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Lives Saved — Bad Metrics, Bad Faith

By Rebecca Oas, Ph.D.

Is saving a life the same as averting a death? Not exactly—one involves leaving a survivor, while the other deals with theoretical probabilities. But that subtle distinction has huge implications for how global health programs are structured, how billions of dollars are spent, and ultimately how human lives around the world are valued.

As an advocacy strategy, the "lives saved" metric is powerful. If saving just one life makes one a hero, imagine what saving millions of lives must mean.

The tools that experts have at their disposal are just as impressive. Scholars and policy experts can create estimates of how many lives can be saved with this or that package of interventions, and how many more if you were to scale it up here or there. They can tailor it to the rates of death for this cause or for that one. They can base it on the latest data about success rates and the cost of each, particular, intervention. Then they can create amazing graphs that predict how many lives you can save for how much money. All that's needed is funding, the rest is already worked out.

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Make no mistake, this is not all bad. In fact, these metrics are a significant accomplishment considering the fact that not all countries and regions maintain accurate records of the births and deaths that *do* occur. And these metrics have been vetted by scholarly peers who complain that, despite being very popular for advocacy, estimates of lives saved are often flawed in their underlying methodology, tendencies toward overestimation, and the fact that they are simply impossible to verify.

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There is one big problem, though, that has gotten little or no attention. That is, while lives are saved on paper, there are not always real people walking around to show for it. This is not just a question of bad metrics, it's a problem of bad faith.

The claim to have saved a life rests on the basic assumption that there was a life there to begin with, and that a timely intervention relieved a specific threat to that life. Family planning advocates are increasingly turning that assumption on its head by using lives-saved modeling to argue that the best way to prevent maternal deaths is to prevent pregnancy, and the best way to prevent child deaths is to reduce the number of children born.

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This attempt to distort the very concept of saving a life is troubling at a conceptual level. Its use as a ploy to redirect much-needed funds away from maternal and child health programming toward contraceptive promotion is both cynical and dangerous. But given the relentlessly pro-abortion agenda within the international family planning movement, it is important that the pro-life community be aware of how bad metrics are being used to fund and empower their opponents on the global stage—at the expense of mothers and children.

FAMILY PLANNING AND MATERNAL HEALTH: METRICS AT CROSS-PURPOSES

The most popular modeling software to measure lives saved in global maternal and child health strategies is the Lives Saved Tool (LiST), developed Johns Hopkins Bloomberg School of Public Health with funding by the Bill & Melinda Gates Foundation. Using LiST, users can predict reductions in maternal deaths in two ways: by deploying interventions that prevent or treat complications of pregnancy and birth, such as hemorrhage or infection, or by reducing the pool of pregnant women by scaling up contraceptive use. Family planning advocates like the Guttmacher Institute argue that investing in contraceptives alongside maternal and child health care makes sense because "the cost of preventing an unintended pregnancy through use of modern contraception is far lower than the cost of providing care for an unintended pregnancy."[1]

As a purely economic argument, this sounds compelling, but it is important to remember that the argument for international maternal and child health assistance is based on the fact that preventable deaths occur in developing regions, concentrated among the poorest people, at highly disproportionate levels compared with the developed world. It isn't just that these deaths occur at higher *numbers*, it's that they occur at higher

rates. The risk to each pregnant woman or infant is far higher in some regions than others, regardless of whether the pregnancy was intended or not. Therefore, if the goal is to reduce the inequity in maternal and child outcomes, the goal must be to lower the *rates* of maternal and child deaths, as compared to the number of live births.

While some attempts to model the impact of family planning on reducing maternal deaths by increasing birth spacing, most projections focus on the demographic effect instead: fewer pregnancies means fewer women exposed to the risks associated with pregnancy and birth. As a result, major global donors like the United Kingdom and the United States have presented lives-saved estimates based on their maternal health programming overseas in which contraception is credited with saving a projected 62[2] and 64[3] percent of women's lives, respectively. When you bring in the economic argument as presented by Guttmacher, a compelling case emerges that the best investment in maternal health is to reduce one's investment in it altogether and redirect that funding toward family planning. But for the women living in low-resource settings who want to have children, this argument rings hollow, with potentially life-threatening consequences.

In most cases, averting a death and saving a life are synonymous. The one exception is in the case where the life itself is the thing being averted.

FAMILY PLANNING, INFANTS, AND CHILDREN: WHEN AVERTING A DEATH IS NOT SAVING A LIFE

For all its cynicism, the strategy of saving maternal lives by preventing maternity at least anticipates that for each projected "life saved," there is a surviving woman. When the model extends to infants and children and incorporates family planning, this is not always the case. If family planning averts maternal deaths by removing exposure to the risks associated with pregnancy and birth, it averts infant and child deaths by removing exposure to the risks associated with infancy and childhood. In other words, by virtue of not existing, the hypothetical child's death is averted.

In most cases, averting a death and saving a life are synonymous. The one exception is in the case where the life itself is the thing being averted. With LiST, users can predict the demographic impact of scaling up contraceptive use in terms of the number of births averted. They can then use current infant and child mortality rates to estimate how many of those children, had they been born, would likely have died in infancy or in the first five years of life. Family planning differs from other child health interventions in that it does not address cause-specific mortality, but rather works at a demographic level, and unlike other interventions, does not leave behind a predicted survivor,

just a hypothetical averted death.

Many researchers who use LiST attempt to distinguish between the two categories in some way. When presenting a proposed global investment framework for women's and children's health, Stenberg and colleagues specified, "the difference in deaths between any two scenarios portrays both the reduction in births arising from enhanced access to contraceptives (avoidance of unintended pregnancies or deaths averted) and the effect of the health interventions on those who are born (lives saved)." Later, they state that those child deaths prevented by family planning would account for 53% of the total, and "be a particularly effective investment, accounting for half of the deaths averted, at a small cost."[4]

From a purely demographic perspective, the number of potential surviving children averted by family planning is likely to outnumber the projected child survivors attributable to the other lifesaving interventions being considered by the LiST model.

If Stenberg and colleagues were at least unwilling to refer to child deaths averted by contraception as "lives saved," others are less conscientious. When the United States Agency for International Development (USAID) launched its maternal and child health framework "Acting On the Call" in 2014, using LiST methodology, they referred to that category as "child lives saved from demographic impact."[5] These averted lives accounted for a full third of the projected "lives saved" of children by the year 2020.

If lives-saved estimates can include hypothetical nonexistent people, it's important to remember that there is another category of phantom children being ignored in this analysis: those who would be projected to survive if born. Even in the most resource-poor environments with the highest infant and child mortality, the likelihood that any given child will survive past his or her fifth birthday far exceeds the chance of a premature death. If one in ten children in a given location is predicted to die before the age of five, ten births would have to be averted by contraception in order to avert one death. The other nine would-be-survivors are only accounted for in the analysis by virtue of the cost savings of not having to provide them with health care. From a purely demographic perspective, the number of potential surviving children averted by family planning is likely to outnumber the projected child survivors attributable to the other lifesaving interventions being considered by the LiST model. This has the effect of subtly embedding a strong antinatalist agenda within maternal and child health frameworks.

SCALING UP FAMILY PLANNING: NOT AS SIMPLE AS ADJUSTING A STATISTICAL MODEL

It is important to note here that scaling up family planning use

in a software program is far simpler than doing so in the field. While Stenberg and colleagues wrote about "increased access to contraceptives" as a life-saving intervention, their predictions were based on use, not mere access. But to what extent is contraceptive use limited by lack of access in the developing world? The concept of "unmet need" for family planning is widely misinterpreted as lack of access.[6] According to survey data analyzed by the Guttmacher Institute, only about 5% of "need" for family planning is attributed to lack of access, and even less to lack of knowledge of methods.[7] Far more women cite concern about health risks and side effects, infrequent sex, and personal opposition as the reason they don't use contraceptives. When tools like LiST project that contraceptive prevalence can be increased for the cost of providing access to the commodities alone, this assumption is not supported by evidence. But such claims can lead to wasteful investments in promoting family planning in an already saturated market, increasing the potential for coercion, and diverting investments away from maternal and child health care that actually results in surviving mothers and babies.

WHY PRO-LIFE ADVOCATES SHOULD CARE

The growing trend of measuring the impact of global health programming in terms of lives saved—and using family planning to pad the numbers—is more than just statistical sleight-of-hand. There are real-world implications when large investments are made, both from a moral and pragmatic perspective. Family planning advocates frequently say investment in contraception is "the right thing to do, and it is the smart thing to do."[8] But is it truly smart to justify siphoning money away from maternal and child health interventions that save lives in cause-specific ways in favor of flooding the market with yet more contraceptives, in the absence of significant unsatisfied demand? Is it smart to conduct costing analyses of maternal and child health frameworks that consider human lives only in terms of the costs of bringing them into the world and sustaining them to the age of five, while ignoring entirely the human capital they represent as they grow older?

While efforts have been made both domestically and internationally to keep abortion and family planning separate in policy and funding, these organizations strongly oppose any such restrictions. For those organizations seeking to promote contraception but not abortion, finding partners is fraught with moral dilemmas.

As for increased funding for family planning being the right thing to do, it should be noted that the organizations aggressively pushing for a global human right to abortion are first and foremost family planning organizations, such as the International Planned Parenthood Federation and Marie Stopes International. While efforts have been made both domestically and internationally to keep abortion and family planning separate in policy and funding,

these organizations strongly oppose any such restrictions. For those organizations seeking to promote contraception but not abortion, finding partners is fraught with moral dilemmas.[9] At a minimum, any "lives saved" metrics that place a heavy thumb on the scale in favor of contraceptives will almost certainly be used to justify sustained—and increased—funding to organizations that seek to promote abortion around the world.

The claim that the best and cheapest way to save a child's life is to prevent that child's existence is indefensible. Those who would make such a claim tend to rely on the fact that they will not be called upon to defend it. While the pro-life movement must regularly contend with the brazen assaults on the rights of children in the womb, we cannot ignore the subtler attempts to redefine human life in global health policy that lead to funding for the abortion agenda. Taking a stand against "therapeutic nonexistence" in lives-saved analyses is ultimately a pro-life position. There is no life saved without a living survivor.

ABOUT THE AUTHOR

Dr. Oas is Associate Director of Research at C-Fam. She earned her doctorate in genetics and molecular biology from Emory University.

Endnotes

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