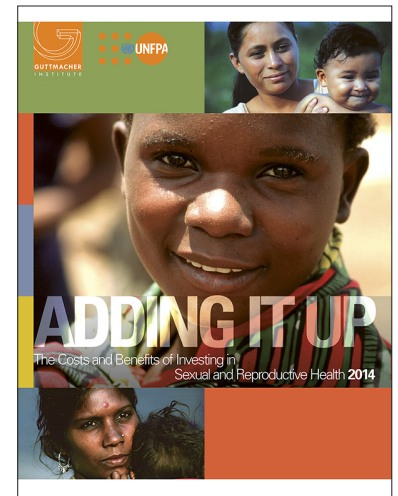




Executive Summary

Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014



Women need sexual and reproductive health services from adolescence through the end of their reproductive years, whether or not they have a birth, and those who give birth need essential care to protect their health and ensure their newborns survive. The declines in maternal and infant deaths in developing countries in the last decade are a welcome sign that increased global attention and resources devoted to safe motherhood and child survival are paying off.

Still, disparities in maternal and newborn deaths between the wealthy and poor countries of the world are far too wide, especially given that most of these deaths could be prevented with existing knowledge and technology. Across all world regions, the greatest burden of ill-health among women and infants is concentrated in places where health systems are weak and services are unavailable or inadequate. Thus, much more work remains to be done to provide essential health services to the poorest and most vulnerable people, and information is needed to guide action and investment.

New estimates for 2014 show that sexual and reproductive health services fall well short of needs in developing regions. An estimated 225 million women who want to avoid a pregnancy are not using an effective contraceptive method. Because increases in contraceptive use have barely kept up with growing populations, this number is virtually unchanged since the *Adding It Up* report for 2008.

Of the 125 million women who give birth each year,

- 54 million make fewer than the minimum of four antenatal visits recommended by the World Health Organization (WHO);
- 43 million do not deliver their babies in a health facility;
- 21 million need but do not receive care for major obstetric complications;
- 33 million have newborns who need but do not receive care for health complications; and
- 1.5 million are living with HIV, more than one-third of whom are not receiving the antiretroviral care they need to prevent transmission of the virus to their newborns and to protect their own health.

Another 65 million women each year have a pregnancy that ends in a miscarriage, stillbirth or abortion. Among these women, a substantial number are not receiving the medical care they need.

For instance,

- seven million do not receive adequate antenatal care;
- five million do not get facility-based care at the time of a miscarriage or stillbirth; and
- just over three million with complications from unsafe abortions do not receive post-abortion care.

If all women who want to avoid a pregnancy used modern contraceptives *and* all pregnant women and their newborns received care at the standards recommended by WHO, the benefits would be dramatic. Compared with the current situation,

- unintended pregnancies would drop by 70%, from 74 million to 22 million per year;
- maternal deaths would drop by 67%, from 290,000 to 96,000;

- newborn deaths would drop by 77%, from 2.9 million to 660,000;
- the burden of disability related to pregnancy and delivery experienced by women and newborns would drop by two-thirds; and
- transmission of HIV from mothers to newborns would be nearly eliminated—achieving a 93% reduction to 9,000 cases annually.

STIs other than HIV receive relatively little attention but take an enormous toll on women's reproductive health. In developing regions each year, an estimated 204 million women have one of the four major curable STIs (chlamydia, gonorrhea, syphilis or trichomoniasis), but 170 million (82%) do not receive STI services. Although data are limited, new estimates reveal that compared with the current situation,

- fully meeting women's need for chlamydia and gonorrhea treatment would prevent 27 million women from developing pelvic inflammatory disease and seven million of these women from developing infertility; and
- fully meeting women's need for syphilis screening and treatment during pregnancy would prevent 110,000 fetal deaths and stillbirths and 50,000 deaths among newborns, and would also prevent 100,000 infants from being born with syphilis.

How much would it cost to provide a package of sexual and reproductive health services for all sexually active women and their newborns?

- Fully meeting the need for modern contraceptive services would cost \$9.4 billion.
- Providing the recommended levels of maternal and newborn health care for women who have a live birth would cost \$21.7 billion.
- Providing the recommended care for women whose pregnancies end in miscarriage, stillbirth and abortion (assuming no change in relevant laws or practice) would cost \$2.0 billion annually.
- Meeting the need for HIV testing and counseling for all pregnant women and antiretroviral treatment for those living with HIV (during pregnancy and up to six weeks after delivery) would cost \$3.0 billion.
- Meeting the needs of newborns for testing and treatment related to HIV in the first six weeks of their lives would cost \$1.3 billion.
- Treating the major curable STIs for all women of reproductive age would cost \$1.7 billion.

These investments, if made together, would bring the total cost of sexual and reproductive health

care to \$39.2 billion annually. The total represents more than a doubling of the current costs of these services, but amounts to only \$25 per woman of reproductive age annually, or \$7 per person in the developing world.

The additional investments would not only have major health benefits; they would also be cost-effective, because helping women choose the number and timing of their pregnancies makes health care more affordable overall. With far fewer unintended pregnancies, the cost of improving pregnancy and newborn care and preventing mother-to-child transmission of HIV is much lower than it would be otherwise. Spending one dollar for contraceptive services reduces the cost of pregnancy-related care, including care for women living with HIV, by \$1.47. In addition, the results of a limited analysis on services for STIs other than HIV suggest that the burden of illness is so large and solutions so cost-effective that STI services are long overdue for additional investment.

As with current spending, the additional funds must come from the individuals who receive the services and national governments—who together account for the largest share of expenditures—and from contributions from NGOs and international donor agencies. Discussions about the needed funds, however, must take into account that the people most in need of services are among the least able to pay. Low- and lower-middle-income countries account for 80% of the increase in spending needed to fully meet all unmet needs for sexual and reproductive health care. Latin America accounts for only 4% of the total increase, while Africa (where health systems are in greatest need of strengthening) accounts for 71% and Asia for the remaining 25%.

Investments in sexual and reproductive health are critical for saving lives and reducing ill-health among women and their children—and for fulfilling their internationally recognized right to good health. The immediate health benefits alone are well worth the cost, and the payoffs are even greater when taking into account the broader, long-term benefits for women, their partners and families, and societies. These include increases in women's education and earnings, increases in household savings and assets, increases in children's schooling, increases in GDP growth and reductions in poverty.

Recent improvements in the health of women and newborns in developing countries have given the

world hope that the health problems related to pregnancy and childbirth that industrialized countries addressed long ago would soon be resolved in poorer countries as well. However, much more work remains to be done to reach the poorest and most vulnerable people. With sufficient resources and political will, the poorest women and families will see substantial gains from additional investments—and nations as a whole will see greater progress toward achieving their development goals.



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