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New Population Council research is defining the broad benefits of family planning for women, couples, children, and societies. See story, page 2.

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Today, more than 200 million women worldwide would like to avoid pregnancy but do not use an effective method of contraception. They face many obstacles: lack of access to information and services, opposition from their husbands and communities, side effects, and the cost of modern contraceptives. As a result, they experience high levels of unintended pregnancies and preventable maternal and infant deaths. At the same time, funding and support from donors and policymakers have not kept pace with the growing demand for voluntary family planning. New Population Council research is defining the broad benefits of family planning for women, couples, children, and societies. Voluntary family planning programs enhance human freedom, improve health, and reduce poverty. The Council is changing the way global leaders think about this uniquely comprehensive development tool.

**Family planning reduces fertility**

High-quality voluntary family planning programs significantly reduce fertility, even in poor countries (e.g., in Bangladesh, Indonesia, Nepal, Rwanda, and Sri Lanka), says demographer and Population Council distinguished scholar John Bongaarts. These are traditional, rural, and agricultural societies, yet fertility has declined to low levels. Bongaarts explains that these unexpected trends are the result of the priority given by governments to the implementation of high-quality, voluntary family planning and health programs and to social

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In 2011, the Population Council completed the highly successful Family Advancement for Life and Health (FALAH) project, a family planning initiative that dramatically increased contraceptive use—an average of 28%, with the highest uptake among poor, rural, and younger couples—in less than four years in conservative areas of Pakistan. The project promoted the idea of healthy birth spacing to protect women and infants, and engaged the support of religious leaders who hold strong influence over family planning decisions. Government health ministers have committed to expanding the FALAH approach nationwide with support from development partners.

Fertility decline in Bangladesh, India, and Pakistan between 1990 and 2008 has made a substantial contribution to a reduction in maternal mortality ratios. Anrudh K. Jain, sociologist-demographer and Population Council distinguished scholar, found that about 35 percent of the reduction in maternal mortality between 1990 and 2008, representing 42,000 mothers’ lives saved, can be attributed to fertility decline.
development (e.g., schooling, infant survival, and women’s empowerment).

Anrudh K. Jain, sociologist-demographer and Council distinguished scholar, concurs. He and his colleague John A. Ross examined Demographic and Health Survey data from 40 developing countries to determine associations among strength of family planning program effort, socioeconomic conditions, and fertility. “For any given social setting, the average total fertility rate declines as the strength of the family planning program improves,” Jain said. “Improving female education and reducing infant mortality further reinforce fertility decline.”

No fertility decline has been observed in a poor and largely illiterate country in the absence of a strong family planning program.

Family planning improves maternal and child health

In another study, Jain measured the effect of fertility decline on the maternal mortality ratio in Bangladesh, India, and Pakistan. He found that fertility decline in those countries between 1990 and 2008 has made a substantial contribution to a reduction of the maternal mortality ratio. His analysis showed that in these countries about 121,000 fewer women died because of pregnancy-related complications in 2008 than in 1990. According to Jain’s calculation, about 35 percent of mothers’ lives saved (or about 42,000) can be attributed to fertility decline. Continued fertility decline between 2008 and 2015 will contribute considerably to the achievement of Millennium Development Goal no. 5, reduction in maternal mortality.

Family planning reduces poverty

Voluntary family planning programs are also powerful tools to boost economies and reduce poverty, contends Bongaarts, who examined the effects of family planning on poverty with his colleague Steven W. Sinding, former director general of the International Planned Parenthood Federation. First, by reducing the birth rate, family planning programs can create a “demographic dividend” that spurs economic growth for a few decades by increasing the size of the labor force relative to both young and old dependents, and by making it possible for people to save more money. About a third of the rapid economic growth rates experienced by East Asian tiger economies is the result of this dividend.

Second, slower population growth allows families and communities to invest more in providing quality education and health care and to improve infrastructure. Children who are healthy and educated are primed to become productive adults who can help to fuel the economy.

Third, when families are able to plan and space their pregnancies, they can invest more in each family member. And women who have fewer children have more time to earn wages outside the home, which increases family income and quality of life and reduces poverty.

The Population Council documented the benefits of family planning in studies of a landmark project undertaken by the icddr,b in the Matlab district of Bangladesh. The Matlab population of 173,000 people was divided into two areas: an experimental area, where access to high-quality family planning services was greatly expanded, and a control area, which received the standard set of less intensive services that were available countrywide. The impact in the experimental area was large and immediate: contraceptive use increased markedly, fertility declined rapidly, and women’s health, household earnings, and use of preventive health care improved. Children in the experimental area were more likely to survive until the age of five and to attend school than were children from households in the control area.

Family planning strengthens societies

In countries that have adopted voluntary family planning programs—such as Indonesia, Kenya, and Rwanda—economies, public health, and standards of living are improving relative to demographically similar countries that have not adopted such programs.

“Voluntary family planning programs—simply permitting people to realize their individual reproductive goals—are a cost-effective way to improve health, enhance human freedom, and reduce poverty,” explains Bongaarts. “High-income countries should substantially increase funding for international family planning, particularly in sub-Saharan Africa, where leadership and funding have been most lacking. Government leaders in developing countries, especially those in sub-Saharan Africa who have neglected these issues, should follow the example of the Rwandan government, for example, which has made a successful recent effort to strengthen health and family planning services.”

Sources


Outside funding

William and Flora Hewlett Foundation
In the United States, poor and low-income women are the most likely to experience unintended pregnancy. In 2006, the rate of unintended pregnancy among the poorest women in the United States was more than five times the rate among the wealthiest women, and nearly half of their pregnancies were unintended. Novel strategies for improving access to contraception among poor women are clearly needed. Recent research has shown that one such innovative approach, the not-for-profit Access to Resources in Contraception Health (ARCH) Foundation, is enabling poor women to avoid unintended pregnancy.

The ARCH Foundation provides Mirena free of charge to poor women who want to avoid pregnancy. Mirena® is a levonorgestrel-releasing intrauterine system (LNG-IUS). Levonorgestrel is a hormone similar to progesterone. More than 2 million American women use Mirena, and it has been used by more than 15 million women in over 100 countries worldwide. Mirena is an extremely effective contraceptive, with fewer than 1 in 100 women becoming pregnant during five years of use. Moreover, it is an effective, FDA-approved treatment for heavy menstrual bleeding and is commonly recommended for women with perimenopausal bleeding in lieu of hysterectomy. It was co-developed and tested by the Population Council and the pharmaceutical company now called Bayer Schering Pharma of Finland. Bayer HealthCare Pharmaceuticals Inc. markets Mirena in the United States.

Ensuring social justice

“The Council has pioneered the creation of new strategies to ensure the socially just allocation of family planning methods,” said John Townsend, a Population Council vice president and director of the Council’s Reproductive Health program. “To make certain that poor women have access to our products, we require that the pharmaceutical companies we have licensed to manufacture and distribute our products find ways to provide the products to the poorest women. The ARCH Foundation is the result of such an agreement. We are proud of our continuing partnership.”

The ARCH Foundation (http://www.archfoundation.com/) has provided free Mirena to more than 120,000 American women since 2002. Similarly, the International Contraceptive Access (ICA) Foundation (http://www.ica-foundation.org) was established by Bayer Schering Pharma AG and the Population Council in 2003. The ICA Foundation donates the LNG-IUS—an IUS that is identical to Mirena, except for the insertion technique—to international development agencies and public health organizations, which then offer the IUS to poor women around the world. The ICA Foundation has donated nearly 40,000 IUSs to organizations in 15 developing countries.

Does the ARCH Foundation’s work succeed?

Researchers from the University of North Carolina School of Medicine, who are not affiliated with the Population Council or Bayer, compared pregnancy rates in two groups of women aged 15–44. The women were all poor, uninsured, and clients at one of two health clinics in North Carolina between 2003 and 2009. The women all wanted to avoid pregnancy and were eligible for a free IUS from the ARCH Foundation. The researchers compared pregnancy rates between the women who chose to use Mirena and those who did not. The investigators were able to contact 90 of the 321 women who qualified for Mirena during that time period. Sixty-five of the women had chosen to use Mirena, while 25 had decided against it.

The study found:

• 11 percent of the women who chose to use Mirena had gotten pregnant; all of the pregnancies occurred after the IUS was removed; three of the pregnancies were planned; and, because most women kept the IUS for years, most of the pregnancies occurred more than three years after the IUS was inserted.
• 32 percent of the women who chose not to use Mirena had subsequently gotten pregnant; nearly all of these pregnancies happened within 18 months of deciding not to use the free IUS.

The scientists concluded, “If experience in these two North Carolina clinics is representative, the national impact of the ARCH Foundation on poor women, their families, and society has likely been profound.”

SOURCES


Recent Population Council studies have identified new details about the lives of sex workers—about their reasons for entering sex work and their daily experiences—that will help the government of India shape more successful policies and interventions to protect them from HIV.

Over a two-year period, Population Council researchers surveyed some 5,500 female sex workers from four states with high HIV prevalence: Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu. They focused on women who had moved to at least two different places for sex work in the past two years, as part of a major five-year study aimed at understanding the role of migration and mobility in vulnerability to HIV.

While some women enter sex work by choice or because it is a family profession, Population Council researchers found that more than 85 percent of Indian women who travel to find sex work were trafficked (i.e., forced, deceived, or trapped), or do so because of poverty, domestic violence, or other negative social conditions.

“One common pathway into sex work is the desire to escape from marital life, which represents freedom from violence, humiliation, and dominance from the husband,” says Population Council demographer and biostatistician Niranjan Saggurti, lead researcher on the study. “These women also have a desperate need to earn money for self-survival and to provide for the family.”

Council research has shown that these impoverished women are significantly less likely to use a condom every time they have sex than are women who enter sex work by their own choice or because it is a family profession. More than 40 percent of them drink heavily. They also face rape and physical abuse. These women are significantly more likely than others to experience reproductive and sexual health risks, including unplanned pregnancy, forced abortion, and stillbirth. These circumstances greatly compromise their health and well-being.

**Building skills and knowledge**

On the basis of these findings, the Population Council delivered recommendations to the Government of India and the agencies that implement HIV prevention programs in various states. These recommendations will improve the lives of women who are already sex workers. They will also help younger women avoid entering sex work.

Current initiatives for sex workers often focus on increasing these women’s self-esteem and offering them self-defense skills. While useful, these approaches are not sufficient to ameliorate their HIV risks. Initiatives for sex workers should also include comprehensive reproductive health services as well as education to raise their awareness about their rights and to help them identify and address vulnerabilities that are within their control.

Impoverished young rural women urgently need programs that will build their life skills and knowledge so that they can make informed choices, achieve their rights, and protect themselves. The Population Council has pioneered such initiatives for adolescent girls and is expanding them in countries around the globe.

**SOURCES**


**OUTSIDE FUNDING**

Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation

![Women who enter sex work for pressing social or economic reasons are likely to take risks that can damage their health and well-being.](image-url)
to be infected with (or to have contracted) HIV than nonmigrants. The survey of women from the three study areas also showed that the odds of HIV infection were higher among women with migrant husbands than among women with nonmigrant husbands.

The researchers found that even when they return to their hometowns, migrant men were more likely than nonmigrant men to engage in unsafe sexual behavior, which raises their risk and their wives’ risk of HIV infection. On the basis of these findings, India adopted a national HIV prevention strategy that focuses on corridors of migration, which include hometowns, destinations, and the transit points between them, rather than the destination areas alone.

Quantifying the role of migration in the spread of HIV

Council researchers found that in areas from which men migrate to find work, one-half to three-quarters of HIV infections among both men and women can be attributed to transmission from male migrants. In all study areas, when the spouses had different HIV statuses, it was more likely for the husband to be HIV-positive and the wife to be HIV-negative. This suggested a need for an increased focus on preventing the transmission of HIV from husband to wife in the hometowns, such as programs to help husbands and wives discuss condom use.

These findings led the Indian government to define a national goal of reducing the HIV infection rate among migrants to the level among nonmigrants by 2017.

Data underscoring the importance of a centralized approach to prevention

Researchers also surveyed policymakers, program managers, and study participants about the types of programmatic activities that could successfully arrest the spread of HIV. Council findings suggest that piecemeal initiatives from independent nongovernmental organizations would be less effective in reducing HIV among migrant populations than a synchronized approach.

On the basis of Council recommendations, India is now building its internal capacity and infrastructure to implement coordinated structural interventions with long-term sustainability. “As a result of our expertise,” says Saggurti, “we are assisting the Government of India’s National AIDS Control Organization in delivering solutions that lead to more effective policies and programs to reduce HIV among migrants and their wives.”

In a foreword to a report on these findings, Sayan Chatterjee, secretary and director general of India’s Department of AIDS Control, wrote that the findings are “an important resource for designing future interventions and preparing the health systems to address the changing face of the epidemic.

I encourage all agencies to take action in this direction.”

SOURCES

OUTSIDE FUNDING
United Nations Development Programme

Note: Arrows indicate the direction of migration.
HIV AND AIDS


POVERTY, GENDER, AND YOUTH


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HIV AND AIDS

Council Research Improves HIV Policy for Male Migrants in India

Programs developed by India’s National AIDS Control Organization and its partners have reduced the number of new annual HIV infections by more than 50 percent over the past decade. However, in some districts where HIV was previously rare, HIV incidence has slowly increased in recent years. Men from many of these districts migrate to other states to work—a practice called out-migration. These migrants experience long separations from their wives and may be more likely to engage in transactional sex.

A recent landmark study by the Population Council, the first of its kind in India, examined the role of migration in HIV transmission. In response to study findings, the Population Council worked closely with India’s government and other partners to overhaul national policies and programs aimed at reaching people who migrate in search of work.

The Council’s study was undertaken in three major corridors of migration: from Ganjam in Orissa to Surat in Gujarat, a distance of more than 1,000 miles (1,600 kilometers); from northern Bihar to Delhi and Haryana, a distance of nearly 700 miles (1,100 kilometers); and from eastern Uttar Pradesh to Thane in Maharashtra, a distance of more than 1,000 miles (1,600 kilometers). These travel corridors were characterized by extensive sex work activity and high HIV prevalence among female sex workers. The researchers, led by Population Council demographer and biostatistician Niranjan Saggurti, surveyed roughly 800 married men (migrants and nonmigrants) and women from each of these three migration corridors.

Groundbreaking data on male migrant HIV risk behavior

The study showed that in northern Bihar, odds of HIV infection were eight times higher among migrant men than nonmigrant men, after controlling for possible confounding factors. In eastern Uttar Pradesh and Ganjam districts, migrant men were almost four times more likely...