EVERY WOMAN'S RIGHT

How family planning saves children's lives

NO CHILD BORN TO DIE

Save the Children

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Save the Children

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We save children's lives. We fight for their rights.
We help them fulfil their potential.

Acknowledgements

This report was written by Kathryn Rawe, with contributions from Ashley Dunford, Jamie Stewart, Jessica Espey, and John Stoeckel. The author would also like to thank colleagues at Save the Children UK, Save the Children US and around the world who contributed their knowledge and expertise, and John Cleland at the London School of Hygiene and Tropical Medicine for his early input.

Published by
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First published 2012

Cover photo: Josephine and her one-year-old baby boy Daniel, outside their home near Kingsville, Liberia (Photo: Aubrey Wade/Save the Children)

Typeset by Grasshopper Design Company
Printed by Page Bros Ltd.

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THE STORY IN NUMBERS

222 MILLION

The number of women who have an unmet need for family planning.[1]

570,000

The number of newborn babies' lives that would be saved if the unmet need for family planning was fulfilled. **79,000** women's lives would also be saved.[2]

60%

The increased risk of death for babies born to teenage girls under 18, compared to babies born to mothers older than 19.

NUMBER 1 KILLER

For girls and young women aged 15–19, pregnancy and childbirth is the number one killer. It's the cause of 50,000 deaths of teenage girls every year.[4]

£1 : £4

Every **£1** spent on family planning saves at least **£4** that would be spent treating complications from unintended pregnancies.[5]

DOUBLE THE RISK

Children born less than two years after a sibling are two times more likely to die within the first year of life than those born three or more years later.[6]

1.8 MILLION

Healthier birth spacing, where mothers delay conceiving until 36 months after giving birth, could prevent 1.8 million deaths of children under five a year – 25% of annual child deaths.[7]

10 MILLION

The estimated number of girls under 18 years old who are married every year, the equivalent to more than 25,000 every day.[8]

PHOTO: LUCIA ZORO/SAVE THE CHILDREN

"I personally believe that it's very important for women to have access to contraception," says Wallansa.

Wallansa, 27, from the Afar region of Ethiopia, has three children – Abdul, age 7, Ahmed, 4, and Robn Mohammed, 2. The photo shows Wallansa and her sons outside a government health clinic, where Save the Children provides essential drugs and trains staff. The clinic also offers a reproductive health service where patients can discuss family planning and sexually transmitted infections with the clinicians.

"When I was younger there were no contraceptive methods, but now they're available," says Wallensa. "I use the contraceptive injection. It's available in private clinics, and here at this clinic."

"If I had a chance to talk to Prime Minister Zenawi," she adds, "I'd tell him I would like him to continue what he is doing now with family planning."

INTRODUCTION AND OVERVIEW

Family planning is a fundamental right. More surprisingly perhaps, it's also vital to improving children's chances of survival. Ensuring women are able to plan whether or when to have children means babies and young children are more likely to survive, and it saves the lives of adolescent girls and women who are pregnant. And it helps countries to achieve their goals on development, and improve the lives of many millions of people.

In the last two decades there has been dramatic progress in reducing the number of children who die before their fifth birthday. In 2010, 12,000 fewer children under five died every day than in 1990.[1] There has also been a one-third reduction over the same period in the number of mothers who die in childbirth.[2] Global efforts to improve child and maternal health are paying off.

Family planning services are absolutely key to sustaining and accelerating this progress: it is estimated that fulfilling the unmet need for family planning would save the lives of 570,000 newborns and 79,000 mothers.[3] And it would contribute significantly to achieving Millennium Development Goal 4 – to reduce by two-thirds the number of children who die before their fifth birthday.

However, while the percentage of couples worldwide using modern methods of contraception increased from 41% in 1980 to 56% in 2009, over the last decade progress slowed drastically, with an annual growth rate from 2000–09 of just 0.1%.[4] It means at least 222 million women who would benefit from being able to decide whether to delay their first pregnancy, to allow a longer space between their pregnancies, or to limit the size of their families, do not have the option.

HOW FAMILY PLANNING HELPS SAVE CHILDREN'S LIVES

There are strong links between the provision of family planning and improvements in child health and survival. There are two key ways that access to contraception can impact the health and well-being of children and their ability to fulfil their potential:

1. **Healthy spacing of pregnancies:** Having a baby too soon after a previous birth is dangerous for mothers and babies. Ensuring women have reliable access to family planning, and are therefore able to allow a space of at least three years between their births, could help save the lives of nearly 2 million children each year.[5]

2. **Children having children:** Worldwide, complications in pregnancy are the number one killer of girls and young women aged 15–19. Every year 50,000 teenage girls and young women die during pregnancy or childbirth, in many cases because their bodies are not ready to bear children.

   Babies born to young mothers are also at far greater risk than those whose mothers are older. Each year around 1 million babies born to adolescent girls die before their first birthday.[6] In developing countries, if a mother is under 18, her baby's chance of dying in the first year of life is 60% higher than that of a baby born to a mother older than 19.[7]

   Many adolescent girls know little or nothing about family planning, let alone where to get it. Their low status within their families, communities and societies mean they lack the power to make their own decisions about whether or when to have a baby. No girl should die giving birth, and no child should die as a result of its mother being too young.

THE GLOBAL UNMET NEED FOR FAMILY PLANNING

Two-fifths of births in the developing world are unintended.[8] Millions of women wishing to decide whether or when to have children, and how many children to have, are unable to access family planning services.

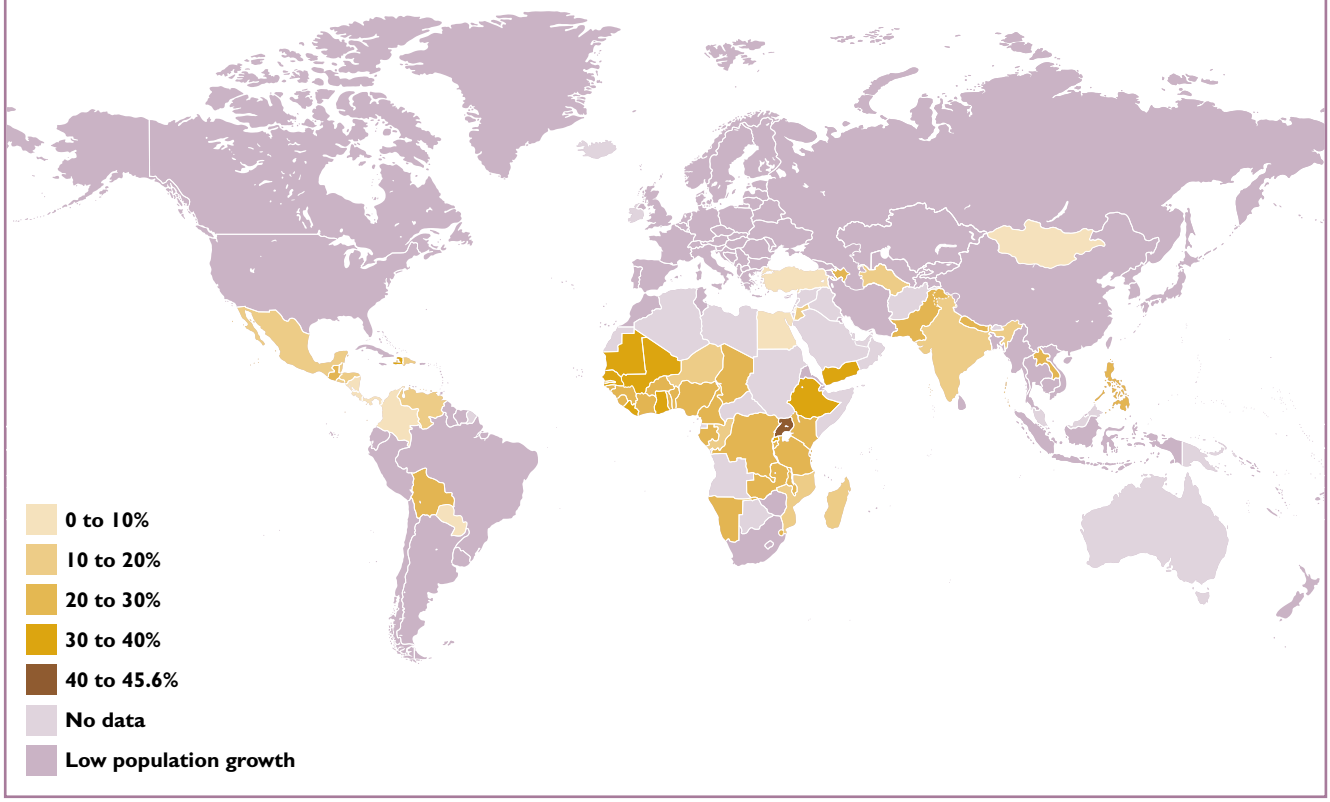
The biggest unmet need is in countries with large populations, particularly in south Asia – 64 million women in India, 15 million in Pakistan and 10 million in Bangladesh.[9] In Africa, the country with the biggest absolute need is Nigeria, where 10 million women say they would like to be able to control their fertility. The greatest relative need is in Uganda, where 41%, of women have an unmet need. Many countries in west Africa also have very high percentages of women who would like to plan their families but are not using contraception – 32% in Senegal, 32% in Mauritania and 31% in Mali.[10]

FAMILY PLANNING, POPULATION GROWTH AND DEVELOPMENT

Family planning, population growth and development are interrelated and complex issues. The 'demographic transition' – a key stage in development where a country moves from high death rates and high birth rates to low death rates and low birth rates – accounts for 25–40% of economic growth in some countries.[11] Lowering fertility rates and slowing population growth through increased access to family planning services clearly have a role to play in facilitating the demographic transition, with enormous associated potential benefits for development.

Conversely, most of the countries that are furthest from achieving the Millennium Development Goals on child and maternal mortality also have high fertility and high rates of population growth. In Somalia and Mali – where child mortality rates are among the highest in the world, with nearly one child in five dying before their fifth birthday – the average number of children per woman in 2010 was 6.3.[12]

FIGURE 1: THE UNMET NEED FOR FAMILY PLANNING



Source: UNFPA, *State of the World's Population 2011*

Poor families often have large numbers of children, partly because they have limited or no access to contraception. Increasing access to family planning to the world's poorest families is therefore vital. Nevertheless, it is important to remember that high levels of child mortality and poverty are also determining factors in family size: for example, having a large number of children is often a way for poor people, who do not have social security or a pension to fall back on, to ensure they will be looked after when they are no longer able to work.[13]

A GOLDEN OPPORTUNITY

This report comes at a crucial moment. In July 2012 the London Summit on Family Planning will be a crucial opportunity to re-invigorate global efforts to provide millions of women with access to contraception they demand. The summit – hosted by the UK government, the Bill and Melinda Gates Foundation and partners including USAID and the United Nations Population Fund (UNFPA) – will seek financial and political commitments from governments in rich and poor countries, from civil society and from the private sector.

It is vital to tackle both the supply-side and demand-side of the issue in tandem. This report sets out what needs to be done to achieve this goal. The summit must deliver concrete actions by national governments, international donors, civil society and the private sector on four key issues:

- the supply of family planning commodities
- support for health workers and health services
- tackling unequal access to family planning
- female empowerment, to stimulate demand for family planning.

SUPPLY OF FAMILY PLANNING COMMODITIES

'Stock-outs' of contraceptive commodities are a huge barrier for many women who rely on the health service to provide regular access to family planning. For this reason it is important that significant new financial resources are dedicated to family planning, within the broader context of reproductive, maternal, newborn and child health.

Family planning services represent excellent value for money. It costs only around £1 per person a year to provide the relevant services including contraception.[14] It is estimated that every £1 spent on family planning saves at least £4 that would otherwise be spent treating complications arising from unintended pregnancies.[15]

SUPPORT FOR HEALTH WORKERS AND HEALTH SERVICES

Health workers are a vital part of service delivery too, and they must be able to work within a strong, functioning and supportive health system. The London Summit on Family Planning must ensure that any new initiatives also provide opportunities for countries to scale-up improvements in health service delivery.

There must be investment to ensure that family planning services reach the women who need them most. Family planning is the most inequitable of all the routine healthcare interventions, so the summit must take steps to tackle this.[16]

FEMALE EMPOWERMENT, TO STIMULATE DEMAND FOR FAMILY PLANNING

A major barrier to family planning is that many vulnerable women and girls are unable to exercise their rights and make decisions over their own healthcare, including family planning. When women – and especially girls – are empowered to make their own decisions over when and whether to become pregnant, fewer babies die and fewer mothers die during childbirth. The continued use of family planning also means that a woman is able to plan for her future, complete her education and find decent employment. Education and the opportunity to earn a living empowers women, and brings a host of incidental benefits for the society. But for many women and adolescent girls, family planning is not accessible, or affordable. Others are unable to use it because of social or cultural attitudes, or are unwilling to use it for ill-informed fears of the side-effects and the many myths surrounding contraception.

There is an urgent need for a step-change in the global availability and usage of family planning. The London Summit on Family Planning should be the start of a new drive to empower women so that they are able to demand and make use of family planning. It is an opportunity to send a message that positive policies, laws and practices that guarantee access to education, women's rights and equal status in society need to be adopted.

OVERVIEW OF THIS REPORT

This report looks at the contribution that increasing the use of family planning methods could make to child survival. Chapter 1 looks in more detail at how healthy spacing and timing of pregnancies improve children's health and chances of survival.

Chapter 2 focuses on the supply of family planning. It looks at how to provide contraception for those couples who want it, and how barriers of cost and access can be addressed. Chapter 3 examines how to stimulate demand for family planning. It looks at how women can be empowered to demand family planning and to exercise their right to plan their pregnancies.

DEFINITIONS

Family planning: allowing individuals and couples to anticipate and attain their desired number of children, and to achieve healthy spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Family planning services: includes information and counselling by health workers about modern contraceptive methods, provision of these methods or prescriptions, and related surgical procedures (for example, intra-uterine devices (IUD) insertion or sterilisation).

Modern methods of contraception: includes oral contraceptive pills; implants; injectables; patches; vaginal rings; diaphragms; IUDs; male and female condoms; vasectomy or female sterilisation.

Unmet need: the percentage of women who do not want to become pregnant but are not using modern methods of contraception.

Adolescent: defined by the United Nations as those between 10 and 19 years of age.[17]

1 TIME AND SPACE: HOW HEALTHY TIMING AND SPACING OF PREGNANCY SAVES LIVES

Family planning is a basic human right. As far back as 1968, The United Nations International Conference on Human Rights declared that, "parents have a basic human right to determine freely and responsibly the number and spacing of their children."[1]

However, it is a misconception to see family planning solely as a matter of *controlling* the number of births a woman has; it is also vital to helping millions of children survive. Evidence shows that children born less than two years after a brother or sister are more than twice as likely to die as a child who is born after a three-year gap.[2] Increasing the use of family planning for healthy timing and spacing of pregnancies, therefore, has the potential to drastically reduce child deaths.

As well as significantly improving babies' and young children's chances of survival, family planning can be a lifesaver for girls in their teenage years. For girls aged 15–19, complications in pregnancy are the leading worldwide cause of death. Pregnancy poses particular risks for these girls because their bodies are still developing. Greater access to family planning for this group could save the lives of 50,000 teenage girls a year.[3] Babies born to young mothers are also at greater risk: if a mother is under 18, her baby's chance of dying in the first year of life is 60% higher than that of a baby born to a mother older than 19.[4] Yet, adolescent girls make up a disproportionate number of the women who are not able to control their fertility. They often lack the social status or power to make decisions about their own health needs.

This chapter explores the link between child mortality and family planning. It looks in turn at these two issues of birth spacing, and adolescent girls and childbirth.

BIRTH SPACING

Having children too close together is dangerous for both mother and child. In 2005, the World Health Organisation convened an expert review of the evidence on pregnancy spacing, which recommended that a mother should wait at least two years after having a baby before trying to become pregnant again.[5] To reduce the risk for herself, her existing children and her unborn baby, mothers should leave a gap of at least 33 months, or almost three years, between each birth.[6]

If mothers were able to delay conceiving again for 24 months after giving birth, deaths of children under five would fall by 13% – nearly 900,000 deaths averted. If mothers delayed conceiving until 36 months after giving birth, 25% of deaths of under-fives – 1.8 million children's deaths a year – could be averted, just through healthier spacing.[7]

Birth spacing is about encouraging healthy fertility rather than lower fertility. Reliable access to contraception is vital for millions of women who want to allow a healthy space between their pregnancies in order to protect themselves and their children. Half of the total unmet need for contraception comes from women who wish to space their births. It means that 112 million women are unable to plan their families in a way that is safest and healthiest for themselves and their children because they cannot get the contraception they need.

The following subsections look in turn at the impact of birth spacing on newborns, infants, children and mothers.

NEWBORNS

Pregnancy and breastfeeding can deplete the stores of vitamins and minerals in a mother's body, particularly iron folate, which is vital to a baby's healthy development in the womb.[8] Healthy birth spacing reduces the chance that a baby will be premature or underweight. In developing countries, babies conceived less than six months after a prior birth were found to be 42% more likely to be born with a low birthweight than those born after more than two years; babies conceived within 6–11 months after a prior birth were 16% more likely to have a low birthweight.[9]

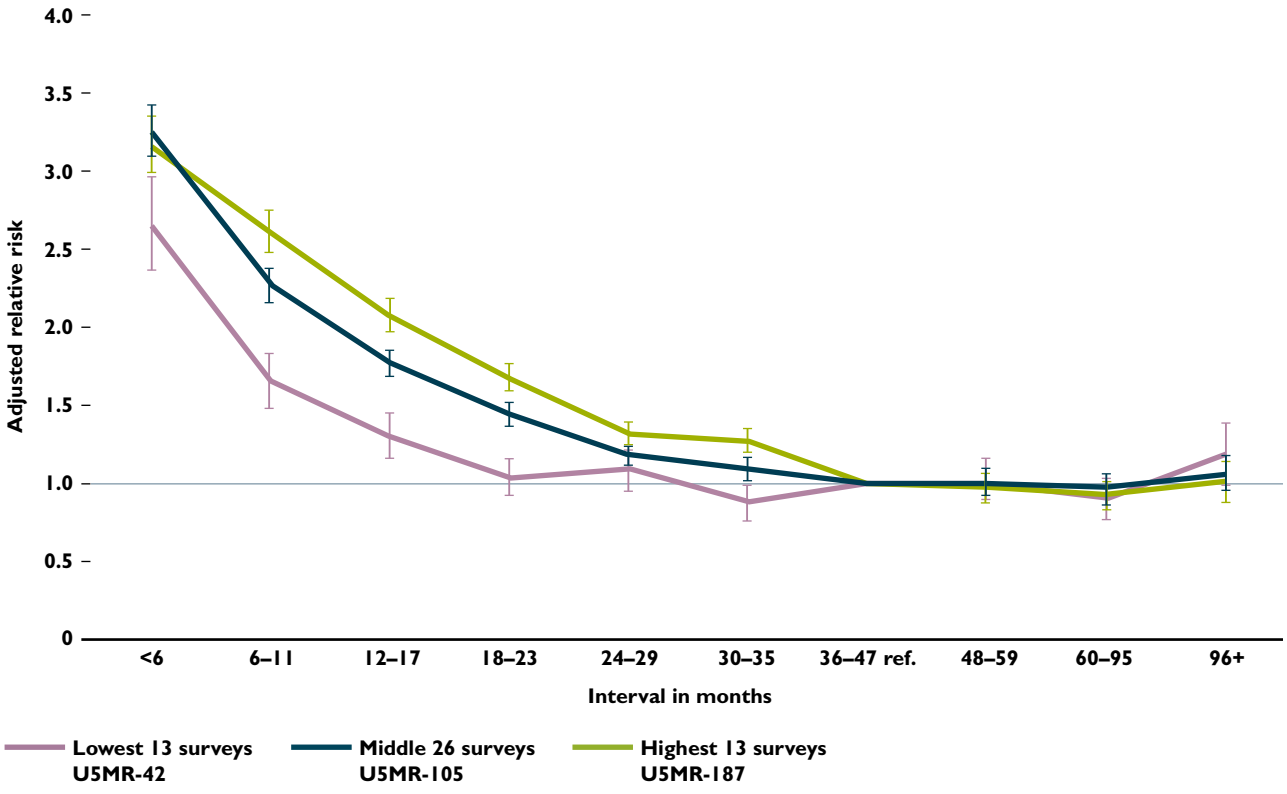
Waiting longer to conceive after a birth means a mother can give her new baby the best start in life; she will have more time to care for her baby and for breastfeeding. It also gives parents time to prepare for the next pregnancy, including ensuring there are enough household resources to cover the costs of food, clothing, housing and education.

INFANTS AND CHILDREN

The risks associated with being born within a relatively short space of time after a sibling continue to affect children through infancy. These children are more likely to be malnourished, putting them at greater risk of dying from childhood illnesses like pneumonia and diarrhoea. In many developing countries, children born less than two years after a sibling are two times more likely to die within the first year of life than those born three or more years later (see figure 3). In developing countries, children conceived after an interval of 12–17 months were also found to be 23% more likely to be stunted and 19% more likely to be underweight than children conceived after an interval of 36 to 47 months.[10]

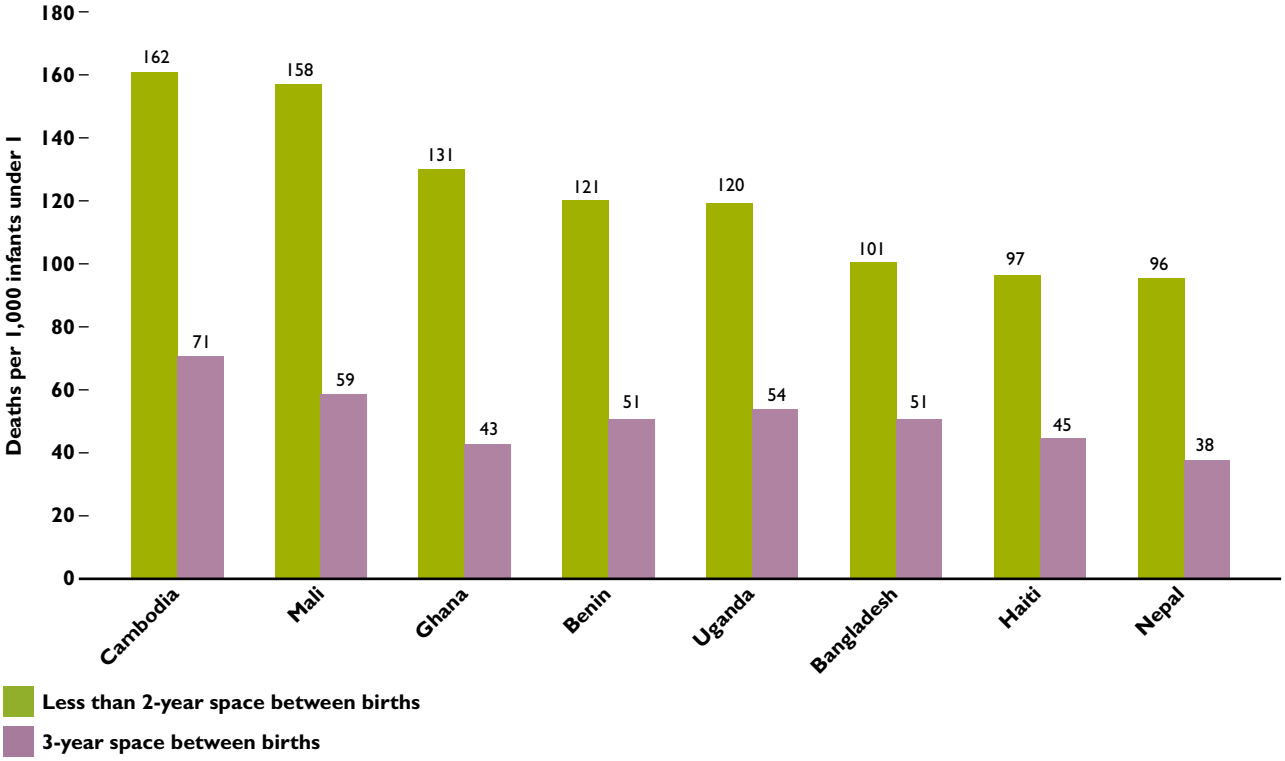
Earlier research into birth spacing indicated that short birth intervals affect children even when they are older. Children whose mothers gave birth to a younger sibling within two years were found to be twice as likely to die between the age of one and two as children whose younger sibling was born after two years. The reasons given include competition for household resources, and siblings being at a higher risk of cross-infection from disease.[12] For an older sibling, the risk of being chronically malnourished (stunted and/or underweight) decreases as the time between their birth and the birth of the next child increases.

FIGURE 2. RELATIVE RISKS OF UNDER-FIVE MORTALITY BY BIRTH INTERVAL



Source: Rutstein, S O (2008) *Further Evidence of the Effects of Preceding Birth Intervals on Neonatal, Infant, and Under-Five-Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys*, DHS Working papers, USAID

FIGURE 3. INFANT MORTALITY BY BIRTH INTERVAL[11]



Source: Population Reference Bureau (2009) *Family Planning Saves Lives, 4th edition*

MOTHERS

Short spaces between births are dangerous for mothers too. Women who become pregnant again less than five months after a birth are 2.5 times more likely to die because of a pregnancy related cause than a woman who is able to wait for 18 to 23 months.[13] Women with shorter intervals between a birth and a subsequent pregnancy are at higher risk of premature rupture of the membrane, and from infection.[14]

Birth-to-birth intervals between 36 and 59 months are considered to carry the lowest risk to mother and child. However, more than two-thirds of women who are carrying their second, third, or higher order child give birth in a higher risk category. No developing country has more than half of births in the lower risk category.[15]

Healthy birth spacing is not simply a recommendation put forward by global health bodies; women themselves want to extend the intervals between their births. Analysis of household surveys from 1985 to 2008 showed that the average (median) length that a woman has between births (birth-to-birth interval) is 32.1 months, but that they would prefer to leave a period of 41.5 months – more than nine months longer.[16]

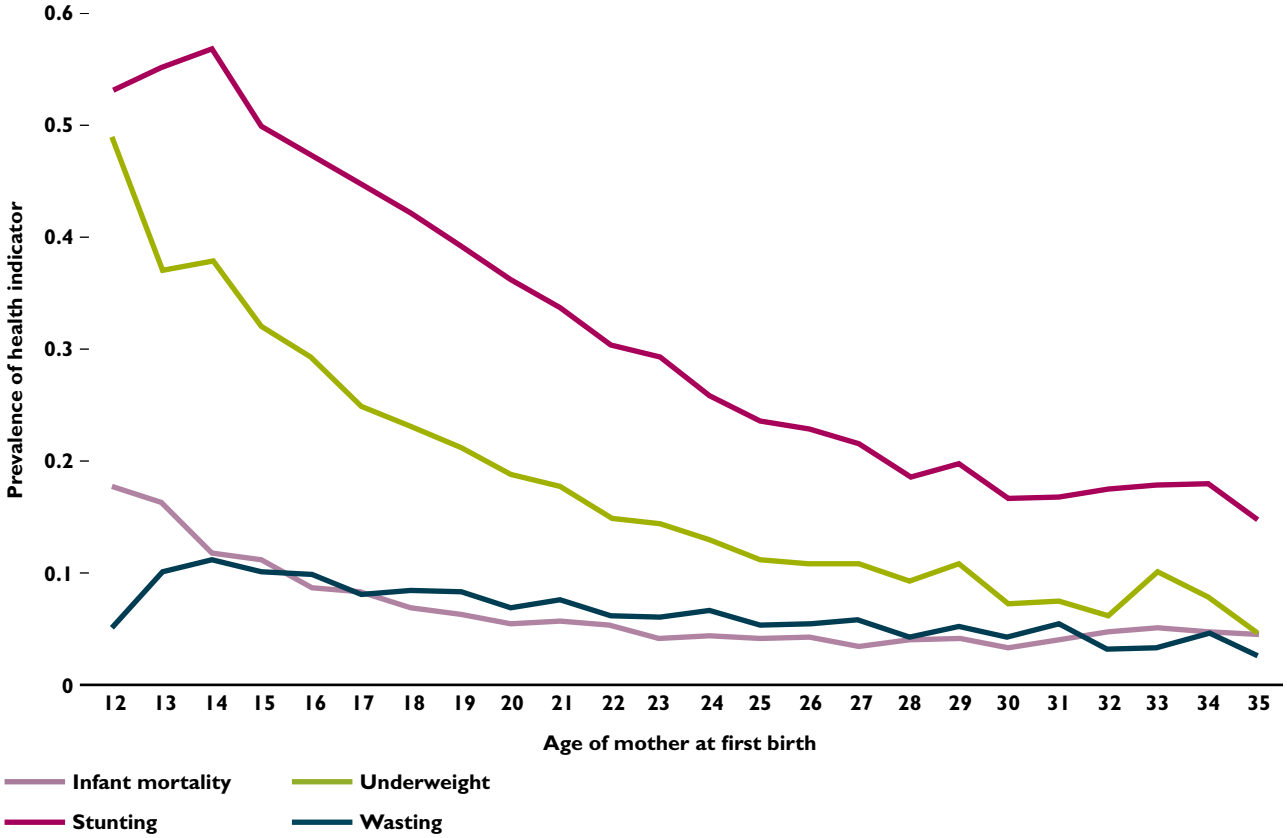
Only one woman in seven had her latest birth within three months of her preference. Globally, median birth intervals are getting longer at a rate of only one-quarter of a month every year,[17] meaning that at the current rate of progress it will take 37½ years for actual birth intervals to match with what women want.

ADOLESCENT GIRLS AND FAMILY PLANNING

Adolescent pregnancy carries high risks, both for the teenage girls and for their babies. The risk of maternal death is twice as high for girls aged 15 to 19 as for women in their 20s, and five times higher for girls aged 10 to 14.[18] Globally, around 50,000 teenage girls die each year during pregnancy and childbirth.

According to the latest available estimates around 1 million babies born to adolescent girls die before their first birthday.[19] Babies born to adolescent mothers account for 11% of all births worldwide; 95% occur in developing countries.[20] The proportion of stillbirths and deaths in babies' first week of life are 50% higher among women under 20, than among women aged 20–29.[21]

FIGURE 4. INFANT MORTALITY AND MALNUTRITION RATES FALL AS AGE OF MOTHER AT FIRST BIRTH INCREASES



Source: Finlay JE, Özaltin G and Canning D, The association of maternal age with child anthropometric failure, diarrhoea and anaemia for first births: evidence from 55 low- and middle-income countries, *BMJ Open 2011*; 1:e 000226

Ensuring that adolescent girls are able to use suitable contraception to delay the age at which they first become pregnant is a key part of the family planning challenge. Around 16 million girls between the ages of 15 and 19 give birth each year.[22] Many girls give birth even younger: in Bangladesh, Guinea, Madagascar, Mali, Niger and Sierra Leone, girls have a one-in-ten chance of becoming a mother before they reach the age of 15.[23] Globally, one in five women will have had a child by the age of 18.[24] Young mothers are likely to be poor, less educated and living in rural areas – in some of the poorest countries, such as Niger, Chad and Mali, nearly half of girls become pregnant before 18.[25]

Girls under 18 years of age are more likely to give birth to premature babies and experience complications during labour, including heavy bleeding, infection and eclampsia because they are not physically ready for childbirth. Their bodies are not fully developed and their pelvises are smaller, so they are more prone to suffer obstructed labour. In the absence of emergency obstetric care this can be deadly for both mother and baby.[26] Prolonged and obstructed labour can also cause great damage to an adolescent girl's body, leading to obstetric fistula.[27]

Rates of anaemia and underweight are higher in adolescent girls than in boys of the same age. This is a particular concern given high rates of early pregnancy, as underweight and anaemic mothers have a higher risk of mortality and morbidity. In India 47% of girls aged 15–19 were found to be underweight and 56% are anaemic.[28]

There are many social factors involved in early pregnancy. In many societies, adolescent girls have a particularly low status and are not given opportunities to make decisions about their own reproductive healthcare, including family planning. Instead, these decisions are made by parents,[29] husbands or extended family. One study in Ecuador found that sexual abuse, parental absence and poverty were key factors in the high rate of adolescent pregnancy.[30] The level of sexual abuse and violence among adolescent girls is significant – evidence suggests that up to 23% of married young women (aged 15–24) in developing countries had been forced to have sex by their spouse; women who married in adolescence were more likely to experience more episodes of violence than women who married later.[31]

Lack of information on sex and what to expect means that adolescent girls' early experiences of sex and marriage are characterised by 'anxiety and fear'.[32] Lack of knowledge about sex and misconceptions about the side-effects of family planning methods are often cited by women and girls as reasons why they do not use contraception.[33] In a 2008 household survey in India, more than half of unmarried girls between the ages of 15 and 24 said they had never had any education about sex or family life, 30% of these girls did not know about condoms, and 77% said they had never discussed contraception with anyone.[34]

CHILD MARRIAGE AND EARLY PREGNANCY

Early pregnancy is intrinsically linked to the practice of child marriage. An estimated 10 million girls under 18 years old are married every year, the equivalent of more than 25,000 every day.[35] The percentage of girls aged 15–19 who are married is 46% in Bangladesh, 59% in Central African Republic and 30% in India. The rate is much lower for boys and is often not recorded. Only 5% of boys of the same age are married in India. Child marriage impacts the age at which girls become sexually active and, without contraception, married adolescent girls are more likely to have early and frequent pregnancies before their bodies are sufficiently physically mature to cope with childbirth.

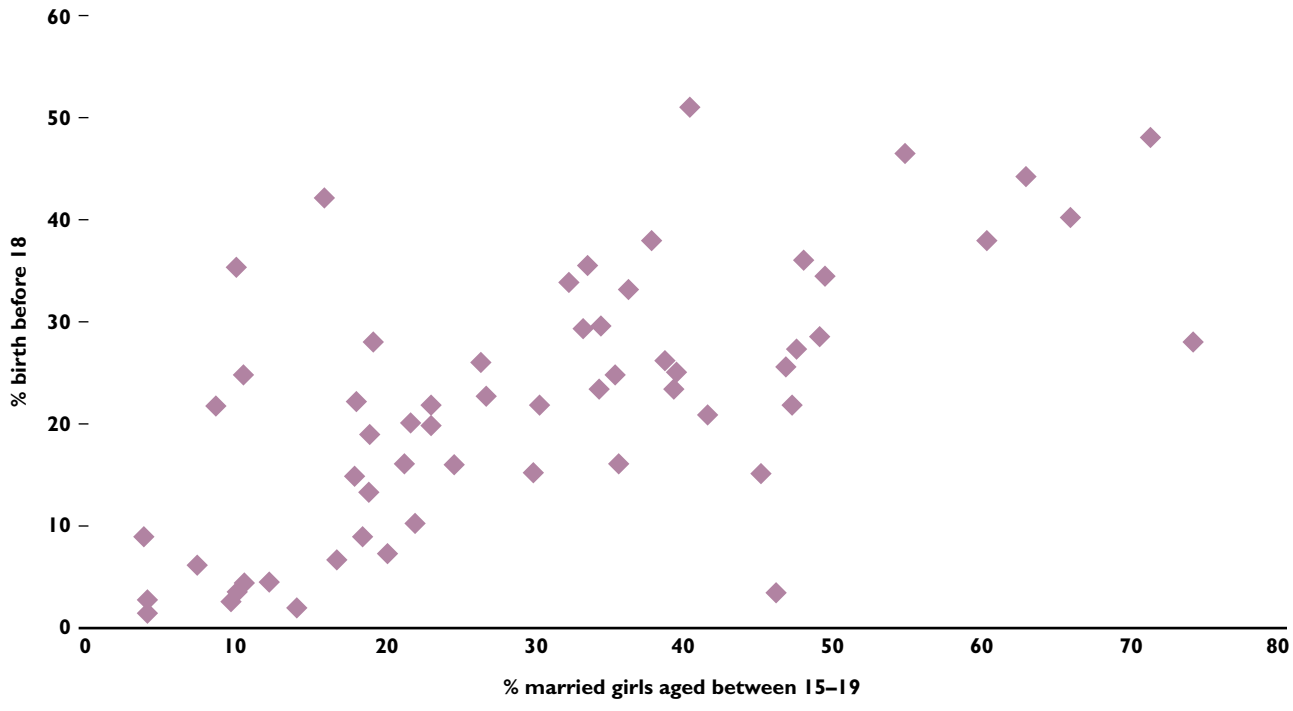
Adolescent girls entering into marriage below the age of 18 have more limited access to contraception and family planning services than older women. A UNICEF study found that 46% of 15–19-year-old girls who were married or in unions had never used any contraception.[36] This low level of contraceptive use may be caused by a number of factors, including:

- social pressures to have children early following marriage
- inability to discuss family planning with anyone
- fear of a husband who is older and who makes decisions and controls the family finances
- lack of mobility, as adolescent girls' young age and low status in the marriage result in them being unable to leave the home to access family planning services.

These factors can be exacerbated by a lack of availability of commodities or health workers to administer family planning services to adolescents in the community.

Many countries still have national laws that permit marriage under the age of 18. It is legal for a girl to be married at 15 in DRC, Chad and Tanzania and at 16 in Afghanistan, Pakistan and Senegal. Such laws are in breach of the Convention on the Elimination of Discrimination Against Women and the Convention

FIGURE 5. COUNTRIES WITH HIGH LEVELS OF CHILD MARRIAGE ALSO HAVE HIGH RATES OF EARLY PREGNANCY



Source: UNICEF (2012) *State of the World's Children 2012*

on the Rights of the Child, both of which prohibit countries from recognising marriage with persons under 18. In some of these countries the legal age for consent to sexual relations is higher than the legal age for marriage. For example, in Tanzania, a girl can consent to get married at 15 but cannot consent to non-marital sexual relations before she is 18. In Afghanistan, the legal age for sexual consent is 18 with an exception for girls who are married under this age.

Where laws do exist, they are often not enforced. This can be due to pervasive and entrenched cultural traditions or religious beliefs. A further complication is that often children's births are not registered and they do not have birth certificates or identity documents to prove that they are under age. In March 2012 the United Nations Human Rights Council passed a resolution guaranteeing birth registration and the right of everyone to recognition everywhere as a person before the law.[37] The UN Convention on the Rights of the Child also states that all children are entitled to official registration of their identity. However, WHO estimate that one-third of children born each year – 40 million – never get a birth certificate.[38]

Given the high rates of child marriage in many countries, it is essential that adolescents have early access to family planning services and that they understand the dangers of early pregnancy. Chapter 3 sets out the need for governments to enact and enforce a minimum legal age for marriage. And it sets out the need for initiatives to empower girls more broadly, and to provide adolescent girls and boys, as well as wives, husbands, families, communities and broader society, with the information they need about reproductive health.

PHOTO: ALIXANDRA FAZZINA

Kali is just 12 years old. But she's already married, and is now expecting her first child. She lives with her husband, Faqeera, 18, in Sindh province in Pakistan.

"I had my first period a fortnight after I got married," says Kali. "I had no clue what was happening. My husband explained to me what it was.

"But next month nothing happened. When a second month passed and again nothing happened, I told my husband. He said I might be pregnant. He took me to a doctor, who confirmed that I was two months pregnant.

"I was ecstatic. I immediately called my home and told my mother. She was worried that I was too young for all this. I didn't pay any attention, but later, when my sister told me about the danger signs and complications of pregnancy, I became anxious. Now fear has overtaken my feelings of joy.

"Whenever I look in the mirror I see a new Kali, one who will be a mother soon."

2 IMPROVING THE SUPPLY OF FAMILY PLANNING SERVICES

It is estimated that around 867 million women in developing countries currently want to avoid pregnancy, of which 645 million women – roughly three-quarters – are using modern methods of contraception.[1] This leaves around one quarter who are either using no method or are relying on less effective traditional methods.

There are huge disparities in the coverage of family planning services around the world. Usage rates of contraception vary significantly both between and within countries. In some places family planning is not available because of a lack of actual contraceptive commodities, known as 'stock-outs'. Elsewhere, there are no health workers or health facilities to deliver family planning services, and so contraception products end up sitting in warehouses unused. This chapter looks at the supply-side challenge of meeting the need for family planning.

In other cases women are not using the services that are on offer because they are not able to make their own decisions about family planning. Chapter 3 looks in turn at the demand-side barriers to family planning.

REACHING THE HARDEST TO REACH

The challenge of reaching the one in four women whose family planning needs are currently unmet is not to be underestimated. Many of the areas with the greatest needs have inadequate health facilities, a critical shortage of health workers, a lack of funding, and weak infrastructure – eg, poor roads, lack of fuel and fragile supply chains. These challenges are exacerbated in fragile states, and those that have been disrupted by conflict or natural disaster.

Inequity in access exists between rich and poor, urban and rural, and between women of different educational levels. Analysis by Save the Children suggests that access to modern methods of family planning is the most inequitable of routine health interventions.[2] The scale of inequality in use of modern family planning methods is much greater than in other routine health interventions. For example, in developing countries the richest 20% of the population are six times more likely to use modern family planning services than the poorest 20%.[3] Other public health interventions such as access to doses of diphtheria, tetanus and pertussis vaccination, while still inequitable, are much less so – where globally the richest 20% are only 1.6 times more likely to access the service.[4]

The lack of attention to inequality in family planning is a key obstacle to progress. Fairness in access to family planning must be put at the top of the agenda at the 2012 London Summit on Family Planning.

THE SUPPLY OF CONTRACEPTIVE COMMODITIES

Problems with the supply chain for contraception and stock-outs can lead to women losing faith in the health service and discontinuing use of contraception. Making the journey to a health centre can be expensive for a woman, in terms of the cost of travel and the lost income from being away from work. A study in Ethiopia found that some rural women would need to make a round-trip of up to four days to receive a three-month contraceptive injection.[5] If a woman has gone to a great deal of trouble to get to a clinic, only to find that contraceptive supplies have run out or her method of choice is out of stock, or if she is directed to a private provider that she cannot afford, she may well choose not to return.

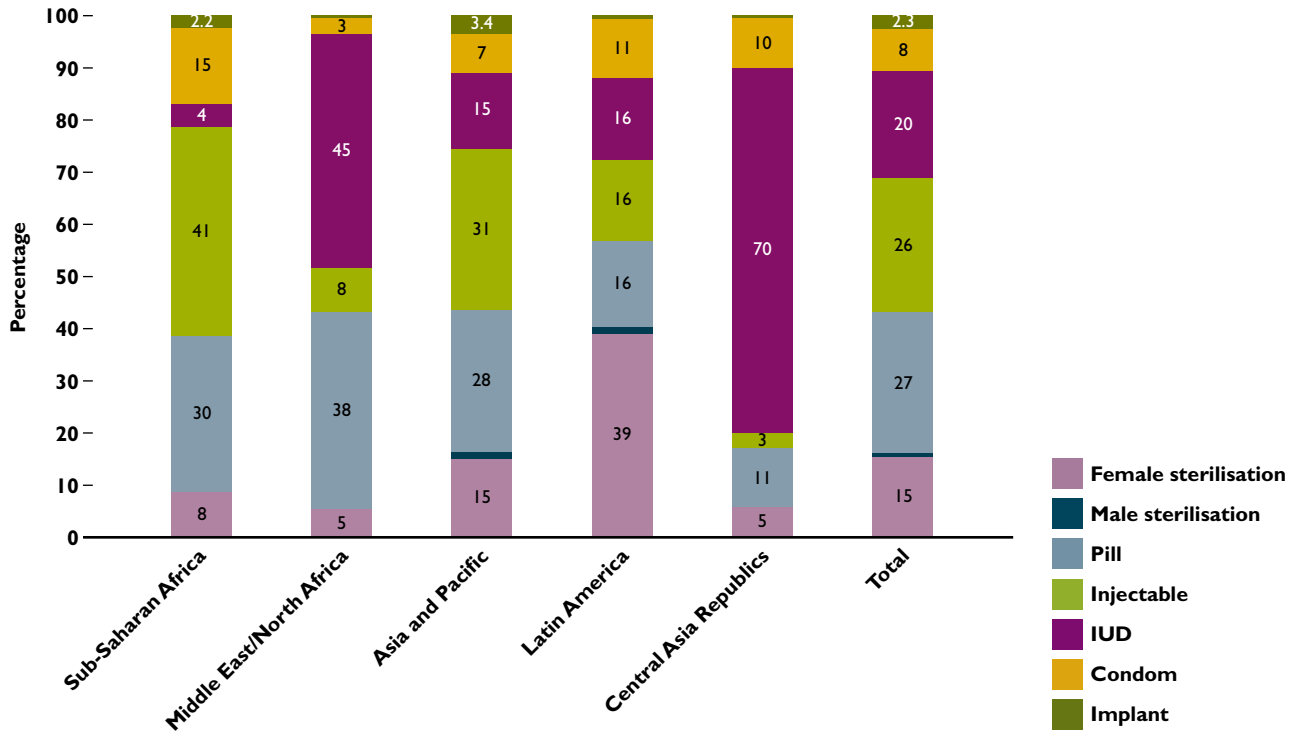
EXPANDING WOMEN'S OPTIONS

Access to a range of different methods of contraception is important in order to meet women's specific needs and circumstances. In richer countries, women are able to choose from a range of contraceptive products to suit their needs, including pills, male and female condoms, IUDs, implants, and injectables. These are sometimes provided free through the health service, as in the UK, for example, where a range of products is also widely available in shops.

Many women in developing countries prefer longer-acting reversible methods of contraception as well as permanent methods, including sterilisation, that require less frequent visits to the clinic and provide longer-term protection.[6] There is currently no way of monitoring how many women in developing countries were able to access their first choice of contraceptive method, but an indicator which tracked this could reveal a lot about the quality of the health service and how it was meeting women's needs.

Expanding the choice of contraceptive methods available in developing countries would enable more women to find the most suitable method for them. But as outlined below, sufficient numbers of well-trained health workers are needed to make a wider range of different methods available.[7] HIV prevention programmes have shown that people without formal medical training can effectively provide condoms; other forms of contraception must be prescribed or administered by a skilled health worker. Research into new methods of contraception that are not reliant on a highly skilled health worker to administer could greatly benefit women in rural areas who have limited access to healthcare.

FIGURE 6. MODERN CONTRACEPTIVE METHOD MIX BY REGION FOR THE YEAR 2008[8]



STIs, HIV AND CONTRACEPTION

Condoms are the only form of contraception that can prevent sexually transmitted infections (STIs), and are therefore a critical part of the HIV response. The WHO recommendation is that dual methods are used to ensure maximum protection against HIV and other STIs, as well as against unintended pregnancy, although this is not always feasible.

Raising awareness of HIV and other STIs should be part of all family planning programmes, so that men and women have the information they need to prevent unintended pregnancies and STIs. Education on HIV prevention and condom promotion must be designed to overcome the challenges of complex gender and cultural factors.

Condom promotion and distribution should be part of all family planning programmes in populations with a high burden of HIV or other STIs. Prevention programmes need to ensure that high-quality male and female condoms are accessible to those who need them, when they need them, and that people have the knowledge and skills to use them correctly. Condoms must be readily available universally, either free or at low cost, and be promoted in ways that help overcome social and personal obstacles to their use.

THE ROLE OF HEALTH WORKERS IN PROVIDING FAMILY PLANNING

The health worker shortage is a major hurdle in addressing the unmet need for family planning. The World Health Organization stipulates that 23 health workers are needed for every 10,000 population, but many countries are falling far below that figure. There is a global shortage of at least 3.5 million health workers – including doctors, nurses, midwives and around one million community health workers, who work on the front line of healthcare.[9]

Effective family planning services are dependent on health workers[10] to provide counselling on healthy timing and spacing of pregnancies, including information on different types of contraception. 23% of women with unmet need said the reason they did not use contraception was because of concern about health risks and side effects, highlighting the importance of good counselling.[11] In many countries, the majority of women who were not currently using contraception reported that they had not been in contact with a family planning provider, meaning they had not had the opportunity to discuss their needs or receive advice on contraception.[12] The health worker's role is even more important in the case of contraceptive methods like implants and injectables, as a trained health worker is needed to administer the product.

The quality and effectiveness of the family planning services that health workers can provide depends on a number of factors – where they are, what they are trained to do, what they are permitted to do, their attitudes and opinions, and what supplies they have:

1. **Equitable deployment of health workers**: In many countries the health workers that are employed are concentrated in rich, urban areas where the quality of life is better for the health worker and their family. The World Health Report in 2006 showed that despite the population being split 50–50 between urban and rural, only 38% of nurses and 24% of physicians were based in rural areas.

2. **The type of health workers**: Frontline health workers who work at village or community level are the first, and often the only, point of contact for millions of people who live beyond the reach of hospitals and clinics. While frontline health workers can be doctors, nurses or midwives who work at the village or community level, the category also includes community health workers (CHWs), who are given shorter training but are able to provide basic health services and advice and to refer more serious cases up to the health centre.

   Programmes that have concentrated on the role of frontline health workers in the delivery of family planning services have been successful. For example, in India, Bangladesh, Nepal, Rwanda and Peru the use of modern methods of contraception among married girls and women aged 15–49 years has climbed to around 50%; and in Vietnam, Indonesia, Zimbabwe, Nicaragua and Brazil, use of modern methods has reached 60% or higher.[13]

   Following extensive reviews of CHW programmes, research found "robust evidence that CHWs can undertake actions that lead to improved health outcomes."[14] However, experts also concede that many programmes are not successful, and that several areas need to be addressed if further success is to be achieved.[15] These include strengthening the training and supervision of CHWs and reducing the high rate of attrition.

3. **Training, skills and mandate**: Task sharing – where lower cadres of health workers are trained, empowered and mandated to provide certain services with the same quality as those provided by health workers with more training – has been explored with success. Evidence shows that through task-sharing, CHWs can safely provide a wide range of contraceptive methods including injectables,[16, 17, 18] implants,[19] oral contraceptives and emergency contraception.[20] Defined as the "rational redistribution of tasks among health workforce teams", task-shifting or sharing has been widely endorsed.[21]

4. **Attitudes**: Health workers are a key source of information about contraception for many women and girls. Those health workers who come from within a community are likely to have been exposed to the same traditions and cultures as the people with whom they are working. So, if health workers have prejudices or misconceptions about certain types of contraception, they can easily be transmitted to their patients, particularly those who are adolescents. The core training of health workers who provide contraception must uncover and challenge some of these negative beliefs.

5. **Supplies**: Health workers must have sufficient supplies, materials and equipment available to do their jobs. If clinics are stocked-out or frontline health workers do not have sufficient supplies to take to the communities where they work, they

will not be able to provide family planning services, and the people they are working with will lose trust in them.

As well as delivering family planning services, health workers of course contribute significantly to wider health aims, particularly for women and children, and they are key to strengthening a country's entire health system.[22] WHO and the US government have both highlighted that the integrated services for reproductive health and family planning, maternal and child health, and HIV and AIDS that community health workers can deliver is a key way to improve national health systems.[23]

For the reasons outlined above, it is vital that health workers and the role that they play in delivering family planning services and contributing to strengthening the health service is duly recognised. During the London Summit on Family Planning in July 2012, governments should ensure that a significant proportion of funds raised – and commitments made – focus on the actions that will improve family planning services and contribute to strengthening health systems and filling the health worker gap.

THE FUNDING GAP FOR FAMILY PLANNING SERVICES

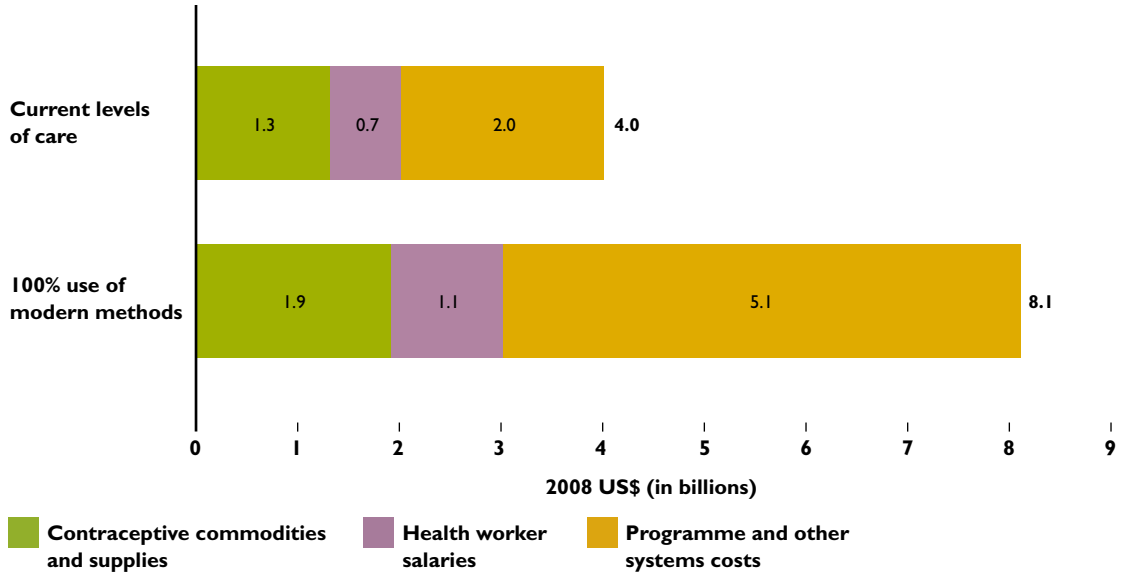
The cost of providing contraception to the 645 million users in the developing world was estimated as $4.0 billion in 2012. To extend family planning services to the remaining 222 million women who want it would cost an additional $4.1 billion a year.[24] The cost is greater to reach these remaining women because they are the hardest to reach. Those who are already using family planning are likely to be richer and living in urban areas, and therefore are more able to afford to buy contraception in shops or private clinics; they are also likely to be better served by government-run health services.

The cost of providing contraception is made up of commodities – the products that are used – and service delivery, including recruiting, training and paying health workers and support staff; maintaining and monitoring the supply chain; and meeting the cost of running health facilities. As mentioned above, it is essential that both the supply and services are considered together, as it is futile to provide additional commodities to a country that has a weak health system and that lacks the capacity and the health workers to get those products into the hands of the women who need them.

In fact, the vast majority of the $4.1 billion funding gap for family planning services is made up of these service delivery costs. An additional $600 million is needed for commodities, and the remaining $3.5 billion is for services and health worker salaries. This estimate does not include the cost of programmes to generate demand and empower women, which requires an approach that includes many sectors other than health.

The London Summit on Family Planning in July 2012 presents an unparalleled opportunity for

FIGURE 7. CURRENT SPENDING ON FAMILY PLANNING IN DEVELOPING COUNTRIES AND PROJECTED COST OF COMPREHENSIVE COVERAGE[25]



governments, donors and international organisations to work together to set new and ambitious targets for meeting unmet need, and to back them up with sufficient funding that reflects the relative need for commodities and service delivery.

FAMILY PLANNING: WHO PAYS?

The money needed to pay for family planning services in developing countries comes from three main sources (though the relative shares of each vary from country to country):

- the national health budget
- the overseas aid budget of richer countries
- private 'out-of-pocket' payments by individuals.

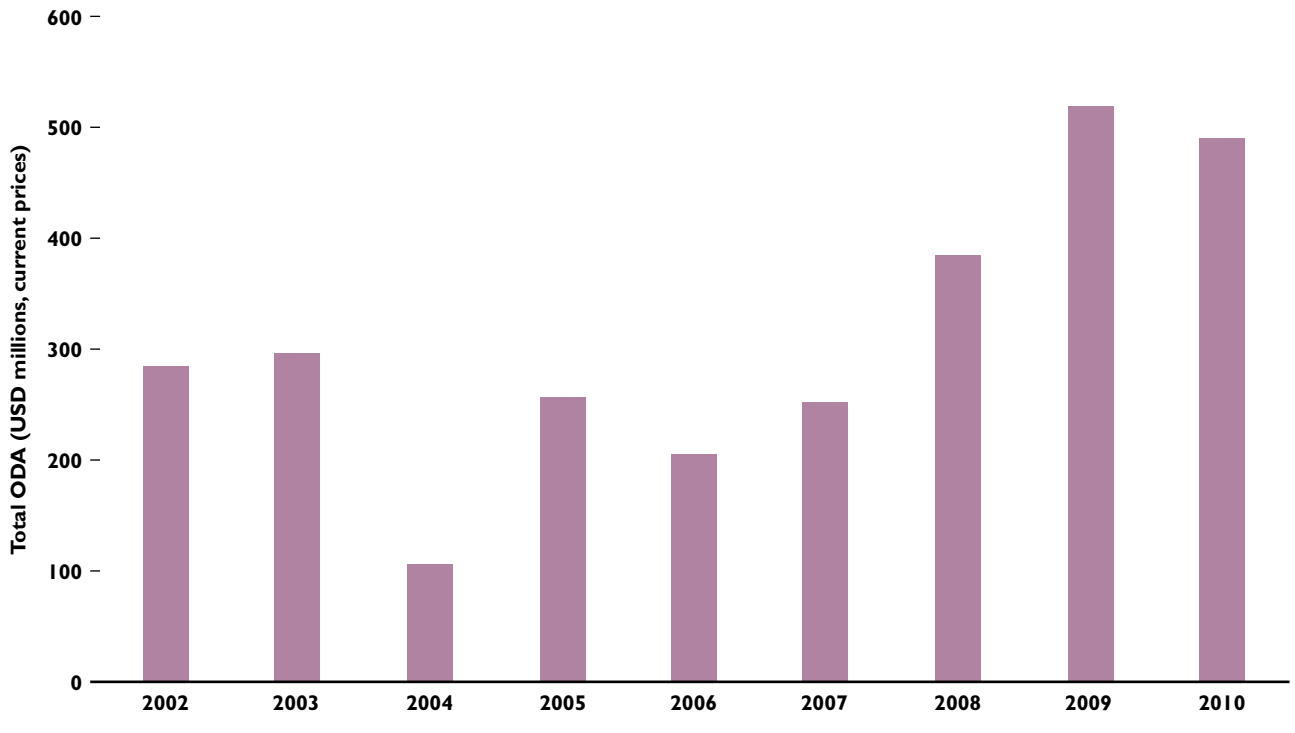
The amount of funding that a developing country government commits from its own budget for family planning is a strong indicator of the overall political commitment which that country has to providing family planning services to its population. Less reliance on donors and a dedicated budget line for family planning in the health budget means that funding is more reliable and stock is less likely to run out. It can also indicate a wider sense of engagement in the issue and a government that will be more willing to overcome barriers.

However, a study by the Reproductive Health Supplies Coalition in 2009 stated that 88 countries were dependent on external donors to meet their contraceptive needs – 39 of which were in sub-Saharan Africa, 15 in Asia and 17 in Latin America.[26] And in a study of 47 developing countries carried out by USAID, only 20 reported using internally-generated funds to procure contraceptives.[27]

International funding for family planning has increased since 2002, although it is still far below required levels, and it has been inconsistently disbursed. In 2002 contributions to family planning in developing countries were $285.5 million, rising to $520 million in 2009, before falling to $491.7 million in 2010.[28] Since 2003 only a small contribution has come from multilateral agencies (an average of 4%), with the majority coming from bilateral donors. The largest bilateral donors are the USA and the UK.

In practice, given poorly stocked health facilities and the continued existence of user fees, it is consumers who pay the largest part of the price for contraceptives. For those who can afford it, private family planning providers, which include not-for-profit NGOs as well as clinics run for profit, may offer a more reliable or convenient option than visiting a government-run health facility, which may be poorly stocked and require payment of a user fee.

FIGURE 8. OFFICIAL DEVELOPMENT ASSISTANCE FOR FAMILY PLANNING



Source: OECD International Development Statistics online databases on aid and other resource flows – The Creditor Reporting System

Private sector providers are likely to reach those groups that are most accessible – the 'low-hanging fruit' – leaving the most vulnerable and most in need underserved. Research has shown that poor people are not inclined to use what little income they have to pay for preventative healthcare, so those who cannot afford family planning will go without and take the risk. The private sector should therefore be considered as just one part of a 'total market approach' to family planning that also includes public resources to subsidise the costs of healthcare for the poor.[29]

In developing countries, on average, more than 60% of total domestic expenditure for sexual and reproductive healthcare – of which family planning is an important component – comes from consumer out-of-pocket payments. In Asia and the Pacific, this rises to 71%, and in sub-Saharan Africa, 50%.[30] For healthcare generally, out-of-pocket payments, including user fees, place a disproportionate burden on the poor. International experts agree that user fees represent the most regressive (or unfair) way of funding healthcare.[31] The same applies to family planning: charging user fees for family planning services discourages take-up and disproportionately affects the poor. However, it is essential that any decision to remove user fees takes into account the overall effects on the system, including the possibility of the emergence of informal fees, loss of revenue from the fees that may be critical to the delivery of services, and effects on health worker morale.

NATIONAL FAMILY PLANNING POLICIES

Family planning is a vital part of the package of healthcare interventions that have been identified by health experts – eg, *The Lancet* – as essential for saving the lives of mothers and children and reaching international goals. It is the responsibility of the government to act as the steward of the health sector, regulating the quality of care provided by all healthcare providers, and ensuring universal access to the basic package of services. This depends on the existence of strong legislation and policies, as well as sufficient funding.

Governments must ensure that national policies on family planning are clear, effective and focused on strengthening the health system.

The legislative and policy framework that regulates supply in each country can either facilitate or hinder the provision of family planning services. Laws or policies that create unnecessary barriers – such as

SIERRA LEONE: FAMILY PLANNING IN A POLICY VACUUM

A lack of effective legislative or policy regulation of family planning provision in Sierra Leone has led to difficulties in guaranteeing consistency in the quality and supply of contraceptives, with:

- a lack of distribution in communities due to lack of community health workers in many parts of the country
- a shortage of trained reproductive health specialists
- frequent stock-outs[32]
- a lack of integration of non-state service-providers with the public sector.

In Sierra Leone, the majority of family planning services are provided by Marie Stopes International (MSI). MSI charge fees to wealthier clients in order to subsidise free or token price services to remote rural and urban slum areas. This model has not been scaled up to cover the whole country and a 2008 study on barriers to family planning use in Sierra Leone reported that, in the absence of any formal legislation or policy, organisations delivering family planning services had adopted their own guidelines and fees. Different providers operated different policies and the imposition of 'informal' fees was common.[33] Although some respondents to the study said that family planning services were supposed to be free, it was not clear whether this applied to all types of service and methods or only certain aspects.

In 2010, healthcare was made free for pregnant and lactating women, and children under five but the initiative does not currently have any reproductive health component embedded in it, and it has had little impact on the contraceptive prevalence rate, which is currently only 11%.

Adolescent girls face particular challenges in Sierra Leone – almost two in five girls give birth before the age of 18, and one in 14 gives birth before the age of 15.

those which limit the use of specific methods of contraception, the use of contraception by specific age-groups or the use of contraception by unmarried women – should be reformed. Bottlenecks in the supply chain for bringing contraceptive products into the country should be removed, and bureaucratic hurdles facing businesses wishing to manufacture contraceptives minimised.

Legislation on its own is insufficient to guarantee women have adequate access to family planning services. Effective policies and plans are required that ensure that the legislative guarantees to family planning services are implemented equally throughout the country.

Responsibility for implementation must be clearly allocated. In some countries responsibility for providing family planning is decentralized. Clear allocation of responsibility for implementation is required to ensure that ownership of family planning programmes is effectively devolved to district or municipal levels. For example, following de-federalisation of the Population Welfare Program in Pakistan in 2002, financial, administrative and operational responsibility for the implementation of family planning policies shifted from the federal to provincial level but the federal government continued to fund the programme. The result was that the provincial governments failed to develop the desired level of ownership.[34] This was understood to be a contributing factor to the stagnation in contraceptive use among married women after 2003, after it had previously increased steadily since the early 1980s.[35]

In certain countries, governments have issued detailed national strategies on family planning, which set out the aspirations and policy goals but, unlike legislation or binding policies, these strategies are not generally enforceable. This is the case in Bangladesh, Nigeria and Ethiopia, where the strategies in place for reproductive health, including family planning, are progressive in terms of provision of family planning. For example, the Ethiopian National Reproductive Strategy includes ensuring adequate supplies of contraceptives are available and the provision of youth-friendly family planning services through the public sector. The Bangladeshi National Communication Strategy for Family Planning and Reproductive Health includes as its goals increasing access to and community involvement in family planning and reproductive health services and service delivery, as well as improving family planning / reproductive health service quality and service delivery. Such strategies can be useful in terms of setting out a state's intentions with regard to family planning and identifying the areas where improvements are required. However, while these are an important first step, governments need to ensure that effective action plans are made for their implementation and that they are followed through.

THE WAY FORWARD

Providing universal free coverage of family planning is a huge challenge. Even with donor aid money and technical assistance, many countries are a long way from meeting this goal. Nevertheless, as the remarkable progress over the last decade in tackling child mortality and ensuring more children go to school has demonstrated, change is achievable. Expanding coverage of family planning to those who are hardest-to-reach – and most in need of it – will require the coordinated efforts of national governments in developing countries, international donors and the private sector.

National governments are key to making any family planning initiative a success – and overcoming challenges on both the supply and demand side. They must demonstrate their commitment by putting financial, political and, where appropriate, legislative weight behind their pledges and strategies.

The ultimate goal is for a reliable supply of a suitable mix of family planning methods to be accessible, delivered by trained health workers in the community or in primary healthcare centres, so that every couple who wishes to plan their family has the means to do so. A strong national human resources for health plan, which includes the recruitment, support and remuneration of sufficient health workers who are trained to deliver effective family planning services, will be a cornerstone of achieving this goal.

In the meantime, national governments must act to ensure that the private sector providers, including non-profit organisations, who are currently helping to fill the gap, are well regulated and are able to operate in a conducive policy environment. Governments should take care to prescribe minimum standards for the quality of contraceptives sold in the market to ensure safety for all users.

International donors must support efforts within developing countries by channelling new and substantial funds to the provision of family planning in countries with large proportions of unmet need. They must help fill the funding gap in a way that is sustainable and equitable and encourages long-term

commitment to the goals of eradicating unmet need and ensuring that every couple who wants to use family planning can do so, regardless of their ability to pay.

The private sector has a role to play in improving access and equity – companies that manufacture contraceptive products should lower prices for developing countries and support local manufacturers to scale up supply and improve quality. They can contribute to filling the funding gap either through offering funds directly, or reducing the price of contraceptive commodities they manufacture for low-income countries and countries with high levels of unmet need.

RECOMMENDATIONS

This chapter has shown that there are a number of supply-side challenges that will need to be tackled to fulfil the unmet need for family planning. As well as boosting the supply of commodities to avoid stock-outs, rich and poor countries must use the opportunity of the London Summit in Family Planning in July 2012 to commit significant new funding for family planning. And they must ensure that a proportion of that money goes towards putting in place the frontline health workers who are needed to ensure that family planning services reach the women that need them most.

- **Fill the funding gap**
  At the 2012 London Summit on Family Planning, international donors, national governments and private sector organisations should put financial resources behind their commitments to help fulfil the unmet need for family planning. Globally, the total funding gap for family planning in all developing countries has been estimated at $4.1 billion a year. This is made up of $600 million for commodities and $3.5 billion for service delivery.
- **Put health workers at the heart of family planning services**
  All efforts to improve access to family planning must include investment in the long-term recruitment, training, remuneration and support of sufficient health workers. Participants in the 2012 London Summit on Family Planning must ensure that their financial and policy commitments reflect the need to dedicate resources to service delivery, which should be earmarked for improving the quality of the national health service, and for training and recruiting health workers.
- **Equity**
  Family planning strategies should include goals to ensure that contraception is accessible and affordable and that the needs of the poorest and most vulnerable women are addressed. Reaching the hardest to reach should be one of the core principles of the 2012 London Summit on Family Planning. Part of the challenge to overcome inequity is that governments must play a stewardship role, by developing national family planning strategies and coordinating the activities of various players, including NGOs and the private sector.

3 STIMULATING DEMAND FOR FAMILY PLANNING THROUGH EMPOWERING WOMEN

While ensuring a reliable supply of contraceptive commodities is a huge logistical and financial challenge, attempts to increase usage of family planning will fail unless they also focus on increasing demand. Even when contraception is provided free of charge at a reliable nearby clinic, many women are still unable to use family planning due to discrimination and lack of empowerment. Universal access to family planning will not be achieved without empowering more women to demand it, and involving men to support use.

For a woman or adolescent girl to be able to make use of family planning services she must be empowered to make her own decisions about whether, when and how many children she wants to have. As well as providing couples with the commodities they need, effective family planning services ensure couples have the facts, advice and support they need to know their rights and make their own decisions. National policies must be in place to ensure these rights are protected.

However, the lack of demand for family planning is largely due to deep-rooted gender discrimination that is embedded in women's lives. Tackling it is therefore a major challenge. Women need to be empowered at all ages, in many different parts of their lives and within their families, communities and societies. While recognising that any attempt to provide an overview of the empowerment agenda will struggle to capture the complexity of the issues, this chapter covers three key areas where action is needed:

- **Education** – to enable more girls to go to school and stay in school longer, and to improve awareness of sexual and reproductive health
- **Social policies** that promote positive change in attitudes towards women and women's rights, particularly with respect to child marriage and the age of consent
- **Supportive economic policies** that help women to make a decent living, tackle discrimination in the workplace and enable women to plan their families around their work.

EDUCATION

The link between the level of education a girl receives and her future achievements and empowerment is well-established. Girls who stay longer in school are more likely to be involved in making decisions that affect the family, to have more control over the household resources, be more aware of the outside world and be better able to communicate with their partners.[1] Putting girls in developing countries through secondary school is one of the most important factors that influences the number of babies they will have, as it increases capacity and motivation to reduce fertility.[2] For these reasons

EDUCATION AND CHILD SURVIVAL

A mother's education is a key determinant in her children's health. A mother's education influences how often she visits health services, both during pregnancy and after the child is born; how clean and sanitary the home is; and what she eats and what she feeds her children.

A study in the Philippines found that a child's chance of survival increased as its mother's level of formal education and income rose. The under-five mortality rate for children of mothers with no education was 136 deaths per 1,000 live births, against 18 deaths per 1,000 live births for children whose mothers were college educated.[6]

a girl's educational level is closely linked with her current and future use of family planning, her ability to space her children, her desired number of children and her actual number of children. Higher levels of female education correlate with women having fewer children.

The strong positive relationship between education and women's use of contraception can be seen in many countries. In Vietnam there is a significant difference in family planning use between women who never attended school and those who did, even if they did not complete primary level. In Vietnam 83% of women who completed lower secondary school use contraception, compared with 66% of women with no education.[5]

FIGURE 9. THE RELATIONSHIP BETWEEN A WOMAN'S EDUCATIONAL LEVEL AND USE OF FAMILY PLANNING[3]

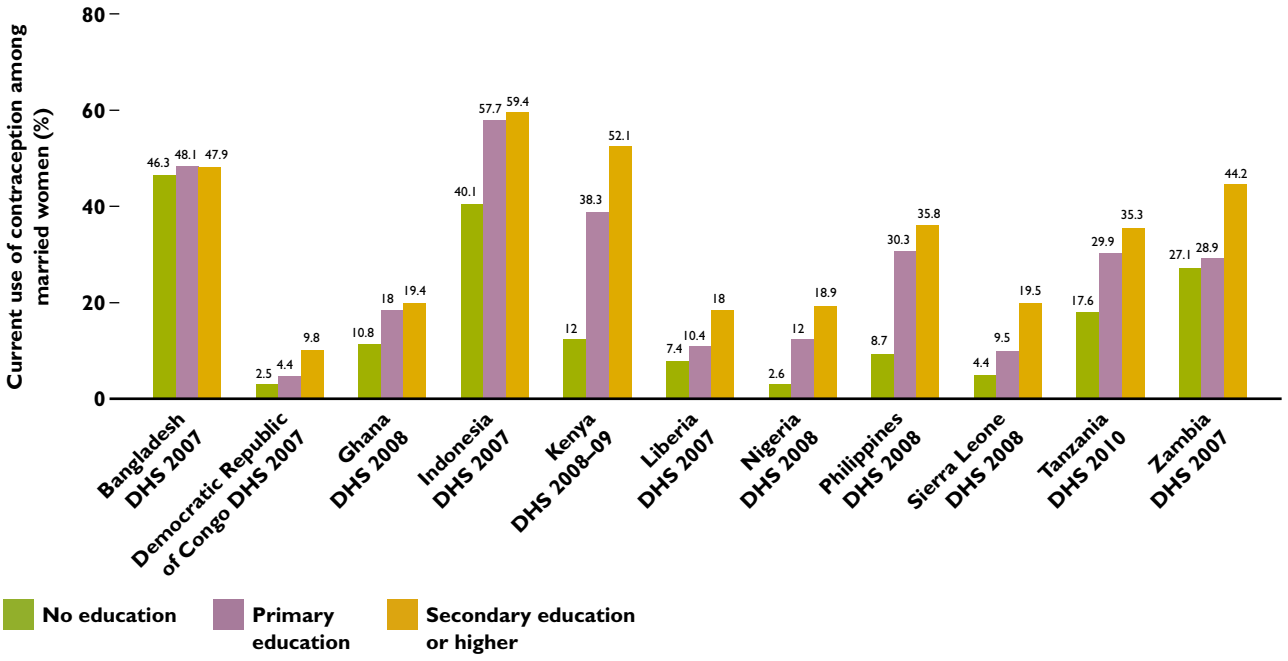
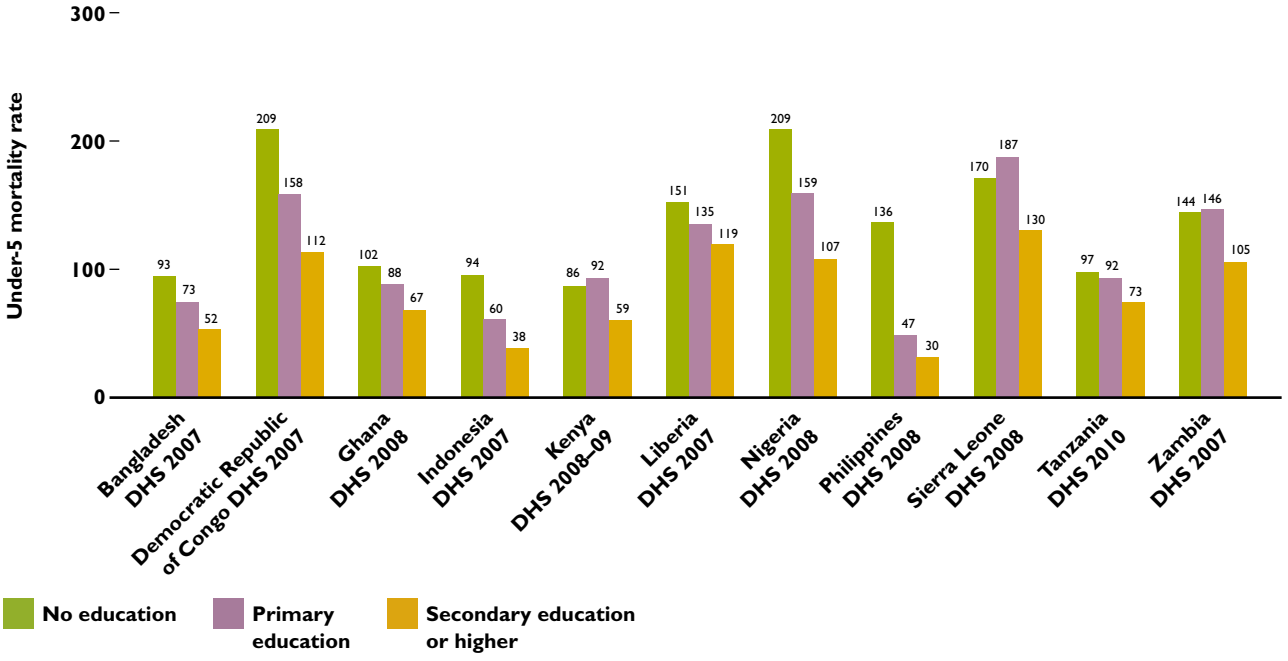


FIGURE 10. THE RELATIONSHIP BETWEEN A WOMAN'S EDUCATIONAL LEVEL AND CHILD SURVIVAL RATES[4]



SEXUALITY AND REPRODUCTIVE HEALTH EDUCATION

Teaching girls and boys about sexuality and reproductive health from an appropriate but early age is a vital part of both a child's education and a country's family planning policy. Sexuality education is key to addressing adolescent sexual health and the risks associated with early pregnancy. It has been found to delay the age girls first become sexually active.

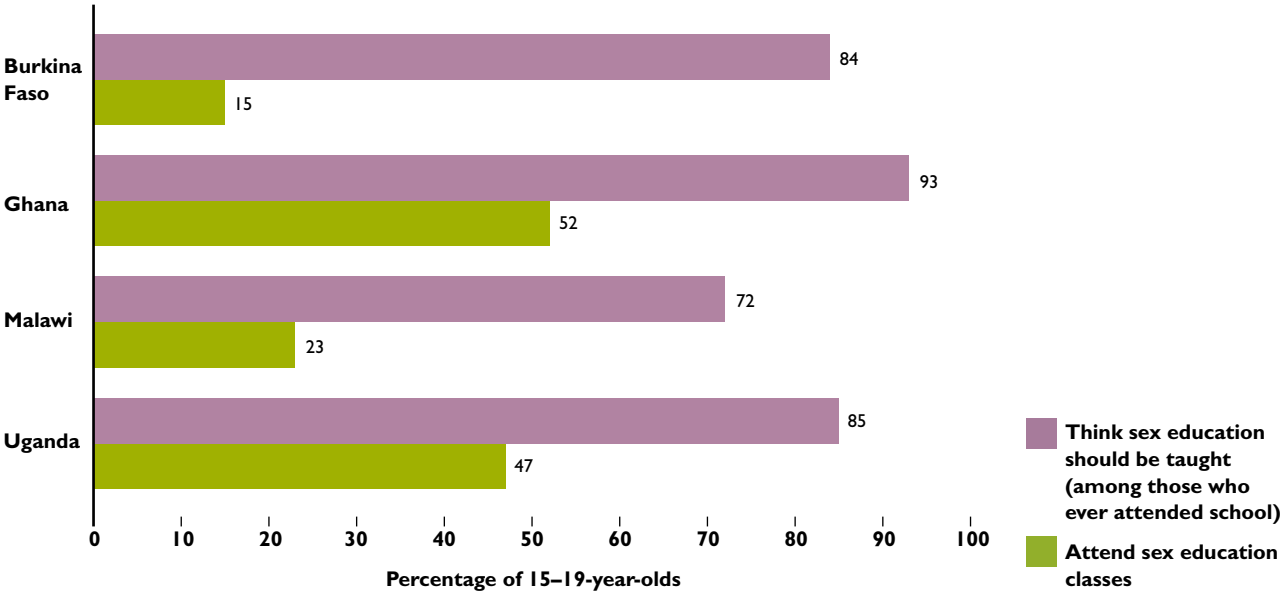
Sexuality education should start to be taught to children and adolescents before they begin to have sex. There is increasing consensus among international health experts that it should begin as soon as a child enters adolescence, which can be as young as 10.[7] Starting before girls hit puberty is particularly important as some adolescent girls leave school in order to get married. Sexuality education should be age-appropriate, covering increasingly complex topics from upper primary to early secondary school levels, and it should be mandatory. Governments should dedicate resources to improving the quality of sexuality education, by training teachers and young peer educators, and providing them with good-quality materials.[8]

Education about contraception is important to tackle myths and preconceptions that can influence women's and girls' choices about family planning throughout their reproductive years. For example, a national survey in Nigeria in 2005[9] found almost one-third of women believed that certain methods of contraception could lead to female infertility. In Uganda, doctors reported that women believed taking contraception caused cancer and that if they got pregnant again later they would have deformed babies.[10]

It is vital that sexuality education covers the rights of girls and women. In some countries up to 30% of first sexual encounters are forced: 24% in rural Peru, 28% in Tanzania, 30% in rural Bangladesh, and 40% in South Africa.[11] The percentage of both men and women who believe that a husband is justified in beating his wife under certain circumstances remains worryingly high in many countries. One fifth of women in Zimbabwe thought a husband was justified in beating his wife if she went out without telling him; in Egypt, 37% of women said arguing with your husband was a justifiable reason to be beaten; and in Guinea 62% of women thought refusing to have sex was a justifiable reason.[12] Educating boys and girls at a young age about girls' and women's rights is vital to preventing the violation of girls and women, reducing the risks of early pregnancy and protecting girls and women from other forms of violence.

However, in many countries there is a severe lack of sexuality education. In India fewer than half of unmarried girls and women aged 15–24 had ever had any education about sex or family life, despite 81% of women in this group saying it was important.[13] There is a similar picture in sub-Saharan Africa (see figure 11).

FIGURE 11. ATTITUDES AND EXPERIENCE OF SEXUALITY EDUCATION OF 15–19-YEAR-OLD GIRLS AND YOUNG WOMEN IN FOUR COUNTRIES IN SUB-SAHARAN AFRICA[14]



PROMOTING ADOLESCENT SEXUAL HEALTH

Adolescent sexual and reproductive health is a core component of Save the Children's global health work in countries including Ethiopia, Liberia, DRC, Uganda, Sierra Leone, Myanmar (Burma), Nepal, South Africa, Afghanistan, Bangladesh, Malawi, Mozambique, Philippines, Bolivia, Georgia, Vietnam and Egypt. Our programmes are designed to target a wide range of poor and vulnerable young people including the displaced and hard to reach, young adolescents entering puberty, in-and out-of school youth, married girls, teen mothers, HIV positive youth and adolescents in emergency settings.

Ethiopia: In hard-to-reach districts of Amhara, Save the Children works with vulnerable adolescent girls and boys to improve knowledge about sexual and reproductive health and rights, and works to increase access to good-quality services, including contraception. Our three-year programme uses a variety of approaches including peer education, arranging discussion groups in the community, reproductive health clubs in schools, and counselling. Wherever possible the programme involves the wider community and seeks to raise awareness of the impact on girls and women of harmful traditional practices such as child marriage and female genital mutilation.

South Africa: Save the Children's health work is introducing a vast outreach education programme in 75 schools to promote sexual and reproductive health for girls and boys, in order to help tackle the high levels of sexual violence within schools.

Nigeria: As part of a consortium funded by the UK and Norwegian governments (and known as PRRINN-MNCH), Save the Children is supporting the Nigerian government to implement its Maternal Newborn and Child Health Initiative (2006–13). The initiative provides 'safe spaces' that allow married adolescent girls to access essential maternal health services, including advice on family planning and birth spacing. The spaces provide a safe environment for young mothers to discuss problems they may be facing within the marital home, to get support from peers, and to access advice and services for themselves and for their children.

Education about reproductive health should continue throughout a woman's life. Ongoing education and refresher training is important as new family planning methods are developed and introduced and knowledge of their effectiveness and side effects changes with new research. For girls who do not receive family planning education while at school, it is not too late for them to benefit from reproductive health education after they leave school.

The use of mass media to disseminate messages about family planning has been very successful in reaching large numbers of women.[15] However, if a woman lives in a remote location, has little education or is illiterate, she has little opportunity to get accurate information about family planning through mass media. In Indonesia, 43% of women with secondary or higher education saw a family planning message on television, compared with 7% of women with no formal education; and 30% of women with secondary or higher education level read family planning messages in a newspaper or magazine in the previous six months, compared with only 2% of women who only had some primary education.[16] It is therefore important that information on contraception and reproductive health is made available to women with little or no education through health centres or community health workers.

AFGHANISTAN: HELPING WOMEN TAKE CONTROL OF THEIR FERTILITY

In Afghanistan, a literacy programme for mothers helped to build self-esteem, and made it easier for the women who attended to discuss birth spacing and contraceptive issues with their husbands. In addition to literacy skills and teaching women about birth spacing and family planning, the programme offered guidance on how to respond to societal and family pressures and objections relating to the use of contraceptives.[17]

SOCIAL EQUALITY: POLICY AND PRACTICE

Women's social inequality in developing countries is a huge barrier to increasing coverage of family planning. In two-thirds of countries, half of women do not participate in household decisions, including whether a woman should use family planning and how many children to have. Pervasive social, cultural and religious beliefs and practices often act as barriers to women's empowerment, ranging from norms for women's role in the household and community – for example, where they can go and with whom at various ages – to harmful traditional practices, such as child marriage and female genital mutilation. Many girls are forced into marriage and to have sexual intercourse, and denied access to family planning services. As a result, they have no say in when and whether to become pregnant.

ENSHRINING WOMEN'S RIGHTS

Many countries have made public commitments to the principles of female empowerment, equality and non-discrimination. The United Nations Convention on the Elimination of Discrimination against Women, which commits countries to eliminate discrimination against women, has been ratified by 187 countries.[18]

However, while signing up to the Convention is a welcome step in the process of enshrining female empowerment, it is meaningless unless it translates into action at the country level. Laws banning child marriage and gender-based violence should be implemented, enforced and monitored. But many governments have a long way to go to harmonise national laws in line with their international obligations, and even further to go to ensure that these laws are enforced. For example, despite the legal age of marriage being 18 in Bangladesh, two-thirds of women said they had been married before that age.

The Convention also obliges States to provide advice on family planning through education (article 10(h)), and to ensure women have an equal right with men to make decisions about birth spacing, and about when to have children, and to have access to information, education and means to enable them to exercise these rights (article 16(e)). But despite the Convention's guarantee of a right to family planning, these services are generally regulated through vaguely worded policies or legislation, rather than being enshrined in strong, enforceable laws that can be used to hold governments accountable. As a result, citizens have little chance of legal redress in the event that the state fails to enforce or implement the policy.

Many countries have enacted wide-ranging and progressive *strategies* that aim to increase access to family planning services. However, these strategies are not legally binding. Bangladesh and Ethiopia, for example, have progressive strategies in place for reproductive health, but they face a huge challenge translating them into concrete action that results in change on the ground (see box on page 26).

PUTTING WOMEN'S RIGHTS INTO PRACTICE

To make a real difference to women's lives, governments must put the Convention on the Elimination of Discrimination against Women and national legislation into practice by doing two things. First, they must take the lead in empowering women to benefit from these laws or policies. Women need to be made aware of their rights through education and community awareness-raising initiatives. If they have knowledge and information on such policies, women and adolescents can be empowered to challenge any restrictions imposed locally that conflict with the national legislation or policy.

Second, governments must work to overcome the de facto barriers to female empowerment that are imposed by other parties, such as religious leaders, spouses or other members of the family or community – or even by other lower levels of local government. If governments enshrine the rights of all women and adolescents in legislation or formal policy, it reduces the ability for restrictions to be imposed by others as a result of social and cultural norms. Sadly, in many countries there is a large gap between the policy and practice on equality and women's rights.

Aligning family planning policy and practice

Pakistan, like many other countries, faces a challenge in reconciling its policy on family planning with practice. The country's policy agrees to: '[Ensure] reproductive health rights by involving men, women and adolescents, through non-coercive measures for family planning and promoting the small family norm in recognition of the principle of population stabilisation through the adoption of a rights-based approach'.[19] However, the prevailing norms of women being confined to the family home, and men and women being segregated, can be more influential than policy when it comes to actual use of family planning

services. A woman may need permission from her husband or household elders to seek healthcare, and may be prevented from using family planning services with male practitioners, or in areas where there may be men present. Save the Children is working to help align policy and practice, and a key part of our work on family planning and adolescent health in Mali, Guinea, Ethiopia and Pakistan has involved developing positive relationships with religious leaders.

Opposition from husbands to the use of family planning is another barrier. In India, country surveys show that less than one in five currently married women reported discussing family planning with their husbands.[20] In Nigeria, nearly 20% of women who were not using contraception said they did not intend to on the basis of husband opposition or opposition on religious grounds.[21] Governments should introduce clear policy guidelines at the national level prohibiting any restriction on access to contraception for women and adolescents, including conditions requiring parental or spousal consent, and ensuring women are aware of their right to contraception.

Some countries are blazing a trail with positive legislation and policies. The Children's Act in South Africa expressly guarantees access to contraceptives for all adolescents over 12 years old – a specific and enforceable guarantee that can be relied upon by adolescents denied access to contraceptives. Brazil and Vietnam have expressly legislated for the provision of family planning at both the constitutional and legal levels. And crucially, in both countries, the government has put in place detailed plans for the implementation of the legislation (see the two case studies below).

ALIGNING FAMILY PLANNING POLICY AND PRACTICE IN BRAZIL

In 2005, Brazil set itself the target of guaranteeing total coverage of sexual and reproductive healthcare by the country's National Health System. The government also launched the National Sexual and Reproductive Rights Policy to increase the number and variety of contraceptive methods distributed to women of reproductive age. Two years later, the government launched its National Family Planning Policy, to provide free contraception to men and women of reproductive age. Contraceptives were also made available in the Popular Pharmacy network at very low cost. According to the UN Population Fund, the contraceptive prevalence rate in Brazil was 77% in 2008.[22]

The Federal Constitution of Brazil enshrines the right to family planning and obliges the State to provide education and scientific resources to allow this right to be enjoyed. Brazil has enshrined this right through a comprehensive legislative and policy framework that guarantees equal access to information and different methods of contraception.

VIETNAM: REALISING THE RIGHTS OF ADOLESCENTS TO REPRODUCTIVE HEALTHCARE SERVICES

In Vietnam, the national Reproductive Health Strategy places special emphasis on adolescents. It includes the creation of counselling centres that provide adolescents with reproductive healthcare services, including supplying contraceptive methods such as condoms for preventing STIs and, where conditions permit, establishing gynaecological wards for young female patients.

The previous national Reproductive Health Strategy for 2001–10 specifically called for the education of men and women about sexual relations and sexuality so that they can:

- fully exercise their rights and responsibilities in regard to fertility
- have safe and responsible sexual relations based on equality and mutual respect
- generally improve their reproductive health and quality of life.

Ensuring reproductive health services meet women's needs

Women's and adolescent girls' experience of pregnancy and childbirth means that they have very different requirements from the health service from men. Government policy must be sensitive to the specific additional needs that women have. There is a need for a fully funded national health policy in every country that is sensitive to women's health issues. Accompanying budgets should not only consider reproductive and sexual health services and family planning, but should include the recruitment, training and deployment of sufficient female health workers trained in modern family planning methods.

However, against a backdrop in most developing countries of extremely inadequate health budgets, many countries' national health plans do not make any provision for women's additional health needs. As a result, women are missing out on the vital healthcare they need to protect them and their babies. Nevertheless, examples from Brazil, Vietnam and Ethiopia show what can be achieved (see boxes on pages 25 and below).

EMPOWERING WOMEN BY SUPPORTING THEM IN THE WORKPLACE

If a woman is earning her own living she is more likely to have more control over when, whether and how many children to have. Increased economic opportunities have been proven to increase women's decision-making power as well as their financial independence.[24] Such women have more say in household decisions, including decisions about their own healthcare and how household resources are spent – for example, on accessing healthcare.

However, improvements in women's job opportunities do not automatically lead to greater empowerment for women at home. Studies show that increased incomes for women can result in a higher incidence of domestic abuse and violence in the home, which can put women and girls at further risk.[25] Working with communities to change negative attitudes about women's empowerment is therefore vital.

In developing countries, women's economic empowerment is more about improving women's working conditions and pay and implementing policies and legislation that improve their ability to participate fully in the workplace, whether they choose to be mothers or not.

However, for many women, even those in paid employment, economic empowerment is a distant goal. Women's employment tends to be lower status, and women are more likely to be employed in casual work in the informal sector with flexible hours, such as farming or textile work. Their employment is likely to be more vulnerable, their employers less likely to be regulated and their rights as workers less protected. Women make up 90% of the workforce for rice-cultivation in south-east Asia.[26] In Kenya, 75% of agricultural labour is carried out by women.[27]

Women are also the main providers of childcare and carry out the bulk of other domestic responsibilities, such as gathering water or cooking. Evidence has shown that poorer women have a disproportionate burden of household responsibilities.[28] And for many women, the amount of time they spend on childcare is not sufficient to allow them to do paid work. There is a close relationship then between the provision of

ETHIOPIA: REACHING WOMEN THROUGH HEALTH EXTENSION WORKERS

Although Ethiopia's National Reproductive Strategy (2006–15) is not legally enforceable, it is a progressive family planning strategy that has made progress. The country introduced a new body of 34,000 health extension workers, whose task includes providing family planning in communities. The health extension workers, who are able to provide one-on-one advice to women, helped bring about an increase in the percentage of all women using a modern form of contraception from 10% in 2005 to 19% in 2011.[23]

The strategy also includes specific targets to address the underlying social and cultural barriers to increased contraceptive prevalence in Ethiopia. This includes policy objectives to encourage religious leaders to promote family planning and to provide youth-friendly family planning services through the public sector.

family planning and the length of time – hours per day, or over a number of years – that a woman spends on childcare, and her availability to take on paid employment.

Empowering women is clearly vital to developing better societies. Part of that involves empowering women to take greater control of their fertility. Governments and employers must work together to improve the working conditions of women and protect their rights as workers, in tandem with efforts to promote access to family planning. Governments must ensure that women in the formal and informal sectors are entitled to equal pay and benefits, and ensure that women are not discriminated against in the workplace – for example, through violence. Governments should reward women for their role in providing a social service as child carers and ensure that strong policies on maternity are in place. They must ensure that the informal sector is closely monitored, that a minimum wage is in place, that there are tight regulations to prevent the abuse of women's rights, and that those rights are being met.

MEN AND FAMILY PLANNING

Take-up of family planning and its effectiveness depends on men's involvement. In many societies, men act as 'gatekeepers' to women's access and utilisation of family planning services – from male policy-makers and male doctors influencing women's ability to access family planning services, to husbands and partners making decisions about women's contraceptive use. In some societies, the choice to stop or limit childbearing is decided by the male partner. A recent study of three Nigerian states found just 40% of respondents reported joint decision-making on whether to continue childbearing. Similarly, a couple being able to make joint decisions about the use of family planning was found to be a key factor in levels of contraceptive use.[29]

Male attitudes, or perceptions of male attitudes, towards family planning are often a significant barrier for women.[30] In Pakistan, recent analysis found that perceived opposition from husbands to contraceptives was a key reason why women were not using contraception.[31] Additionally, analysis of household surveys in eastern and western Africa reveal a large gap between a woman's approval of family planning and her perception of her partner's approval of family planning.[32]

The 1994 International Conference on Population and Development (ICPD) recognised the need to include men in family planning. Increasingly, family planning programmes are addressing men's own contraceptive needs as well as their shared responsibility as partners, husbands and fathers in family planning. Acceptance of contraception by men requires knowledge and awareness of appropriate family planning methods, and increased communication between partners. Successful interventions to reach men include mass media campaigns, communication skills counselling, and engagement with local leaders and extension workers.

MALAWI: CHANGING MEN'S BEHAVIOUR

The Malawi Male Motivator project was designed by Save the Children to increase contraceptive use among couples. Delivered through male peer educators, the project targeted men and was built on three insights:

1) men need information on the availability of modern family planning methods
2) men must be motivated to act on the knowledge of these methods
3) men require behavioural skills, such as communication skills, to facilitate conversations around family planning with their partners.

Recent evaluation of this project demonstrated a significant increase in contraceptive use by couples participating in the programme.[33]

BOOSTING DEMAND

As this chapter has demonstrated, the demand side of the family planning coin is equally as vital as the supply side to improving the take-up of services. Women's empowerment – through education, and through progressive policies on women's rights and on women's work – boosts demand for family planning. Governments are ultimately responsible for introducing and upholding laws and policies that enshrine women's rights. But there are many more who can play an active role in empowering women: teachers, health workers, mothers, extended family, civil society and the private sector.

Discrimination against women is deep-seated. To tackle it, the response needs to be equally stong and broad, running across different sectors. World leaders meeting at the London Summit on Family Planning in July 2012 must take action to generate demand and empower women to make their own decisions about family planning. The summit must be the start of a new drive to empower women and girls to decide whether, when and how many children they want to have.

RECOMMENDATIONS

Invest in girls' education

Every girl has the right to complete her education, but one in 10 girls are still out of school in developing countries. There must be a significant improvement in the number of girls who regularly attend school, the number of years that they attend school, the percentage that complete school and the quality of their school environment.

Introduce good-quality sex education

We believe that all girls and boys should be given comprehensive education on sexual and reproductive health and rights, that adheres to the UNESCO guidelines for age-appropriate sexuality education. This will require negotiation with ministries of education and ministries of health, and support from civil society.

Remove harmful legislation and introduce positive policies or legislation to guarantee all women and adolescent girls have the right to access family planning

Every country must have laws and policies that guarantee women's rights, secure women's and girls' equal status in society and cater for women's specific reproductive health needs. Establishing legislative guarantees to family planning means that the obligation to provide contraception is formalised, and citizens can demand their rights.

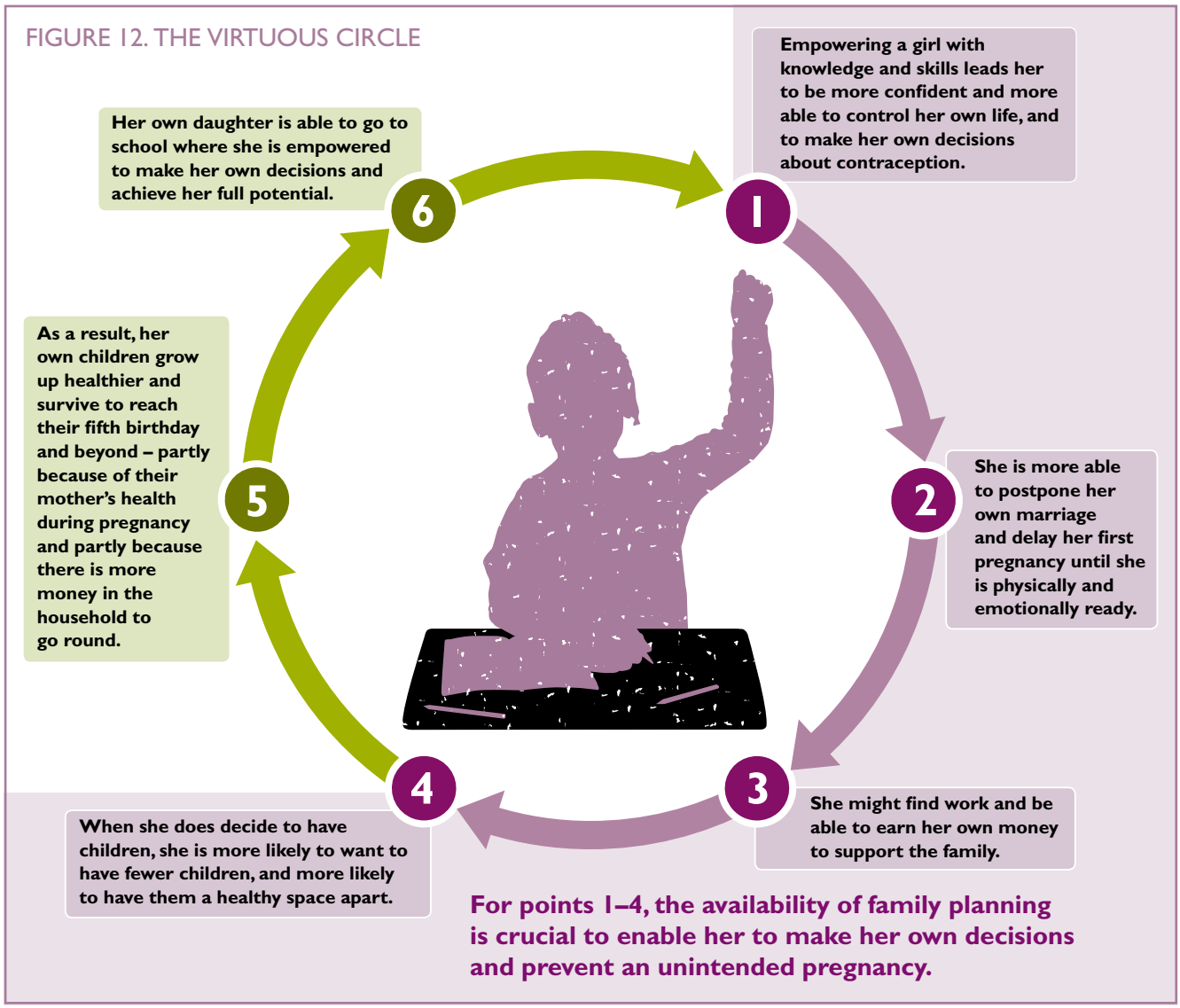
Help women to find a decent way to make a living

Every country must create the conditions that enable and empower women to earn a living and find decent work, and must put in place policies and legislation that improve women's ability to participate in the formal workforce (for example, equal pay and benefits, maternity policy, etc). Such legislation and policies must improve conditions and pay for women in more informal work (for example, ensuring that women workers are free to organise).

CONCLUSION

The relationship between women's empowerment, and the demand, supply and availability of family planning services constitutes a virtuous circle.

FIGURE 12. THE VIRTUOUS CIRCLE



The good news is that, worldwide, the percentage of couples using modern methods of contraception increased from 41% in 1980 to 56% in 2009. However, since 2000, rate of progress has slowed considerably to an annual growth rate of just 0.1 percent.[1]

Re-invigorating efforts to increase access to family planning and fulfil unmet need holds the key to saving babies' and children's lives and preventing adolescent girls from dying in childbirth. These efforts also increase women's ability to control whether or when they have children, and how many children they have, thus reflecting and enabling their empowerment. Smaller family sizes and a more equal social status and role for women leads to broader benefits for society.

The London Summit on Family Planning in July 2012 presents an unparalleled opportunity for high-level actions to align behind shared global goals on family planning. When world leaders come together in London, we urge them to make game-changing financial and political commitments to family planning.

We call on world leaders to seize the opportunity to tackle the key barriers that leave women with an unmet need for family planning. They must address the great shortages in the supply of family planning, by investing in health workers as well as filling the commodities gap. They must underline the importance of providing family planning services as part of the essential core package of women's and children's health interventions.

This moment should also be the start of a new drive to empower women so that they are able to demand and make use of family planning. It is a vital opportunity to send a message that positive policies, laws and practices need to be adopted that guarantee girls' access to education, women's rights and their equal status in society.

FIVE-POINT PLAN FOR THE 2012 LONDON SUMMIT ON FAMILY PLANNING

1. **Fill the funding gap**

   Globally, the total funding gap for family planning in all developing countries has been estimated at $4.1 billion a year. This is made up of $600 million for commodities and $3.5 billion for service delivery.

   The 2012 London Summit on Family Planning, which focuses on a subset of 69 developing countries, is a huge opportunity for international donors, national governments and private sector organisations to help fill this funding gap. All those attending the summit and making pledges to meet the unmet need for family planning should back their commitments with significant financial resources.

2. **Put health workers at the heart of family planning services**

   All efforts to improve access to family planning must include investment in the long-term recruitment, training, remuneration and support of sufficient health workers. Participants in the 2012 London Summit on Family Planning must ensure that their financial and policy commitments reflect the need to dedicate resources to service delivery, which should be earmarked for improving the quality of the national health service and to train and recruit health workers.

3. **Equity**

   Family planning strategies should include goals to ensure that contraception is accessible and affordable and that the needs of the poorest and most vulnerable women are addressed. Reaching the hardest to reach should be one of the core principles of the London Summit on Family Planning. Part of the challenge to overcome inequity is that governments must play a stewardship role to set out national family planning strategies and coordinate the activities of various players, including NGOs, and the private sector.

4. **Invest in education**

   There must be a significant improvement in the number of girls who regularly attend school, the number of years that they attend school, the percentage of girls who complete school and the quality of their school environment. It is also vital that all girls and boys are given comprehensive education on their sexual and reproductive health and rights. World leaders meeting at the 2012 London Summit on Family Planning must incorporate improvements in education into their commitments and pledges

5. **Introduce positive policies to protect women**

   Countries should use the opportunity of the 2012 London Summit on Family Planning to ensure that they have the right laws and policies in place to guarantee women's rights, secure women's and girls' equal status in society, and cater for women's specific reproductive health needs. They must recognise that earning a living is a vital part of empowerment; they must enable women to find decent work; and they must put in place policies and legislation that improve women's ability to participate in the workforce, and that improve conditions and pay.

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CHAPTER 1 TIME AND SPACE: HOW HEALTHY TIMING AND SPACING OF PREGNANCY SAVES LIVES

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CHAPTER 3 STIMULATING DEMAND FOR FAMILY PLANNING THROUGH EMPOWERING WOMEN

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CONCLUSION

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EVERY WOMAN'S RIGHT

How family planning saves children's lives

Around the world, more than 200 million women who do not wish to become pregnant are currently unable to access or use contraception.

Improving access to contraception would give more couples the power to decide whether or when to have a child. More surprisingly, it's also vital to improving children's chances of survival.

Every Woman's Right: How family planning saves children's lives sets out why providing contraception is vital to sustaining and accelerating progress in reducing the deaths of babies, children and mothers:

- Ensuring women are able to allow a healthy space between births means babies and young children are more likely to survive.
- Delaying the first pregnancy until a girl is physically ready can save the lives of both adolescent girls and their newborn babies.

The challenge of increasing uptake of family planning must be approached from both the supply and demand sides of the equation. This report answers two key questions:

- How can barriers of contraceptive costs and access be addressed?
- How can women and girls be empowered to demand family planning and to exercise their right to plan their pregnancies?

The London Summit on Family Planning in July 2012 presents an unparalleled opportunity for coordinated high-level action on family planning. This report puts forward a five-point plan for international donors, national governments and private-sector organisations.

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