

Achieving Universal Access to SRH: Cost, Benefits and Challenges
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Summary of the presentation given at EuroNGOs International conference, 7th
September 2009, Riga, Latvia

The Guttmacher Institute has recently done an assessment of the costs, benefits and challenges to achieving universal access to SRHR in the midst of a growing global recession. What we know now is that the recession is affecting the ability, or at least the willingness, of governments to meet their commitments to both the MDGs and the ICPD Programme of Action.

What about the impact of the recession on fertility at individual level? There have been some recent headlines in the United States – one of the world's wealthiest countries – about the topic, for example:

- 'Recession linked to more abortions, vasectomies', Reuters
- 'Abortions, vasectomies on increase in economic crisis', Associated Press (AP)
- 'Uptick in vasectomies seen as sign of recession', New York Times

However, at the moment, we do not have hard data on how the economic crisis is affecting the fertility intentions of American couples, how it is affecting their ability to pay for contraception or how both increased need and reduced buying power may be affecting their choice of birth control methods. We do know that every day fewer Americans have private health insurance to cover the rising cost of contraception, and more Americans each day are turning to government-funded family planning clinics for care – just at a time when those same clinics are struggling with the rising cost of drugs, diagnostics and medical devices. Five years ago, 20% of US women of childbearing age and 40% of low-income women were without health insurance, and the numbers are inevitably higher now. Even without new research findings, we can surmise that women without health insurance are foregoing some preventive health care, possibly including contraception, or at least the most effective but also more expensive methods of contraception. We can surmise that more and more women, faced with unintended pregnancy, perhaps *because* they switched to a less expensive over-the-counter method, or went without contraception entirely, are resorting to abortion. And we can surmise that more and more men who are worried about losing their jobs, along with in their health insurance (which, in the US, is usually provided through their employer), are turning to a permanent form of contraception, something that would explain the sudden 50% increase in vasectomies in some clinics.

If this is happening in the US, we do not need to imagine what is happening in sub-Saharan Africa or South Asia and other developing regions around the world. In a recession, more couples want to delay or limit childbearing. But growing poverty increases dependence on government-supported health services, at the same time that governments are disinvesting in preventive health care. Over the long term, economic development, including rising levels of education and economic opportunity, especially for women, *increases* the demand for smaller families and *increases* the demand better control over the timing of pregnancies. Yet the grinding, hopeless poverty that still afflicts a significant portion of the world's population makes family planning, or planning of any kind life for that matter, seem fruitless. Not to mention the fact that families making less than \$2 a day can hardly cover the full cost of modern contraception. The UN estimates

that 155 million more people have already been pushed into poverty by rising food and fuel costs, and 100 million more could be by 2015.

Many donor governments cannot keep up, or simply do not prioritize global health and/or SRHR. Shortfalls in funding for contraceptive services are likely to have serious consequences.

On the other hand, investing in SRH services not only saves money, it saves lives. Guttmacher made estimates in 2003 of the number of unwanted or mistimed pregnancies, abortions and maternal and infant deaths that could be averted by contraceptive use. Along with UNFPA, it will release a whole new set of global cost and benefit figures in early December 2009 – for the first time analyzing the combined impact of investing in pregnancy prevention and maternity care services – which we expect will be extremely useful for advocates in making the case.

What we know from previous research is that in the US, the government saves \$4.02 for every \$1 invested in contraceptive services to prevent a pregnancy the woman did not want or plan for. Because the poorest developing countries spend less per capita on maternal and newborn health care, their return on investments in family planning may be lower. But worldwide, governments save from \$1.70 to \$4.00 *in the first year alone* for every dollar invested in contraceptive services to prevent an unplanned pregnancy. If governments increased investments in HIV prevention, including wider availability of free or reduced-cost condoms, screening and treatment of other sexually transmitted infections, and public education, they would realize substantial savings over time in the cost of treating and caring for people living with AIDS, because preventing a new HIV infection is 27 times more cost effective than treating and caring for people living with AIDS.

Costs and benefits of contraceptive services: A case study from the Philippines

This spring, the Guttmacher Institute released a major new cost-benefit study of contraceptive services in the Philippines, a country where parliamentarians still are struggling to pass a ground-breaking new reproductive health bill against fierce opposition from the Conference of Catholic Bishops and more tempered opposition from the Arroyo government, which supports only family planning methods relying on periodic abstinence. It includes some important lessons for other countries.¹

Of the 10.2 million Filipino women at risk for unintended pregnancy, about 71% use some method of family planning, but less than half use a modern method. Guttmacher estimates that 3.4 million pregnancies occur in the Philippines annually, resulting in 600,000 abortions a year (all illegal), 1.3 million births that were unwanted at the time of conception or mistimed by two or more years, and 1.5 million wanted births or miscarriages.

We then modeled use by everyone at risk of unwanted pregnancy because they use natural family planning. While this scenario does reduce unintended pregnancy, natural family planning use by all women at risk did not reduce the abortion rate. On the other hand, simply meeting the unmet need for family planning with the current method mix

¹ Darroch JE et al., Meeting women's contraceptive needs in the Philippines, *In Brief*, New York: Guttmacher Institute, 2009, No. 1.

would have a major impact on unintended pregnancy, abortion, miscarriages and unplanned childbearing.

In the statistical modeling that was done, however, universal use of modern methods showed the very best outcomes: reducing abortion six-fold and unplanned births and miscarriages by more than six times.²

Not surprisingly, this scenario also has the greatest impact on maternal mortality. Two-and-a-half thousand Filipino women die every year as a result of unsafe abortions (900) or medical complications from pregnancies they did not intend to have (1,600). More than twice as many would die if no one used family planning. With universal use of modern contraceptives, about 400 women would die unnecessarily from unsafe abortion and unintended pregnancies.

Universal use of modern contraception also provides the best return on government investment. In 2008, medical costs for unintended pregnancy were at least 3.5 billion Philippine pesos, compared to only 1.9 billion spent on family planning services that might have prevented those pregnancies. Maternal and newborn care related to intended pregnancies cost an additional 3.9 billion pesos for total expenditures of 9.3 billion. Just meeting unmet demand with the current mix of modern and traditional methods would save enough money on care for unsafe abortion and pregnancy complications that it would cover the increased cost of contraception.

But the last scenario with slightly higher costs is best, because it saves more lives and provides women and families with better control over the timing and number of pregnancies. Providing modern contraceptive services to all women at risk would raise annual family planning spending from 1.9 billion pesos to 4 billion pesos; however, medical costs for unintended pregnancy and unsafe abortion would fall from 3.5 billion pesos to 600 million pesos, resulting in a reduction of 2.9 billion pesos in these costs and a net savings of 800 million pesos. This is important information in a time of economic recession.

Global unmet need for contraception

More than one-third of all pregnancies worldwide each year are unintended, and one in five end in abortion. Fewer than half of the 205 million pregnancies a year result in a wanted birth; one in five ends in abortion; and another 16% ends in an unwanted or mistimed birth. In other words, at least one-third of pregnancies a year are unintended.³

In developing countries, two-thirds of unintended pregnancies occur to women who were not using any family planning method at the time of conception. Another 14% occurred to the relatively small proportion of women using a traditional method.⁴

² Ibid.

³ Sources: Sedgh G et al., Induced abortion: rates and trends worldwide, *Lancet*, 2007, 370(9595):1338–1345; The Alan Guttmacher Institute (AGI), *Sharing Responsibility: Women, Society and Abortion Worldwide*, New York: AGI, 1999; Population Division, United Nations Department of Economic and Social Affairs, *World Population Prospects: The 2004 revision*, New York: United Nations, 2005; and Leridon H, *Human Fertility: The Basic Components*, Chicago: University of Chicago Press, 1977.

⁴ Source: Singh et al., *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*, New York: The Alan Guttmacher Institute and United Nations Population Fund, 2003.

Almost a third of women in the developing world – about 200 million – have an unmet need for effective contraception. The largest numbers of women with an unmet need live in South and Southeast Asia, but in terms of the proportion of women, unmet need is highest, and has declined the least, in Sub-Saharan Africa.

Staying the course despite the global recession: Investing in SRH services makes sense/cents

Support for SRH services falls far short of commitments. Essentially, 2007 expenditures for SRH were less than half of what UNFPA estimates is needed in *this year!* Developing countries are much closer to meeting their goal of one-third of the total than are donor countries.⁵

At the April meeting of the UN Commission on Population and Development, UNFPA released new multi-year estimates for achieving the goals of the 1994 ICPD Programme of Action – estimates that include not only the costs of SRH but also, for the first time, maternal health and HIV and AIDS. This new, more comprehensive estimate is \$64.7 billion for 2010, rising to 69.8 billion by 2015. Here is how the major costs break down for 2010 and 2015:

- Direct family planning costs would be 2.6 billion, rising to 4.1 billion by 2015.
- Maternal health costs would be 7.9 billion in 2010, rising to 18 billion.
- HIV/AIDS costs would be 32.4 billion in 2010, rising to 36.2 billion.

We can and must continue to make the case for the value of investing in SRHR, and to keep the pressure on to protect and promote progressive policy changes to improve the way services are delivered. And we must seize the opportunity of these tough economic times to make the case that SRHR is not so much an end in and of itself, but a means to virtually all of the ends articulated in the MDGs.

Later this year Guttmacher will publish updated and more comprehensive evidence to use with economists and finance ministers to make the case that investing in SRH services is a good deal for everyone. Visit www.guttmacher.org for more details.

⁵ Source: UNFPA Report of the Secretary General “The flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development, April 2009.