Family Planning as an Economic Investment

John Bongaarts and Steven W. Sinding

Family planning—the provision of the information and services people need to determine for themselves the number and spacing of their children—has always been a controversial and sensitive subject in public policy. We briefly review the evolution of the population policy environment over the past half-century, before focusing on the critical years since the mid-1990s when international support for family planning declined sharply. Our main argument is that investments in family planning are highly cost effective because they have powerful poverty reduction effects in addition to providing health and human rights benefits.

A Brief History of Family Planning Policies

As recently as 1958, President Eisenhower responded to a Presidential Commission recommendation that the United States should add family planning to its international development programs by declaring it an inappropriate subject for government action. Then, during the late 1960s and into the 1970s, as the United Nations and donor countries urged developing countries to address the problem of high fertility and rapid population growth, many of these countries responded by accusing the industrialized countries of neo-colonial and imperialistic efforts to keep developing countries weak and impoverished. The Roman Catholic Church, long opposed to artificial birth control as well as abortion, assumed an increasingly aggressive opposition to government-sponsored family planning programs beginning with the papacy of John Paul II. U.S. administrations, when Republicans occupied the White House, have also generally taken a stance against international family planning programs, usually couching this in terms of opposition to abortion.

From the mid 1970s to the mid 1980s the intensity of debate diminished and international cooperation on family planning enjoyed something of a worldwide consensus. During that period, most developing countries acknowledged the need to bring down high fertility rates and most saw family planning as an important element of the strategies needed to do so, along with associated actions such as reducing child mortality, educating girls, and providing employment opportunities for women. In the United States, a bipartisan consensus supported international family planning

John Bongaarts is Vice President and Distinguished Scholar, Population Council. Steven Sinding is the former Director General of the International Planned Parenthood Federation.

© 2011 by The Johns Hopkins University Press
assistance, resulting in U.S. leadership in this field and relatively generous budgets to support family planning programs around the world. During this same period contraceptive use increased dramatically and fertility began to fall sharply, particularly in East Asia (such as Korea, Taiwan, Province of China, Thailand, Singapore) and Latin America (Colombia, Costa Rica, Mexico, Brazil), and generally in all countries that mounted robust family planning programs, including several predominantly Muslim states (Indonesia, Tunisia, Morocco, and later Bangladesh).

However, controversy arose again after 1984 when the United States, under President Reagan, announced a dramatic reversal of policy and the Vatican began the vigorous campaign cited above. In addition, the world’s two most populous countries began coercive family planning programs: China established its one-child policy in 1978, involving forced sterilizations and abortions, and Indira Gandhi invoked India’s forced sterilization efforts during the Emergency in 1975–1977. Both provoked outrage among human rights and women’s health advocates, including Human Rights Watch and the International Women’s Health Coalition. Some opponents argued that many family planning programs were crossing the line between reproductive freedom and state-imposed control. Many participants and government delegations expressed that concern at the third and most recent International Conference on Population and Development (ICPD) in Cairo in 1994. In response, women’s health and human rights advocates called for a rights-based “reproductive health approach” as an alternative to the primarily family planning approach that had existed up to that time. Reproductive health included not only family planning services and contraception but also a range of services that addressed reproductive tract infections, including HIV/AIDS; prenatal care, safe delivery, and postnatal care; prevention and treatment of infertility; the prevention of unsafe abortion and post-abortion care; and sexuality education and counseling. In addition, the Cairo conference strongly confirmed the right of women to freely choose when and how often to get pregnant and to fully control their reproduction.

Since 1995 there has been a precipitous decline in international support for family planning, per se. By 2005, only 0.2 percent of official development assistance from all OECD countries was allocated to family planning supplies and services, well below its 1995 level. President Obama hoped to change this trajectory and during his initial two years in office the administration substantially increased funding for international family planning activities. But, following the 2010 midterm elections, family planning is once again on the defensive. The newly elected Republican House of Representatives sought to strip it out of the omnibus 2011 appropriations bill and to defund Planned Parenthood in the United States. Although this effort did not succeed, the new infusions of resources that occurred while the Obama Administration controlled both houses of Congress will likely be challenged again.
International support for family planning declined from $723 million in 1995 to $338 million in 2007. Over the same period funding for reproductive health (primarily maternal and child health) and for the HIV/AIDS epidemic rose sharply. As a result, commitment of policy makers and staff at the national and international levels shifted from family planning programs to these new initiatives. Several factors were responsible for the downward trend in resources for family planning. First, the very success of these programs and other population policy measures from the 1970s to the 1990s in reducing fertility led many observers to believe that the so-called “population crisis” identified in the 1960s was at an end. This belief was reinforced by the advent of the HIV/AIDS pandemic and fears that high AIDS mortality would soon halt population growth without the need for additional government intervention.

Second, some admittedly apocalyptic early predictions, such as worldwide famine and the depletion of natural resources, failed to materialize. Neo-Malthusian predictions of rising mortality rates (such as that by Paul Ehrlich) simply proved to be wrong.

Third, the opposition of conservative governments and institutions, such as the Bush administration and the Vatican, made the very subjects of population and birth control controversial once again, causing governments and international institutions like the World Bank and the UN to become reluctant about addressing them. One interesting manifestation of this was the United Nations’ decision to exclude any mention of population and reproductive health from the Millennium Development Goals (MDGs) when they were adopted in 2000–2001—the only agreed-upon global goals emerging from a series of international conferences in the 1990s to be so excluded.

Fourth, other critical health issues emerged during the 1990s, particularly the global AIDS epidemic, that drew resources away from reproductive health and family planning.

Fifth, there continued to be fallout from statist birth control programs, particularly as they were carried out in China. These gave family planning a negative image and raised fears that other countries might follow this example.

Sixth, in the 1990s, fertility in many high income countries (like Europe and Japan) dropped below the “replacement” level of two children per woman, diminishing these “donor countries’” interest in lowering fertility levels elsewhere. If these low fertility levels are sustained, population declines and rapid aging will follow, with adverse economic consequences. These countries would be better off with somewhat higher fertility. In the long run, fertility near the replacement level avoids the negative impacts of rapid population growth and of population decline.
This cluster of issues moved family planning from a position of high priority in international development programs in the 1970s and 1980s to a second- or even third-tier ranking by the middle of the last decade.

The Obama Administration aims to reverse this trend for a number of reasons. The population of the poorest parts of the world continues to expand by more than seventy million per year, just as has been the case every year since 1980, and the AIDS epidemic’s demographic impact has turned out to be smaller than feared earlier (the population of Sub-Saharan Africa is expected to grow by one billion, or 129 percent, by 2050).\(^{10}\)

Large numbers of unintended pregnancies continue to result in preventable maternal and infant deaths; concerns about the environment, in particular global warming and potential shortages of natural resources, have resurfaced; and rapidly growing numbers of young unemployed males are likely a significant factor in socio-economic tensions and political instability in countries with high birth rates.

As critiques of family planning programs gained widespread credence in the early 1990s, proponents of family planning and reproductive health services emphasized their health and human rights benefits while downplaying economic or demographic justifications. Unfortunately, these rationales have not gained much traction with economic decision makers, in ministries of finance or planning, who tend to give highest priority in budgets to investments on which there is a clearly demonstrated economic return or for which there is a powerful political constituency. As a consequence, family planning now typically receives low priority in budget allocations at the national and international level.

However, there are, in fact, powerful and under-appreciated economic and poverty reduction impacts of family planning. Before turning to those arguments, it is important to note that voluntary family planning programs are highly valued by women because they help avoid unintended pregnancies. Each year, seventy-five million unintended pregnancies occur in the developing world (out of a total of 186 million).\(^{11}\) Most of these end in abortions or unintended births, with detrimental health and economic effects for women and their families. Unintended pregnancies occur because over one hundred million women have an unmet need for contraception: they don’t
want to get pregnant but are not using contraception. Among the reasons for this unmet need are a lack of knowledge about contraception, difficult access to supplies and services, the cost of contraception, fear of side effects, and opposition from spouses and other family members. Family planning programs have been shown to be effective in reducing these obstacles, thus reducing unintended pregnancies and birth rates. For example, one of the best known and most influential controlled family planning experiments was undertaken in the Matlab district of Bangladesh. Matlab’s population of 173,000 in 1977 was divided into roughly equal experimental and control areas. Starting in 1977, the quality of family planning services (including home visits, access to an array of contraceptive methods, and follow-up care) were greatly improved in the experimental half of the district while no additional services (other than much less intensive country-wide services) were provided in the control half of the district. The impact of the new services was large and immediate: contraceptive use among women of reproductive age jumped from five to thirty-three percent in the experimental area in the first eighteen months and remained about twenty-five percent higher than in the control area in subsequent years. As a result, fertility declined in the experimental area and the difference between the areas of about 1.5 births per woman was maintained over time. The Matlab experiment convincingly demonstrated that family planning programs can substantially reduce fertility in a very poor country.

**Economic Benefits of Family Planning**

So, how can family planning reduce poverty and encourage economic growth? The existing literature suggests several pathways.

First, fertility decline produces a temporary boost to economic growth as the proportion of the population of working age rises. Countries with high birth rates typically have very young populations. For example, in several West and Central African countries—where women on average bear about seven children over their lifetime, half the population is under age fifteen. In contrast, there are many fewer young people, relative to the number of working-age people, in countries that have experienced rapid fertility decline. For example, in China today only twenty percent of the population is under age fifteen, compared to thirty-four percent shortly after fertility started falling in the early 1980s, and forty-one percent in 1964. Clearly, fewer births lead to a decline in the proportion of the population under age fifteen. This trend has beneficial macroeconomic effects (called the “demographic dividend”) because it reduces the size of the dependent population relative to the size of the economically productive group (fifteen to sixty-four). There are fewer young mouths to feed and children to educate but more people to earn wages that can support improvements in the quality of life for the young and the very old. More workers per capita directly raises per capita income and frees up resources for investment in health, education, and other development sectors, thus further contributing to economic growth.
The demographic dividend is temporary, but it can last for decades and it is now raising economic growth in many developing countries. For a country to take advantage of the demographic dividend, or window of opportunity, it must also have in place a set of socioeconomic policies that contribute to and reinforce economic growth. Liberal, export-oriented economic policies alongside strong commitments to improved education and health seem to be essential ingredients. Fertility declines that began in the 1960s and 1970s were a major contributor to the “economic miracles” of China and the East Asian Tigers as governments pursued population policies that were part and parcel of comprehensive economic development strategies that included investments in public health, education, and infrastructure. In sum, by examining the impact of changing age structures resulting from fertility decline, economists have now established a highly plausible causal connection between demographic change and economic growth.

Second, rapid population growth, and in particular growth of the young population (under age fifteen), imposes on communities a growing burden that can be reduced by family planning programs. In poor communities around the developing world the population growth rate can reach as high as several percentage points per year, implying a doubling of population size in two or three decades. These communities must therefore build schools, health care facilities, and infrastructure at least at the same rate in order for standards of living not to deteriorate. Many communities are unable to keep up, as is evident from the steep and ongoing rise of populations living in slums in poor countries. Reducing the rapid growth of the young by reducing the number of unintended pregnancies and unwanted births makes it easier for communities to expand health care and school enrollments, and build infrastructure. On average, a dollar invested in family planning saves about two dollars in expenses related to antenatal, maternal and newborn health care. If savings in other development sectors are taken into account as well, the return is still larger. According to a recent UN report, “For every dollar spent in family planning, between two to six dollars can be saved in interventions aimed at achieving other development goals.” The largest benefits are in education and maternal health, with significant additional savings in water and sanitation, immunization, and malaria programs.

Third, at the family level, wanted children bring joy and social and economic benefits to their parents while unwanted births unnecessarily raise family expenses for food, clothes, shelter, schooling, and health care as well as time devoted to childcare and rearing. The benefits for women
and their children of reducing unwanted fertility through family planning programs are well documented in the Matlab experiment. Compared to the control area, the intervention area (with its rapid fertility decline) showed significantly larger long-run family welfare outcomes, including in women’s health, household earnings and assets, use of preventive health inputs, and intergenerational effects on the health and schooling of these women’s children.22

One of the key mechanisms through which families benefit from lower fertility is that women spend less time on childcare. This allows them to become wage earners outside the family, thus boosting family income and reducing poverty. Of course, women in poor societies often work very long hours, but they usually work on farms or other family enterprises without pay, attending to household chores and childcare. Once countries begin to develop, the proportion of female workers earning wages rises steeply and in an approximately inverse relationship to the level of fertility.23 Fertility declines are often associated with increases in women’s paid labor force participation.24

Fourth, family planning programs that reach out to disadvantaged groups contribute to reducing inequality between women in different socioeconomic groups. Unintended childbearing is more common among poor, rural, and uneducated women than among their well-off, urban, and educated counterparts. As noted, an unmet need for contraception is attributable to a range of social, health, and economic factors that pose barriers to women who wish to practice contraception. Such obstacles are larger and more common among women of low socioeconomic status and these women, therefore, have greater difficulty implementing their reproductive preferences.

Conversely, women of higher socioeconomic status typically have more knowledge about and access to contraception, have greater autonomy in reproductive decision-making, and are more motivated to implement their preferences because of the higher opportunity costs of unintended childbearing. It is, therefore, not surprising that countries with family planning programs that emphasize outreach to underserved areas and groups have smaller socioeconomic differences in unplanned reproductive outcomes. An analysis of unwanted fertility by household wealth status in forty-one developing countries by Gillespie et al.25 found that unwanted fertility was on average more than twice as high in the poorest than in the richest quintile (1.2 vs. 0.5 births per woman). For example, in Indonesia, where the family planning program has been strong for many years, unwanted fertility is very low on average (0.4) and the difference between the highest and lowest quintiles is just 0.1 births per woman. In contrast, in the Philippines, with a According to a recent UN report, “For every dollar spent in family planning, between two to six dollars can be saved in interventions aimed at achieving other development goals.”
weak program (in part due to strong opposition from the Catholic church), unwanted fertility averages 1.0 birth per woman and reaches 2.2 births per woman among the poorest quintile. Family planning programs thus help reduce fertility differentials and this in turn contributes to reducing income inequality.

The current evidence shows that family planning, in conjunction with other progressive development policies, is a cost-effective measure for reducing poverty and stimulating economic growth. Of course, the same can be said for many other measures such as schooling, healthcare, or infrastructure development. How do policy makers choose among a wide range of sector investments to optimize the welfare of people? We don’t have a precise recommendation for how much should be invested in family planning versus other sectors, but two things are clear: 1) family planning is very inexpensive and the return on investment is high; and 2) very little is being invested in it today. The proportion of international development assistance devoted to family planning is now two-tenths of one percent. Within most countries the proportion of government budgets allocated to family planning is similarly low. If family planning is so cost-effective, why have governments and international donors not given it higher priority? Several reasons have already been mentioned: past fertility declines, the AIDS epidemic, opposition from conservative institutions, and fear of controversy. In addition, family planning deals with a highly sensitive matter (sexual behavior) and governments are reluctant to intervene in the private decision-making of families. The case for government intervention would be relatively weak if all births are the result of deliberate and well-informed decisions of parents to have a certain number of children while forgoing other consumption. This would be the case even if such childbearing adversely affects others. However, the evidence is clear that a substantial proportion of births and abortions are the result of unintended pregnancies. The argument for intervention is, therefore, strong: everyone benefits, including the mothers and children, the community and society, and the environment.

Family planning, as a key component of reproductive health, must become more firmly embedded in the international consensus on development priorities as reflected in the [Millenium Development Goals].

Family planning and reproductive health were added as a target under the maternal mortality reduction goal, specifically as Target 5.b.—to provide universal access to reproductive health by 2015 and to reduce the unmet need for family planning. When the current MDGs are reviewed at the end
of their fifteen-year timeframe in 2015, family planning should be restored to the high priority it enjoyed three decades ago and seen not only in terms of its health and rights benefits but as a critical investment in economic development and raising living standards. The imminent arrival of the seven billionth human being (the result of adding more than seventy-five million each year since 1970) should stimulate greater investment in family planning to ensure slower growth and to enhance human development.

Notes

8 Ibid.
9 Ibid.
20 United Nations, Department of Economic and Social affairs, “What would it take to accelerate fertility decline in the least developed countries?” *UN Population Division Policy Brief No. 2009/1*.
22 Paul T. Schultz, “The Gender and Intergenerational Consequences of the Demographic Dividend: An Assessment of the Micro- and Macrolinkages between the Demographic

