

# COSTING THE THREE TRANSFORMATIVE RESULTS

Produced by United Nations Population Fund

November 2019

The cost of the  
transformative results  
UNFPA is committed to  
achieving by 2030



● Ending preventable maternal deaths ● Ending the unmet need for family planning ● Ending gender-based violence and all harmful practices, including child marriage and female genital mutilation



# COSTING THE THREE TRANSFORMATIVE RESULTS

The cost of the transformative results that UNFPA is committed to achieving by 2030



IHME



UNIVERSITY of WASHINGTON



United Nations Population Fund

This publication focuses on new research to estimate the costs associated with a programmatic approach and the global cost of achieving these three transformative results by 2030.

The costing analysis pertains to the global effort led by UNFPA towards: (a) ending preventable maternal deaths, (b) ending the unmet need for family planning, (c) ending gender-based violence and all harmful practices, including child marriage and female genital mutilation.

UNFPA wishes to thank the following researchers who have contributed to this work:

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UNFPA recognizes the contributions of Robert Gustafson of Gustafson Associates in preparing this publication.

UNFPA further recognizes the efforts of the following UNFPA colleagues for their inputs in this publication: Howard Friedman, Tharanga Godallage, Charles Katende, Itamar Katz, Marie Anne Luron, and Helena Carvalho Schmidt.

The views and opinions in the research articles included within this publication are those of their respective authors and do not necessarily reflect the official policy or position of the United Nations Population Fund.

**Design and Layout:**

Missing Element

**Editing:**

Beyond Jargon LLC

**Photo credits:**

UNFPA photo collection.

**How to cite this publication:**

United Nations Population Fund (2019). *Costing the Three Transformative Results*.

New York, New York.

**Available at:** [www.unfpa.org](http://www.unfpa.org)

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ISBN: 978-16-1-800037-8

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# FOREWORD

Since the 1994 Cairo Conference, the global community has undertaken a concerted and largely effective effort to advance the sexual and reproductive health and rights of women and girls in developing countries, guided by the International Conference on Population and Development (ICPD) Programme of Action. The number and rate of women dying from complications of pregnancy or childbirth has been halved. Tens of millions more women have access to modern methods of family planning. Harmful traditional practices such as female genital mutilation (FGM) and child marriage are declining.

Yet, 25 years on, many women and girls are still left behind. Sexual and reproductive health and harmful traditional practices remain a leading cause of death, disability and economic and social disempowerment for women in the developing world.

Over 300,000 women die in childbirth of preventable causes every year. Ninety-seven per cent live in low- and middle-income countries (LMICs). Over 200 million women lack access to modern methods of family planning. Many millions of girls continue to suffer negative lifelong health, social and economic consequences from early marriage, FGM and gender-based violence (GBV).

The global community is reflecting on the progress and promise of the ICPD on its 25th anniversary and the deadline to achieve the Sustainable Development Goals (SDGs), convening at the Nairobi Summit where world leaders agreed to come together and end these scourges once and for all. Consensus has converged around the three transformative results set forth by UNFPA, the United Nations Population Fund, to be achieved by 2030:

- ending the unmet need for family planning
- ending preventable maternal deaths
- ending gender-based violence and all harmful practices against women and girls

With the publication of this report, the final, critical piece of knowledge is in place to move boldly forward. **For the first time, the global community knows the cost and the new investments that must be made to achieve these three world-changing goals.** With this information in hand, we are at *kairos* – that ancient Greek word for the opportune and decisive moment when conditions are right for the accomplishment of this crucial action.

ICPD25 and the Nairobi Summit represent a decisive moment to accelerate the groundbreaking promise of the ICPD Programme of Action and critical elements of the Sustainable Development Goals embodied in UNFPA's strategic plan to achieve the three zeros on behalf of women and girls globally. We are working towards zero unmet need for family planning, zero preventable maternal deaths

and zero gender-based violence and harmful practices. Governments and donors must seize the opportunity to “create financing momentum” – one of the five thematic areas of the Nairobi Summit – around this well-defined and ambitious, but entirely achievable, set of objectives.

Now that the path has been clearly defined, the decisions we make, the actions we initiate and the funding we commit will determine whether we achieve the three transformative results, live up to the ICPD promise and achieve the Sustainable Development Goals by 2030. It is truly a defining moment.

This new analysis makes clear that the costs of achieving the three zeros will be high, but the benefits will be much greater. Our work is firmly grounded in recognizing and respecting the human rights for all women, girls, men and boys. It is difficult to calculate the very real harm caused when a child grows up without its mother or a young girl experiences FGM. The emotional, social and economic harms may last a lifetime and impact future generations. But the economic benefits of ensuring that all women can freely plan and space pregnancies, no woman dies of preventable maternal complications and girls can complete their schooling and join the job market by avoiding child marriage are **quantifiable** and over time will **far exceed** the investment made in achieving the three transformative results.

This new analysis is a true road map to achieve these critical goals. It goes beyond calculating costs. It also identifies the specific interventions needed to achieve the three transformative results by 2030 and sets the stage for next steps, including developing country investment cases and costing of the work of UNFPA country programmes to achieve the transformative results.

Armed with this new costing information, encouraged by new commitments made at Nairobi and emboldened by the focused energy generated by the Nairobi Summit, we stand at a defining moment for global human rights and women's health and development.



Ramiz Alakbarov  
Director  
Policy and Strategy Division  
UNFPA

# INTRODUCTION

UNFPA embraces the vision set forth in the 2030 Agenda for Sustainable Development and the targets contained in the 17 Sustainable Development Goals. UNFPA has organized its work around three transformative and people-centred results in the period leading up to 2030. These are:

(a) ending preventable maternal deaths; (b) ending the unmet need for family planning; and (c) ending gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

UNFPA selected these results based on the mandate, comparative advantage, work experience and capacity for advancing elements of the Sustainable Development Goals. While UNFPA's mandate supports all 17 Sustainable Development Goals, the Fund is most directly aligned to the following:

- **Goal 3:** Ensure healthy lives and promote well-being for all at all ages
- **Goal 5:** Achieve gender equality and empower all women and girls
- **Goal 10:** Reduce inequality within and among countries

- **Goal 16:** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- **Goal 17:** Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

All of these Goals contribute directly to Goal 1, to end poverty. Goals 10, 16 and 17 are enabling conditions to help attain 3 and 5. In this context, the three transformative results reflect UNFPA's prioritization and commitment to achieve Sustainable Development Goal 3 and Goal 5.

More specifically, the three transformative results are aligned with the following targets:

- **Target 3.1:** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births<sup>1</sup>
- **Target 3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education and the integration of reproductive health into national strategies and programmes

**Figure 1. Universal and people-centred transformative results**



**Implemented through:**

UNFPA "bull's eye" for three consecutive strategic plan cycles

**Enabled by:**

Evidence and population expertise

**Focusing on:**

Empowerment of women and young people, especially adolescent girls

**Delivered in:**

Humanitarian and development settings

Source: DP/FPA/2017/9

<sup>1</sup> Ending preventable maternal deaths is also part of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

- **Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- **Target 5.3:** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

UNFPA, working with partners across the globe, plans to attain the three transformative results by 2030 through three consecutive strategic plan cycles: (a) Strategic Plan 2018–2021, Set the vision and start action; (b) Strategic Plan

2022–2025, Consolidate gains; and (c) Strategic Plan 2026–2030, Accelerate achievements.

With this publication, the final, critical piece of the puzzle to achieve the three transformative results is now available. For the first time, **we know the global price tag** to achieve these three world-changing goals. This new research makes clear that the costs of achieving the three transformative results will be high, but the benefits will be much greater.

**Table 1. The three transformative results advance the ICPD Programme of Action and Sustainable Development Goals**

<b>UNFPA transformative results (2018)</b>	End the unmet need for family planning, including modern methods of contraception	End preventable maternal deaths	End gender-based violence and all harmful practices against women and girls, including child marriage and female genital mutilation
<b>Sustainable Development Goals (2015)</b>	Achieve zero unmet need for family planning information and services, SDG target 3.7 and SDG target 5.6	Reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, SDG target 3.1	End gender-based violence, SDG target 5.2. End child marriage, SDG target 5.3. End female genital mutilation, SDG target 5.3
<b>ICPD Programme of Action (1994)</b>	“Universal access to reproductive health services, including family planning...” (Section 1.12)	“To achieve a rapid and substantial reduction in maternal... mortality.” (Section 8.20)	“Eliminate child marriages and female genital mutilation.” (Section 5.5) “Advancing... the elimination of all kinds of violence against women” (Principle 4)



# MESSAGES AND KEY FINDINGS

## PRINCIPAL MESSAGES

1. The world will not achieve the transformative results by 2030 without substantially accelerating progress towards these goals. The acceleration will not happen without filling the resource gaps and stepping-up political commitment.

The global community has spoken with a clear voice for over 25 years in support of ending the unmet need for family planning, preventable maternal deaths and harmful practices against women and girls. As 2030 fast approaches, the real work of bridging the substantial resource gap and implementing the broad-ranging programmes necessary to achieve these results must be embraced with a sense of extreme urgency. Political will must rapidly evolve beyond words to become concrete commitments of resources followed by immediate actions to implement programmes to achieve the three transformative results.

Funding must be increased now, substantially and from all quarters – no stakeholder should stand back wondering if they are needed in this effort. Everyone is critical to success and everyone will be asked for more than they anticipate and quite probably more than they will be comfortable contributing. But even substantial new funding is not enough. Backed by increased resources, acceleration of the many and diverse programmes described in this paper must start today and increase exponentially, not in a linear trajectory, without rest or cessation until 2030. If political will mobilizes the needed resources to fund the full range of appropriate programmes, then this vision for transformational change can be realized.

2. Filling the resource gaps to achieve the three transformative results means accelerating 2030 Agenda through implementation of the ICPD Programme of Action and achieving the Sustainable Development Goals.

Global efforts to achieve the three transformative results align with and support the existing global framework and consensus to end poverty and improve the lives of people around the world. The resources being mobilized and the programmatic actions being taken to achieve the three transformative results are in alignment with the ICPD Programme of Action, which supports the Sustainable Development Goals and will ultimately contribute to the achievement of the 2030 Agenda.

Global approaches in achieving transformative results need to be complemented by national actions from all stakeholders including governments, the private sector, civil society and individuals.

It is essential that every relevant category of funder contribute fully to planning and programmes to achieve the three transformative results. The inputs of multilateral and other international donors will be indispensable, but the rapid development and robust implementation of ambitious national plans will be critical to success. The early, visible and enthusiastic participation of national actors in each country, including the government, the private sector, civil society and individuals, will be a clear gauge of the level of national commitment to these goals and the likelihood of success within the tight time frame.

4. Domestic resources are the most sustainable source of investment in achieving the transformative results.

While all categories of donors have a major role to play in this effort, ultimately national governments are the most reliable and sustainable source of funding for programmes that benefit their citizens. Early action by national governments that demonstrate commitment to the three transformative results, identify areas where the government can make additional investments and also identify gaps where outside assistance is needed will mobilize and effectively target the most resources and help ensure success at the national level.

5. The transformative results need to be incorporated in public budgets and development cooperation efforts.

The level of new resources needed to achieve the three transformative results is substantial, and increases rapidly year-on-year as coverage targets are projected to increase steadily. In order to achieve this level of sustained commitment, it will be imperative that national governments factor these new resource needs into their public budgets, perhaps with new budget lines earmarked for this initiative or a robust increase in relevant existing budget lines. Likewise, all donor governments will be facing a new and sustained demand for additional funding through their development assistance budgets. Private sector donors will have to coordinate their enhanced efforts with governments and donors to ensure coordinated programming focused on results. It will be necessary to develop strategies to make this new funding available while maintaining current commitments.

## MAJOR FINDINGS

Groundbreaking research undertaken by UNFPA and its partners has for the first time determined a preliminary cumulative global price tag to achieve the three transformative results by 2030.

Achieving the three transformative results by 2030 in priority countries will cost \$264 billion. Of this sum, \$42 billion is currently projected to be provided by donors in the form of development assistance during this period.

This means that **new investment of \$222 billion will be required** to meet the three transformative goals by 2030. This new investment will come from domestic government spending, additional development assistance, the private sector, civil society and individuals.

### Investment needed to end preventable maternal deaths:

- The cost from 2020 to 2030 of ending preventable maternal deaths is \$115.5 billion for 120 priority countries.
- The amount in development assistance that will be spent in 120 priority countries is \$11.9 billion. Ending preventable maternal deaths by 2030 in 120 priority countries requires investments totalling \$103.6 billion.

### Investment needed to end the unmet need for family planning:

- The cost from 2020 to 2030 of ending the unmet need of modern family planning is \$68.5 billion in 120 priority countries.
- The amount in development assistance that will be spent in 120 priority countries is \$8.6 billion. Ending the unmet need for modern family planning by 2030 in 120 priority countries requires investments totalling of \$59.9 billion.

### Investment needed to end harmful practices:

- The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is \$2.4 billion. The amount in development assistance that will be spent in 31 priority countries is \$275 million. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of \$2.1 billion. Only \$95 are required to avert one case of female genital mutilation.
- The cost from 2020 to 2030 of ending child marriage in 68 countries with a high burden of child marriage is \$35 billion. The amount in development assistance that will be spent in 68 priority countries is \$10.9 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling \$24.1 billion. Only \$600 are required to avert one case of child marriage.

### Investment needed to end gender-based violence

- The cost from 2020 to 2030 of ending gender-based violence in 132 priority countries is \$42 billion. The amount in development assistance that will be spent in 132 priority countries is \$9.5 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling \$32.5 billion.

**Table 2. Achieving the three transformative results: cost and funding gap**

Transformative result	Total amount needed, 2020-2030	Projected amount available to spend, 2020-2030 as development assistance at the country level	New investment needed, 2020-2030
<b>End preventable maternal death</b>	\$115.5 billion	\$11.9 billion	\$103.6 billion
<b>End the unmet need for family planning</b>	\$68.5 billion	\$8.6 billion	\$59.9 billion
<b>FGM</b>	\$2.4 billion	\$275 million	\$2.1 billion
<b>Child marriage</b>	\$35.0 billion	\$10.9 billion	\$24.1 billion
<b>GBV</b>	\$42.0 billion	\$9.5 billion	\$32.5 billion
<b>Total</b>	<b>\$264 billion</b>	<b>\$42 billion</b>	<b>\$222 billion</b>

\* Figures may not add due to rounding.

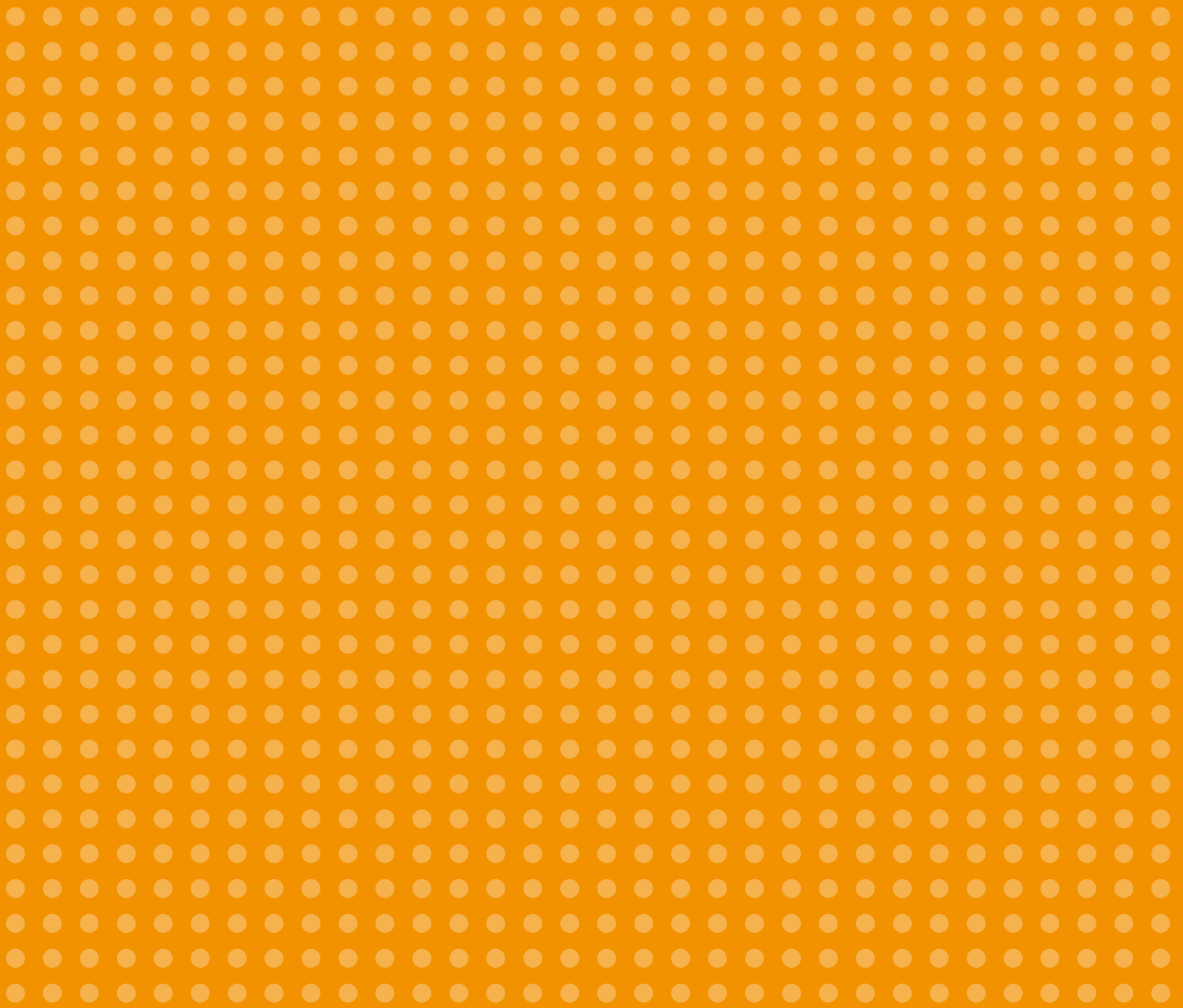
**Table 3. Road map for achieving UNFPA's three transformative goals**

The goals are set	End preventable maternal deaths	End the unmet need for family planning	End harmful practices against women and girls
<b>The challenges are known</b>	Nearly 300,000 women die as a result of childbirth annually, usually of preventable causes	232 million women in developing countries have an unmet need for family planning	High rates of child marriage, female genital mutilation and gender-based violence
<b>The solutions are at hand</b>	A set of known interventions to prevent and treat the leading causes of maternal death	Reduce barriers, enhance demand and make modern contraception accessible to all women and provide other essential services	Targeted programmes (e.g. secondary education, community empowerment, social norms and other targeted programmes) in affected countries to end harmful practices
<b>The partners are in place</b>	Governments, donors, NGOs, UNFPA and other multilaterals	Governments, donors, NGOs, UNFPA and other multilaterals	Governments, donors, NGOs, UNFPA and other multilaterals
<b>Now... the investments must be made</b>	<p>The cost from 2020 to 2030 of ending preventable maternal deaths is \$115.5 billion for 120 priority countries</p> <p>New investment of \$103.6 billion is needed</p>	<p>The cost from 2020 to 2030 of ending the unmet need of modern family planning is \$68.5 billion in 120 priority countries</p> <p>New investment of \$59.9 billion is needed</p>	<p>The cost from 2020 to 2030 of ending child marriage in 68 countries with a high burden of child marriage is \$35 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling \$24.1 billion</p> <p>The cost from 2020 to 2030 of ending gender-based violence in 132 priority countries is \$42 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling \$32.5 billion</p> <p>The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is \$2.4 billion. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of \$2.1 billion</p>

“ A new investment of \$222 billion will be required to meet the three transformative goals by 2030.

”

Every day 810 women die  
from preventable causes  
related to pregnancy  
and childbirth.



## TRANSFORMATIVE RESULT: ENDING PREVENTABLE MATERNAL DEATHS

# CHAPTER 1

# COST OF ENDING PREVENTABLE MATERNAL DEATHS

## SUMMARY

Ending maternal deaths from preventable causes is a cornerstone of the ICPD Programme of Action and an important indicator in the Sustainable Development Goals. Substantial progress has been made in reducing maternal mortality over the past 25+ years and globally, the number of maternal deaths has dropped 38 per cent since 2000. However, an estimated 295,000 women still die at or around the time of childbirth annually, with the least developed countries bearing the majority of the burden and 86 per cent of maternal deaths occurring in sub-Saharan African and Southern Asian countries. To drive progress towards Goal 3.1 for a “global maternal mortality ratio (MMR) less than 70 per 100,000 live births by 2030,” the *Every Woman Every Child* global movement was launched in 2010 to mobilize international and country-level action “to address the major health challenges facing women, children and adolescents around the world”. Many maternal deaths and injuries are preventable by scaling up evidence-based interventions to be delivered through high-quality and timely care.

The Bloomberg School of Public Health at Johns Hopkins University has developed a model to estimate the global cost of ending preventable maternal deaths in 120 low- and middle-income countries using available country-level data. The evidence-based approach assumes that maternal mortality and morbidity will decline if all women gain access to a core subset of 29 maternal health interventions spanning the continuum of care from the periconceptual to postpartum periods (the time around conception and

after childbirth). To estimate impact, the number of lives saved or mortality rate reductions attributable to expanded coverage of key interventions was quantified using a linear and deterministic modelling platform that applies country-specific conditions of mortality and health from population-based surveys or global databases.

## THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending preventable maternal deaths is \$115.5 billion for 120 priority countries.**
- **From 2020 to 2030, \$11.9 billion is available to spend as development assistance at the country level towards ending preventable maternal deaths in the next decade.<sup>2</sup> The total new investment needed to end preventable maternal deaths is \$103.6 billion.**

<sup>2</sup> This estimate of donor funding to address maternal mortality and morbidity 2020–2030 was developed by the Institute for Health Metrics and Evaluation (IHME), an independent global health research centre at the University of Washington. [www.healthdata.org/](http://www.healthdata.org/)

## 1.1 OVERVIEW

Global consensus exists on the need to end preventable maternal deaths. Eliminating preventable maternal deaths is a cornerstone of the ICPD Programme of Action and is an important indicator of both Sustainable Development Goal 3.7 and Goal 5.7.

Supported by this global consensus, progress has been made to reduce preventable maternal deaths. Since 2000, the global maternal mortality ratio has fallen a total of 38 per cent, from 342 maternal deaths per 100,000 live births in 2000 to 211 deaths per 100,000 live births in 2017. Many countries have halved their maternal death rates in the last 10 years.

Despite global agreement and several decades of progress, nearly 300,000 women still die annually from preventable causes at or around the time of childbirth – more than one maternal death every two minutes.

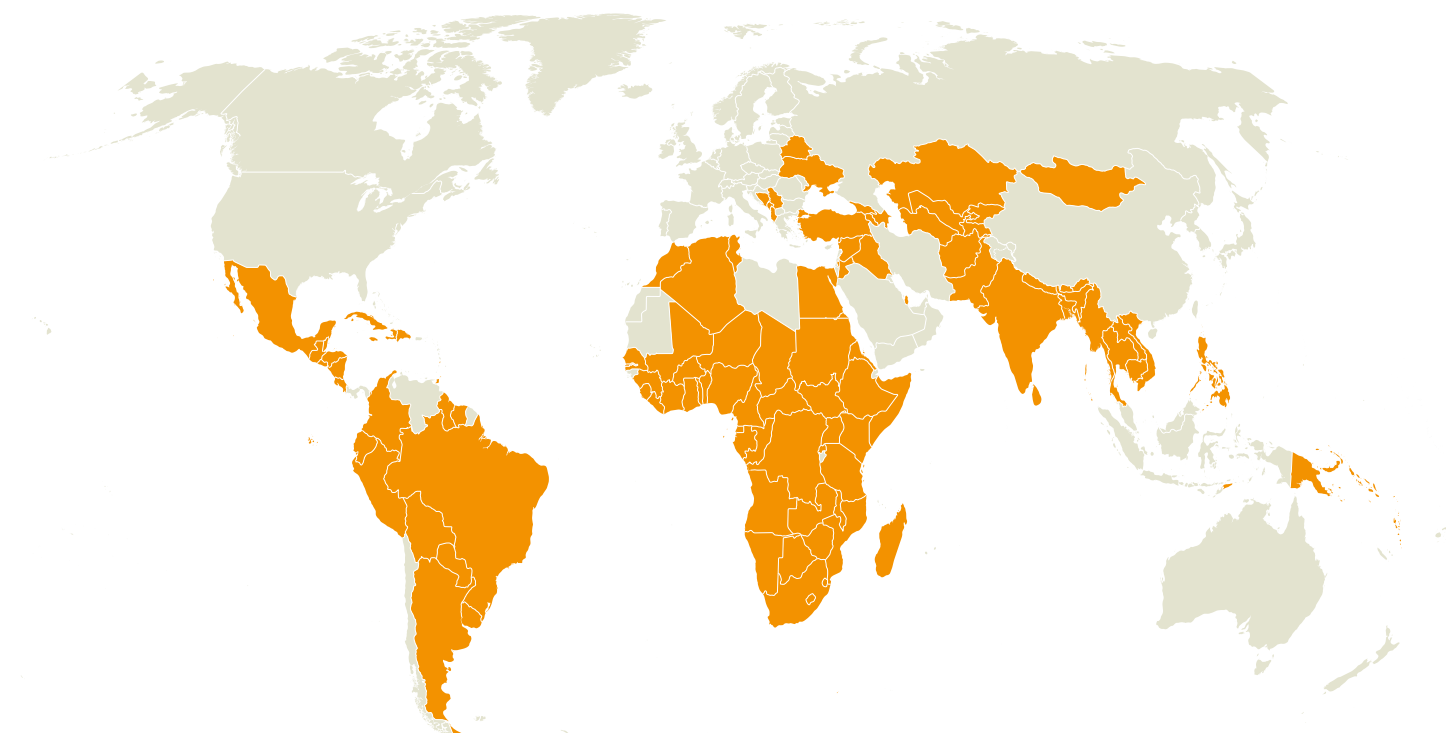
Every maternal death is a human tragedy for the woman and her family. About one million children are left motherless each year. These children are more likely to die within two years of their mothers' death than children with both parents living. And for every woman who dies, 20 or 30 suffer injuries, infections or disabilities. Ongoing high levels of maternal death and disability are also detrimental to the social development and economic well-being of communities and countries.

The majority of maternal deaths are preventable. About three quarters of all maternal deaths are caused by postpartum haemorrhage, hypertensive disorders such as pre-eclampsia/eclampsia, infections, unsafe abortion and other delivery-related complications. In theory, all of the major causes of maternal death can be treated with timely clinical interventions supported by quality care. In practice, however, even if a woman manages to access prenatal care and deliver in a health facility with a skilled birth attendant, poor quality of care can be life-threatening. Non-communicable diseases also play an important and growing role and may contribute to underlying cause of deaths that occur during pregnancy, delivery and the postpartum period.

## 1.2 OPERATIONALISING ENDING PREVENTABLE MATERNAL DEATHS

Ending preventable maternal deaths can only be achieved if all women have access to a core subset of high-quality maternal health interventions spanning across the continuum of care from periconceptual to postpartum. Ending preventable maternal deaths centres on improvements in maternal health interventions in a total of 120 priority LMICs, representing various levels of engagement dependent on country needs. These countries account for more than 99 per cent of all maternal deaths worldwide. For the purposes of this study, ending preventable maternal deaths is achieved when these evidence-based interventions for maternal health have been scaled up to reach 95 per cent of women in the targeted 120 countries. This study includes the needs of internally displaced persons and refugees.

**Figure 2. Map of 120 priority countries for ending preventable maternal deaths**



### 1.3 SCOPE

The estimated global price tag for ending preventable maternal deaths includes the commodity, service delivery and programmatic costs of delivering a package of 29 lifesaving medical interventions to all women during periconceptual, pregnancy/antenatal, and post-partum periods in 120 countries which account for more than 99 per cent of maternal deaths globally.<sup>3</sup>

### 1.4 METHODOLOGY

Ensuring that all women have access to a basic package of health services for prevention and treatment of complications of pregnancy and childbirth will reduce preventable maternal mortality and morbidity. To estimate impact quantified as the number of lives saved or mortality rate reductions attributable to expanded coverage of key interventions, the Lives Saved Tool (LiST) was used to

**Table 4. The path to ending preventable maternal deaths**

<b>Ensure that these 29 interventions are universally available...</b>	Folic acid supplementation/fortification Safe abortion services Post-abortion case management Ectopic pregnancy case management Blanket iron supplementation/fortification TT – Tetanus toxoid vaccination IPTp – Intermittent preventive treatment of malaria during pregnancy Syphilis detection and treatment Calcium supplementation Iron supplementation in pregnancy Multiple micronutrient supplementation in pregnancy Balanced energy supplementation Hypertensive disorder case management Diabetes case management Malaria case management MgSO <sub>4</sub> management of pre-eclampsia Immediate drying and additional stimulation Neonatal resuscitation Antibiotics for preterm or prolonged PROM Parenteral administration of anti-convulsants Parenteral administration of uterotonics Parenteral administration of antibiotics Assisted vaginal delivery Manual removal of placenta Removal of retained products of conception Surgery Blood transfusion Induction of labour for pregnancies lasting 41+ weeks Maternal sepsis case management
<b>In these 120 countries. . .</b>	Afghanistan, Albania, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Colombia, Comoros, Congo, Costa Rica, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Jamaica, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mexico, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Occupied Palestinian Territory, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Rwanda, Saint Lucia, Samoa, São Tomé and Príncipe, Senegal, Serbia, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia, Zimbabwe
<b>At the appropriate time for women . . .</b>	Periconceptual, pregnancy/antenatal, postpartum
<b>Ends preventable maternal mortality caused by... [1]</b>	Embolism (3.2 %), abortion (7.9%), hypertensive disorders (14.0%), postpartum haemorrhage and antepartum haemorrhage (27.1%), other direct causes (9.6%), indirect causes[2] (27.5%), sepsis (10.7%)[3]
<b>Which results in...</b>	Zero preventable maternal deaths

[1] Percentages represent the global causes of maternal death.

[2] Indirect causes of death are defined as those resulting from previous existing disease or disease that developed during pregnancy, which was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy. Indirect causes include infections (e.g. malaria and hepatitis), cardiovascular disease, psychiatric illnesses (e.g. suicide and violence), tuberculosis, epilepsy and diabetes (WHO et al., 2010).

[3] Percentages may be found at: [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(14\)70227-X/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70227-X/fulltext)

### SPOTLIGHT ON MIDWIFE TRAINING AS A LIFESAVING INTERVENTION: UNFPA MATERNAL AND NEWBORN HEALTH THEMATIC FUND

Launched in 2008 the Maternal and Newborn Health Thematic Fund (MHTF) works in 39 countries with some of the highest maternal mortality rates in the world. The Fund is committed to making childbirth safer for all women, girls and newborns by supporting training for midwives and strengthening health systems overall, especially in their ability to deliver lifesaving emergency obstetric and newborn care. Only 51 per cent of women in low-income countries benefit from skilled care during childbirth. Well-trained midwives could help avert roughly two thirds of all maternal and newborn deaths and deliver 87 per cent of all essential sexual, reproductive, maternal and newborn health services.

**Ethiopia:** In less than a decade, the number of midwives increased 10 times, while the maternal mortality rate fell by 40 per cent.

In 2009, Ethiopia had only 1,275 midwives caring for a population of over 85 million people. This critical shortage contributed to some of the highest maternal and newborn death rates in the world. Through the support of the UNFPA MHTF, policy changes were implemented and resources mobilized from other partners. Today, 12,069 midwives are equitably distributed across Ethiopia. The maternal mortality ratio has fallen over 40 per cent between 2008 and 2015.

**Bangladesh:** 3,000 new professional midwives have been trained and maternal deaths have fallen by nearly 61 per cent.

Since 2010, the UNFPA MHTF has supported the Government of Bangladesh in its pledge to train an additional 3,000 midwives and double the share of births attended by a skilled health professional. Bangladesh has launched two new midwifery programmes, resulting in significant improvements in maternal and newborn health and declines in mortality and morbidity.

model country-specific conditions of mortality and health. LiST is a mathematical modelling tool that allows users to estimate the impact of coverage change on mortality in low- and middle-income countries. Scenarios incorporate baseline coverage of interventions drawn from routine household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) and the effectiveness of interventions to reduce specific causes of death.

This basic package of health services is intended to be representative of the types of services and costs that are required; it is not a recommendation of what each country, or regions within countries, should do. The actual package would be tailored to each country context. The cost of the programme is estimated by multiplying the number of women reached with each service by the unit cost of providing that service. In addition to these service delivery costs, infrastructure and programme costs for support

functions such as administration, research, training and monitoring and evaluation have also been estimated.

## 1.5 RESULTS AND FINDINGS

The causes of preventable maternal death are well known. The solutions to ending most preventable maternal deaths are equally well known. Now, for the first time, the total resources needed to end preventable maternal mortality are known.

- The total investment needed is \$115.5 billion between 2020 and 2030.
- Donors are projected to provide \$11.9 billion of this amount between 2020 and 2030. The new investment required is \$103.6 billion.

**Figure 3. Methodology for estimating impact of coverage in number of lives saved**





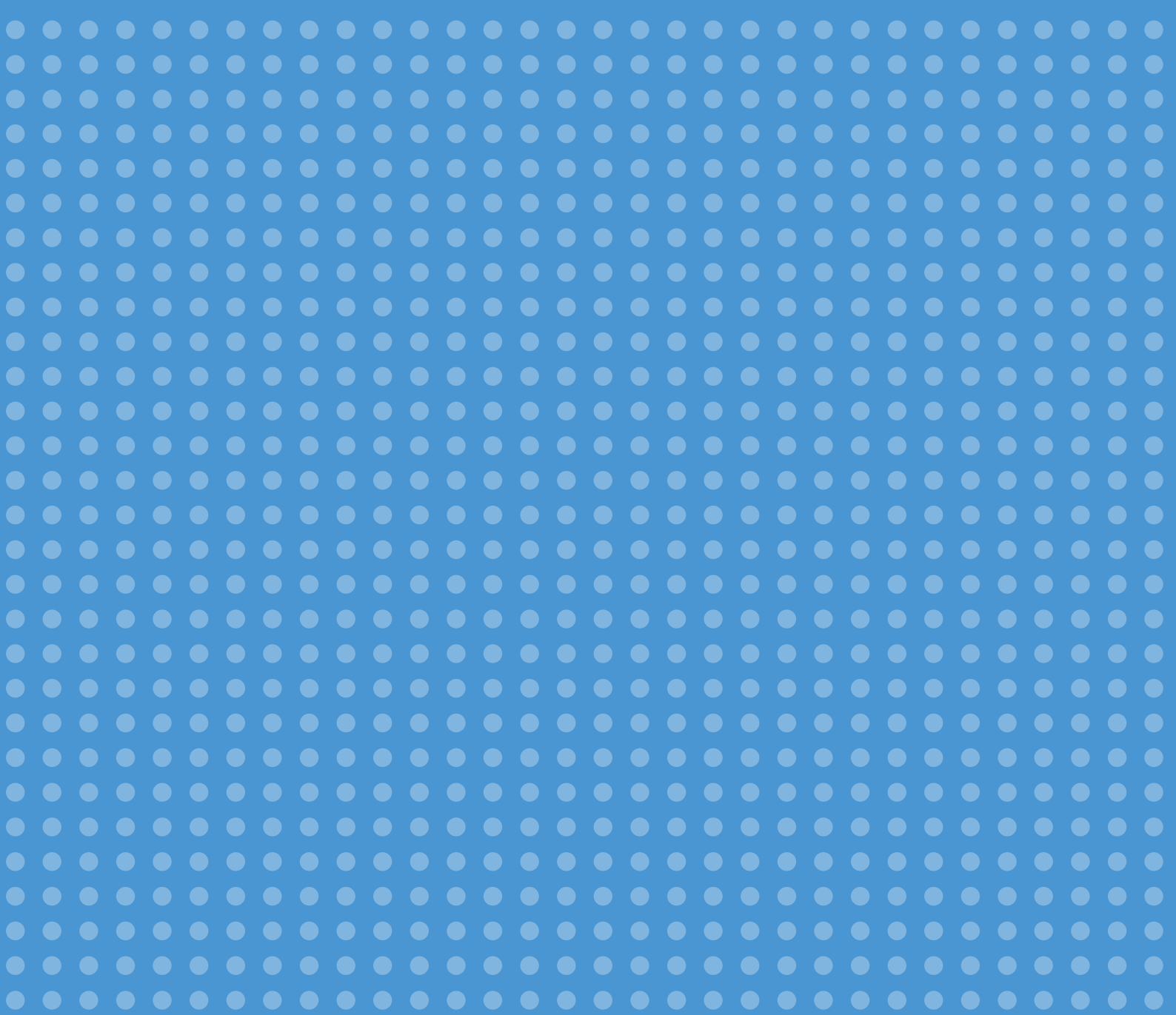
- Annual spending needs to increase from \$4.0 billion in 2020 to \$16.1 billion by 2030 to meet this goal.
- Ending preventable maternal deaths centres on improvements in maternal health interventions in a total of 120 priority countries representing various levels of engagement dependent on country needs.
- There is a relationship between unmet need for contraception and the incidence of preventable maternal death, where countries with high unmet need for family planning often have higher rates of maternal complications and deaths. This study assumes that ending unmet need for family planning will also be achieved by 2030. If unmet need for modern forms of family planning is not eliminated by 2030, the costs of ending preventable maternal deaths by 2030 could be substantially higher.
- More investment in maternal health would also make easily preventable and treatable conditions that arise from complications in childbirth – such as obstetric fistula – extremely rare.
- Providing these interventions in all 120 countries would also have the added effect of reducing newborn deaths by 33 per cent and still births by 57 per cent.

While the resources required are known, what is not known is whether the global community will take the action necessary to end preventable maternal deaths by 2030. Based on this new information, all that stands in the way is a commitment to implement all available and known interventions to save women's lives.

“**Ending preventable maternal deaths by 2030 in 120 priority countries requires investments totaling \$103.6 billion.**”

”

There are 232 million women in developing countries who want to prevent their pregnancies but are not using modern contraceptives.



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## TRANSFORMATIVE RESULT: ENDING THE UNMET NEED FOR FAMILY PLANNING

# CHAPTER 2

# COST OF ENDING UNMET NEED FOR FAMILY PLANNING

---

## SUMMARY

Substantial progress has been achieved in making voluntary family planning available to women globally over the past 25 years. Women have experienced a 25 per cent increase in global modern contraceptive prevalence since 1994, which has led to a decline in unintended pregnancies and contributed to a decline in maternal death. Ending unmet need for modern methods of family planning is a cornerstone of the ICPD Programme of Action and an important indicator in the Sustainable Development Goals .

Avenir Health has developed a model to determine the global cost of ending unmet need for modern family planning in 120 low- and middle-income countries. The study assumes that a country's unmet need will be satisfied when the projected modern contraceptive prevalence rate (mCPR) meets the current level of unmet need for any contraception plus the current rate of traditional family planning use and modern contraception use, accounting for population change over the 10-year period. The costs of providing a range of modern methods of contraception to all women is calculated on a country-by-country basis factoring in cost differentials based on each country's specific situation, including commodities, service delivery and programmatic costs.

## THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending the unmet need of modern family planning is \$68.5 billion in 120 priority countries.**
- **The amount in development assistance that will be spent in 120 priority countries from 2020 to 2030 is \$8.6 billion. Ending the unmet need for modern family planning by 2030 in 120 priority countries requires investments totalling of \$59.9 billion.**

## 2.1 OVERVIEW (INCLUDING NEED)

Global consensus exists on the importance of making voluntary family planning available to all women. Advancing universal access to family planning is a cornerstone of the ICPD Programme of Action and is an important indicator of both Sustainable Development Goal 3.7 and Goal 5.7.

Progress has been made in the last 25 years. The number of women using modern methods of contraception has almost doubled from 470 million in 1990 to 840 million in 2018.

Universal access to family planning is a human right and will save lives and have the effect of promoting healthier populations, more efficient health systems and stronger economies. Voluntary access to modern methods of contraception and related services prevents unintended pregnancies and births, lowers the number of abortions and reduces maternal death and illness related to complications of pregnancy and childbirth. If all women in developing countries with an unmet need for family planning had access to modern methods of contraception, maternal deaths would fall by about 76,000.

Despite consensus on this simple goal, in 120 low- and middle-income countries an estimated 232 million women are not using contraception despite wanting to avoid pregnancy. This gap in access to safe and effective modern family planning methods threatens women's health and undermines women's ability to build a better future for themselves, their families and their communities.

Making modern methods of family planning accessible to all women is a proven and cost-effective intervention.

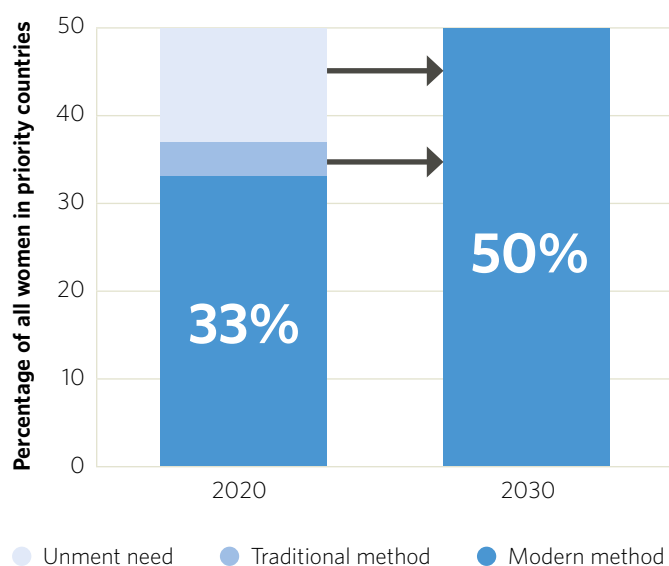
## 2.2 OPERATIONALIZING ENDING UNMET NEED FOR FAMILY PLANNING

UNFPA's goal of eliminating unmet need by 2030 has been operationalized for the purposes of this costing exercise as increasing the use of modern contraception to the level of current unmet need plus current use of all methods. This means that by 2030 the modern contraceptive prevalence rate would rise in each country by the amount of current unmet need and current use of traditional (vis-a-vis modern) methods of family planning. A small number of countries that currently have low contraceptive use and low unmet need would remain low, but by eliminating unmet need most countries would have a much higher modern contraceptive prevalence rate in excess of 45 per cent by 2030.

## 2.3 SCOPE

This analysis addresses 120 low- and middle-income countries that are home to a majority of the unmet need for family planning globally. Achieving the goal of ending unmet

**Figure 4. Operationalizing "ending unmet need" for family planning**



need will require a 40 per cent increase in users of modern methods. One quarter of that increase is due to population growth and three quarters is due to the increase in the modern contraceptive prevalence rate. The study has costed on a country-by-country basis a variety of programmatic interventions including access to a steady, reliable supply of quality modern contraceptive commodities, service delivery, programme management, research, training, data systems, NGO strengthening and other components. The study has also accounted for other causes of unmet need including access barriers, concerns about side effects and demand creation.

## 2.4 METHODOLOGY

The use of modern methods of contraception (see table 5) by all women of reproductive age (15-49) varies from a low of about 4 per cent to a high of 68.5 per cent in low- and middle-income countries. Unmet need for family planning refers to the percentage of women of reproductive age who want to avoid or space pregnancy within the next two years, but are not using any method of family planning. Unmet need varies from a low of 3 per cent to a high of 27 per cent in LMICs.

The costs of family planning programmes include the costs of commodities but also service delivery, programme management, research, training, data systems and other components. Rather than estimate the cost of each component, this study estimates of the total expenditure on family planning programmes by country published by FP2020.<sup>4</sup> These estimates are based on work by the Track20 project, Kaiser Family Foundation, Netherlands Interdisciplinary Demographic Institute, UNFPA and the World Health Organization to estimate expenditures on

**Table 5. Interventions needed to end the unmet need for modern methods of family planning by 2030**

<b>Ensure that these interventions are universally available...</b>	A steady, reliable supply of quality modern contraceptives (pills, implants, injectable methods, IUDs, male and female condoms, male and female sterilization, lactational amenorrhea, emergency contraception and Standard Days Method®)  Service delivery, programme management, research, training, data systems and other components
<b>In these 120 countries...</b>	Afghanistan, Albania, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Colombia, Comoros, Congo, Costa Rica, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Jamaica, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mexico, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Occupied Palestinian Territory, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Rwanda, Saint Lucia, Samoa, São Tomé and Príncipe, Senegal, Serbia, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia, Zimbabwe
<b>End the unmet need for family planning by...</b>	Ensuring that all women in the 120 target countries have ready access to a mix of modern contraceptive methods and appropriate programmes to support universal access
<b>Which results in...</b>	No unmet need for family planning

family planning by country from international donors, domestic governments and consumers. From this work we can estimate the expenditure per modern method user for 120 countries. For countries without data this study uses the regional average expenditure per modern method user as an input for scaling up national-level cost projections.

Projections of the number of women of reproductive age in target countries are available from the United Nations Population Division.<sup>5</sup> This study estimates the number of women using modern methods of contraception by multiplying the annual number of women of reproductive age by the per cent projected to use modern contraception. The calculation indicates that the number of modern method users would increase from about 685 million in all low- and middle-income countries in 2019 to about 970 million by 2030 if the goal is met.

From this work the study estimates the expenditure per modern method user for 120 countries. The average cost is about \$12. For some countries with incomplete data the study has assigned regional average costs per user. There is a wide range from less than \$5 per user to as much as nearly \$40. Countries with higher rates of contraceptive use have less variation in unit costs. By 2030, countries with low unit costs may be expected to experience higher costs as they improve quality and those with high unit costs will experience reductions as they become more efficient. Therefore, the study assumes that by 2030 all countries will have unit costs in the range of \$10 to \$20. For countries already in that range the study assumes constant unit costs. For countries outside that range the study assumes that costs will gradually increase or decrease to be within the range by 2030.

## 2.5 RESULTS AND FINDINGS

All that stands in the way of ending unmet need for modern methods of family planning is a commitment to provide the resources to implement the known interventions.

The causes of unmet need for family planning are well known. The solutions to ending unmet need for family planning are equally well known. Now, for the first time, the total resources needed to end the unmet need for family planning are known.

- The total investment needed to end the unmet need for family planning is approximately \$68.5 billion between 2020 and 2030.
- Donors are currently projected to provide \$8.6 billion of this need between 2020 and 2030 leaving the new investment required \$59.9 billion.
- Total resources from all sources will have to increase from about \$6.3 billion annually in 2020 to about \$10.8 billion annually by 2030.
- The global price tag for ending unmet need is 0.20 cents per person on earth per day between 2020 and 2030.

While the expenditures required to scale up family planning to end the unmet need are large, net savings are likely to be realized. With reduced requirements for maternal health care and delivery, child health care, education and other services, **the savings will be many times larger than the expenditure** on family planning.<sup>6</sup>

5 United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019*, Online Edition.

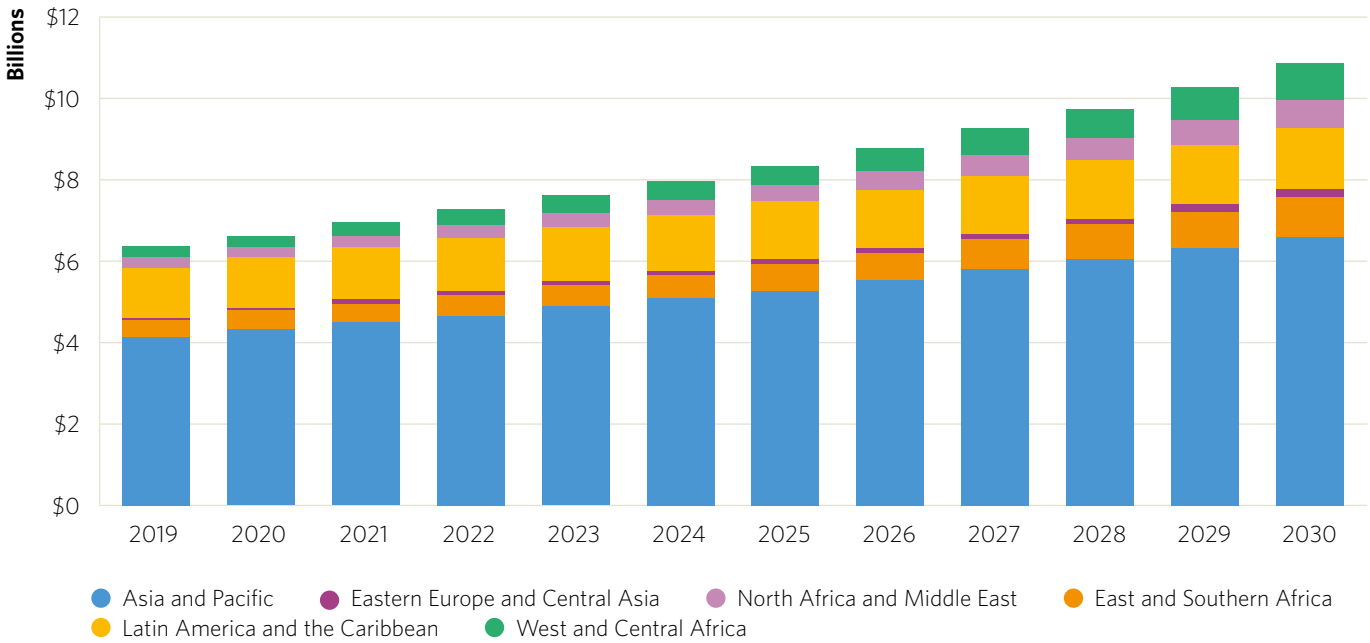
6 [www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017](http://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017)

The largest amount of funding will be required in Asia and the Pacific (63 per cent), followed by Latin America and the Caribbean (16 per cent), East and Southern Africa (8 per cent), West and Central Africa (6 per cent), North Africa and the Middle East (5 per cent) and Eastern Europe and Central Asia (1 per cent).

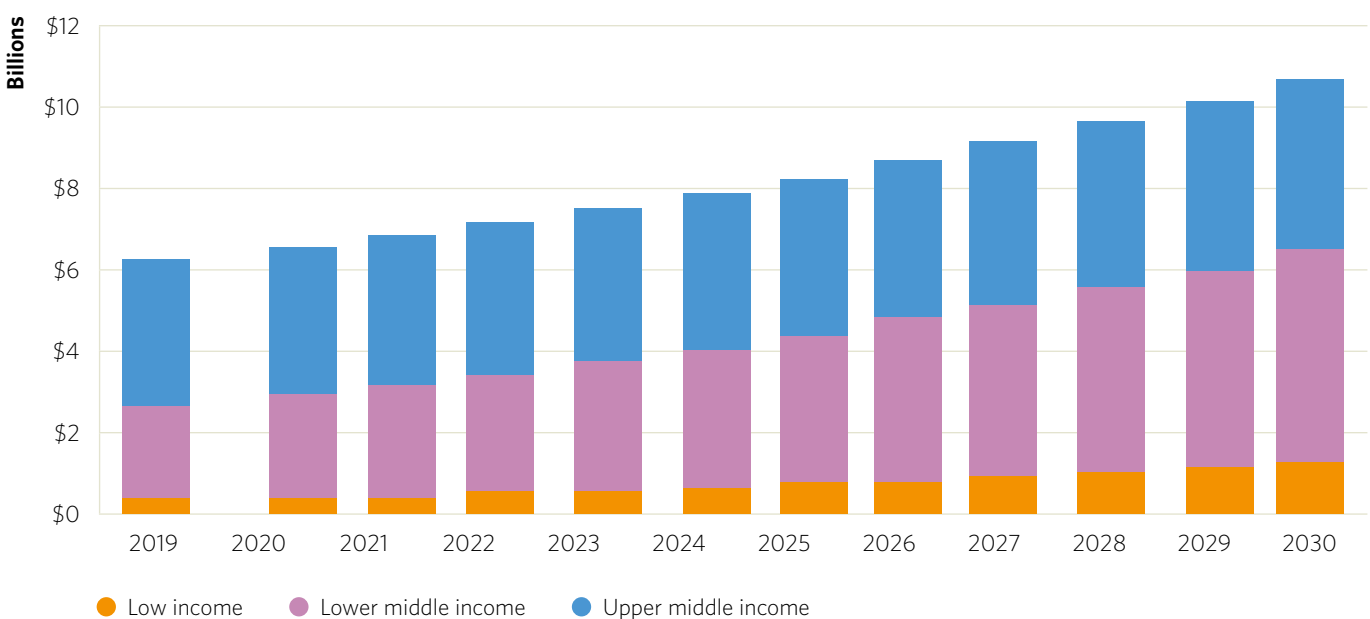
The largest amount of resources is needed for upper-middle-income countries (47 per cent), followed by lower-middle-income countries (43 per cent) and low-income countries (9 per cent).

(Note: Sums may not total 100 per cent due to rounding).

**Figure 5. Resources required for family planning in low- and middle-income countries, by region (in US dollars)**



**Figure 6. Resources required for family planning in low- and middle-income countries, by income category (in US dollars)**

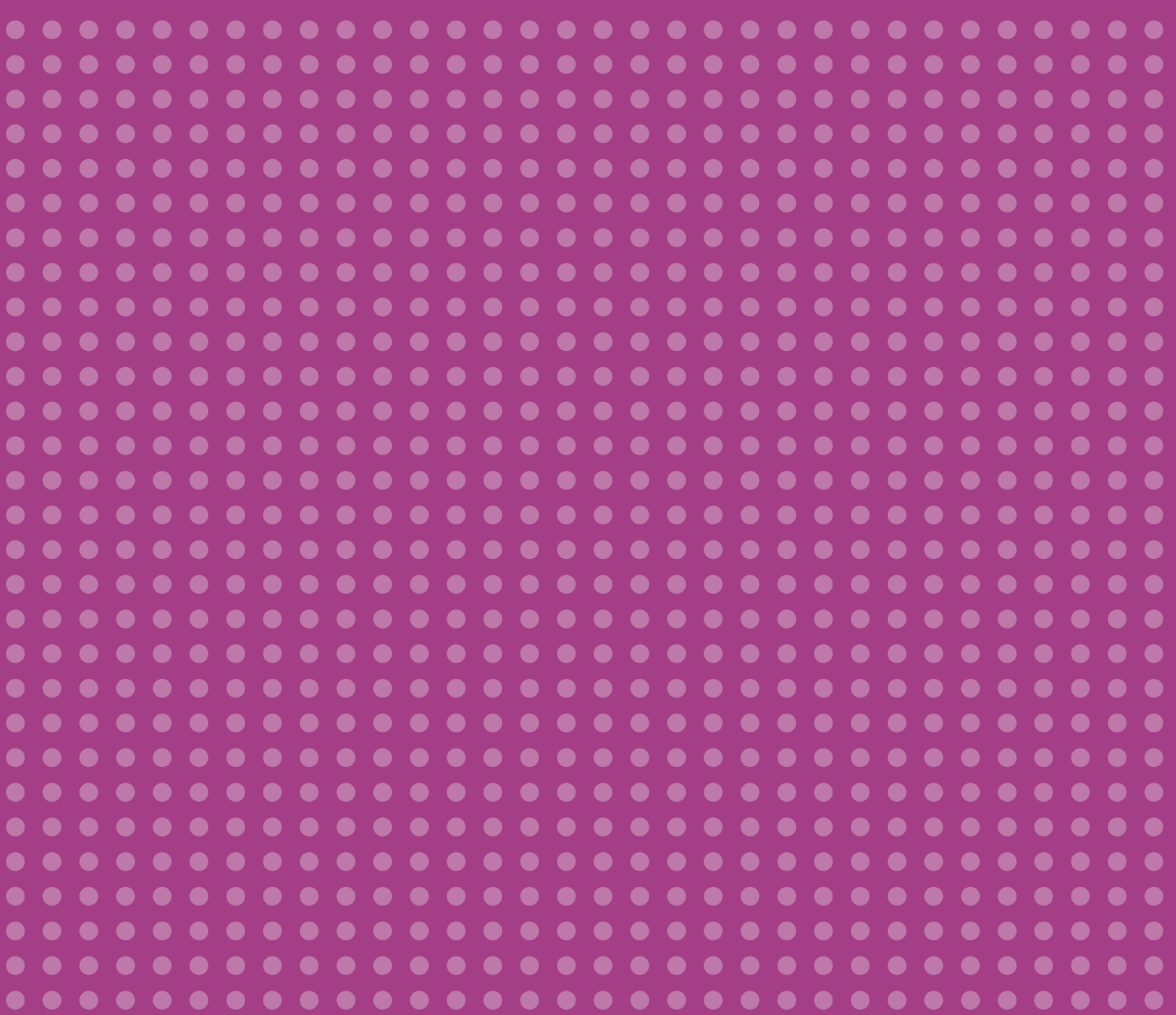




**An overall investment of \$68.5 billion would end the unmet need for family planning in 120 priority countries.**



Over 200 million girls  
and women alive today  
have experienced female  
genital mutilation.





## TRANSFORMATIVE RESULT:

## ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

# CHAPTER 3

# COST OF ENDING FEMALE GENITAL MUTILATION

## SUMMARY

An estimated 200 million women alive today have undergone female genital mutilation. FGM is a violation of girl's human rights and is often a precursor to early marriage, which usually ends the girl's education and dims her economic prospects. The causes of FGM are varied and programmes to promote its abandonment include prevention, protection and treatment and care.

This analysis seeks to identify and estimate the cost of implementing interventions that would result in ending female genital mutilation in 31 high-incidence countries. The operational definition of ending FGM for the purposes of this study is reaching all communities in 31 high-incidence countries with direct or indirect community empowerment programming to promote abandonment of female genital mutilation.

## THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is \$2.4 billion.**
- **The amount in development assistance that will be spent in 31 priority countries from 2020 to 2030 is \$275 million. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of \$2.1 billion.**
- **The average cost of preventing one case of female genital mutilation is \$95.**

### 3.1 OVERVIEW

An estimated 200 million women alive today have undergone female genital mutilation. FGM is a violation of girl's human rights and is often a precursor to early marriage which usually ends the girl's education and dims her economic prospects.

The causes of female genital mutilation are varied and may include social, religious and economic elements. Programmes to promote the abandonment of female genital mutilation commonly focus on changing social norms around female genital mutilation at the community and institutional level, enabling girls, women, men and families to more easily abandon the practice. Pre-existing programmes encouraging its abandonment along with growing urbanization, education and other dynamics have led to historic trends that will avert 46.5 million cases of female genital mutilation between 2020 and 2050 in the absence of additional interventions. Nevertheless, an additional 68 million girls are at risk of undergoing female genital mutilation between 2015 and 2030 if current age-specific rates remain constant.

### 3.2 OPERATIONALIZING ENDING FEMALE GENITAL MUTILATION

The operational definition of ending female genital mutilation utilized for this study is when all communities with majority approval for FGM in the 31 high-incidence countries are reached with direct or indirect community

empowerment programming to promote abandonment of the practice.

### 3.3 SCOPE

This analysis seeks to identify and estimate the cost of implementing interventions that would result in the ending of female genital mutilation in 31 high-incidence countries. These interventions include prevention, protection and care and treatment.

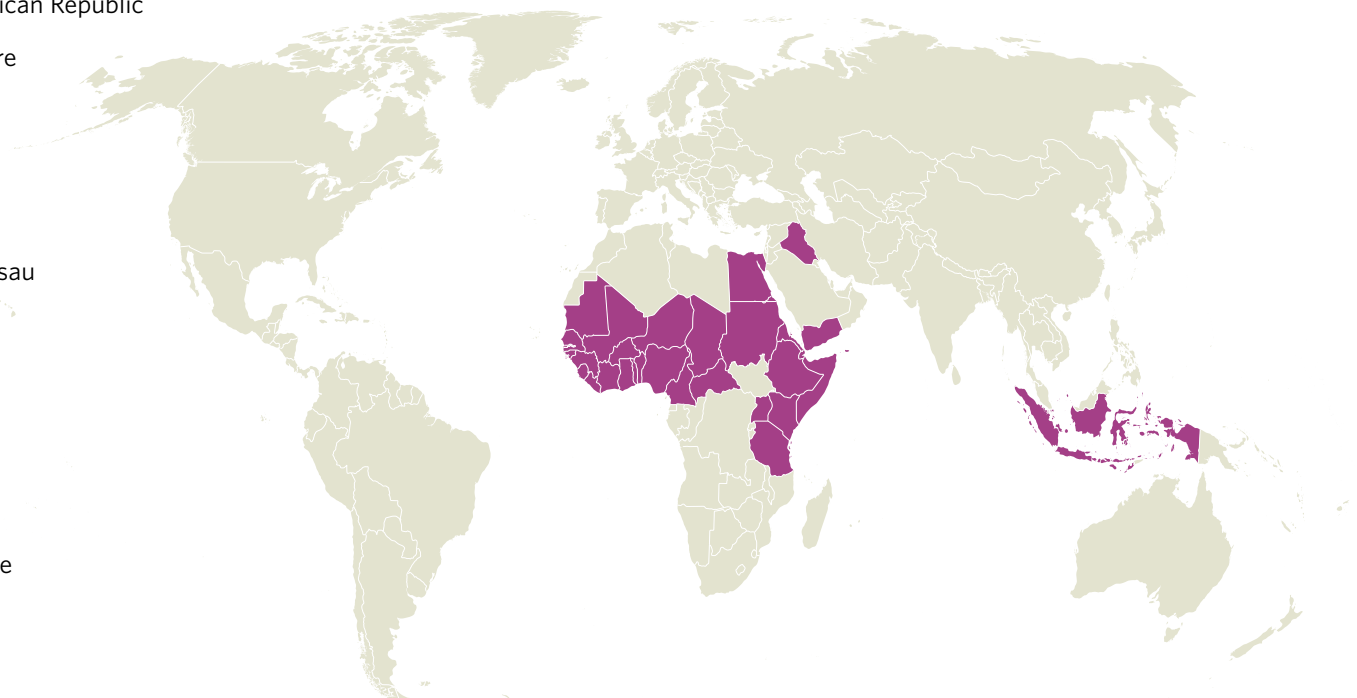
Grouping countries by historic trends and levels of approval for FGM makes it possible to identify where investment will have the greatest impact. The most cost-effective investments are in the countries with relatively more communities with majority approval rates for the practice and limited historic change. In these instances, the average cost per case of female genital mutilation averted is between \$2 and \$56. Countries with many communities with majority approval and a pre-existing historic trend downward, interventions are still cost-effective, but impacts attributable to new prevention programmes are lower. In these instances, interventions costing approximately \$200 per case averted.

### 3.4 METHODOLOGY

We calculated the incidence of FGM for children aged 0–14 using a multistage process. We tabulated the age-specific incidence of FGM from Demographic and Health Surveys or

**Figure 8. Target countries for elimination of female genital mutilation**

Benin  
Burkina Faso  
Cameroon  
Central African Republic  
Chad  
Côte d'Ivoire  
Djibouti  
Egypt  
Eritrea  
Ethiopia  
Gambia  
Ghana  
Guinea  
Guinea-Bissau  
Indonesia  
Iraq  
Kenya  
Liberia  
Maldives  
Mali  
Mauritania  
Niger  
Nigeria  
Senegal  
Sierra Leone  
Somalia  
Sudan  
Togo  
Uganda  
Tanzania  
Yemen

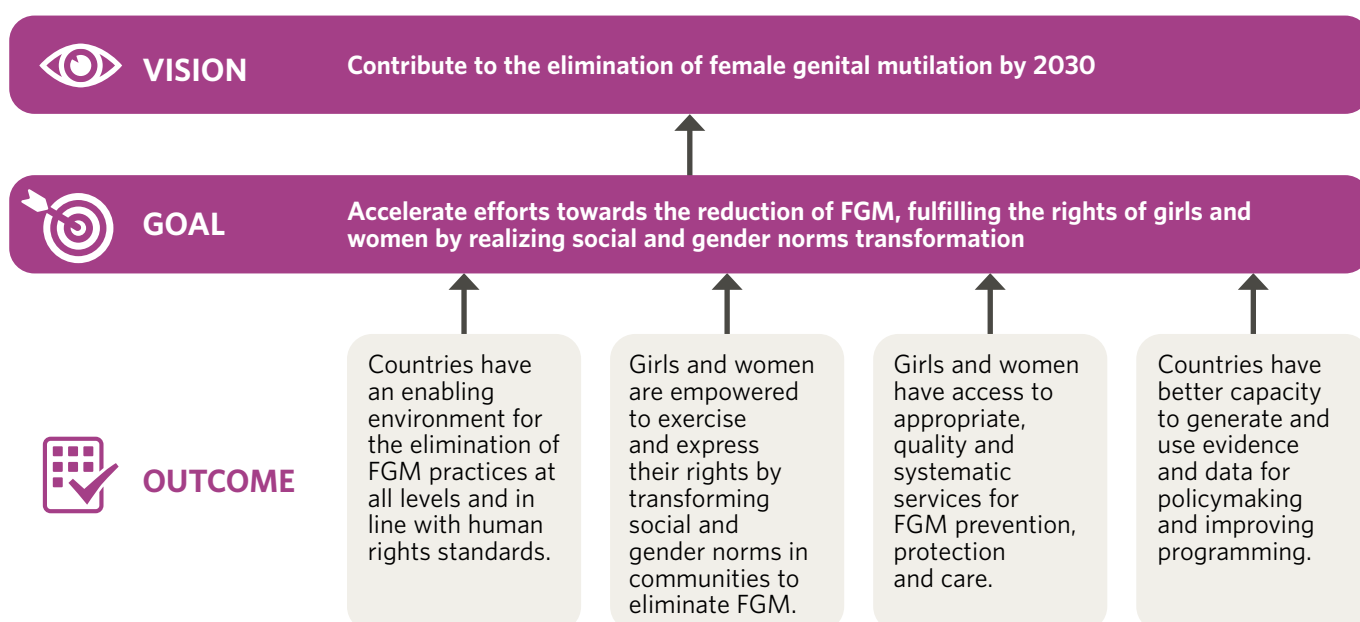


**Table 6. Interventions necessary to end female genital mutilation**

Sector	Intervention
Prevention	Supporting agency of girls and women  Community empowerment prevention programmes, including: Education, dialogue and consensus-building for all Religious and traditional leaders engagement Schools and social services strengthening to prevent the practice Men and young people mobilization
	Mass and social media education and amplification of the new norm
	Health and social providers capacity building on prevention
Protection	Legislation and policy development, including costed plan of action, political public statements, advocacy for domestic budget lines
	Laws enforcement and mobile courts
	Capacity building for legal personnel
	Psychosocial support
Treatment and care	Capacity building for health providers on treatment and care

Multiple Indicator Cluster Survey data sets for the year of the survey based on responses of a mother to queries about whether her child has been cut, and if yes, at what age she was cut.

1. We calculated a time trend for FGM reduction based on a tabulation of the historical age-specific incidences for the age at which incidence of FGM is greatest in a country. This age varies by country – in most West African countries it is children less than 1 year old, while in East and North Africa the ages range mostly from 5 to 12 years old.
2. We calculated an intervention-specific reduction based on the regression described in the subsequent section. This reduction is spread across 12 years (for consistency with cost estimates).
3. We applied a year-to-year incidence reduction at every age, calculated as the sum of the historical trend (step 2) and the intervention-based reduction (step 3). Note that the historical trend is applied at every year between the year of the latest survey and the end of the projection period. The intervention-based reduction is applied only to the years 2018 through 2030.

**Figure 9. Theory of change of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation**

The age-specific prevalences of FGM are the sum of incidences at each age and year previous to current year.

We calculated the impact of community programmes as follows:

1. A regression was run to calculate logistic equation coefficients that were used to calculate probabilities that a daughter is cut. The independent variables included: mother's support for FGM, community support for FGM, age of mother, household wealth status, education, religion and residence.
2. Women's support status was changed based on the effectiveness of programmes on changing attitudes. Levels of community support were recalculated based on the changes in individual women's support.
3. The new probability of a daughter being cut was calculated by using the regression coefficients applied to a specific country data set with the women's and community attitudinal changes adjusted via the effect sizes above to reflect the effect of the women's attitude changes on community support.

### 3.5 RESULTS AND FINDINGS

The estimated total investment needed to end female genital mutilation by 2030 is \$2.4 billion for 31 high-incidence countries. This equals less than three cents per year for every person on earth. Of the \$2.4 billion:

- \$2.1 billion will be used for prevention programmes
- \$225 million will be used for protection programmes
- \$130 million will be used for care and treatment

Donors are currently projected to provide \$0.3 billion of this need between 2020 and 2030. The total new investment needed to end female genital mutilation is \$2.1 billion.

If a programme to end female genital mutilation globally were implemented, the average cost of preventing one case of female genital mutilation is \$95.

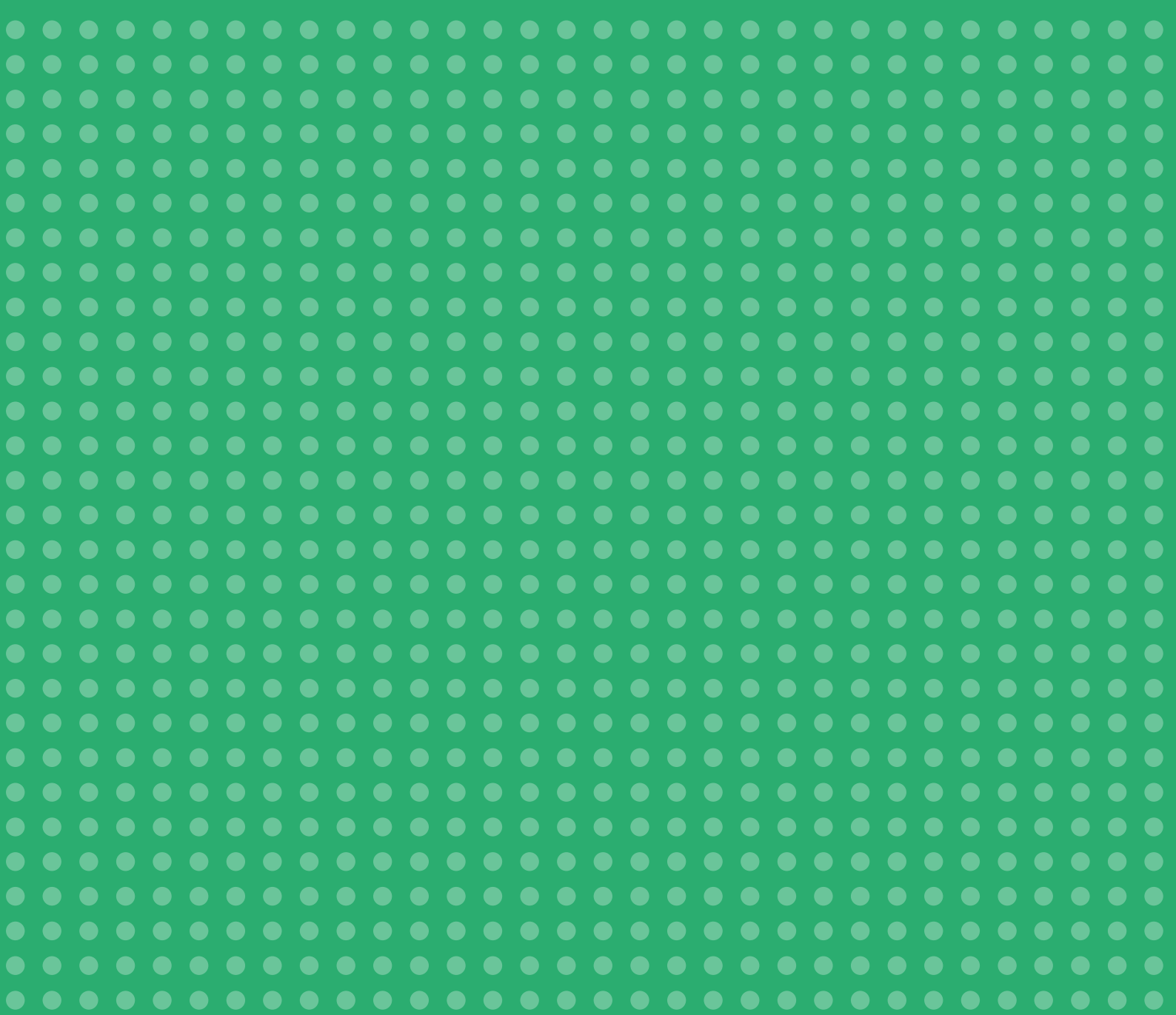
**Figure 10. Methodology to calculate the impact of community programmes on FGM**



“Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of \$2.1 billion.



Each year, 12 million girls are married before the age of 18.



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## TRANSFORMATIVE RESULT: ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

# CHAPTER 4

# COST OF ENDING CHILD MARRIAGE

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## SUMMARY

Nearly 650 million women alive today became brides before they turned 18 years old – some even before age 10 – and an additional 12 million girls are expected to be married each year. Child marriage is a human rights violation that deprives girls of their education, health and security. Child brides often drop out of school and have diminished economic opportunities. They are at elevated risk for domestic violence and adolescent pregnancy, increasing the risk of maternal and newborn death and injury. Child marriage also has intergenerational impacts. Interventions are emerging that hold great promise to reduce the incidence of child marriage.

This study has developed a methodology for estimating the cost of ending child marriage in 68 countries that are host to about 90 per cent of the current global burden of child marriage. For the purposes of this study, ending child marriage is defined as lowering the rate of child marriage below 5 per cent in the 68 target countries.

## THE PRINCIPAL FINDINGS

- **The total cost of ending child marriage for the 68 countries modelled over the period 2020 to 2030 is \$35 billion.**
- **The amount in development assistance that will be spent in 68 priority countries is \$10.9 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling \$24.1 billion.<sup>7</sup>**
- **Only \$600 are required to avert one case of child marriage.**

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<sup>7</sup> This estimate of donor funding that addresses child and early marriage 2020–2030 was developed by the IHME.

## 4.1 OVERVIEW

Globally, 650 million women and girls alive today were brides before they reached the age of 18. The impact of child marriage on these women and girls, the estimated 12 million additional girls who are married each year and the societies in which they live is significant. Child marriage is a human rights violation that deprives girls of their education, health and security. Child brides often drop out of school and have diminished economic opportunities. They are at elevated risk for domestic violence and adolescent pregnancy, increasing the risk of maternal and newborn death and injury and child marriage has intergenerational impacts.

Ending child marriage is an objective of Sustainable Development Goal 5.3.

Child marriage is caused by a variety of social, cultural, religious and economic factors. The most significant among them are: prevailing gendered social and cultural norms; poverty; financial transactions around marriage such as dowry or bride price, and a lack of positive alternatives for girls and families such as quality education and opportunities for decent work. The girls at greatest risk of early marriage are often from poor families, marginalized groups or rural areas and may be the hardest to reach.

Interventions are emerging that hold great promise to reduce the incidence of child marriage. A set of programmes focus on directly impacting early marriage include life skills (generally including information on sexual and reproductive health and rights), conditional economic incentives and community mobilization. A complementary cadre of programmes support girls' education by focusing on transfer payments to girls to stay in school, school infrastructure, the special needs of rural schools, pedagogical changes and teacher training. These programmes seek to lower dropout rates and increase the number of years girls stay in school.

## 4.2 OPERATIONALISING ENDING CHILD MARRIAGE

The objective of the model is to identify the interventions necessary to achieve the practical elimination of child marriage, that is, a marriage rate below 5 per cent, at least intervention cost.

## 4.3 SCOPE

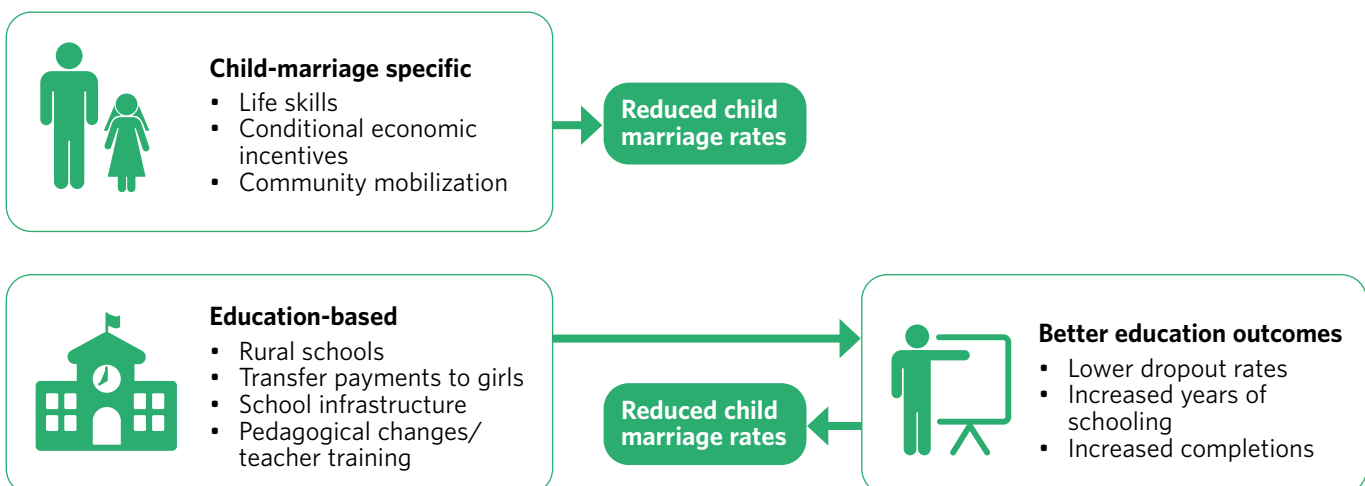
The study focuses on 68 countries with about 90 per cent of the global child marriage burden. Educational interventions as well as interventions related to changing social norms are assumed to reduce the incidence of child marriage in these target countries.

## 4.4 METHODOLOGY

The Child Marriage Optimal Interventions (CMOI) Model was utilized in this study to identify the interventions necessary to achieve the operational elimination of child marriage in 68 target countries at the lowest intervention cost by 2030.

In many countries and regions, child marriage rates are declining rapidly as a result of existing child marriage programmes and changing community attitudes. These trends are incorporated into the model as the “base” against which an intervention scenario is compared. The intervention scenario applies a set of education and specific child marriage interventions to further reduce the underlying base trend to the target level. Child marriages averted are the difference between the base and the intervention scenario.

**Figure 11. Interventions to reduce child marriage**





The function of the CMOI Model is to determine the optimal mix of interventions for each country that can reduce child marriage to at least 5 per cent by 2030 at the least cost. The CMOI Model covers 68 countries that account for 87 per cent of all child marriages across the globe. Given that child marriage rates vary substantially between urban and rural areas, the optimal mix of interventions was modelled for both urban and rural settings. In addition, as India represents approximately 28 per cent of the total estimated child marriages, the CMOI Model analysed India in greater detail. Each of 13 Indian states with the largest number of child marriages were separately modelled. Unfortunately, this level of granularity was not available for other countries with large child, early and forced (CEF) marriage burdens, such as Bangladesh, Brazil, Ethiopia and Nigeria.

The sources of data needed to construct the CMOI Model include the following: current rate and trend of child marriage, population forecasts, intervention costs and urban/rural splits.

## 4.5 RESULTS AND FINDINGS

Donors are presently projected to provide \$10.9 billion between 2020 and 2030 to reduce child marriage with a substantial amount of this contribution related specifically to investments in secondary education. The total cost of ending child marriage for the 68 countries modelled over the period 2020 to 2030 is estimated to require an additional \$35 billion.

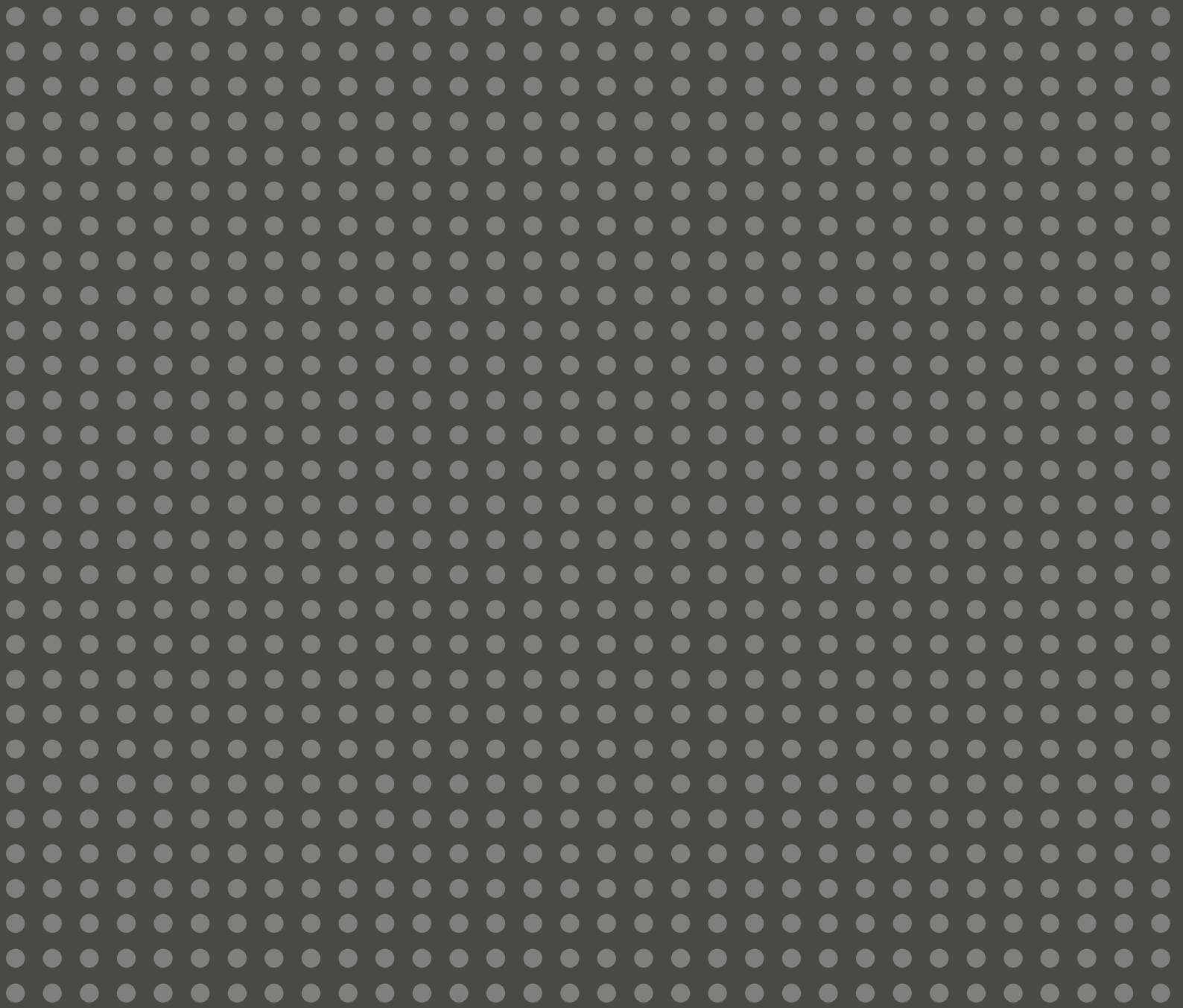
If this investment is realized, approximately 58 million child marriages will be averted over this period at an average, non-discounted cost of \$600 each.

The benefits of ending child marriage extend well beyond those directly addressing immediate human rights, health and other direct effects of child marriage. The increased educational outcomes generated by ending child marriage provide girls with the opportunity to get jobs in the formal economy or make a more productive contribution to the household enterprise if they continue to work in the informal sector.

**Ending child marriage by 2030 in 68 priority countries requires investments totalling \$24.1 billion.**



1 in 3 women worldwide  
have experienced physical  
and/or sexual intimate  
partner violence or sexual  
violence by a non-partner.



## TRANSFORMATIVE RESULT:

ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

# CHAPTER 5

# COST OF ENDING GENDER-BASED VIOLENCE

## SUMMARY

The number of women and girls impacted by gender-based violence (GBV) are staggering, with some estimates indicating that as many as one in three women and girls globally will be victims of GBV in their lifetimes. Gender-based violence undermines the health, dignity, security and autonomy of its victims and also has local, national and global impacts, limiting the contributions women and girls make to international development, peace and progress.

For the purposes of this analysis we assume that a range of anti-GBV programming will be scaled up to impact 80 per cent of women in 132 target low- and middle-income countries by 2030. Funding will be deployed slowly at first, expand rapidly around 2025 and then slow as target coverage of the interventions is achieved in 2030. For the purposes of costing an end to gender-based violence this analysis has identified a basic package of prevention and treatment services for intimate partner violence (IPV) based on the available data.

## THE PRINCIPAL FINDINGS

- **Implementing prevention and treatment programmes to end gender-based violence in 132 countries by 2030 will cost a total of \$42 billion.**
- **The amount in development assistance that will be spent in 132 priority countries is \$9.5 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling \$32.5 billion.**
- **The need for these funds is not steady over the course of the decade with relatively large sums needed in years 6 through 10.**

## 5.1 OVERVIEW

Gender-based violence occurs in all countries and economic and social groups and takes on many forms.<sup>8</sup> The number of women and girls impacted by GBV are staggering with some estimates indicating that as many as one in three women and girls globally will be victims of GBV in their lifetimes. The self-reported incidence of GBV in LMICs indicate that GBV impacts an average of 17 per cent of women across these countries, with a range of between 4 to 46 per cent.

Gender-based violence undermines the health, dignity, security and autonomy of its victims and also has local, national and global impacts, limiting the contributions women and girls make to international development, peace and progress. Victims of gender-based violence can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death.

To date, the global community has dedicated only limited resources to finding solutions and implementing programmes to end GBV. However, solutions to GBV are slowly emerging as more prevention and treatment programmes are implemented, new approaches are explored and results are analysed. Using available data, analysis suggests that most new resources are needed for programmes addressing three areas: community mobilization, outreach to male youth and economic empowerment of women and girls. Additional programming is needed for reaching women in the workplace, outreach to female sex workers, mass media, counselling and treatment and NGO strengthening.

## 5.2 OPERATIONALIZING ENDING GENDER-BASED VIOLENCE

For the purpose of this analysis, ending GBV is defined as a global scale-up of GBV prevention and treatment programming that would increase to cover 80 per cent of appropriate populations with effective interventions by 2030.

## 5.3 SCOPE

For the purposes of this analysis we assume that a range of anti-GBV programming will be scaled up to impact 80 per cent of women in 132 target LMICs by 2030. Funding will be deployed slowly at first, expand rapidly around 2025 and then slow as target coverage of the interventions is achieved in 2030. Interventions will include community mobilization, mass media, sensitivity training for male youth, economic empowerment, outreach for sex

workers, counselling and treatment and strengthening non-governmental organizations. It is outside the scope of this effort to expect to reach all women everywhere as some countries experience very low rates of GBV and interventions in those countries would be cost prohibitive.

## 5.4 METHODOLOGY

There is not a large body of research on the effectiveness of a range of interventions to combat GBV. This analysis relied on 63 articles that reported GBV prevention interventions and included measures of impact or cost. Among those studies that found significant results and reported odds ratios or information that could be transformed into odds ratios, there were 36 results. There is not enough information to extract different impact values by type of intervention, setting and indicator measured. However, a massive scale-up of efforts to prevent GBV would quickly expand knowledge about what works and how to tailor interventions to specific cultural settings.

For the purposes of costing an end to gender-based violence this analysis has identified a basic package of prevention and treatment services for IPV based on the available data. This package may contain elements of the following interventions depending on country: reaching women in the workplace; community mobilization; education and sensitivity training for adolescents; gender sensitivity training for male youth; enabling environment for sex workers; gender perspectives in health services; and NGO strengthening. In addition, the analysis calculated the cost of treatment, which generally consists of counselling to help with the trauma of violence and care for injuries in the case of rape or severe injury.

This package is not intended to be a recommendation of what each country, or regions within countries, should do, but rather representative of the types of services and costs that are required. The actual package would be tailored to each country context. The cost of the programme is estimated by multiplying the number of people reached with each service by the unit cost of providing that service. To this base cost we add \$100,000 per country for NGO strengthening and 15 per cent for support functions such as administration, research, training and monitoring and evaluation.

## 5.5 RESULTS AND FINDINGS

Implementing prevention and treatment programmes to end gender-based violence in 132 countries by 2030 will cost a total of \$42 billion. Donors are currently expected to provide \$9.5 billion for this purpose, leaving a funding gap of \$32.5 billion over the next decade. The need for these funds

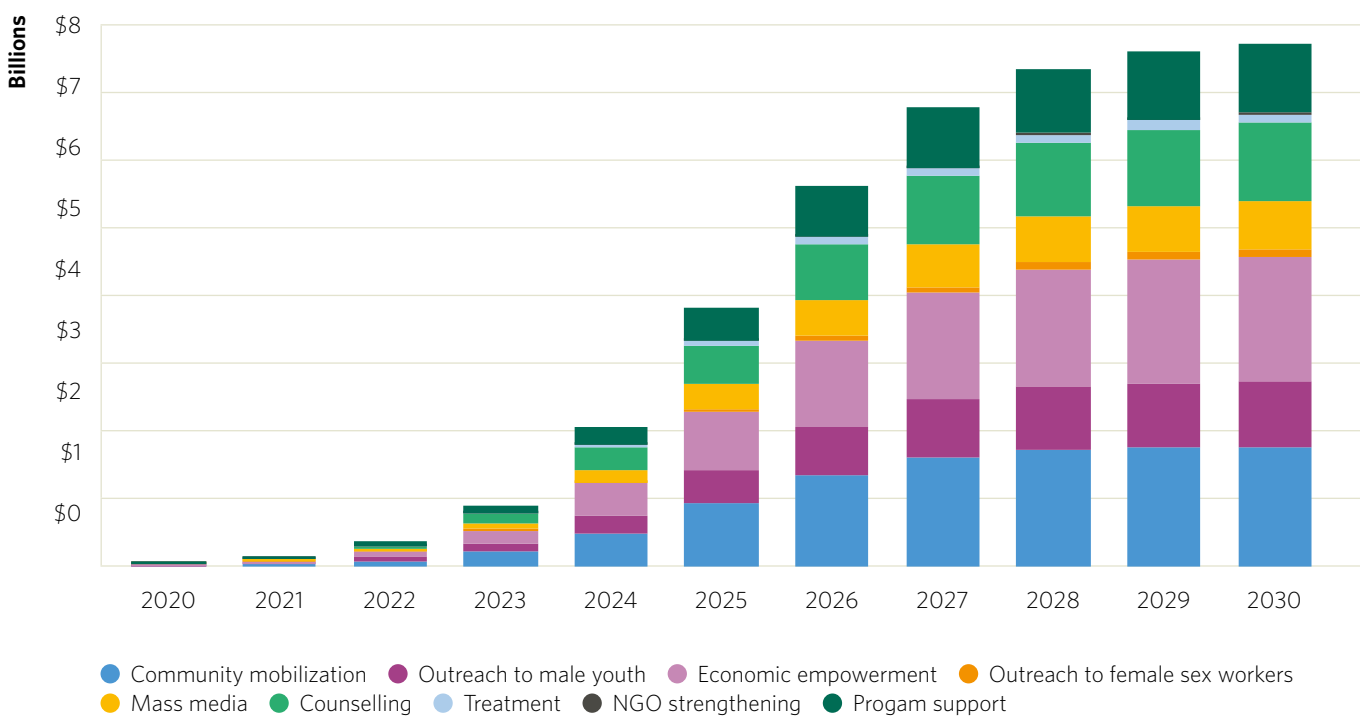
<sup>8</sup> GBV takes on many forms including violence against children and elder abuse as well as physical and/or sexual intimate partner violence, sexual assault, forced or unwilling sex, and physical or sexual violence by anyone. The GBV indicator most reported is intimate partner violence (IPV). IPV is the experience of physical or sexual violence committed by husband/partner in the past year. For the purposes of this analysis women's self-reported experiencing IPV is the main measure of GBV.

is not steady over the course of the decade with relatively large sums needed in years 6 through 10.

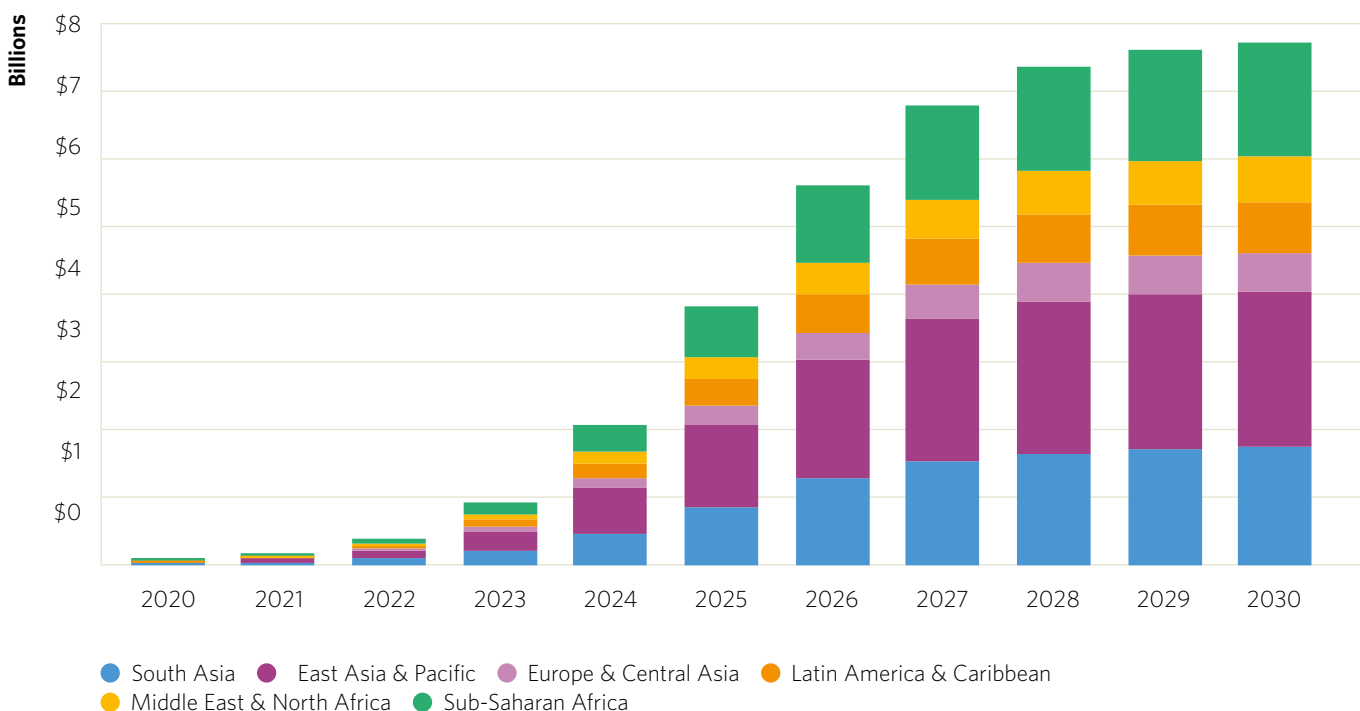
A comprehensive global effort to address GBV would provide counselling to over 180 million women by 2030 and treatment to nearly 700,000 victims of rape.

The largest amounts of resources are needed in East Asia and the Pacific (33 per cent) followed by roughly equal shares for the other regions as shown in figure 13.

**Figure 12. Resource needs to end gender-based violence in 132 countries by 2030, by intervention**



**Figure 13. Resource needs by region**



“  
\$42 billion would end  
gender-based violence in  
132 priority countries.  
Of this sum, \$32.5 billion is  
needed in new investments.”

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## ABBREVIATIONS AND ACRONYMS

<b>CEF</b>	Child, early and forced
<b>CMOI</b>	Child Marriage Optimal Interventions
<b>DHS</b>	Demographic and Health Surveys
<b>FGM</b>	Female genital mutilation
<b>GBV</b>	Gender-based violence
<b>ICPD</b>	International Conference on Population and Development
<b>IPV</b>	Intimate partner violence
<b>LiST</b>	Lives Saved Tool
<b>MHTF</b>	Maternal and Newborn Health Thematic Fund
<b>MICS</b>	Multiple Indicator Cluster Surveys
<b>MMR</b>	Maternal mortality ratio
<b>NGO</b>	Non-governmental organization
<b>SDG</b>	Sustainable Development Goals
<b>UNFPA</b>	United Nations Population Fund
<b>US</b>	United States
<b>WHO</b>	World Health Organization



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