GUTTMACHER INSTITUTE

In Brief

2014 Series, No. 2

Benefits of Meeting the Contraceptive Needs of Malawian Women

The ability to practice contraception is vital to protect the health of Malawian women and to enable them to plan the size of their families and the timing of births. Rising levels of contraceptive use have led to a decrease in the level of unintended pregnancies in Malawi; however, much more can be done to reduce the burden of unintended pregnancy—a problem for which women and society pay dearly in lives, the well-being of families and needless expenditures.

Women must have access to a range of effective, modern contraceptives so that they are able to have the number of children they want, when they want to have them. In Malawi, however, insufficient access to contraceptive services and inconsistent quality of service provision contribute to substantial numbers of unwanted and mistimed pregnancies. Thus, many Malawian women are exposed to the risks of childbirth—for pregnancies they did not want to have—without access to adequate obstetric care or safe abortion services, which endangers their and their family's lives, health and economic well-being, and places a substantial burden on society. This leads directly to the country's high maternal mortality ratio of 510 deaths per 100,000 live births.*[1]

Use of modern contraceptives† promotes the health and well-being of women and their families, in part by reducing maternal and infant mortality and morbidity.[4,5] Family planning directly contributes to the attainment of three Millennium Development Goals (MDGs): reducing child mortality; improving maternal health; and promoting women's empowerment and equality by enabling greater school, workforce and political participation. Improving access to family planning services also contributes to the attainment of three other MDGs: providing universal primary education, ensuring environmental sustainability and combating HIV/AIDS. The United Nations has declared that "accelerated progress and bolder action are needed"—particularly in Sub-Saharan Africa—to achieve these goals.[6]

This brief describes current patterns of contraceptive use in Malawi and documents the high costs of persistent unmet

*According to Demographic and Health Survey (DHS) data, the maternal mortality ratio in Malawi was 675 maternal deaths per 100,000 live births in 2010, a decrease from 984 per 100,000 in 2004.[2,3] Maternal deaths are those that occur to women during pregnancy, or within 42 days of termination of pregnancy, from any pregnancy-related cause.[1]

†Modern contraceptives include male and female sterilization, oral contraceptives, the IUD, the injectable, the implant, and male and female condoms.

Key Points

- In 2013, an estimated 54% of pregnancies in Malawi were unintended.
- More than four in 10 women have an unmet need for modern contraception—that is, they want to avoid pregnancy, but either are not practicing contraception or are using a relatively ineffective traditional method.
- Meeting just half of this unmet need would prevent 213,000 unintended pregnancies annually, which would result in 34,000 fewer unsafe abortions and 800 fewer maternal deaths each year.
- If all unmet need for modern contraception were met, maternal mortality would decline by more than two-fifths, and unintended births and unsafe abortions would drop by 87%.
- Investing in contraceptive commodities and services to fulfill all unmet need for modern contraception would result in a net annual savings of US$11 million (4.1 billion Malawi kwachas) over what would otherwise be spent on medical costs associated with unintended pregnancies and their consequences.
- Expanding contraceptive services confers substantial benefits to women, their families and society. All stakeholders—including the Malawi government and the private sector—should increase their investment in modern contraceptive services.

Methods

The estimates in this report are for 2013 and were projected from the most recent available data. Unless otherwise noted, the data were calculated using the following methods and sources. An appendix, that describes the methods and sources in more detail is available online at <http://www.guttmacher.org/pubs/appendices/IB-2014-2.pdf> or from the authors.

The number of women in each region, by marital status, desire to avoid pregnancy and contraceptive use in 2013, were estimated using data from the 2010 Malawi Demographic and Health Survey (MDHS) and from regional estimates of the number of women aged 15–49 from internal files of demographic projections supplied by the Central Bureau of Census and Population Studies.

The numbers of unintended pregnancies under current contraceptive use patterns and alternative scenarios were calculated using contraceptive use failure rates and pregnancy rates for nonusers from the MDHS and other sources (references 23 and 29), adjusted to the estimated number of unintended pregnancies in each region in 2013.

Pregnancy intendedness and pregnancy outcomes were estimated from regional data on the planning status of recent births from the 2010 MDHS, estimates of induced abortion rates in 2009 (reference 19) and estimates of the number of miscarriages.

The number of pregnancy-related deaths was estimated using the national estimate of the maternal mortality ratio provided by the World Health Organization (WHO) for 2012; the WHO estimate, unlike that from the DHS, is adjusted for underreporting and misclassification of maternal deaths. Regional estimates of unsafe abortions used the regional estimate of the abortion rate published by researchers at the Guttmacher Institute. Regional infant death rates were estimated from the 2010 MDHS. National-level estimates of pregnancy-related disability-adjusted life years (DALYs) among women and newborns were calculated by adjusting the 2009 estimates from the WHO Department of Measurement and Health Information.

Costs of contraceptive services and maternal and newborn health care were estimated from basic cost elements. For each contraceptive method or health care intervention, we combined the costs (in 2013 U.S. dollars) of drugs, supplies and materials, and of labor and hospitalization, with program and system costs, to arrive at a cost per user per year of protection against unintended pregnancy per woman receiving pregnancy-related medical care. Operational data and special studies from Banja La Mtsogolo (BLM), Abt Associates (Malawi) and PSI-Malawi supplied much of the information on costs per users. Program and system costs, which are indirect costs (e.g., overhead and capital expenditure), were taken from the United Nations Economic and Social Council. Direct costs of drugs, supplies, materials and labor used for family planning and mother and newborn health care interventions were taken from the United Nations Population Fund's Reproductive Health Costing Tool, from cost studies conducted in Malawi and from documents available in Malawi.

need for modern contraception. Building on prior work,[7–9] we use national data to estimate the net benefits to women and society of averting unintended pregnancies for 2013, both with current levels of use and under two hypothetical scenarios of increased investment in modern contraception. Although family planning provides many health, social and economic benefits to women and their families,[10,11] we focus on the health and financial savings gained by averting unplanned births and unsafe abortions.

The findings in this report provide evidence to help convince policymakers and international donors to increase investment in contraceptive services to reduce maternal mortality and morbidity in Malawi, and to alleviate unnecessary financial burdens on the country's health system. Unless otherwise specified, all data presented here are special calculations using data from the sources listed in the methods box and using the methodology detailed online.

Pregnancy and childbirth entail health risks for both women and newborns

Pregnancy and childbirth can be life-threatening for both women and children, especially in the absence of adequate prenatal and delivery care.[12,13] In Malawi, only 42% of pregnant women obtain the recommended minimum of four prenatal care visits, and just 74% of births are attended by a health care professional.[14] Of special concern are high-risk births, such as those that are too closely spaced or that occur among women younger than 18, older than 35 or who have already had many children.[4,5,15] Use of modern contraceptives can be particularly effective in reducing high-risk births among women wishing not to become pregnant.

The first year of life is risky in Malawi: Seventy-three out of every 1,000 infants die before their first birthday.[3] Unlike other countries in Sub-Saharan Africa, however, the infant mortality rate in Malawi is not related to wealth status: The number of deaths per 1,000 live births is 69 among infants born to women in the poorest households, compared with 71 among those born to women in the wealthiest. Another way to quantify poor health outcomes is to use disability-adjusted life years (DALYs)—a measure that expresses the burden of disease in terms of the number of healthy years of life lost to death or illness. In 2013 alone, perinatal complications contributed to the loss of nearly 770,000 DALYs among Malawian newborns.

The state of maternal mortality in Malawi is similarly grave. In 2010, an estimated 510 women died from pregnancy- and delivery-related causes for every 100,000 live births.[1] Annually, this translates to the death of around 3,450 Malawian women, many of whom had wished to avoid becoming pregnant.

Maternal death represents the worst-case scenario; however, for every death, 20 other women suffer a disability as a result of pregnancy or childbirth.[16] Such morbidity may prevent a mother from properly caring for her newborn or for other members of her family, or from participating in the workforce. The DALYs lost to maternal conditions in Malawi reached an estimated 164,000 in 2013; of those, 88,700 were lost as a result of unintended pregnancies. Expanding contraceptive use would limit women's exposure to the substantial risks inherent in pregnancy and childbearing in Malawi, and would especially help women avoid high-risk births.[4,17]

A leading cause of maternal death and disability is unsafe abortion, to which many women resort when they experience an unwanted pregnancy. Induced abortion is responsible for an estimated 18% of maternal deaths in eastern Africa, where Malawi is located.[18] Abortion is legally restricted in Malawi—allowed only if a woman's life is at risk. Yet, approximately 22 of every 1,000 Malawian women aged 15–49 have an abortion each year—around 78,000 in total.[19] Because most abortions in Malawi are clan-

Table 1

Unintended Pregnancies and Their Outcomes

Unmet need for improved contraception among women aged 15–49 wanting to avoid pregnancy and outcomes of pregnancies, by region and wealth, 2013

Region and wealth quintile	No. of women aged 15–49	Women who want to avoid pregnancy*				All pregnancies†					
		Total no. of women	% using no method	% using a traditional method‡	% with unmet need for modern method§	Total no. of pregnancies	% intended	% unintended	% ending in mistimed births**	% ending in unwanted births††	% ending in induced abortions
All	3,580,000	2,030,000	37.5	5.0	42.5	900,000	45.8	54.2	15.3	21.8	8.7
Region											
Northern	470,000	260,000	35.3	10.3	45.6	120,000	43.9	56.1	14.7	21.0	12.1
Central	1,550,000	890,000	37.1	4.3	41.4	390,000	45.9	54.1	15.3	21.9	8.6
Southern	1,560,000	880,000	38.5	4.2	42.7	380,000	46.4	53.6	15.5	22.1	7.7
Wealth quintile											
Poorest	660,000	370,000	45.7	5.0	50.7	190,000	44.7	55.3	16.1	23.6	7.5
Second	670,000	380,000	39.5	5.4	44.9	200,000	47.2	52.8	15.1	21.2	7.5
Middle	700,000	400,000	39.1	4.6	43.7	190,000	45.7	54.3	16.8	21.9	7.9
Fourth	700,000	400,000	34.9	4.4	39.3	170,000	45.2	54.8	14.2	22.1	9.2
Wealthiest	840,000	490,000	30.6	5.5	36.1	150,000	46.2	53.8	13.9	20.1	12.1

*Women who are married or are unmarried and sexually active (within past three months), are able to become pregnant (in the absence of contraceptive use) and do not want any more children or do not want a child in the next two years. †Includes miscarriages, which are estimated at 16% of all known pregnancies. Because we do not present miscarriages separately, the final three columns that break down unintended pregnancies do not add up to the total of unintended pregnancies. ‡Rhythm, withdrawal and folk methods. §Includes nonusers and users of traditional methods. By modern methods, we mean the pill, IUD, injectable, implant, male condom, and male and female sterilization. **Mistimed births are those to women who did not want a child for at least two years when they became pregnant. ††Unwanted births are those to women who wanted no more children when they became pregnant. *Sources:* <http://www.guttmacher.org/pubs/appendices/IB-2014-2.pdf>.

destine and performed under unsafe conditions by untrained providers, they carry a high risk of complications that endanger women's lives. Annually, more than 30,000 Malawian women need postabortion care, the cost of which can quickly exhaust scarce resources.

Contraceptive use in Malawi is increasing, but still deficient

In 2013, approximately two million Malawian women of reproductive age, or 57% of all Malawian women aged 15–49, were at risk of an unintended pregnancy—that is, they were married (or unmarried, but sexually active), were able to become pregnant and either wanted to delay childbearing for at least two years or wanted not to have any more children (Table 1). These women form the basis for our analysis. Among all married women, 72% (1.8 million) wanted to avoid pregnancy; 280,000 sexually active unmarried women also wished to avoid pregnancy, although this number may be an underestimate, as nonmarital sexual activity is stigmatized and hence underreported.[20–22]

Of all women who wished to avoid a pregnancy, 46% wanted to wait at least two years before having a child and 54% desired to stop childbearing altogether.[14] However, only 58% of women who wished to avoid pregnancy were using an effective, modern contraceptive method. Of the remaining women, 5% were relying on a traditional method, mostly withdrawal and periodic abstinence and 38% used no method at all (Table 1). We define these 43%—women desiring to avoid pregnancy, but not using a modern method—as having an unmet need for modern contraception.*[2,3]

The proportion of women at risk for unintended pregnancy with unmet need for modern contraception varied by region and economic status. Geographically, unmet need was highest in the Northern region (46%), followed by the Southern region (43%), but substantial proportions of women in all regions of Malawi face challenges in attaining their desired fertility goals. In addition, unmet need was substantially higher among the poorest women (51% of at-risk women in the lowest wealth quintile) than among those in the wealthiest households (36%). Poor women evidently face greater barriers to accessing and using modern contraceptives than women with high wealth status.

Norms regarding family size are slowly changing in Malawi. On average, Malawian women now state that the ideal family size is four children—one child less than in 2000, when a family with five children was considered ideal.[3,21] Furthermore, a greater proportion of women in Malawi now desire to stop childbearing altogether than want contraceptives for child spacing. Thus, there is substantial need for both reversible contraceptive methods and permanent or long-term methods.

The injectable is the most commonly used modern method in Malawi: It is used by 54% of women practicing family planning and accounts for 59% of all modern method use. Female sterilization is used by 21% of women practicing contraception; the popularity of sterilization among women seeking to limit childbearing is a relatively new phenomenon and is almost unique in the Sub-Saharan African experience.[21] Eight percent of women rely on condoms, around 5% on the pill, and 3% on the implant; less than 1% of women using a contraceptive rely on the IUD. Women seeking to stop childbearing altogether seem more likely than those wishing to space their births to

*This definition of unmet need differs from the standard definition used in DHS surveys. We include women using traditional methods in our definition, because traditional methods have relatively high failure rates, which leaves users vulnerable to unintended pregnancy and its negative consequences.

be using a modern method (60% vs. 55%).[14]

Despite the widespread use of family planning in Malawi compared with other Sub-Saharan African countries, 42% of at risk women still use no contraceptive method or only an ineffective, traditional one. Reasons for nonuse commonly cited by women include infrequent or lack of sexual activity, concerns about side effects or health risks, postpartum amenorrhea or breastfeeding, and costs and other barriers to access;[24] such barriers include insufficient training of providers, frequent stock outs of contraceptive commodities and limited choice of methods.[25–27] To overcome these obstacles, women and couples need accurate and comprehensive information about contraceptive methods, improved access to a wide range of methods and counseling on how to improve interspousal communication about family planning; outreach may be important for young people.

Nonuse accounts for the vast majority of unintended pregnancies

A woman's likelihood of experiencing an unintended pregnancy depends directly on whether and how effectively she and her partner use modern contraceptive methods.[28] The risk is lowest with sterilization and long-acting reversible methods (such as the IUD, implant and injectable), and highest when no method is used. The pill is more effective than the condom, and both are more effective than traditional methods (such as periodic abstinence and withdrawal).

In Malawi, an estimated 487,000 unintended pregnancies occurred in 2013. Unsurprisingly, the majority of those (88%) were among women not practicing contraception. Of the remaining 12% of unintended pregnancies, those caused by method failure, almost half occurred among women using traditional methods. Only 7% of unintended pregnancies were among women using modern methods.

Many women have more children than they want

In Malawi, insufficient use of modern contraceptives and reliance on less-effective traditional methods have led to high levels of unplanned births—those that occur too soon after a previous birth or when a woman wants no more children at all. In 2013, 49% of births were unplanned[14]—an increase from 40% in 2000.[21] Malawi's average family size has declined in recent years, from 6.7 children per woman in 1992 to 5.7 currently;[3] however, on average, women now report wanting to have only 4.5 children (Figure 1). Thus, the typical woman in Malawi has 1.2 more children than she wants, which underscores the need to improve access to quality family planning services.

Poorer women in Malawi have an especially difficult time achieving their fertility goals. While they generally desire a larger family than their wealthier counterparts, low-income women have the largest gap between their wanted and their actual fertility. The poorest women have, on average, 1.3 more children than they desire, whereas the wealthiest women—who have better access to modern contraceptives—have only 0.7 more children than they want (Figure 1).

Figure 1

Fertility Levels

Malawi women are having more children than they want, especially if they are poor

The difference between desired family size and actual fertility also varies by region. The gap is largest in the Central region (1.3 more children than desired) and smallest in the Northern region (0.9).[3] In general, women in the Northern region have slightly higher family-size preferences and use modern contraceptives less than the national average.[14]

The gap between wanted and actual fertility directly bears on the high level of unintended pregnancies among Malawian women. Of the estimated 900,000 pregnancies in 2013, 54% were unintended (Table 1, page 3). Of those, 28% ended in mistimed birth, 40% in unwanted birth, 16% in abortion and 16% in miscarriage. The proportion of pregnancies that were unintended varied only slightly among regions; however, 12% of women in the Northern region ended such pregnancies in abortion, whereas only 8% of women in the Southern region did so.

Similarly, the proportion of pregnancies that were unintended was unaffected by wealth status; however, although 8% of the poorest women terminated an unwanted pregnancy, 12% of the wealthiest women did so.

Contraceptive use promotes health and saves lives

Because unsafe abortions and other maternity-related risks can be drastically reduced by preventing unintended pregnancies, what are the quantifiable contributions of family planning to women's health and well-being? The following scenarios show the extent to which the number of unintended pregnancies would decline as levels of contraceptive use increase.

Currently, Malawian women have roughly 487,000 unintended pregnancies annually, of which approximately 409,000 end in unplanned birth or miscarriage and 78,000 in induced abortion (Table 2 and Figure 2). If there

Table 2

Unintended Pregnancies and Their Outcomes

Impact of contraceptive use in reducing the numbers of pregnancies (and pregnancy outcomes) and in averting DALYs, 2013

Outcome	No method use	Current method use*	Half of need for modern methods met†	All need for modern methods met‡	Percentage reduction in outcomes		
					Current use vs. no use	Half of modern need met vs. current use	All modern need met vs. current use
Unintended pregnancies	1,108,000	487,000	274,000	61,000	56	44	87
Unplanned births	760,000	334,000	188,000	42,000	56	44	87
Induced abortions	177,000	78,000	44,000	10,000	56	44	87
Miscarriages§	170,000	75,000	42,000	9,000	56	44	88
Maternal deaths	5,600	3,500	2,700	2,000	38	23	43
Infant deaths	80,500	49,500	38,800	28,100	39	22	43
Maternal DALYs	277,000	164,000	140,000	86,000	41	15	48
Perinatal DALYs	1,254,000	770,000	663,000	438,000	39	14	43

*Method mix of 58% modern, 5% traditional and 38% nonuse among women at risk of unintended pregnancies. †Method mix of 79% modern, 3% traditional and 19% nonuse among women at risk of unintended pregnancies. ‡100% modern method use among women at risk of unintended pregnancies. §Miscarriages from unintended pregnancies.

were no modern contraceptive use at all, however, the country would be faced with 1.1 million unintended pregnancies each year. Of those, 930,000 would likely end in unplanned birth or miscarriage; 177,000 would end in abortion—almost all of which would be unsafe. Thus, the current level of modern contraceptive use already yields considerable benefits, by averting an estimated 621,000 unintended pregnancies and 99,000 abortions each year.

Because childbirth in Malawi carries risks and unsafe abortion is particularly dangerous, the pregnancies prevented by the current level of contraceptive use in turn prevent more than 2,100 maternal deaths annually, compared with the no contraceptive use scenario. In addition, contraceptive use provides an additional 113,000 DALYs for women each year by reducing the number of maternal disabilities. Overall, the current level of contraceptive use has reduced these negative maternal outcomes by 38–41%, compared with the no method use scenario.

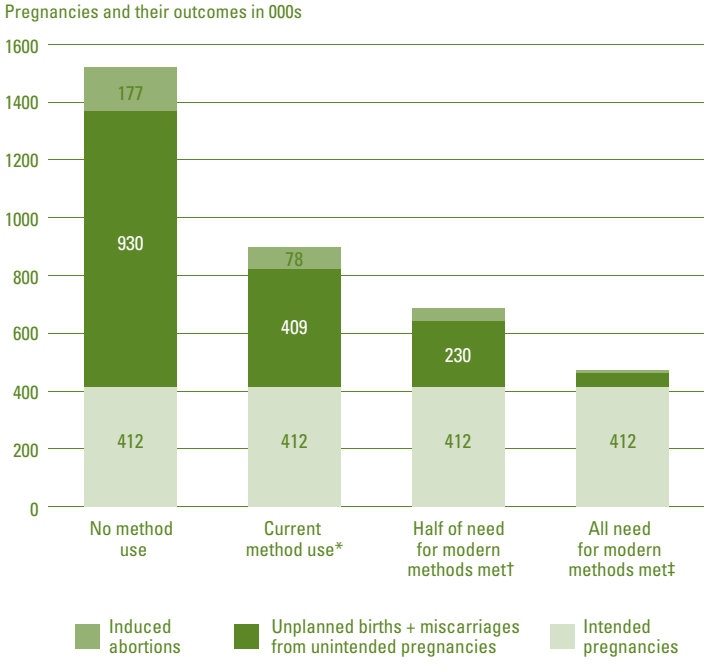
If use of effective contraceptives was increased beyond the current level through increased family planning efforts, Malawian women and their families would receive additional health benefits. Ideally, all women who want to plan their families would use modern contraceptive methods. In such a hypothetical scenario with zero unmet need, only 61,000 unintended pregnancies would occur each year (those caused by method failure)—426,000 fewer than currently occur (Table 2). In turn, the annual numbers of unplanned births, abortions and miscarriages would all be reduced by 87–88%, the number of maternal deaths would drop by 43% and an additional 78,000 years of healthy life would be restored to women. Moreover, each year, 1,500 fewer women would die in pregnancy and childbirth, the number of induced abortions would decline by 68,000 and 21,000 fewer infant deaths would occur. These are tangible outcomes that would dramatically improve the physical and emotional well-being of women and their families.

Of course, fully meeting the need for modern contraception would require large investments in infrastructure, personnel development and outreach services. A more modest scenario would be meeting just half of current unmet need. Even in this less demanding scenario, the benefits over the current situation would be striking. Seventy-nine percent of women who want to avoid pregnancy would use a modern method, and 213,000 (44%) fewer unplanned pregnancies would occur each year. This would result in 146,000 fewer unplanned

Figure 2

Benefits of Reducing Unmet Need

Use of contraception, especially modern methods, reduces abortions and unplanned births



Notes: See Table 2.

births, 34,000 fewer induced abortions and 800 fewer maternal deaths than currently occur. In addition, women would gain an extra 24,000 years of disability-free life.

Modern contraception also saves money

Every dollar spent on family planning saves money that would otherwise be spent on maternal, newborn and postabortion care resulting from unintended pregnancies. In Malawi, the estimated total expenditure on family planning in 2013 was US$12.5 million (Figure 3). Family planning expenditure would jump to US$17.1 million to fulfill half of all unmet need for modern contraception and to US$21.6 million to satisfy all unmet need. These are total costs including the expenditure on contraceptive commodities; staff salaries; overhead; upgrades to the country's health infrastructure; counseling; and information, education and communication activities.

Although these costs may seem high at first, they are considerably less than the savings that would be realized by avoiding medical expenditures related to unintended pregnancies and unplanned childbearing. For example, we estimate that the cost to the Malawian health system of providing prenatal, delivery and routine newborn care, covering all obstetric emergencies and treating postabortion complications was US$46.1 million in 2013; however, the cost would be substantially higher—US$75.3 million—without any modern contraceptive use, because the numbers of unintended pregnancies and unplanned births would be higher. Because this saving of US$29.2 million is greater than the cost of providing family planning (US$12.5 million), the current level of contraceptive use already provides a net saving of $16.6 million (6.1 billion Malawi kwachas) annually to Malawi's health system. In making this comparison, we consider only short-term savings in health care costs over a one-year period; longer-term savings would also be experienced in other areas, such as education, water, sanitation, immunization and malaria control.[11]

If the health system were able to satisfy half or all unmet need for modern contraception, a greater number of unintended pregnancies would be averted and the reduction in health care costs would be even more dramatic. The total cost of pregnancy-related medical care would fall by US$10.0 million if half of women who wanted to delay or limit childbearing used a modern method (from US$46.1 million to US$36.1 million), and by US$20.0 million if all unmet need were met.

Although reducing unmet need would require greater expenditure on family planning services, considerable net savings would result. Compared with current expenditures on contraceptive services and maternal, newborn and postabortion care, meeting just half of the unmet need for modern contraception would result in a net saving of US$5.5 million (2.0 billion Malawi kwachas), and fulfilling all unmet need would save US$11.0 million (4.1 billion Malawi kwachas), despite the additional expenditure in family planning to eliminate unmet need. The bottom line is that every additional US$1.00 spent on contraceptive services will save the health system US$2.20 in maternal and newborn care.

Expanded contraceptive use especially benefits poor women

Compared with the poorest women, those who are economically well-off have better access to contraceptive services and, consequently, benefit more from the advantages that result from contraceptive use. Thus, poor women stand to gain more from increased access to family planning. For example, if unmet need for modern contraception were fully satisfied, nearly twice as many unintended pregnancies would be averted among poor women than among well-off women (261 vs. 137 pregnancies per 1,000 women who want to avoid pregnancy). Similarly, the reduction in maternal mortality would be most pronounced among the poorest women: Fulfilling all unmet need would avert 94 maternal deaths per 100,000 poor women who wish to avoid pregnancy, compared with 44 per 100,000 among the wealthiest women. Investments in meeting women's reproductive needs will dramatically reduce existing reproductive inequities.

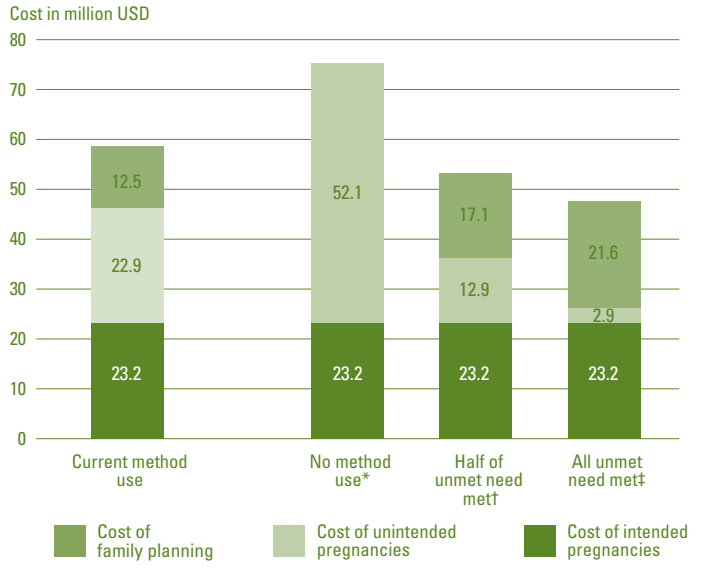
Additional funding is needed now

The Malawi government has committed itself to the African Union Commission and United Nations Population Fund's Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which has identified family planning as a key component of the strategy to improve public health.[29] In addition, the government pledged at the International Family

Figure 3

Cost Savings of Contraception

Investing in contraception could greatly reduce costs associated with unintended pregnancy



*Method mix of 58% modern, 5% traditional and 38% nonuse among women at risk of unintended pregnancies. †Method mix of 79% modern, 3% traditional and 19% nonuse among women at risk of unintended pregnancies. ‡100% modern method use among women at risk of unintended pregnancies. *Note:* Medical costs include costs for prenatal care, routine newborn care, professional delivery care, obstetric emergency care and treatment of complications from unsafe abortion.

Planning Summit held in London in July 2012 to increase funding for family planning to address unmet need.[30] Furthermore, it has approved a strategic plan for reproductive health in which a key goal is to increase the prevalence of modern contraceptive use from 42% in 2010 to at least 60% by 2016.[31] However, expenditures for reproductive health, in general, and for family planning, in particular, have been modest and, as budgeted for 2012–2013, average only US$7.34 and US$ 3.14 per woman of reproductive age, respectively.[32]

Achieving significant reductions in maternal and infant mortality and their associated costs will require greater investments in health care infrastructure and the provision of quality family planning services. The total budgeted outlay for reproductive health care translates to 14% of the country's total health expenditure.[33] Although Malawi—largely through the contributions of foreign donors—has raised health spending significantly over the last decade, the latest national health accounts show that about US$25 is spent per capita on health, still considerably short of the US$34 recommended by WHO.[34] The Malawi government has recently added a line to its annual budget exclusively for the procurement of contraceptives.[35] Extending this to a separate budget for family planning activities would reinforce its commitment to reducing unmet need and unintended pregnancies.

As this report has shown, an effective strategy for reducing maternal and infant death and disability is to lower women's exposure to the risks of pregnancy and childbirth in the first place. An estimated 87% fewer unintended pregnancies would occur annually in Malawi if all women with unmet need for modern contraception had access to and used a modern method. As women and couples increasingly desire to have smaller families, the demand for family planning will only grow. The responsibility for fulfilling this demand will have to be shared by various stakeholders, including the government, the private sector and international development partners. Improving publicly funded family planning—by increased investment, continuous quality improvements and adoption of client-based strategies—is especially important for the economically disadvantaged strata of the population.

Increased contraceptive use will enable the country to attain the MDGs—especially those that focus on mothers' and children's health—more quickly (even if not by the target date) and affordably, by helping to decrease maternal and infant death and disability through the reduction of unintended pregnancies. And investment in contraceptive services not only promotes healthy mothers and babies, it also saves money. Overall, every additional dollar spent on family planning will lower expenditure on mother and newborn care by more than two dollars. Increased contraceptive use will also increase labor productivity by improving the health of working women and allowing women more opportunity to participate in the workforce. Furthermore, the savings generated by averting unintended pregnancies can be directed to other development-enhancing investments. The benefits of improved quality of life and lives saved would be an incalculable gain to Malawian families.

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CREDITS

This *In Brief* was written by Michael Vlassoff of the Guttmacher Institute, and Maxton Tsoka of the Centre for Social Research, Zomba, Malawi. It was edited by Jared Rosenberg.
The authors are grateful for suggestions provided by Brooke Levandowski, SUNY Upstate; Nyovani Madise, University of Southampton; Olive Mtema, Futures Group; Nissily Ngaghana Elness Mushani, Ministry of Economic Development and Planning; Chris Oyepipo, UNFPA; Masepuka Prisca, Banja La Mtsogolo; and Eliya Zulu, African Institute for Development Policy. The authors thank the following Guttmacher colleagues for their contributions: Suzette Audam, Akinrinola Bankole, Sneha Barot, Jenna Jerman, Jessica Malter, Susheela Singh, Gustavo Suarez and Aparna Sundaram. They also thank Banja La Mtsogolo, Abt Associates (Malawi) and Population Services International/Malawi for their generous help and for sharing data. This publication was supported by a subgrant from Population Services International under the Dutch Ministry of Foreign Affairs' *Choices and Opportunities Fund*.

Suggested citation: Vlassoff M et al., Benefits of meeting the contraceptive needs of Malawian women, *In Brief,* New York: Guttmacher Institute, 2014, No. 2.

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