POLICY Analysis
Center for Family and Human Rights

Seven Reasons Why the REACH Act Falls Short

Rebecca Oas, Ph.D. (rebecca@c-fam.org)
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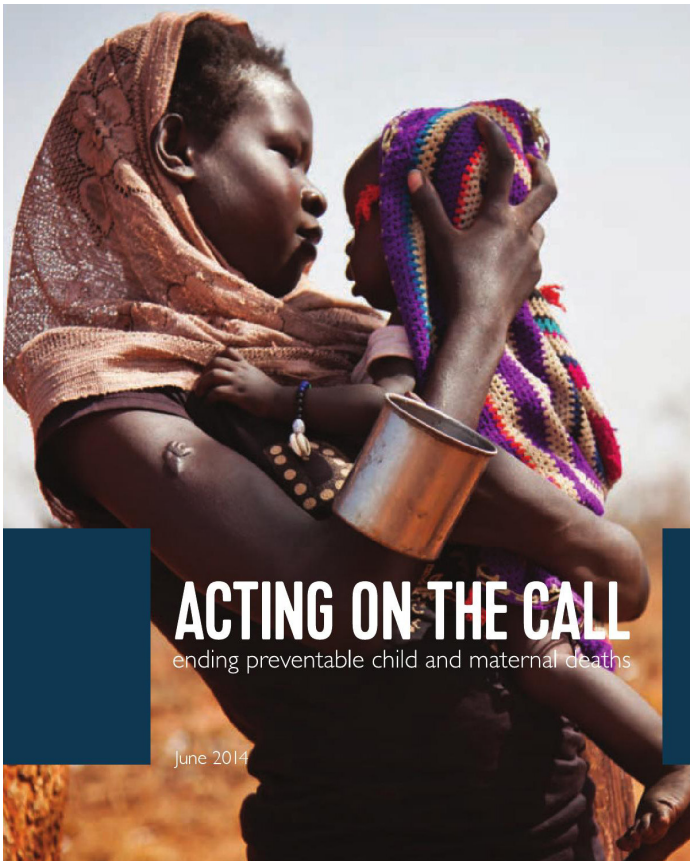
OVERVIEW: The Reach Every Mother And Child Act (REACH Act) was first introduced in the 114th Congress as Senate bill 1911 and House bill 3706. It has been reintroduced in the 115th Congress as Senate bill 1730 and House bill 4022. Its stated goal is to consolidate USAID efforts to eliminate preventable maternal and child deaths in 25 target countries by prioritizing the most cost-effective methods that save the most lives. The bill does not include new appropriations, but would set clear benchmarks for success, create a position of Child and Maternal Survival Coordinator within USAID, and realign nearly $3 billion in existing grants to focus on impacts measured in "lives saved." In its earlier iteration, this proposed legislation drew many bipartisan cosponsors. However, the reintroduced version retains many of the problematic aspects of the earlier one, which originate in the 2014 USAID "Acting On the Call" (AOTC) report that serves as the blueprint for the proposed realignment.



For the following seven reasons, we urge members of Congress to oppose the REACH Act as it is currently drafted:

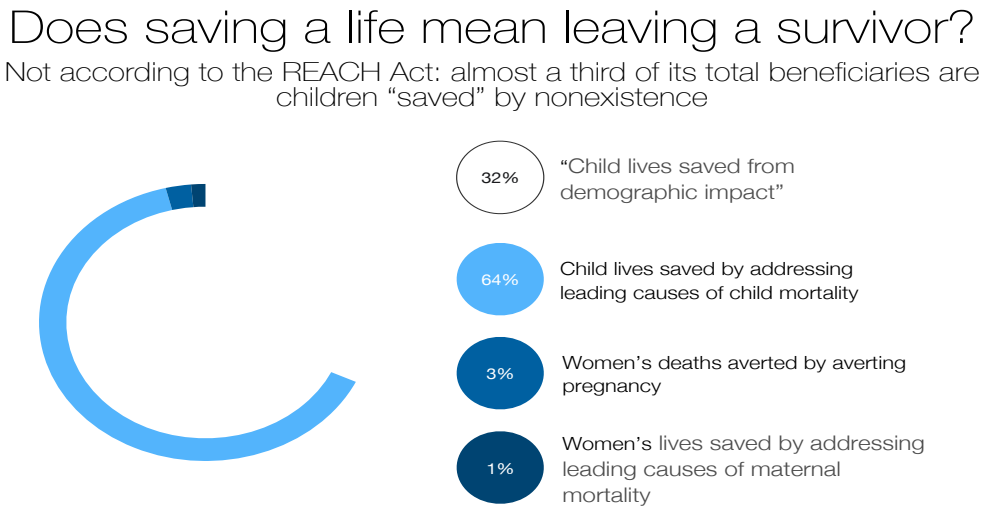
1. The REACH Act definition of "saving a life" is deceptive and misleading.

The AOTC report sets out a goal to save 15 million children's lives and 600,000 women's lives between 2012 and 2020 as an intermediate goal in ending preventable maternal and child deaths. However, 5 million of the child lives—a third of the total—are to be "saved by demographic impact." AOTC explains, "demographic impact is the projected impact of family planning interventions on reducing the number of deaths due to fewer unintended pregnancies."

While it is objectively true that fewer pregnancies and births mean fewer people, and therefore fewer deaths, defining these averted deaths as "lives saved" is both confusing and cynical. AOTC aims to save

15 million child lives by leaving only 10 million survivors. For the 5 million phantom beneficiaries of this proposed legislation, their life-saving intervention takes the form of nonexistence.

In contrast to both versions of the 2015 REACH Act, AOTC is not mentioned by name in either the House or Senate version of the 2017 legislation. However, the goal to save 15 million children and 600,000 women—lifted directly from AOTC—is included once in the Senate version and thrice in the House version.



DATA SOURCE: USAID. Acting on the Call: Ending Preventable Child and Maternal Deaths Report, June 2014

2. REACH Act metrics are skewed to direct maternal health investments toward family planning.

By redefining what it means to save a life, and thus by padding the number of potential lives saved by 5 million (a third of children saved, and a third of the total lives saved), AOTC places a heavy thumb on the scale when it comes to assessing the most effective—and cost-effective—interventions to be prioritized. Providing the commodities and services to prevent a conception costs less than a full range of prenatal, birth, postpartum, and early childhood care. By including hypothetical children in the "lives saved" metric, a stronger case is made for shifting funds away from maternal and child health and other life-saving interventions, and towards family planning on the basis of it saving more lives per dollar spent.

However, this is not only based on a redefinition of "lives saved," but also the assumption that a large unsatisfied demand for family planning services exists in USAID target countries. While family planning advocates frequently misconstrue the figure of 214 million women with an "unmet need" as lacking access to contraceptives, the reality is that only about 5% of women with a purported "need" for family planning in developing countries cite lack of access as their reason for nonuse. Furthermore, there is little evidence to suggest that women described as "needing" family planning have any intention of using it. In fact, many women cite health concerns and personal oppositions as their reasons for refusal.

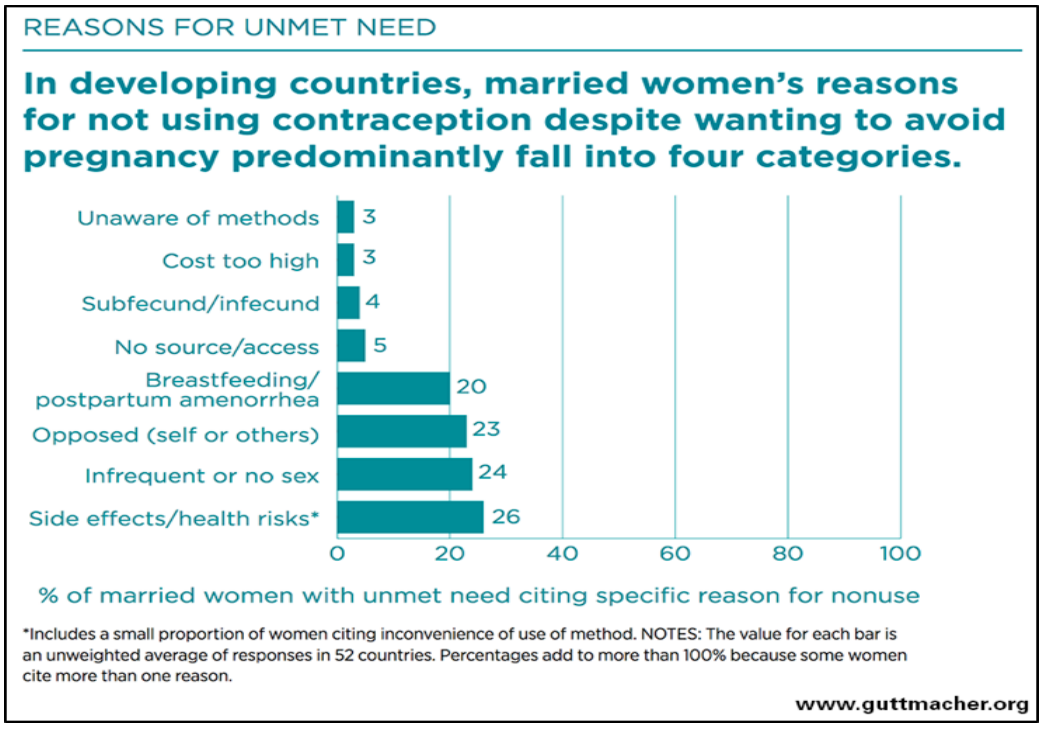
3. The REACH Act relies on measurements of mortality risk and lives saved that are in internal conflict.

The stated purpose of the REACH Act is to end preventable maternal and child deaths, based on the fact that in developing countries, women and children die from preventable causes at disproportionate

rates to wealthier and more developed countries. This inequity is clearly seen by comparing maternal mortality ratios and child mortality rates, which are expressed as the number of deaths compared with the number of live births. These are measurements of risk: the risk of giving birth or the risk of birth, infancy, and early childhood. Many of the interventions outlined in AOTC work to reduce obstetric and pediatric risk of death, therefore they would work to drive down these ratios.

In contrast, "lives saved from demographic impact" can only be calculated by using existing maternal and child mortality ratios applied to estimates of averted pregnancies and births. Therefore, the higher maternal and child risk of death is, in a given setting, the more effective family planning will appear to be at saving lives. Contraceptive use will instead deliver diminishing returns of "lives saved" as the relative risk of pregnancy, birth, and early childhood are reduced through other interventions.

The conflict between these measurements becomes more troubling in light of the fact that AOTC metrics (and, therefore, the REACH Act) have clearly been chosen and modified to elevate the impact of family planning to the point of bringing in hypothetical persons. These metrics would therefore be



SOURCE: Sedgh G et al., Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method, New York: Guttmacher Institute, 2016

used to justify siphoning away resources from risk reducing maternal and child health interventions and redirecting them toward family planning. This kind of model, instead of treating the complications of pregnancy and infancy, treats pregnancy and infancy themselves as complications.

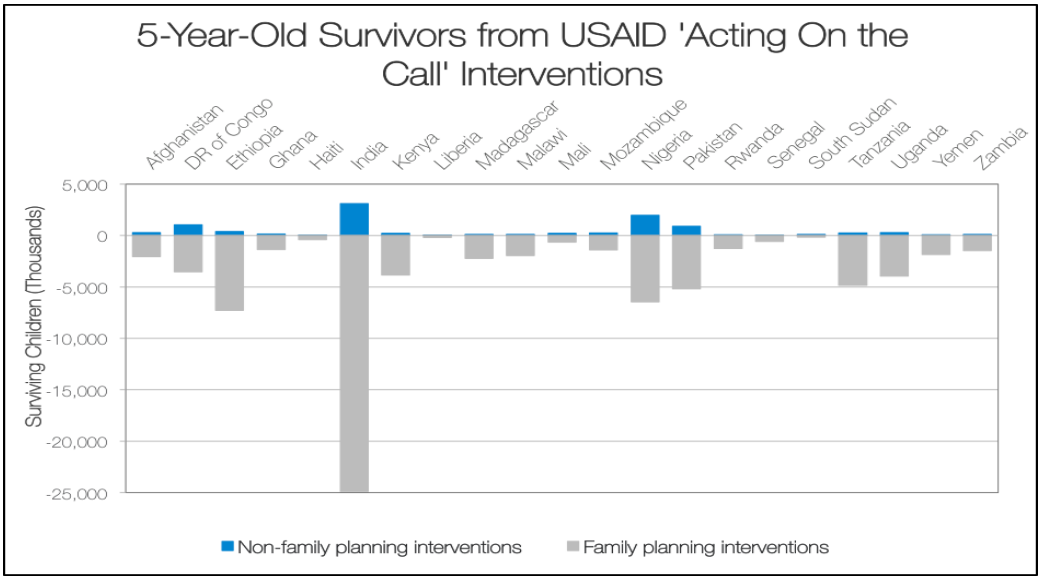
4. REACH Act measurements reflect demographic priorities like fertility reduction over healthy timing and spacing of pregnancy.

While REACH Act advocates, as well as AOTC, emphasize the importance of ensuring healthy timing and spacing of pregnancies as a function of family planning, the metrics employed by AOTC when calculating the 5 million child "lives saved from demographic impact" do not account for this when setting the targets reflected in the REACH Act. Most notably, the major goals set by AOTC make no attempt to differentiate between high-risk and other pregnancies. The AOTC report states that "achieving both the demographic and high-risk pregnancy impacts would avert a combined estimated seven million

under-five and 450,000 maternal deaths," but only the demographic impact is reflected in the goals of the proposed bill.

Furthermore, the inclusion of hypothetical children in the measure of "child lives saved from demographic impact" ignores the fact that even in the poorest of USAID's target countries, early childhood death remains the exception, not the rule. Therefore, for every child whose early death might be averted by family planning, many other children's lives must also be averted—children who would presumably have survived past their fifth birthdays. It is notable that the only potential outcome for these "lives averted" that AOTC contemplates is an early death, with no consideration of the immense human capital that must also be averted to "save the lives" of the few by nonexistence. Taken together, if the impact of AOTC interventions were measured in terms of surviving children who reach their fifth birthday, the outcome would be read in negative numbers, as the number of hypothetical child survivors averted by family planning in each target country dwarfs the number of actual lives saved by other interventions proposed in AOTC.

While it is questionable that AOTC includes hypothetical children in its estimates at all, at a minimum it should not cherry-pick the hypothetical children likely to die young, while ignoring the majority of hypothetical children whose survival is statistically probable with or without USAID assistance. Doing so continues a highly controversial U.S. Foreign Policy legacy of emphasizing population control through investments in family planning.



DATA SOURCE: Acting On the Call, 2014. Survivor lives averted calculated by subtracting the total births per country averted by family planning from the deaths averted by family planning ("child lives saved from demographic impact.") Estimated total births averted were calculated by dividing the deaths averted by family planning by the average of each country's 2012 and projected 2020 child mortality rates.

5. The REACH Act framework for accountability is deeply flawed.

Supporters of the REACH Act describe it as a way to ensure accountability to ambitious, yet measureable targets, and to ensure that USAID funding goes to the most cost-effective methods of saving lives. Ultimately, for all its inspirational messaging and laudable goal of ending preventable deaths, this proposed legislation succeeds or fails based on its metrics, which it seeks to impose by force of law on future funding. As outlined above, the metrics of the REACH Act, as defined in AOTC,

are factually misleading, internally inconsistent, and ultimately cynical—a fundamentally anti-natalist agenda buried within an ostensibly pro-natalist advocacy package.

Because this bill is based on and influenced by AOTC, it is irrevocably tied to a framework that is based on flawed metrics. While current USAID efforts to improve maternal and child health in its target countries have been criticized as uncoordinated and possibly duplicative, this current legislation does not offer an improvement, but rather a way to ensure that engineered inefficiencies are distributed equally across all projects simultaneously.

6. The REACH Act will undermine the Mexico City Policy and U.S. Law by empowering the international abortion lobby.

As discussed above, the skewed metrics originated in AOTC and proposed as law by the REACH Act heavily favor family planning as a priority. As discussed above, "unmet need" for family planning is a widely misunderstood concept that is a poor reflection of the priorities of the women it describes and may lead to investing in programs that are wasteful at best, and coercive at worst.

While the Helms Amendment of 1973 and President Trump's reinstated Mexico City Policy offer safeguards against USAID funding going to to abortion or groups that promote it, the proposed REACH Act aims to set in motion an agenda that will last beyond the current administration, just as the 2015 iteration sought to extend the impact of the Obama administration beyond 2016. In the international context, the loudest and most persistent advocates for an international right to abortion are family planning organizations, as evidenced by the extreme reactions of family planning advocates and their distaste for the Mexico City Policy when it came into effect in 2017.

Because its metrics skew and exaggerate the impact of family planning, the REACH Act, if enacted, would safeguard and possibly expand funding to these same family planning groups who, if relieved of the constraints of the Mexico City Policy, would resume their abortion advocacy. It would also resume funding to those groups who chose to favor abortion advocacy over compliance with U.S. restrictions. Furthermore, even under the Mexico City Policy, funding remains intact to U.S. registered NGOs that are among the most aggressive in promoting abortion abroad, including Population Services International, PATH, and the Population Council. These are the groups that will benefit from the intentional flaws in the AOTC framework.

7. The REACH Act undermines U.S. restrictions on funding for family planning to protect women and families from coercion.

As noted above, the notion of "unmet need" is an unreliable measure of women's priorities, as it characterizes women who do not want to use contraception as having a "need" for it. For all "unmet need" to be met, millions of women would have to disregard their religious convictions, their concerns about their own health, and, indeed their right to say no to drugs and devices they would prefer not to use.

AOTC further proposes the establishment of a benchmark of 75% of contraceptive "demand" satisfied by modern methods, in which "demand" is defined as current contraceptive use plus "unmet need." While USAID's proposed benchmark was not included in the UN's Sustainable Development Goals, proponents praised the "demand satisfied" indicator for being linearly correlated with contraceptive use. In practice, it amounts to a quota for contraceptive use that undermines longstanding requirements of U.S. Law against quotas and other targets that can lead to coercion in U.S. funded family planning.

CONCLUSIONS

At a time when global demand for family planning is increasingly saturated, Congress should consider reevaluating the justification for existing spending in that area, not giving legislative force to new and misleading measurements designed to ensure the spigot remains open. At a minimum, the commendable focus on ending preventable maternal and child deaths should not be diminished by cynical metrics that prescribe nonexistence as a life-saving measure. Congress should consider instead:

1) Greater efficiency toward accomplishing the wrong goals is not an improvement. The stated purpose of this bill is laudable, and it is likely true that USAID's maternal and child health efforts would benefit from some reforms to make them more efficient. However, the blueprint contained in AOTC could result in USAID moving with greater efficiency and accountability in the wrong direction.

2) Bad metrics make bad policy. Bad metrics enshrined in law make bad policies harder to fix. Many of the Obama-era "reforms" outlined in AOTC are likely being implemented already within USAID, but could be changed by this administration to better reflect its priorities. If the REACH Act were passed, it would give the AOTC "reforms" the full force of law, further cementing them in place along with all their misleading metrics and definitions.

3) Can this legislation reasonably be salvaged? Since this bill exists to ensure that USAID's maternal and child health efforts are accountable to the measurements, definitions, and goals of AOTC, it is highly unlikely that it can be improved by amendment. If all links to AOTC, including the 600,000 women and 15 million children figure, were stripped out, there would be very little left over. It would be more advisable to begin afresh. Congress should draft legislation that ensures reforms to USAID's programming and grant allocation to benefit existing persons. Such reforms should work to reduce inequities between countries and regions, make pregnancy, birth and early childhood safe rather than rare, and ensure that nothing in the law might lead to coercion.

C-Fam | Center for Family & Human Rights
New York · Washington, DC

805 3rd Avenue, Suite 1440
New York, New York 10022
(212) 754-5948
info@c-fam.org
www.c-fam.org