POLICY *Analysis*
Center for Family and Human Rights

Pro-Life Concerns with USAID's Updated Maternal and Child Health Framework

In March 2023, USAID launched its updated policy to prevent maternal and child deaths in developing countries: *Preventing Child and Maternal Deaths: A Framework for Action in a Changing World*.

The vision of this framework is a world where all women, newborns, and children survive, by reducing preventable child and maternal mortality in 25 priority countries and increase coverage levels of lifesaving interventions across those countries.

Saving the lives of mothers and babies and enabling them to thrive and lead healthy lives is central to the mission of the pro-life movement. However, this framework, like the *Acting on the Call* strategy that preceded it, raises important concerns for advocates for a pro-life U.S. foreign policy that improves global health without exporting abortion using taxpayer funds and with the logo "From the American People."

The scale of the issue

Recent data from the UN indicate that progress in reducing maternal deaths around the world hit a plateau between 2016 and 2020.[1] This means that each day, 800 women die from preventable causes related to pregnancy and childbirth. Maternal mortality is far higher in developing regions, and is exacerbated by factors like poverty, instability, and a lack of vital infrastructure, such as transportation, electricity, and clean water. Similarly, according to UNICEF, more than 5 million children under the age of five died in 2011, also mostly from preventable or treatable causes.[2]

The U.S. government has long been a leader in providing health aid to countries and people in need, and the good news is that we have the knowledge and interventions necessary to prevent most maternal and child deaths—the challenge is ensuring that pregnant and childbearing women and their children have access to these interventions wherever they live. In order to ensure that we make birth and early childhood safe for all, it is essential that we maintain focus on the core issue: ensuring that pregnancy, birth, and the postpartum period are safe for mother and child and that complications are prevented or treated as they arise.

What does it mean to save a life?

In 2014, USAID launched its *Acting on the Call*, which set the goal of saving the lives of 15 million children and 600,000 women in priority countries by 2020. These projected saved lives were calculated using the Lives Saved Tool (LiST), which uses existing data on mortality rates and their causes, as well as the cost and efficacy of specific interventions. Analysis from C-Fam pointed out that when family planning is included in this analysis, it skews the results such that approximately two thirds of the women whose lives were projected to be saved would survive as the result of never having become pregnant at all. For the children, the projections were

even more cynical: a third of predicted "child lives saved" were hypothetical children whose deaths would be averted by their conception being prevented by contraception, under the Orwellian term "child lives saved from demographic impact."[3] While averting a death and saving a life are usually synonymous, this is the unusual case where the potential death is averted by preempting the existence of the person entirely.

For the last few Congresses, there have been bipartisan efforts to pass the Reach Every Mother and Child Act (or REACH Act), which would have had the effect of codifying *Acting on the Call* in law, with language insisting that USAID should prioritize those interventions that save the most lives per dollar spent. Using the *Acting on the Call* methodology, this would frame contraception as the most cost-effective way to save both women and children's lives and drive further funding in that direction. This creates a maternal and child health strategy that prioritizes making motherhood rare and children scarcer. Meanwhile, the higher maternal and child mortality levels remain in priority countries, the greater the purported "lifesaving" potential of preventing pregnancy and birth altogether.

When the *Acting on the Call* deadline in 2020 came, USAID issued a report summarizing the results of the program and claiming to have "saved the lives of more than 9.3 million children and 340,000 women."[4] USAID acknowledged that this "fell short of reaching [its] goal," noting that at least part of the shortfall was likely due to the COVID-19 pandemic. Unlike the initial *Acting on the Call* launch report,[5] the final report did not break down its "lives saved" estimates by intervention, and attempts to contact USAID and determine how many of the lives of both women and children were purportedly "saved" by contraception were not answered.

Family planning metrics are often misleading

The new USAID maternal and child health framework is more cautious than its predecessor in setting targets for "lives saved," but again, its metrics are troubling. One chart listing "lifesaving interventions" placed contraceptive prevalence rate alongside things like births taking place in health facilities, access to handwashing and water in the home, and ownership of insecticide-treated nets to prevent malaria. While the word "voluntary" frequently appears before "family planning" in the framework, measuring prevalence as a goal in itself is problematic, as it creates incentives to drive up use and prevent discontinuation of contraceptives regardless of actual demand for such services.

The new framework, as compared with its predecessor, links itself much more closely with UN data sets and aligns itself with the Sustainable Development Goals (SDGs) agreed at the UN in 2015. One metric used under the health SDG is "demand for family planning satisfied by modern methods." This indicator, which was developed by USAID family planning experts[6] and lobbied for by the U.S. during negotiations around the SDGs and their indicators,[7] defines "demand" for family planning as including both current use and "unmet need," a metric commonly misunderstood (and misconstrued) as lack of access. In fact, the vast majority of women with a purported "need" have no demand at all, but rather a series of objections: that they refuse to use it for religious or other reasons, they have concerns about side effects and risks, they have infrequent sex or otherwise believe themselves to be at low likelihood of becoming pregnant, and, underlying many of these reasons, they are not strongly motivated to avoid becoming pregnant at all.[8]

As a descriptive metric, contraceptive prevalence is useful in that it relates what people are already doing. However, as a prescriptive metric, it runs the risk of driving family planning programs in coercive directions where workers strive to reach usage targets (or prioritize the promotion of longer-acting methods that are more difficult to discontinue).

In contrast, other interventions like access to birthing centers and skilled attendants, running water, and antimalarial nets are not invasive and do not have a well-documented history of being forced on women and families against their will, and where they are not used, it is far more likely to be lack of access driving that "unmet need."

Family planning funding drives the global abortion movement

Placing family planning alongside the interventions that prevent specific causes of maternal and child death has many negative effects: it redirects resources from making birth safe to making it rare, it risks fueling coercive and wasteful programs to drive up prevalence, and it represents a major source of funding, along with the legitimacy of U.S. government support, to organizations promoting abortion around the world.

The Helms Amendment to the Foreign Assistance Act bans U.S. funding from going to the provision or promotion of abortions in foreign countries, and under Republican administrations, the Mexico City Policy (rebranded under former President Donald Trump as "Protecting Life in Global Health Assistance") further blocks funding from organizations based overseas that promote or provide abortions using money from other sources.

However, major loopholes still remain. President Trump's expanded Mexico City Policy widened its reach from family planning alone to all of global health, but abortion groups still find a foothold in other areas of U.S. assistance, including on issues like women's empowerment that fall outside the health portfolio. Organizations operating overseas that are based in the U.S. do not fall under the Mexico City Policy at all. While there are some organizations, often faith-based, that work on family planning without including abortion, they are outliers in a movement whose dominant discourse is strongly pro-abortion.[9] A C-Fam analysis of the organizations receiving money for global family planning from the Bill and Melinda Gates Foundation also shows the close linkage between family planning provision and advocacy and abortion.[10]

While the desire of the U.S. government, as well as its taxpayers, to end preventable maternal and child deaths around the world is a worthy goal, the persistent decision to embed a strong family planning component within USAID's framework undermines that goal and opens the door to funding organizations seeking to export death in the name of saving lives.

Endnotes

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