



Women and Societies Benefit When Childbearing Is Planned

Family planning has far-reaching benefits for women and their families. Women who can plan the number and timing of their births enjoy improved health, experience fewer unwanted pregnancies and births, and have lower rates of induced, and often unsafe, abortion. In addition, women who have control over their fertility have a chance to get more schooling and find paid employment—achievements that enhance their social and economic status and improve the well-being of their families.

This *Issues in Brief* presents the most recent information on the pregnancy-related health risks faced by women in developing countries and documents the potentially beneficial impact of family planning on women's lives.

Scope of the Problem

Every year, an estimated 515,000 women—98% of them in developing countries—die as a result of pregnancy or childbirth. The major causes of death are hemorrhage, preexisting conditions that are complicated by pregnancy, acute infection, complications from unsafe abortion, eclampsia, obstructed or prolonged labor and ectopic pregnancy.

Maternal deaths are especially common in Sub-Saharan Africa: More than 1,000 women die for every 100,000 births in Central African Republic, Eritrea, Ethiopia, Mozambique and Rwanda; in many other countries in the region more than 500 women die for every 100,000 births (Table 1, column 1). Women in Sub-Saharan

Africa have a one in 13 lifetime risk of dying from pregnancy-related causes; in other regions, women have a considerably lower lifetime risk: one in 50 in South Asia and the Middle East and North Africa, and one in 160 in Latin America.¹

The World Health Organization (WHO) estimates that for every maternal death that occurs worldwide, an additional 30 women—some 15 million women annually—experience pregnancy-related health problems that often are serious and result in long-term disability. The most common problems include uterine rupture, uterine prolapse (a displacement from the normal position), pelvic inflammatory disease (which can lead to permanent sterility) and obstetric fistula (a muscle tear that allows urine to seep into the vagina and results in permanent incontinence if left untreated).

Maternity Care Lacking

Many of the conditions that result in maternal death or ill health can be treated or managed safely with proper care. However, women in developing countries often give birth without any skilled medical care, and emergency obstetric services are virtually nonexistent. Fewer than half of births are attended by a trained doctor or nurse in 20 of the 26 Sub-Saharan African countries listed in Table 1 (column 2), five of the Asian countries and two countries each in Latin America and in the Middle East and North Africa. In 10 of these countries, fewer than one-quarter of births are attended by a trained professional.

Poverty accounts for much of the lack of adequate prenatal and delivery services. Despite the 20-year international campaign on behalf of safe motherhood, many developing country governments lack the resources to provide the maternal health services that can save women's lives and protect their health.

High-Risk Pregnancies

Improving maternal health services is clearly a critical component of any effort to reduce maternal mortality and morbidity in developing countries. Another is enabling women to avoid pregnancies that often lead to these events—those that occur too soon or too late in a woman's life and those that occur in quick succession.

Many women in developing countries have children in their teenage years, when they are physically immature and often malnourished, conditions that increase their risk of experiencing a difficult delivery and obstetric complications. In addition, adolescent women are less likely than older women to have access to prenatal and obstetric care. Early childbearing is especially common in Sub-Saharan Africa: In Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Guinea, Malawi, Mali, Mozambique, Niger, Uganda and Zambia, 60–70% of women in their early 20s gave birth as teenagers, as did about half of women in Benin, Cameroon, Gabon, Madagascar, Tanzania and Zimbabwe (Table 1, column 3). High levels of adolescent childbearing are also found in Bangladesh, Nicaragua and Nepal.

table 1
Maternal Health and Reproductive Behavior

Country and year	Maternal deaths per 100,000 live births	% of births attended by a trained provider	% of women 20–24 who gave birth before age 20	Wanted fertility rate	Total fertility rate	% of married women using a modern method	% of married women with unmet need for family planning
Sub-Saharan Africa							
Benin Rep., 1996	500	60	50	5.0	6.3	3	26
Burkina Faso, 1998–1999	939	31	62	6.0	6.8	5	26
Cameroon, 1998	430	55	54	4.6	5.2	7	20
Central African Rep., 1994–1995	1,100	46	61	4.7	5.1	3	16
Chad Rep., 1996–1997	830	15	71	6.3	6.6	1	u
Côte d'Ivoire, 1994	600	45	63	4.7	5.7	4	28
Eritrea, 1995	1,000	21	47	5.7	6.1	4	28
Ethiopia, 2000	1,528	6	44	4.9	5.9	6	23
Gabon, 2000	600	43	58	3.5	4.3	12	28
Ghana, 1998	210	44	41	3.7	4.6	13	23
Guinea, 1999	670	35	66	5.0	5.5	4	24
Kenya, 1998	590	44	46	3.5	4.7	32	24
Madagascar, 1997	490	47	57	5.2	6.0	10	26
Malawi, 2000	620	56	62	5.2	6.3	26	30
Mali, 1996	580	24	70	6.0	6.7	5	26
Mozambique, 1997	1,100	44	65	4.7	5.2	5	7
Namibia, 1992	230	87	42	4.8	5.4	26	22
Niger, 1998	590	18	70	7.2	7.5	5	17
Nigeria, 1999	700	42	43	4.8	5.2	9	18
Rwanda, 1992	1,512	26	25	4.2	6.2	13	36
Senegal, 1997	560	47	43	4.6	5.7	8	35
Tanzania, 1999	530	36	56	4.8	5.6	17	22
Togo, 1998	480	51	38	4.2	5.2	7	32
Uganda, 1995	510	38	66	5.6	6.9	8	35
Zambia, 1996	650	47	63	5.2	6.1	14	27
Zimbabwe, 1999	400	73	48	3.4	4.0	50	13
Latin America & Caribbean							
Bolivia, 1998	390	57	36	2.5	4.2	25	26
Brazil, 1996	160	88	32	1.8	2.5	70	7
Colombia, 2000	80	86	36	1.8	2.6	64	6
Dominican Republic, 1996	230	96	39	2.5	3.2	59	12
Guatemala, 1995	190	35	47	4.1	5.0	27	23
Haiti, 2000	600	24	31	2.7	4.7	22	40
Nicaragua, 1998	150	65	52	2.5	3.6	57	15
Peru, 2000	270	59	30	1.8	2.9	50	10
Asia							
Bangladesh, 2000	440	12	61	2.2	3.3	43	15
India, 1998–1999	410	42	u	2.1	2.9	43	16
Indonesia, 1997	450	43	31	2.4	2.8	55	9
Kazakhstan, 1999	70	99	22	1.9	2.0	53	9
Kyrgyz Rep., 1997	65	98	37	3.1	3.4	49	12
Nepal, 1996	540	9	52	2.9	4.6	26	31
Pakistan, 1990–1991	340	19	31	4.7	5.4	9	32
Philippines, 1998	170	56	21	2.7	3.7	28	19
Uzbekistan, 1996	21	98	25	3.1	3.3	51	14
Vietnam, 1997	160	77	19	1.9	2.3	56	7
Middle East & North Africa							
Egypt, 2000	170	61	24	2.9	3.5	54	11
Jordan, 1997	41	97	17	2.9	4.4	38	14
Morocco, 1995	230	40	17	2.2	3.3	42	16
Turkey, 1998	130	81	26	1.9	2.6	38	10
Yemen, 1997	350	22	45	4.6	6.5	10	39

Notes: u=unavailable. Unmet need refers to the proportion of married women aged 15–49 who do not want a child soon or do not want any more children but are not using a contraceptive method. Source: All data are from the Demographic and Health Surveys.

The risks associated with adolescent childbearing are apparent when the maternal mortality ratios (which represent the number of women who die from pregnancy-related causes for every 100,000 live births) of different age-groups are compared. In Nepal, for example, the maternal mortality ratio among teenage mothers is almost double that of women giving birth in their early 20s.

Childbearing is even more dangerous for women in their late 30s and 40s, many of whom suffer from obstetric problems associated with earlier births or from having had several children at closely spaced intervals. In Nepal, the maternal mortality ratio among 35–39-year-old women is about three times that for women in their 20s and early 30s. In Malawi and Zimbabwe, the ratio for women 30–39 is about twice as high as the ratio among women under 30.²

As these statistics make clear, maternal mortality would drop substantially if women in developing countries were able to limit childbearing to their 20s and early 30s.

The risk of maternal death and illness also increases when women have births spaced close together; insufficient time to regain their strength affects women's health and survival, as well as their infants'. Yet 20% or more of all births in 34 of the 49 countries included in Table 1 occur less than two years after a previous birth.³

Prolonged breastfeeding and postpartum sexual abstinence, the traditional means of achieving longer intervals between pregnancies, are becoming less viable as urbanization and moderniza-

tion increase, particularly in Sub-Saharan Africa. For example, the period of protection against pregnancy provided by breastfeeding and postpartum abstinence in Nigeria and Ghana shrank by about four months between the late 1980s and the late 1990s. If modern contraceptive methods are not used to compensate for shorter durations of these practices, closely spaced births are likely to increase in these countries and elsewhere; death and ill health are likely to increase as well.

Achieving Smaller Families

Increasingly, women want smaller families than their mothers and grandmothers did; the vast majority have had all the children they want by their mid-30s. In Latin America, Asia, and the Middle East and North Africa, women generally want 2–3 children (Table 1, column 4). Wanted family size is higher in Sub-Saharan Africa—typically 4–6 children—although the smaller-family norm is beginning to take hold there as well.

However, many women in Sub-Saharan Africa and elsewhere are having more children than they want. In Bangladesh, Benin, Bolivia, Ethiopia, Haiti, Jordan, Kenya, Malawi, Morocco, Nepal, Nicaragua, Peru, the Philippines, Rwanda, Senegal, Uganda and Yemen, women have, on average, 1–2 more children than they wanted. In fact, the average total fertility rate is greater than the wanted fertility rate in all 49 countries listed (Table 1, column 5).

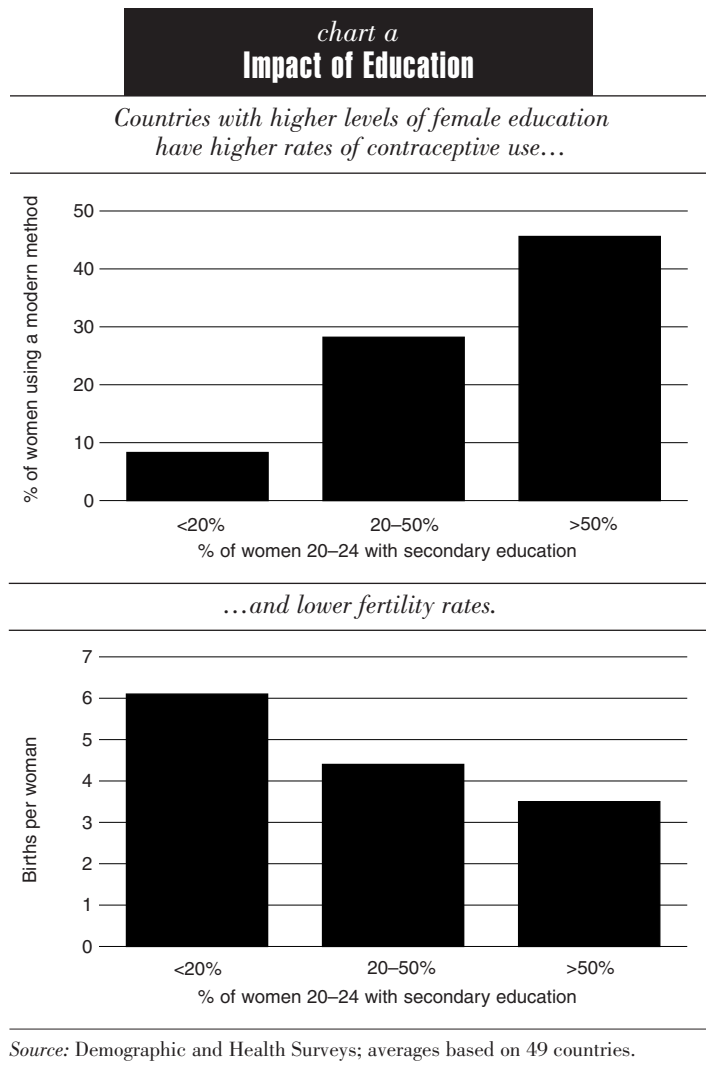
Yet, contraceptive use is generally low. Half or more of married women use a modern family planning method in

only 11 of the 49 countries; prevalence is highest, 64%–70%, in Brazil and Colombia (Table 1, column 6). In most Sub-Saharan African countries, fewer than one in five women use a method, and in 16 countries, fewer than one in 10 do so.

Low levels of contraceptive use do not mean that women do not want to practice family planning. In general, 10–30% of married women of childbearing age throughout the developing world do not want a child soon or do not want any more children but are not using a contraceptive method; in other words, they have an unmet need for family planning (Table 1, column 7). Unmet need is even higher in Haiti, Rwanda, Senegal and Yemen. Even in some Sub-Saharan African countries where large families are wanted—for example, Burkina Faso, Côte d’Ivoire, Ethiopia, Malawi, Mali and Uganda, more than one in five married women do not want a child soon but are not using family planning to space their births.

Reducing Unsafe Abortions

Roughly one in four of the world’s women live in countries that severely restrict access to abortion.⁴ WHO estimates that 20 million unsafe clandestine abortions occur each year, resulting in an estimated 78,000 maternal deaths, the vast majority of which occur in developing countries. In addition, unsafe abortions have many of the same negative health effects as those resulting from giving birth without skilled medical attention. If women were able to avoid the unplanned pregnancies that end in unsafe abortion, both their survival chances and their long-term



reproductive health status would improve.

However, an increase in contraceptive use would not necessarily result in an immediate decline in unsafe abortions. As smaller families become the norm, women who do not have easy access to family planning services will continue to turn to abortion to avoid an unwanted birth. In some countries, therefore, abortion levels may increase in the short term, until the supply of contraceptive services is adequate to meet the demand and women become more adept at using contraceptive methods effectively. In the longer term, however, increased use of effective methods will help

reduce the occurrence of unintended pregnancy and abortion.

Enhancing Women’s Status

Worldwide, women who want children understand that the freedom and ability to decide when to have them and how many to have are fundamental to achieving their goals in other areas of their lives, such as schooling, paid employment and reaching their full potential.

In developed countries, most women did not seek more education and equality with men until family planning became an accepted and routine part of their lives. Women in developing countries are likely to have the

same experience. Aspirations to stay in school, to obtain paid work outside the home and to help improve their family's welfare are dependent on women's confidence that these goals are compatible with their equally strong aspirations to be married and to have children.

In a mutually reinforcing process, being able to plan their families opens new opportunities for women, and women who take advantage of those opportunities have an increased need for family planning. For example, in many developing countries, the increase in women's education over the last two decades is believed to be strongly associated with women's increased ability to postpone childbearing and have smaller families.⁵ Similarly, educated women are more motivated to practice family planning so that they can achieve the smaller families they want and develop their broader life goals (Chart A). Furthermore, women who are accepted as equals by their sexual partners are also more likely to be able to negotiate contraceptive use, particularly use of the condom, than women who are not.

Protection Against HIV

In addition to the beneficial effects of modern contraceptive methods on women's ability to achieve safer pregnancies and births, one method—the condom—offers protection against infection with HIV and other STIs. Throughout the world, but especially in countries with high rates of AIDS and HIV infection, wider use of the condom is crucial to controlling the spread of the epidemic, as well as to reducing high levels of other sexually

transmitted infections, which can result in serious health problems and make people more susceptible to contracting HIV.

Convincing people to use condoms is difficult in societies, including those found in many developing countries, that are unwilling to talk openly about men's sexual relationships outside of marriage or sexual activity among young unmarried people. Information and counseling can help sexually active individuals and couples assess their level of risk and act to protect themselves and their partners against infection. Increasingly, health care providers and policymakers are promoting the use of dual methods—the condom to protect against HIV and other STIs and another method, such as the pill, for better protection against unintended pregnancy.

A Basic Right

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted by the United Nations in 1979 recognizes the right of all women to “specific educational information to help to ensure the health and well-being of families, including information and advice on family planning,” as well as to “access to adequate health care facilities, including information, counseling and services on family planning.”

Fifteen years later, 180 countries attending the International Conference on Population and Development (ICPD) affirmed the “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the

information and means to do so.” The ICPD report called on governments and international donors to take steps to “prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and mortality and morbidity” and “make quality family planning services affordable, acceptable and accessible to all who need and want them.” Eight years later, however, contributions from developed countries have not met the funding targets set at ICPD, levels of contraceptive use are still low in most developing countries, and millions of women who want and need family planning services are unable to obtain them.

As the report acknowledged, the right to plan the timing and spacing of their children will remain inaccessible to many women and couples unless adequate resources are available to make high-quality and affordable family planning services a reality. Achievement of this goal will require that support for family planning remain a high priority for international donors as well as developing country governments.

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Sources of Data

Demographic and Health Surveys (DHS) for 49 developing countries are the main source of data for this report. These are nationally representative surveys with sample sizes typically ranging between 5,000 and 15,000 women of reproductive age; they are carried out with technical assistance from Macro International.

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