocacy Officer, Planned Parenthood Association of Ghana*

"We had one government-provided family planning clinic in my city, which was located in the compound of the City Hall. This was totally inaccessible to young people – they don't do business in the city! My idea of a youth centre is that it should be accessible, maybe by locating it in a school or within a shopping mall ... but in the City Hall?"

– Bryant Gonzales,  
*Youth Coordinator, Family Planning Association of the Philippines*

## Legal restrictions

"Because abortion is illegal, you can't get one at health facilities, but if you walk in and you are bleeding, the doctors will finish the abortion. So many girls go to unqualified doctors and poke with anything they can find, and then the girl bleeds and goes to a real doctor. Some bleed more than others, and often this is the source of women dying from unsafe abortion. Some doctors pierce any part of the cervix, and some women lose a lot of blood. Most often I saw young women coming in after unsafe abortions -- women between the ages of 18 and 25."

– Dr. Moses Muwonge, M.D.,  
*Health Logistics Consultant, Uganda*

## Contraceptives are too expensive for many users

"Reproductive health commodities, such as contraception, are not free in the Philippines, not even from Government clinics. Some local governments do make them available at a cost, but young people don't have much income and are dependent on their parents until about age 24. So they simply can't buy contraception. Also, if you are unmarried in the Philippines, it's a taboo to have sex, so asking your parents for money to buy contraception is out of the question."

– Bryant Gonzales, *Youth Coordinator, Family Planning Association of the Philippines*

## 4.2 Facts and statistics: benefits of investing in family planning

- Every US dollar spent on family planning saves at least US\$4 that would otherwise be spent on treating complications from unintended pregnancies (UN Secretary General 2010).
- If all women at risk of unintended pregnancy used modern contraceptive methods, the declines in unintended pregnancy and unsafe abortion would reduce the cost of post-abortion care by approximately US\$140 million a year (Singh, Darroch et al. 2009; Guttmacher 2010).
- 30–50% of Asia's economic growth from 1965 to 1990 has been attributed to changes in population dynamics, which are strongly influenced by improvements in reproductive health and access to contraception (UN Secretary General 2010; Bloom & Williamson 1998).
- Lower fertility accounts for 25–40% of economic growth in developing countries (Barot 2008; UK APPG on Population, Development and Reproductive Health 2009).
- Maternal mortality would drop by 25–35% if the unmet need for modern contraceptives were fulfilled, saving the lives of close to 100,000 women each year (Barot 2008).
- The level of modern contraceptive use averts 188 million unintended pregnancies each year (Guttmacher/IPPF 2010), which in turn helps prevent 230,000 pregnancy-related deaths and other negative health outcomes (Singh, Darroch et al. 2009).
- Meeting the unmet need would mean that more than half a million fewer children would lose their mothers (Singh, Darroch et al. 2009; Guttmacher/IPPF 2010).
- If women had the means to space their births three years apart, infant and under-five mortality rates would drop by 24% and 35%, respectively (Barot 2008).
- If there were at least two years between a birth and a subsequent pregnancy, deaths of children under-five would fall by 13%; if the gap were three years, such deaths would decrease by 25% (Rutstein 2008).
- As contraceptive use increases, rates of abortion decrease: the current level of modern contraceptive use is estimated to prevent 112 million abortions every year (Guttmacher/IPPF 2010).

## 4.3 Facts and statistics: progress and setbacks in addressing unmet need

- Between 1965 and 2005, use of family planning in developing regions (excluding China) rose from less than 10% to just over 50% (Speidel, Sinding et al. 2009).
- The number of contraceptive users grew from approximately 30 million to 430 million from 1965 to 2005, resulting in decline of more than six children born to each woman during her lifetime, to just over three children (Speidel, Sinding et al. 2009).
- By 2007, approximately 60% of married women of reproductive age were using some form of contraception (UN-DESA 2011).
- The unmet need for family planning has remained at the same moderate to high level in most regions since 2000 (UN 2011).
- As a proportion of total aid for health, aid for family planning declined over the past ten years in virtually all recipient countries (UN 2011).
- In sub-Saharan Africa, unmet need has declined little over the past decade, and in a few countries unmet need has increased (Guttmacher/IPPF 2010; UN 2011).
- Data from 22 countries show that the percentage of adolescents who have their demand for contraception satisfied is much lower than that of all women aged 15 to 49. This disparity has changed little over time, pointing to scant progress in improving access to reproductive health care for adolescents (UN 2011).

### 4.3.1 Quotes: progress and set-backs in addressing unmet need

#### Many regions still do not have comprehensive services

"In 2007, the Government declared a state of emergency for maternal health, which made it possible for expectant mothers who have registered under the National Health Insurance Scheme to get free antenatal and delivery care. This was a laudable initiative, but the Government also needs to make services available for women who are not giving birth by providing free contraceptives and family planning services. If you want to address maternal health, you need a comprehensive package, including family planning on the National Health Insurance Scheme will help address this."

– Nana Amma Oforiwa Sam,  
Advocacy Officer, Planned Parenthood Association of Ghana

"India's flagship national health programme – the National Rural Health Programme – primarily focuses on family planning, reproductive health and maternal health. But family planning is the most under-implemented aspect. The focus is on maternal health, and people haven't yet made the connection between maternal health and family planning."

– Sarita Barpanda,  
Country Programme Advisor, Interact Worldwide, India

"About 45% of people in Ghana are under age 18, and the National Health Insurance Scheme provides free services to those under 18. If you are over 18, though, you have to work to pay for services. For us it's a good start, but not the end of the story."

– Nana Amma Oforiwa Sam,  
Advocacy Officer, Planned Parenthood Association of Ghana

"Cairo was an extraordinary conference. It was the first time we heard about rights and a holistic conception of reproductive health. But if we observe fertility trends in many countries, it is clear that we are not achieving what we set out to achieve."

– Esperanza Delgado, Director of Information and Evaluation, MEXFAM

#### Men are left out of family planning

"We used to give out condoms, but now we can't get regular supplies. In the documentary video we made, in the Kwahu South District of Ghana, one of the community agents remarked 'The young men come to you in the middle of the night, and we don't have them, and it's bad news. They say, 'we have to do it *sacora* – without a condom.' That means 'like a bald head' or 'bald-headed person'. In this case, it's a bald-headed penis!"



Everyone laughs at the remark, but it's all too common that they can't access condoms. We have to include men in our plans to address unmet need, too."

– Nana Amma Oforiwaa Sam,  
Advocacy Officer, Planned Parenthood Association of Ghana

### Stock-outs of supplies are common

"In a hospital in northern Uganda, we experienced stock-outs of contraceptives: condoms, injectables (which is the most common method) and implants. We only had pills, so the method mix wasn't there. If a woman is on injectables and we only have pills, the woman just leaves with no protection. Though there is a wide belief in some circles that pills are convenient, in Ghana this is not always the case. It's difficult to disguise if you have to take a pill every day, but if you walk the distance to get injections only every three months, your husband doesn't know."

– Dr. Moses Muwonge, M.D., Health Logistics Consultant, Uganda

"In 1995 and 1996 I was working in a conflict area, and there were stock-outs of contraceptives. The women would come in the evening and then return home in the morning, as most families would sleep on the streets in the cities where it was safer than the villages ... Women wanted family planning but couldn't get it. The stock-out was at country level, yet other medicines were coming through despite the conflict."

– Dr. Moses Muwonge, M.D., Health Logistics Consultant, Uganda

"We spoke with a doctor who is responsible for reproductive health programmes in Mexico's third largest state. She was very worried because her state simply does not have the contraceptives that women need. We looked into this and found that, although her state received an allotted amount of money specifically for contraceptives, it never reached her office. After a great deal of investigation it became clear that there is a law requiring budget integrity and transparency on the part of the central government, but it does not apply at state level. As a result, the Minister of Health has documentation showing that the Government is investing funds in family planning and supplies, and it looks like a great success. But you discover the truth when you go to the states, where contraceptive supplies are needed and there isn't sufficient funding for them."

Although at central level the Ministry of Health disburses funds for family planning, the money is received at state level by the Ministry of Finance rather than Health. Once funds reach the states, the governors can decide where that money goes: it can decide there are more important priorities than reproductive health and family planning. MEXFAM is now advocating to change this."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

"We started seeing stock-outs of contraceptive supplies. There is a specific labelled budget line for family planning, so we went to the central Government and asked why there were stock outs. They said they did not know. In Mexico, the decentralized system means that all 32 states have to follow the model set at the central level, yet this is not the case with regard to the budget."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

### Contraceptives are expensive for many users and organizations

"The Family Planning Association of the Philippines has 25 chapters, all of which are clinics providing services, such as counselling, as well as contraceptives. However, we still seek donations for our commodities because we have to recover the costs. Although the contraceptives we get from IPPF are free, when the shipments arrive in the Philippines we have to pay taxes on them of around 12%. For us to be exempt from paying these taxes, we have to be included in the law that mandates such exemption, but we're not."

– Bryant Gonzales,  
Youth Coordinator, Family Planning Association of the Philippines

"We've talked about price with people, and frankly people prefer contraceptives to be free. However, they don't have much faith in what's being provided for free by governments. For example, at a Q&A session with adolescents, we were talking about myths and misconceptions, and one thing that came out was that government-provided male condoms often break. This is because they aren't stored properly or were expired. These are some of the things we've heard from young people, and reasons why, even where governments are providing services and supplies, there is less reliance on these sources. In addition, there are no good storage facilities within government institutions, so there is this feeling that the government-provided contraceptives are not good products that people can use with faith. As a result, there's always a dependence on private providers, getting it from the chemists or pharmacy, which is much easier, but there is still limited choice."

– Sarita Barpanda,  
Country Programme Advisor, Interact Worldwide, India

### People know about family planning, but can't get the supplies and services they need

"I believe in family planning. I believe in all of the benefits that family planning provides to individuals and communities and in political life. Just because a country 'develops' economically does not mean that it does not require funding and programmes for family planning. It just requires these in a different way. Family planning is a never-ending story."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

"In my experience at community level, working with men and women, separately and collectively as couples, there was minimal resistance but a lot of curiosity. I don't question the demographics that say knowledge of family planning is at 96%. People know about the pill and other methods, they may have misunderstandings, but the big problem is they can't access it."

– Holo Hochanda, Zambian Commission on Population and Development delegation, BroadReach Healthcare, Zambia

"One reason why knowledge about family planning is nearly universal is because you have many [civil society organizations (CSOs)] working on this, and you have things like radio stations that reach many people. But the reach of the messages is not as good as the reach of the family planning and public health facilities. If someone is within 20 kilometres of a village, they know about family planning, because CSOs have meetings in the villages. The question is, once I have the knowledge, where can I access the services? That is for the public sector. The

more remote areas are most likely to have faith-based health units, for example, the Catholic organizations usually go deeper into villages, but they don't provide contraceptives. They do talk about family planning and natural methods, and they say if you want modern methods, we can't provide them here. To me the issue of knowledge and access are not matching up. We need an alternative method so that women can also access services, not just knowledge."

– Dr. Moses Muwonge, M.D., Health Logistics Consultant, Uganda

"Most social marketing entities and projects do outreach, maybe one outreach in an area in a year. So if anyone misses that, they've missed their chance. To me, we have a mismatch between giving out the message and actually providing the services."

– Dr. Moses Muwonge, M.D., Health Logistics Consultant, Uganda

"There's an organization that has initiated a social franchising model youth centre, and sold it to local governments, and about ten local government units have used that model. They offer counselling and information, but not supplies. So there's really a disconnect: these centres just provide counselling and information, and people have to get the supplies they need at a pharmacy or a private clinic."

– Bryant Gonzales,  
Youth Coordinator, Family Planning Association of the Philippines

"We conducted formal focus group discussions with young people in one of our projects, and it emerged that emergency contraception is in huge demand, but people aren't trained to distribute it. Again, demand and supply gaps and information gaps are huge issues in many states in India."

– Sarita Barpanda,  
Country Programme Advisor, Interact Worldwide, India

### **Vulnerable groups need services, too**

"There was a programme initiated by the Ministry of Health and Population Office in the early 2000s, which involved setting up youth centres in every town through local government units. That wasn't sustainable, though: within two years all the youth centres were gone. Many of the centres we have now are set up by reproductive health organizations rather than the Government."

– Bryant Gonzales,  
Youth Coordinator, Family Planning Association of the Philippines

"One of our clinics provides services to young sex workers, who migrated there because of the nearby American military base. They were really happy that we operated in that area because it meant they didn't have to go to the next city to get pap smears, contraceptives and other essential services. Many of these sex workers were young women not native to that province or village; they migrated there so were isolated from their families."

– Bryant Gonzales,  
Youth Coordinator, Family Planning Association of the Philippines

"We've worked in both rural areas and urban slums, and the issues are the same. The only difference is that information and supplies are more easily available in urban areas if you have the money to buy them; in the rural areas there is simply no access at all."

– Sarita Barpanda,  
Country Programme Advisor, Interact Worldwide, India

"When a right-wing party took power in Mexico, although they were not opposed to family planning, they were also not openly in favour of it. As a result, mass media campaigns for family planning stopped. These were very important campaigns, particularly for adolescents. Not surprisingly, much of the unmet need for family planning in Mexico is among adolescents."

The complete range of contraceptive methods should be available to people throughout Mexico, according to the central Government. This is documented on the National Medicines List and, it is required by law. But if you go to the states, you see that the availability of contraceptives is based on the values and morals of high-level decision makers such as the local Ministry of Health and the Governor. If they decide that contraceptives should not be available to adolescents, or that sex education should not be taught as part of the basic school curriculum, then adolescents do not get these services. Basically, state-level authorities can decide that family planning should not be encouraged for adolescents. This leads to unmet need and all of the consequences associated with it, such as unplanned pregnancies.

We are advocating strongly at the national level to ensure that contraceptive supplies are labelled as strategic supplies, and that they are purchased at the central level. It is important for NGOs to continue making our governments accountable at all levels and at all times – central, state, local and community governments alike."

– Esperanza Delgado,  
Director of Information and Evaluation, MEXFAM

## 4.4 Facts and statistics: future projections of unmet need

- If contraceptive use remains stable, the world population could reach 11.9 billion by 2050. The scenario could worsen if contraceptive use declines, for example, due to lack of investment in family planning (Speidel, Sinding et al. 2009).
- Low growth scenarios put the world's population at 7.8 billion by 2050, compared to 7 billion today. This assumes that contraceptive use will grow faster than it is rising now. It has been reported that the most likely median scenario is that it will grow to 9.7 billion by 2050, assuming a substantial increase in the number of contraceptive users in developing countries (Speidel, Sinding et al. 2009).
- 1.5 billion adolescents are entering their sexual and reproductive years (IPPF 2008; UN 2009).
- The number of women of reproductive age (between ages 15 and 49) will grow by almost 33% in the next decade (Ross and Stover 2009).
- Between 2008 and 2015, the number of family planning users will increase from 645 million to 709 million, a projected increase of 106 million (RHSC).

## 4.5 Facts and statistics: international agreements related to family planning

- In 1994, 179 governments signed the Programme of Action of the International Conference on Population and Development (ICPD), committing to ensuring access for all to reproductive health and family planning supplies and services by the year 2015.
- In 2000, 189 heads of state adopted the UN Millennium Declaration and established eight Millennium Development Goals (MDGs), eventually including a target aimed at ensuring universal access to reproductive health by the year 2015. Tracking progress includes indicators such as contraceptive prevalence rate and the unmet need for family planning, which recognizes that access to contraceptives is an essential component to achieving universal access.
- Approximately 356,000 pregnancy-related deaths occur annually in developing countries (WHO 2010). While maternal mortality declined by one-third between 1990 and 2008, this figure still remains high, and the effort to reduce maternal mortality (MDG 5) is the development goal which has progressed the least (Barot 2008).
- The Muskoka Initiative on Maternal, Newborn and Child Health is a funding initiative announced at a G8 summit in 2010 which commits member nations to collectively spend **an additional US\$5 billion between 2010 and 2015** to accelerate progress toward the achievement of MDGs 4 and 5 in developing countries.

## 5. FREQUENTLY ASKED QUESTIONS

**Q I thought family planning programmes were successful over the past few decades. What has changed?**

**A** Family planning programmes have been hugely successful: since 1965 use of family planning in developing countries (excluding China) went from less than 10% to about 60% (Speidel, Sinding et al. 2009; UN-DESA 2011), and the number of children born to each woman declined from more than six to just over three (Speidel, Sinding et al. 2009).

But over the past ten years, aid for family planning has declined as a proportion of total aid for health in virtually every recipient country (UN 2011). And in some places, such as sub-Saharan Africa, the unmet need has stayed almost the same or even increased during that time (Guttmacher/IPPF 2010; UN 2011).

Despite all the gains, we're at risk of going backwards without continued investment in family planning.

**Q Why should we continue to invest in family planning?**

**A** Today, it's estimated that 40% of all pregnancies in developing countries are unintended (Singh, Wulf et al. 2009). Also, today's adolescents are the biggest cohort of young people in history – as they become sexually active, there will be an ever greater need for investment in family planning.

There are many reasons why investment has declined. For example, restrictions on funding for reproductive health by the US government during the presidency of George W. Bush (i.e., the Mexico City Policy or 'Global Gag Rule') led to dramatic cuts in money available for family planning. While these restrictions are no longer in place, they led to cuts in services in many countries, which is likely to have contributed to increasing unmet need for family planning (Lancet/UCL 2009).

In addition, reductions in funding from donor countries may have come about due to the misperception that family planning is already fully funded. While there have been large increases in funding to 'population' budget lines, much of this money has gone towards HIV/AIDS programmes (Lancet/UCL 2009), and much less has been spent on other aspects of reproductive health, such as family planning. More funding is needed – from both donor countries and developing-country governments – for comprehensive reproductive health programmes which include both family planning and HIV/AIDS programmes.

**Q What is the difference between modern contraception and traditional methods?**

**A** Modern contraception is any clinical or pharmaceutical method of contraception for men or women which has been shown to be effective in scientific studies. Modern methods include sterilization, intrauterine devices, hormonal methods, male and female condoms, and vaginal barrier methods (e.g., the diaphragm or cervical cap). Modern methods are distinct from traditional methods of pregnancy prevention which have limited evidence of effectiveness. Traditional methods include

rhythm, withdrawal, abstinence and lactational amenorrhoea (i.e., infertility that can occur when a woman is breastfeeding and not menstruating within six months postpartum).

**Q Why don't some women use modern contraception?**

**A** Studies have found that women are not using modern contraception for three main reasons. First, they perceive that they are at low risk of getting pregnant – for example, due to infrequent sexual activity or because they have recently given birth or are breastfeeding. Second, contraceptive supplies, services and/or information are unavailable or inaccessible. For example, a woman may not have correct information about contraception, it may be too expensive or she may not be able to reach health facilities to obtain appropriate contraception. Third, women may refuse family planning because of their own, their partner's or their family, cultural or religious beliefs, though this is a less common reason (Sedgh, Hussain et al. 2007).

At the broader political level, the lack of access to supplies and services could be associated with reductions in political commitment and funding for family planning in recent decades.

**Q Our focus is poverty reduction and economic development, not health. So family planning isn't really relevant to us, is it?**

**A** There's good evidence that family planning contributes to higher gross domestic product (GDP), and modern contraceptive use is linked to higher per capita gross national product (GNP) (WHO 2010). Countries with lower fertility and slower population growth have experienced higher productivity, more savings and more effective investment (UNFPA 2002). Also, 30–50% of Asia's economic growth from 1965 to 1990 has been attributed to changes in population dynamics, which are strongly influenced by improvements in reproductive health (Bloom and Williamson 1998). And it's estimated that 25–40% of economic growth in developing countries has been attributed to lower fertility (Barot 2008; UK APPG on Population, Development and Reproductive Health 2009).

**Q Governments are looking for ways to cut spending, not increase it. Why should they spend precious funds on family planning?**

**A** Family planning is one of the most cost-effective investments a government can make. For every dollar spent on family planning, \$4 can be saved. Sure, there are costs for increasing family planning services and supplies, but they're outweighed by the cost savings.

For example, if modern contraceptive services were provided to all women in developing countries who need them, the total cost of services would increase by US\$3.6 billion per year. But the total costs of providing newborn and maternal health services would decrease by US\$5.1 billion per year; and the total costs of providing post-abortion care would decrease by approximately US\$140 million per year.



**Q Why is a 'mix' of methods important? Don't we already have the pill and the condom? Isn't that enough?**

**A** Different people need different methods. Sometimes that's because they experience side-effects in response to a particular method (such as a pill or implant). Or if a woman's husband or family doesn't want her using contraception, she needs a method she can use discreetly (such as going to a clinic for injectables once every three months, instead of having to take a pill every day).

Contraceptive needs also vary over a person's lifecycle. For example, some women, especially older women, want a permanent or long-acting method, to avoid pregnancy altogether, and this is very different from a young woman who wants to have children in the near future.

**Q I understand that the largest generation of young people are coming of age and becoming sexually active. Can't young people get contraceptives in the same places that adults get them?**

**A** In some places, young people may be denied contraceptives due to social, cultural or religious restrictions. In other places, although there may not be specific legal or community restrictions on young people's access to contraceptives, existing services may not be appropriate. For example, most existing family planning programmes are designed to meet the needs of married women, rather than the specific needs of young people; and such services may be located in places that are difficult or inconvenient for young people to get to, or at times when they cannot attend. Where family planning is fee-based, as it is in many countries, young people may simply not have the money to pay for contraceptives.

It is also important to note that in many parts of the world young people may have limited accurate knowledge about sexual and reproductive health, including contraception. This underscores the need to ensure that every generation gets comprehensive sexuality education, which enables them to make informed choices about their sexual and reproductive lives.

**Q To slow climate change, shouldn't we slow the growth of populations in developing countries?**

**A** Climate change is mainly due to consumption and greenhouse gas emissions in developed countries, but less-developed countries are and will continue to be most affected by it (Bryant, Carver et al. 2009; Lancet/UCL 2009; UNDP 2010). Indeed, many developing countries have identified rapid population growth as one of the things that hinders their abilities to adapt to climate change (Bryant, Carver et al. 2009). However, coercive 'population control' policies – like those seen in the 1960s and 1970s – were largely ineffective and violated the human rights of millions of people.

On the other hand, voluntary, rights-based family planning programmes can help developing countries to achieve a sustainable population and mitigate the effects of climate change (Lancet/UCL 2009). Voluntary family planning needs to be part

of a comprehensive policy which also includes, for example, investments in food security, safe water supply, improved buildings, reforestation, and other strategies (Lancet/UCL 2009).

**Q Family planning is only one aspect of women's rights. Shouldn't we focus more generally on improving equality for women – for example, through micro-credit schemes or educational programmes for girls?**

**A** A woman's ability to control her fertility is vital to her freedom and autonomy, and is a fundamental human right. In fact, one of the key indicators of women's empowerment at the household level is the ability to make childbearing decisions and use contraception (Grown, Gupta et al. 2003).

Meeting women's needs for contraception empowers them personally, socially, economically and politically (Center for Reproductive Rights/UNFPA 2010), while also supporting other efforts to promote women's rights. For example, modern contraceptive use by women and girls increases their access to education, in part by reducing the number of girls forced to drop out of school due to pregnancy (Barot 2008). In addition, women who use contraceptives are more likely to be active and productive in the workforce, which means they have increased earning power that allows them to improve their own and their family's economic security (FHI; WHO 2010).

**Q In a nutshell, what needs to be done?**

**A** Donors and governments need specific budget lines for reproductive health and family planning, or more transparency in existing budget lines for 'population'. This needs to be maintained with more political support and policies that recognize how important family planning is to human and economic development.

Policies and budget lines should focus on giving people access to the full range of modern contraceptive methods, with effective distribution, accompanied by accurate information or counselling on how to use them and potential side-effects. These need to be available at low prices or for free, in locations where people can get them easily. Health system strengthening efforts should always include a family planning component.

We also need evidence-based education programmes for adolescents and women about modern contraceptive methods and the risks of pregnancy, and to educate men to promote positive attitudes about contraception.

## 6. ONE-MINUTE TALKING POINTS AND COMMUNICATION STRATEGIES

This section provides suggestions for developing concise messages or strategies for communicating with stakeholders, such as policymakers, donors and journalists, or for use in emails, websites or other publications.

### 6.1 Brainstorming exercise for developing concise talking points

**Aim:** Write three or four bullet points or a short paragraph on a single topic. Ideally, these should fit on an index card that can be easily carried to meetings or other events, or posted next to a telephone or computer for easy reference.

#### Suggested topics:

- What is unmet need for family planning?
- Why should family planning be a priority for governments/donors?
- Haven't family planning programmes been a success? Why do we need to continue investing?
- What are the economic benefits of investing in family planning?
- What are the health benefits of investing in family planning?
- What does family planning have to do with climate change and the environment?
- How can family planning increase opportunities for women and improve gender equality?

**Materials needed:** flip chart, laptop with copy of toolkit and PowerPoint slides, copies of fact sheets, index cards

**Targeting our audience(s):** Before we can decide what to say, we have to know who we're talking to: is this person a sceptic? Or already a supporter? How much knowledge do they have of family planning and need for investment?

As a group, we'll take five minutes to come up with a list of our key audiences (write these on flip chart). We can then keep these audiences in mind when working in our groups.

**Split into groups** (depending on number of participants): Each group chooses at least three topics to work on (ensuring that each topic has at least one group working on it).

In your group:

- One person volunteers to take notes on flip chart
- One or more people agree to write final text on index cards
- Have the toolkit, slides and fact sheets handy – you will use them for inspiration.

For each topic:

1. **Choose ONE key sentence** that you would like a stakeholder to take away from his/her discussion with you. It should be straightforward and not too complicated or long, so that you can remember it.

For example, for the topic 'What are the economic benefits of investing in family planning?', your key sentence might be:

*No country has pulled itself out of poverty while maintaining high fertility, and voluntary family planning is vital to reducing fertility.*

or

*Every dollar spent on family planning saves at least \$4 that would otherwise be spent on complications from unintended pregnancies.*

2. Look through the toolkit to find three or four points which support your key sentence.

For example, if your key sentence is **No country has pulled itself out of poverty while maintaining high fertility, and voluntary family planning is vital to reducing fertility.**

#### Your points might be the following:

- More than a quarter of the economic growth in developing countries is attributed to lower fertility.
- In Asia, at least one-third of economic growth between the mid-1960s and the 1990s has been linked to improvements in reproductive health and fertility rates.
- Family planning is arguably the most important factor in the reduction of global fertility levels in the past 40 years.
- With voluntary family planning, people can balance desires to have children with the need to earn a wage and to invest in their existing children.

There may be a lot of points to support your key sentence. The challenge is to choose only three or four, and ensure they are concise, memorable and not too complicated.

Once you have decided on three or four points, write your key sentence and your supporting points on an index card. If it doesn't fit, you'll need to cut it down to fit.

## 6.2 Example talking points

*Why should family planning be a priority for governments/donors?*

**Audience:** Ministers of Health and Development

**Key Statement:** Maternal mortality is one of the biggest obstacles to development.

**Supporting points:** We know how to prevent it. When women have access to contraceptives, maternal mortality drops.

**Example:** Bangladesh: maternal mortality fell by 40% after contraceptives were made available. Colombia: maternal mortality dropped by 50%.

*Haven't Family Planning programmes been a success? Why should we continue to invest?*

**Audience:** People with some knowledge of family planning

**Key Statement:** Yes, family planning programmes have been successful, but demand is increasing while budgets are falling.

**Supporting points:** 222 million women in developing countries want to avoid pregnancies but cannot. The biggest generation ever of young people are entering their reproductive years. Yet funding for FP has fallen. We risk going backwards in terms of maternal deaths/ population/overburdened health systems.

## 6.3 Example of a communication strategy for journalists

**Target:** Journalist

**Objective:** Persuade him/her to attend an event and write about unmet need

**Theme:** unmet need for family planning

**Start with flattery:** For example, "You are a great advocate for women's rights."

**Provide a 'hook':** For example, "Did you know that over 200 million women do not have the ability to decide how many children to have? That's over half the population of the USA."

**Purpose:** Explain the event or report that you would like him/her to write about.

**Proof points:** "These women don't have access to information, health services or contraceptive methods, which may be too expensive. Often women don't have the right to make the decisions themselves, and there is a lack of political will to address this issue, both from our governments and those in developing countries.  
(Support this with country examples.)

**What can we offer?:** "We can give you access to this event, interviews with distinguished experts, and the latest information about these issues."

## 7. CASE STUDIES

### Increasing access to family planning

#### India

There is evidence that maternal mortality has dropped in Indian states where there are Accredited Social Health Activists (ASHAs). In some states, each village has an ASHA, who is the primary distributor of information and contraception, assists with pregnancies and deliveries, and links pregnant women with government services they may need.

ASHAs support Anganwadi Workers, who provide nutritional support to young mothers and children up to the age of five, and Auxiliary Nurses and Midwives, who provide support for safe institutional delivery.

In each village, ASHAs are selected through a collective decision-making process involving women's groups and religious authorities. ASHAs are usually married women with some education. There is usually one ASHA for every 1000 people. This is a huge workload, especially considering that many ASHAs are

volunteers. However, in some cases honorariums are provided to ASHAs based on the number of clients they are able to refer to other services.

Local governments have been largely supportive of ASHAs, and the scheme has now been extended to all 18 of India's highly vulnerable states. In addition, Concern Worldwide is taking steps to introduce male ASHAs, which could help to increase men's knowledge of and involvement in reproductive health and family planning.

#### Pakistan

In 1993, Pakistan initiated a programme to increase access to basic health services, including contraceptive information and services, in rural areas. Lady Health Workers are women from the local community who visit other women in their homes and provide contraceptive information and supplies, such

as condoms and oral contraceptives, as well as referrals for long-acting or permanent contraceptive methods. A national programme evaluation in 2001 found that 20% of women in rural areas serviced by the Lady Health Workers were using modern contraceptives, whereas only 14% of women in other rural areas relied on modern contraceptive methods. This programme shows how community-based distribution of contraceptives can promote access among populations in which geographical distances or stigma around contraceptive use might otherwise prevent it (Center for Reproductive Rights/ UNFPA 2010).

### **Egypt**

In a 20-year period, from 1980 to 2000, the percentage of women in Egypt using contraceptives rose from 24% to 56%,

and the average number of children born alive to a woman during her lifetime dropped from 5.3 to 3.5 births. Strong family planning programmes, political commitment and donor support contributed significantly to this success.

However, in many rural areas, such as Upper Egypt, the adoption of family planning programmes was less successful, as misinformation about the potential harms of contraceptives and beliefs that family planning is against Islam were prevalent. A pilot programme in the Minya governorate, which had one of the lowest contraceptive prevalence rates in Egypt, focused on encouraging cooperation between local mosques and female physicians at village health clinics. The programme helped to turn the situation around, with contraceptive use rising from 23% to 48%. Training local religious leaders and giving them a role in addressing unmet need helped to redress stigma, myths and suspicion around contraceptive use (USAID).

## **Family planning and sustainable development**

### **Guinea-Bissau**

In Guinea-Bissau, women's organizations have initiated a successful pilot project, which involves partnerships with the government to provide reproductive health services in areas where women collect salt. The women's organizations provide reproductive health and family planning services, along with childcare, counselling for how to start a business and micro-credit services. This is great example of community cooperation that links with government services.

### **Nepal**

The World Wildlife Federation (WWF) implemented an environmental conservation project in Nepal but recognized that it couldn't achieve the programme goals without the full participation of women in the project areas. It realized that many women were often pregnant, sick, anaemic or suffering from other reproductive-health-related problems.

WWF launched a small pilot project to provide family planning services. It found that more young people began using contraceptives, and women's health improved. WWF's main project is now doing well, and it has contacted Vaestollito as well as the Family Planning Association of Nepal to help strengthen the family planning component of its project.

## **Youth-friendly services**

### **India**

In several states in India, non-governmental organizations have launched a pilot project setting up Community Information Access Centres to disseminate information about sexual and reproductive health and rights to adolescents, and take up rights issues at community level. These centres are specifically designed for adolescents, and provide space for the participation of vulnerable young people, parents and community and religious leaders. This project aims to improve the quality of and access to youth-friendly sexual and reproductive health services, as well as to increase knowledge, skills and awareness related to sexual and reproductive health, including HIV, particularly among vulnerable young women and men.

The project is community-based, but with a strong emphasis on promoting adoption and scale-up by state governments under the umbrella of youth 'Plans of Action'. Meetings with the Ministry of Sports and Youth Affairs and the Department for Women and Children have led to a commitment to scale up in 12 districts of Jharkhand and West Bengal. This will enable the project to reach over 10 million young people and 3600 service providers.

In addition, advocacy efforts have led to significant improvements in young people's access to appropriate services: 67% of young people surveyed reported feeling more comfortable attending services.

## Taking a rights-based approach

### Paraguay

- In just six years, the use of modern contraceptive methods increased dramatically, from 48% to 61% percent throughout Paraguay, and from 41% to 55% in rural areas.
- There was a particularly significant increase in the use of modern contraceptives for the youngest and oldest married women – the groups with the highest rates of maternal morbidity and mortality and adverse pregnancy outcomes.

These changes have been attributed in part to the introduction of a constitutional protection guaranteeing every individual the right to decide the number and spacing of their children. There was strong political commitment to implement this right, including earmarking funds for contraceptive commodities, and private–public partnerships. Combined with initial donor support, this led to an expansion of contraceptive services and a wide range of contraceptive choices (USAID/DELIVER 2006).

### Guatemala

In 2005, Guatemala passed legislation to ensure universal access to all contraceptive methods. Despite multiple legal challenges, the law went into effect in October 2009. The Universal and Equitable Access to Family Planning Services Law establishes the goal of achieving universal access to modern contraceptives throughout the country and includes strategies for addressing various barriers to access. In addition to guaranteeing access to contraceptive methods, the law includes provisions that ensure free and informed decision-making,

adequate contraceptive information and counselling, provider training, and sexuality education in both primary and secondary schools. To help meet these goals, the law incorporates elements of a human rights-based approach. For example, it focuses on vulnerable groups, including adolescents and individuals living in rural areas, who lack access to basic health services. Additionally, the law calls for national surveys to identify the unmet need for family planning and recommends the development of tools for monitoring the provision of contraceptive services and evaluating progress in removing barriers to access (Center for Reproductive Rights/UNFPA 2010).

### Colombia

Despite opposition from the Catholic Church, the Colombian government worked with civil society to support reproductive health services, including access to contraceptives. This joint work led to an increase in contraceptive use among married women from 20% in 1969 to 66% in 1990. The unmet need for contraception fell as low as 11%, and maternal mortality dropped from more than 240 deaths per 100,000 live births to an estimated 120 deaths per 100,000 live births in 1990.

In 1991 the country's new constitution recognized health as a basic right and led to significant health reforms, such as establishing universal health insurance that included family planning coverage. Since then the unmet need has dropped even further to 6%, and contraceptive use has increased to 78% among married women. In 2010, a constitutional court decision led to further improvements in the health insurance benefits package for family planning (Singh, Darroch et al. 2009).

## Family planning successes

### Indonesia

The average number of children Indonesian women had during their lifetimes in the 1960s was six per woman, and at least two of these six children were expected to die before reaching school age. In response, the government launched its family planning programme in 1967, with an emphasis on spacing children and a focus on community participation and encouraging couples to think about how, whether and when to have children. This helped to strengthen perceptions that smaller families were acceptable and desirable. Now figures show that families have about 2.6 children per couple, and more than 60% of married couples practise birth spacing, most through the use of modern contraceptives (USAID).

### Togo

Unmet need for family planning remains high in Togo, where the proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a given point in time is only about 9%. This problem has been compounded by cuts in donor funding for contraceptive commodities.

To improve access to contraceptives, the Ministry of Health, in collaboration with multiple stakeholders including the Ministry of Finance, launched a strategic planning process in February 2004. The Ministry of Health advocated with the Ministry of Finance to create a budget line item for contraceptive commodities. Before the strategy was finalized in September 2005, the Ministry of Finance recognized the significance of the resource gap and declared its intention to create a line-item for contraceptive purchases and in the interim, allocated CFA50 million (US\$95,000) to the Ministry of Health for the purchase of contraceptives (RHSC 2009).

## Protecting the health and rights of girls and young women

### Yemen

In some districts of Yemen, almost 60% of families marry off their daughters before the age of 18. In some areas, less than 1% of girls have an education. A project of the Yemeni Women's Union is working to ensure that girls remain unmarried and in school at least until they are 18. Advocacy work is being done to transform the opinions of religious and community leaders and families on the importance of girls' education. One component is working with volunteer community educators who raise awareness about the social and health consequences of child marriage through lively discussions, film screenings, plays, writing competitions, poetry readings, debates and literacy classes. Messages include information about the risks of pregnancy for girls. By delaying marriage, the project aims to slow maternal, newborn and infant deaths and associated conditions, such as obstetric fistula, childhood deformities, mental illness, depression and intimate partner violence. The project has reached nearly 41,000 contacts in a number of districts, and in those areas, child marriage for girls aged 10 to 17 years has decreased (USAID 2009).

### Kyrgyzstan

Child and maternal mortality rates in Kyrgyzstan are high, and early marriage is common: a 2004 United Nations report estimated that 11% of girls between 15 and 19 years of age were married, divorced or widowed. The practice is increasing because of poverty, unemployment and some harmful cultural norms, such as abduction and forced marriage of young women (OECD Development Centre 2007).

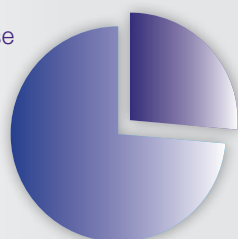
After attending a USAID-supported health seminar in his region, Imam Abinazar wanted to share his knowledge concerning these issues. He reached out to over 400 mosques, organizing educational seminars for imams and their followers on reproductive health issues that are rarely or never discussed in public or private. The meetings were mostly designed for male heads of households, who were taught about family planning, the need to space pregnancies and potential risks of early pregnancy. In addition, Muslim schools have incorporated the material into health classes. Many mosques continue to hold health seminars for adults.



## 8. CUT-AND-PASTE TABLES, GRAPHS AND CHARTS

### Level of unmet need among married women in developing countries\*

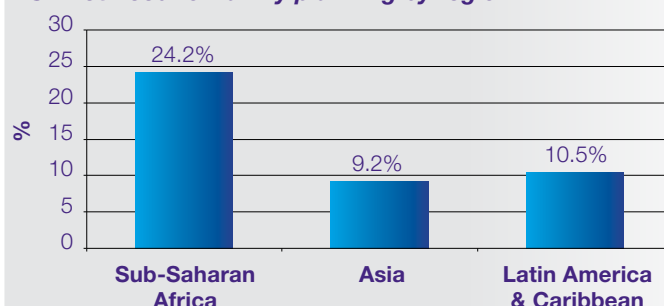
645 million use contraception



at least 222 million are not using any form of modern contraception

women with unmet need

### Unmet need for family planning by region\*



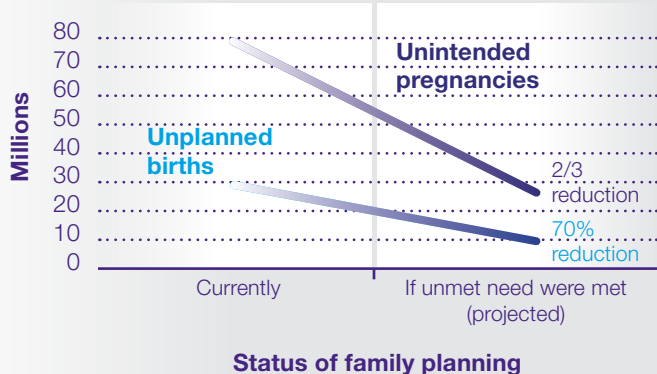
\*Most available data on unmet need focus on married or co-habiting women and rarely on unmarried women or adolescent girls. Thus figures are likely to underestimate unmet need.

Source: Singh S., J. Darroch, et al. (2012) *Adding It Up: Costs and Benefits of Contraceptive Services – Estimates for 2012*. New York: Guttmacher Institute and United Nations Population Fund (UNFPA); RHSC (2009) *Make a Case for Supplies, Leading Voices in Securing Reproductive Health Supplies: An Advocacy Guide and Toolkit*. Brussels: Reproductive Health Supplies Coalition.

\*Most available data on unmet need focus on married or co-habiting women and rarely on unmarried women or adolescent girls. Thus figures are likely to underestimate unmet need. And while the actual number of women with an unmet need is largest in Asia, the proportion of women with unmet need is largest in sub-Saharan Africa, where contraceptive use is low.

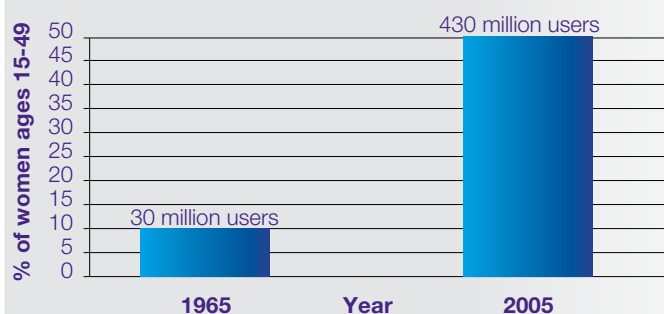
Source: UNPFA 2009

### Unintended pregnancies and births in developing countries



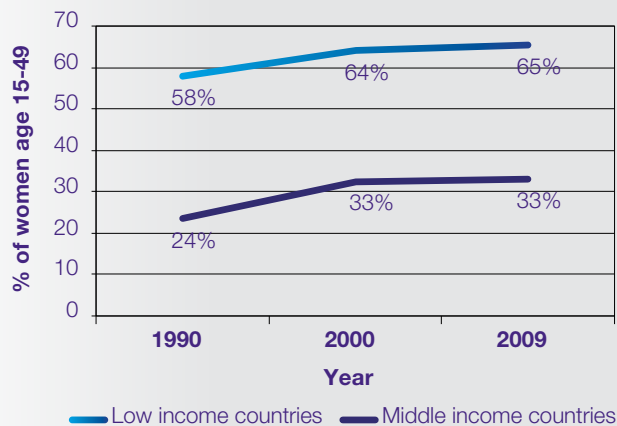
Source: Singh S., J. Darroch, et al. (2012) *Adding It Up: Costs and Benefits of Contraceptive Services – Estimates for 2012*. New York: Guttmacher Institute and United Nations Population Fund (UNFPA). [www.guttmacher.org/pubs/AIU-2012-estimates.pdf](http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf)

### Contraceptive prevalence in developing regions 1965–2005



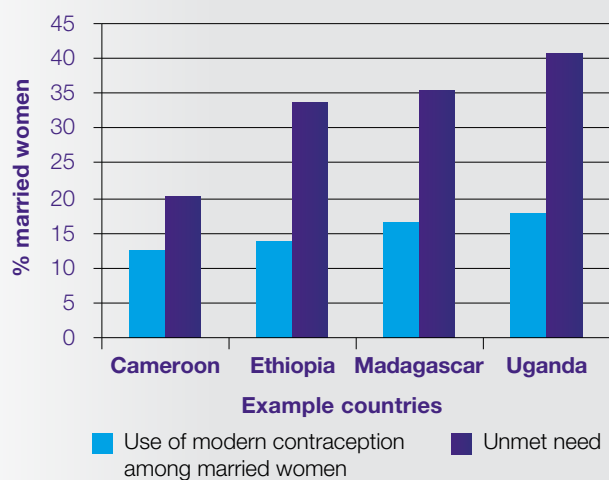
Source: Speidel, J., S. Sinding et al. (2009) *Making the Case for US International Family Planning Assistance*. Baltimore, Maryland: Johns Hopkins Bloomberg School of Public Health, Bill and Melinda Gates Institute for Population and Reproductive Health.

### Contraceptive prevalence trend 1990–2009 in low- and middle-income countries



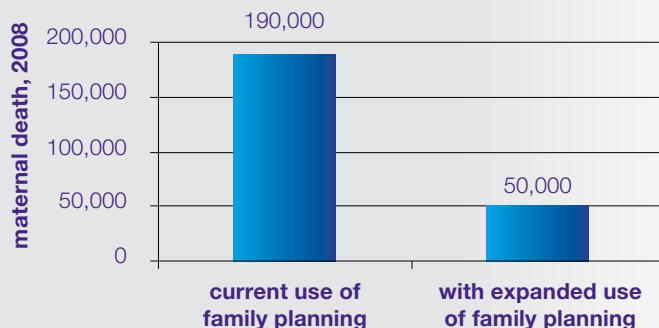
Source: World Bank

### Unmet need exceeds current use in sub-Saharan Africa



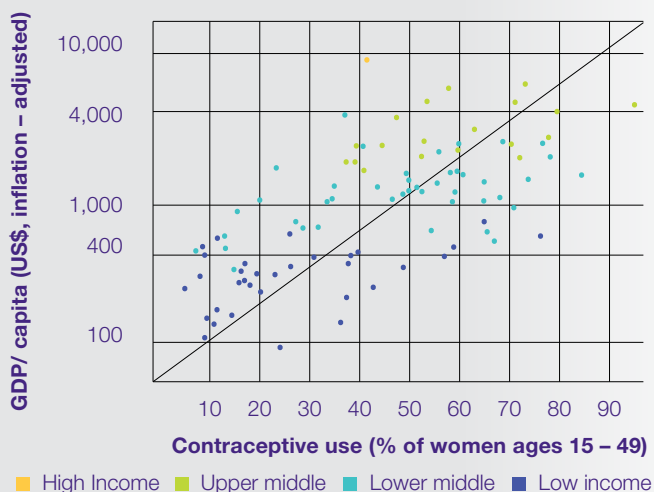
Source: Measure DHS: [www.statcompiler.com](http://www.statcompiler.com).

### Maternal mortality due to unintended pregnancy



Source: Singh, S., J. Darroch et al. (2009) *Adding it up: The costs and benefits of investing in family planning and maternal and newborn health*. New York: Guttmacher Institute and United Nations Population Fund.

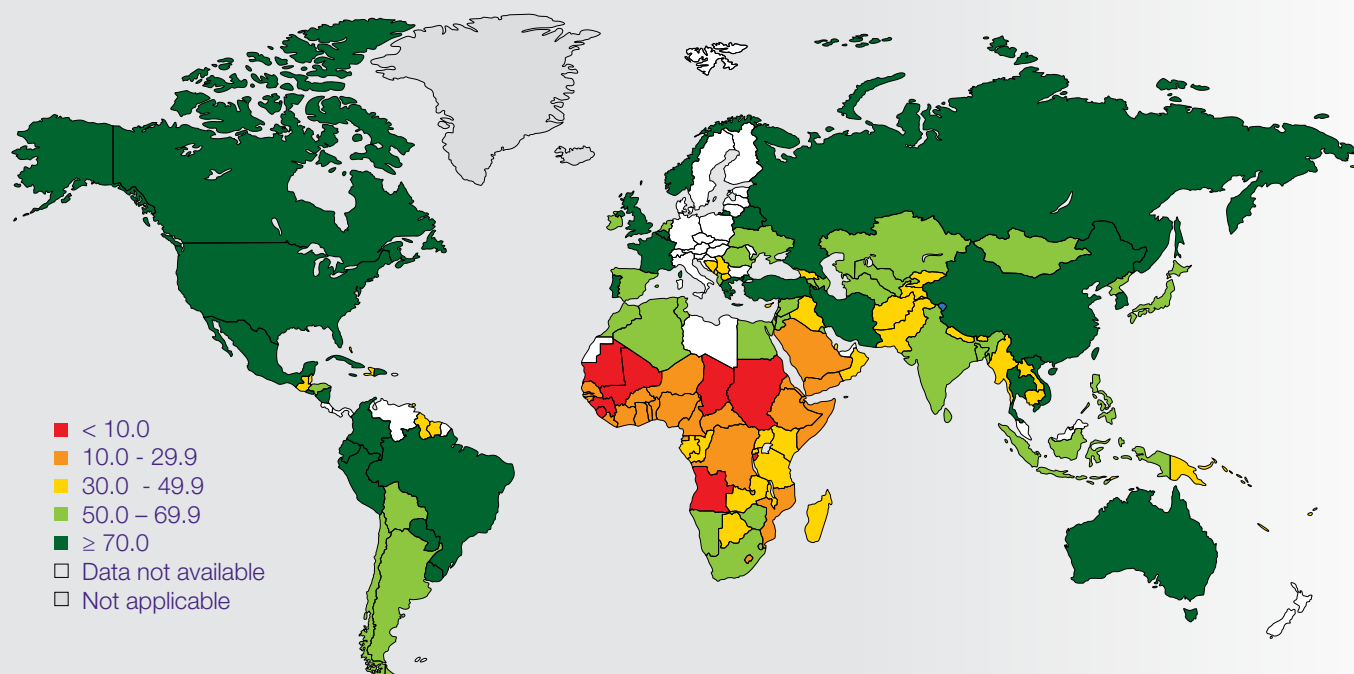
### GDP and contraceptive use, 2005, selected countries



Source: Gapminder.org using World Bank data



### Contraceptive prevalence rate, global, 2000–2010 average



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization  
Map Production: Public Health Information  
And Geographic Information Systems (GIS)  
World Health Organization



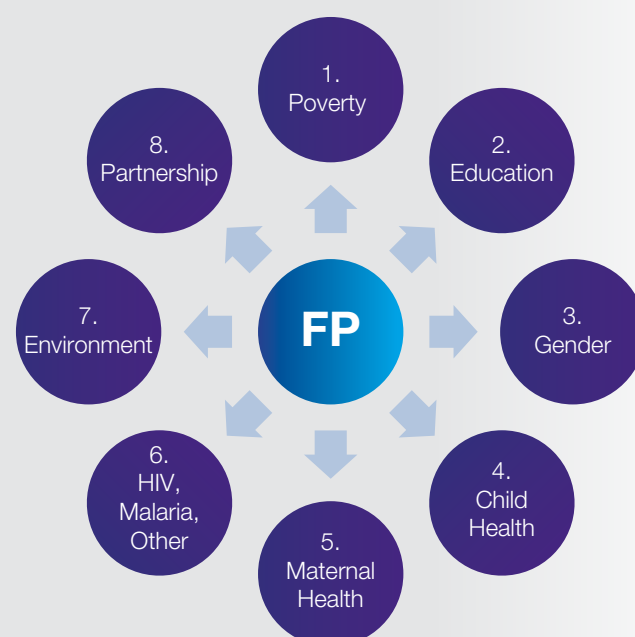
©WHO 2011. All rights reserved.

### Selected benefits of family planning across sectors

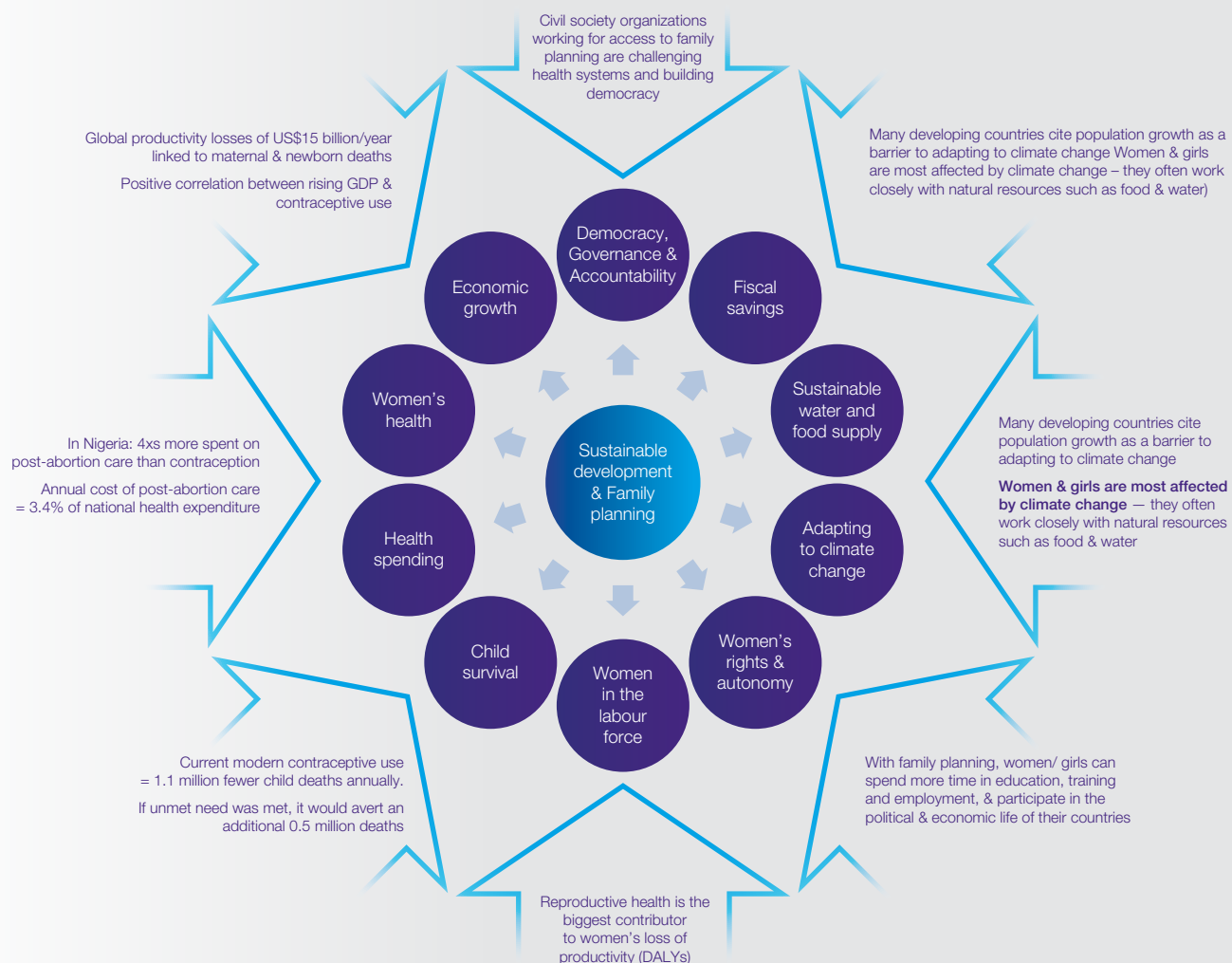
Selected benefits of family planning	
HEALTH	lower maternal and child morbidity/mortality; fewer unsafe abortions; lower incidence of HIV
EDUCATION	fewer girls/young women drop out of school due to unplanned pregnancies
ENVIRONMENT	sustainable population growth; countries are better able to adapt to climate change
ECONOMY	women more productive in communities and economies; lower levels of household poverty; contribution to economic growth.

Sources: Mackenzie et al. (2010), DFID; Ashford (2003), Population Reference Bureau; WHO (2010); Barot (2008), Guttmacher Institute; RHSC (2009), Reproductive Health Supplies Coalition; Speidel, et al. (2009), Johns Hopkins Bloomberg School of Public Health, Bill and Melinda Gates Institute for Population and Reproductive Health

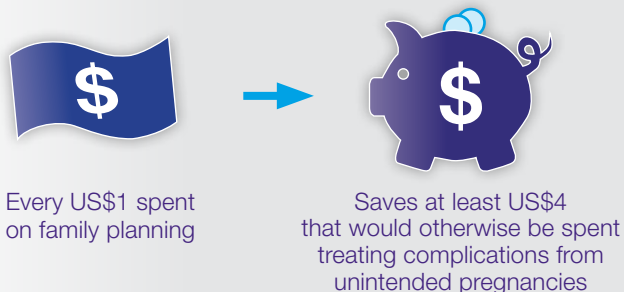
### Family planning influences all of the MDGs



## Links between sustainable development and family planning



### \$1 spent on FP saves \$4

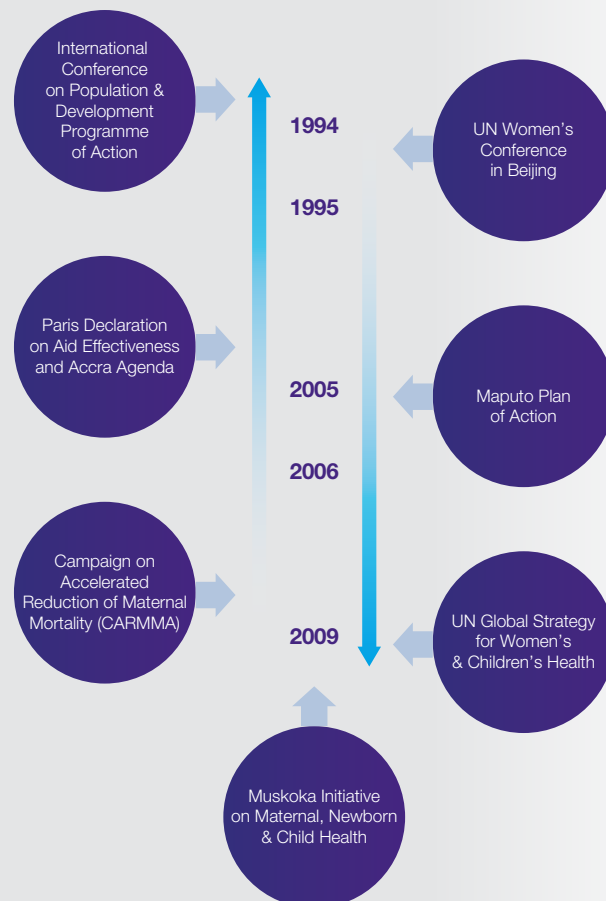


Source: Singh, S., J. Darroch, et al. (2009) *Adding it up: The costs and benefits of investing in family planning and maternal and newborn health*. New York: Guttmacher Institute and United Nations Population Fund; Speidel, J., S. Sinding, et al. (2009) *Making the Case for US International Family Planning Assistance*. Baltimore, Maryland: Johns Hopkins Bloomberg School of Public Health, Bill and Melinda Gates Institute for Population and Reproductive Health.

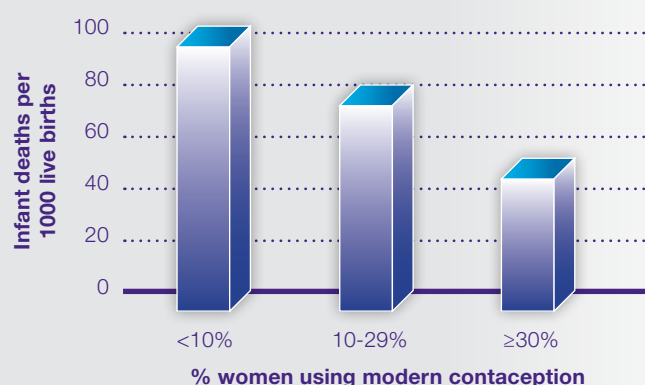
### Timeline: International agreements

International agreements recognizing the importance of family planning, 1994–2010	
1994	International Conference on Population & Development (ICPD) Programme of Action
1995	UN Women's Conference in Beijing
2000	Millennium Summit's Millennium Development Goals (MDGs)
2005	Paris Declaration on Aid Effectiveness and the Accra Agenda for Action
2006	Maputo Plan of Action
2009	Campaign on Accelerated Reduction of Maternal Mortality (CARMMA)
2010	UN Global Strategy for Women's & Children's Health; and Muskoka Initiative on Maternal, Newborn & Child Health

### International agreements recognizing importance of family planning



### Correlation between use of modern contraception and infant mortality (global)



Source: Singh S, Darroch J, Ashford L, Vlassoff M. (2009) *Adding it up: The costs and benefits of investing in family planning and maternal and newborn health*. New York: Guttmacher Institute and United Nations Population Fund. <http://www.guttmacher.org/pubs/AddingItUp2009.pdf>.

### Use of contraception and women's likelihood of paid employment in three countries

#### Egypt

women who use contraception are more likely to be employed than those who don't

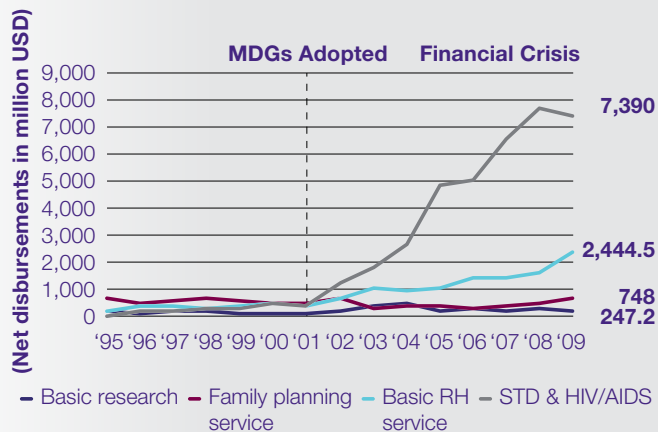


#### Brazil and Indonesia

women who use long-acting or permanent contraception are more likely to work for pay

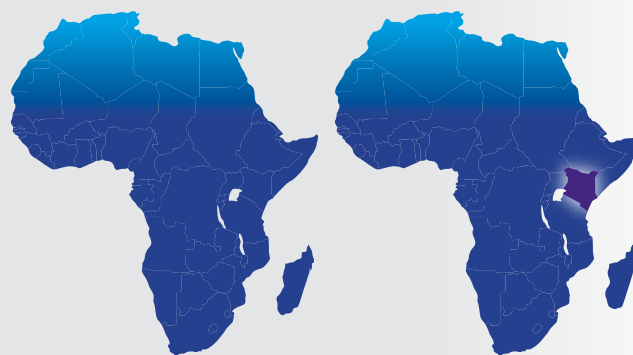
Source: WHO (2010) *Meeting report: Family planning for health and development: actions for change*. Geneva: WHO. [http://www.who.int/reproductivehealth/publications/family\\_planning/fp\\_health\\_dvlpt/en/index.html](http://www.who.int/reproductivehealth/publications/family_planning/fp_health_dvlpt/en/index.html).

### Funding has not kept pace with demand



Includes all donor institutions, including developed country governments, foundations/NGOS and development banks

### % of girls who drop out of school due to unplanned pregnancy



As many as 8–25% of girls in some sub-Saharan African countries drop out of school due to unplanned pregnancy

In Kenya, 10,000–13,000 girls drop out of school each year due to pregnancy.

Source: Pavao A, Ongil M. (2011) *Euromapping 2011: Mapping European Development Aid & Population Assistance*. Brussels: DSW (Deutsche Stiftung Weltbevölkerung) & European Parliamentary Forum on Population and Development (EPF): 28.

## 9. OTHER TOOLS AND RESOURCES

### General information

Advance Family Planning:

- *Tools for creating evidence* – [www.advancefamilyplanning.org/toolkits/advancefp/tools-creating-evidence](http://www.advancefamilyplanning.org/toolkits/advancefp/tools-creating-evidence)
- *Case studies* – [www.advancefamilyplanning.org/toolkits/advancefp/case-studies](http://www.advancefamilyplanning.org/toolkits/advancefp/case-studies)

DSW (Deutsche Stiftung Weltbevölkerung):

*What about reproductive health? Improving the success of development cooperation.* This guide was designed for European Commission Delegations to better understand the links between reproductive health and other development sectors. [www.euroresources.org/whataboutreproductivehealth.html](http://www.euroresources.org/whataboutreproductivehealth.html)

### Online data, graphs and maps

There are a number of sites offering good data which can be downloaded to Excel or another program for making tables, charts and graphs. This includes the most recent data from Demographic and Health Surveys (DHS) and from the World Bank.

It helps if you have some knowledge of statistics and statistical software, and is easiest if you are looking for global data on a single indicator (e.g., unmet need for contraception) or if you are looking for correlation data for a single country (e.g., the relationship between GDP per capita and contraceptive use for Zimbabwe).

In some cases (e.g., Guttmacher Data Center and Gapminder) you can create graphs, charts or even maps with selected data, but it is more difficult to download what you have created and paste it into your own document or website unless you have graphics software and the knowledge of how to use it.

There is a way to work around this using Gapminder (see details below). Also, if you are giving a presentation and will have internet access, you could switch to one of these sites during your presentation, eliminating the need to 'cut and paste' a map or other graphic into your PowerPoint.

In the following descriptions you will find 'low-tech' tips for how to use the data and tools on these sites.

#### MeasureDHS StatCompiler (UNAIDS):

<http://www.statcompiler.com/>

An easy-to-use site with a huge number of indicators, and options for downloading data to Excel, as well as creating tables, graphs, charts and maps that can be easily saved as graphics files. For those with minimal knowledge of working with datasets and creating charts and graphs, this site is most useful for compiling data into charts and graphs for a limited number of countries, rather than for all countries. However, the 'map for' function enables you to quickly create a colourful map showing national- or global-level indicators, such as contraceptive prevalence and unmet need (which is found in the list of indicators, under 'Fertility Preferences').

#### Guttmacher Institute Data Center:

<http://www.guttmacher.org/idc/index.jsp#>

Enables you to download data to Excel and to create interactive maps and other graphics using a range of indicators. It is unclear to what extent one can cut and paste graphics into presentations or documents.

#### World Bank 'World Databank':

<http://databank.worldbank.org/ddp/home.do>

Very useful for downloading data to Excel or creating tables, charts or maps, including trend data (i.e., data about reproductive health over time). The charts and maps are easiest to create for national-level data (i.e., a single country or only a few countries), but it is possible using more complex data sets as well. And all can be easily saved in a number of different graphic formats for use in online or printed documents.

#### Gapminder World:

<http://www.gapminder.org/>

This is a great site aimed at making it easier to use statistics correctly, and to understand them. It requires downloading a simple tool (Gapminder Desktop) to your computer, and then you can have access when you are not online, if required. It is not always clear how to cut and paste a graphic from this site into your own presentations or documents. But if you download Gapminder Desktop software to your computer, you will have access to it at all times and can open it up during a presentation. Alternatively, (for PC users) if you have Microsoft Office Document Image Writer (which is often included with Microsoft Office), you can do this:

- Right-click on the graph or map you have created.
- Choose 'Print' and then choose 'Microsoft Office Document Image Writer' from the menu.
- This will 'print' the graphic to a file on your computer, and from there you can treat it like any image. For example, you may want to crop the image using software such as Microsoft Publisher.

## Videos

- **Marie Stopes International (MSI)** Make Women Matter Campaign short videos: <http://www.makewomenmatter.org/watch>
- **New York Times short video** (4 minutes) about unmet need in Haiti (2009): <http://video.nytimes.com/video/2009/04/04/opinion/1194839118170/saving-lives-with-family-planning.html>
- **Population Reference Bureau (PRB)** video (16 minutes) highlights how family planning contributes to economic growth and poverty reduction at the family, community and national levels, and aims to reposition family planning higher on policy agendas in sub-Saharan Africa: <http://www.prb.org/Journalists/Webcasts/2011/family-planning-poverty-reduction.aspx> (PRB website suggests a French version will be available soon.)

## Photobanks

**Planetwire:** provides free images of development-related topics, including women's and children's health and HIV, to NGOs and others: <http://www.planetwire.org/audiovisuals.php>

**Photoshare:** thousands of international health and development images, free for non-profit and educational use  
<http://www.photoshare.org/>

**World Bank photos:** Images are available for free at high (8"x12" 300dpi) and low resolutions.

**For PowerPoint™ presentations and online documents or websites,** you can use low-resolution images (8"x12" 72dpi).

These are not suitable for printing. Low-resolution images can be found on the World Bank Flickr site: [www.worldbank.org/flickr](http://www.worldbank.org/flickr)  
For PC users, right-click on the image and choose a size from the menu that pops up. This will take you to a page where you can download the photo.

**For printed documents,** use high-resolution images (8"x12", 300dpi). These can be found at the World Bank photo library: <http://secure.worldbank.org/photolibrary/servlet/main?pagePK=149932>

## Glossary

### Contraceptive prevalence rate

The proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

### Family planning

Methods and strategies which enable individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

### Fertility rate

Measures which relate the number of births in a given period to the number of women of reproductive age (unlike the crude birth rate, which relates births to the whole population). The general fertility rate relates births in a particular period, usually a year, to women aged 15–49 or 15–44 years at that time. Age-specific fertility rates relate births to women in specific reproductive age groups, e.g. 15–19, 20–24. These rates are usually expressed per 1000 women. The total fertility rate sums the age-specific rates to provide a hypothetical average number of children each woman would have if the current rates prevailed over her childbearing period.

### Modern contraceptives

Clinic and supply methods of contraception, including female and male sterilization; Intra Uterine Devices; hormonal methods,

such as oral pills, injectables, hormone-releasing implants, skin patches, and vaginal rings; male and female condoms; and vaginal barrier methods, such as the diaphragm, cervical cap, spermicidal foams, jellies, creams and sponges.

### Total fertility rate

Average number of children born alive to a woman during her lifetime. More specifically, TFR is the expected number of children a woman who survives to the end of the reproductive age span will have during her lifetime if she experiences the given age-specific rates. TFR shows the potential for population change in a country. A rate of two children per woman is considered the replacement rate for a population, resulting in relative stability in terms of total numbers.

### Traditional methods of family planning

Non-pharmaceutical or non-barrier methods of pregnancy prevention, including rhythm, withdrawal, abstinence and lactational amenorrhoea (a method based on the natural postpartum infertility that occurs when a woman is fully breastfeeding and not menstruating; women must be continuously and exclusively breastfeeding and less than six months postpartum). Studies show the ineffectiveness of using such methods.

### Unintended pregnancy

A pregnancy that occurs when a woman wants to postpone conception for at least two years or did not want to become pregnant at all.



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