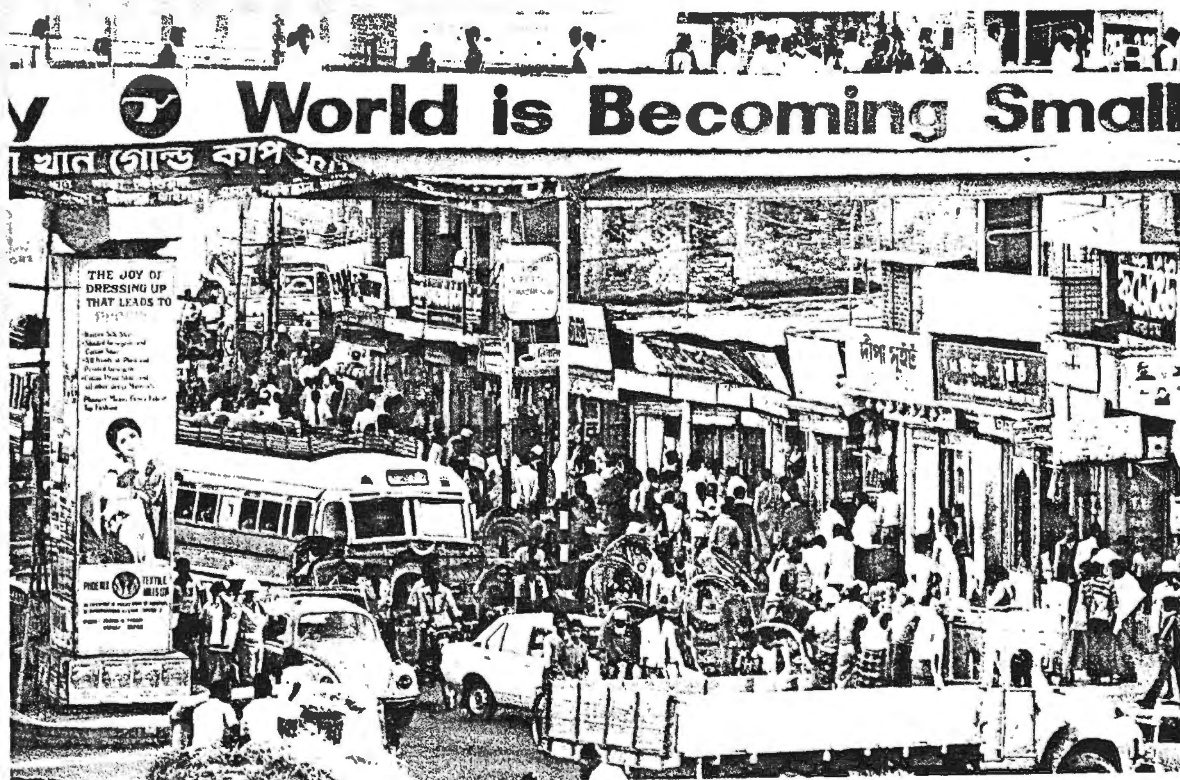
THE STATE OF WORLD POPULATION 1996



CHANGING PLACES: POPULATION, DEVELOPMENT AND THE URBAN FUTURE

United Nations Population Fund
Dr. Nafis Sadik, Executive Director

The tremendous expansion of cities, especially in developing countries, is transforming social dynamics throughout the world. But while it brings daunting challenges, it also brings unprecedented opportunities. This year's edition of *The State of World Population* report from the United Nations Population Fund examines the causes of urban growth and the implications of expanding urbanization.

Within 10 years half the world's people will live in urban areas. Fuelled both by natural population increase and by migration from rural areas, rapid urban growth will continue well into the next century. Much of it will occur in the world's poorest countries.

This transformation will create new possibilities for economic and social progress, but will also vastly increase the difficulties cities already face in providing adequate infrastructure, housing, employment and social services. To be sustainable, development should be better balanced between rural and urban areas, and among small, medium-sized and large cities.

In line with a human-centred approach to development, this report focuses on the conditions of life in the cities, particularly the dimensions of urban poverty. It notes that the viability of cities will depend on their capacity to address people's needs by providing more effective investments in health and education. It calls for community participation in urban development, and emphasizes that women must be full partners. It stresses that one key aspect of empowering women is ensuring their rights to reproductive health and choice in family size.

This approach reflects a consensus about development priorities and human rights that has emerged from the recent cycle of global conferences. I expect the HABITAT II conference on the urban future to advance still further the understanding that social development and gender equality must be at the centre of overall development efforts. It is my hope that this report will contribute to that process.

Boutros Boutros-Ghali
Secretary-General of the United Nations
29 May 1996

CONTENTS

Foreword

1. Introduction: The Urban Potential 1

2. Conditions of Life in Urban Areas 5
Urban Poverty 5
Health 10
Reproductive Health 17
Education 21

3. Urban Population Dynamics 23
The Processes of Urban Growth 26

4. Sources of City Growth 35
Natural Increase 35
Migration 36

5. Urban-rural Links: Transactions and Transformation 41
Urbanization of the Rural Areas 42
Rural Lifestyles in Urban Areas 44

6. Policies, Strategies and Issues for Improving Cities 47
Meeting the Urban Challenge 47
Best Practices 53
UNFPA and the Urban Future 54

Appendix: Follow-up to the ICPD – Implementing the Reproductive Health Agenda 58

Notes 63

Panels
Population Growth Remains High 1
Quantitative Goals of the ICPD 3
A Different View of Development 4
Definitions of Poverty 6
Urban Compared with Rural Poverty 6
A Plague of Urban Violence 8
Cleaner Streets and Health Awareness 10
Dirty Cities, Deadly Cities 12
What is Reproductive Health Care? 18
Situation Analysis 19
The ICPD on Quality of Care 20
Self-reliant Reproductive Health Clinics 22
Asia and the Pacific 23
Eastern Europe 24
Sub-Saharan Africa 28

CONTENTS

Panels

Latin America and the Caribbean 28
Arab States 29
Making a Shanty Town More Livable 30
How Accurate Are Projections of Future City Sizes? 30
Will a Trend Away from the Cities Develop? 31
Flowers among the Garbage 34
ICPD and Urban Strategies 48
Urban Issues at the World Summit for Social Development 49
Beijing and Urban Issues 50
Urban Conferences of the Past Decade 51
Understanding Urban Population Distribution and Service Needs 54
Linking Reproductive Health Services to Community Outreach 55
Integrating Population into Decentralized Urban Planning 56
Reproductive Health for the Marginalized Community 57
Integrating Family Planning into Reproductive Health Programmes 58
Reducing Maternal Mortality 59
Addressing Adolescents' Needs 60
Women and Decision-Making 60
Involving Men 61

Charts and Graphs

Percentage of the Population Living in Urban Areas 24
Levels of Urbanization in Selected Regions 25
Regional Distribution of Urban Population 25
Urban Growth, by Region 26
Natural Increase as a Percentage of Urban Growth 27
Map: World's 15 Largest Cities, 1994 and 2015 (projected) 27
World's 30 Largest Cities, 1950, 1990 and 2015 (projected) 32

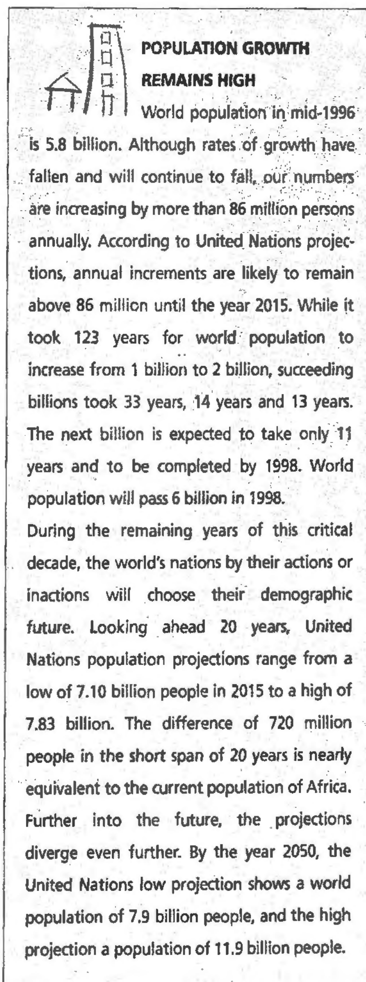
Tables

Monitoring ICPD Goals – Selected Indicators 67
Demographic, Social and Economic Indicators 70
Selected Indicators for Less Populous Countries/Territories 73
Technical Notes 75

CHAPTER 1:

INTRODUCTION: THE URBAN POTENTIAL

ENHANCED INVESTMENTS IN SOCIAL DEVELOPMENT WILL BE THE KEY TO THE SUCCESS OF THE URBAN FUTURE AND THUS THE FUTURE OF DEVELOPMENT ITSELF IN THE 21ST CENTURY.



POPULATION GROWTH REMAINS HIGH

World population in mid-1996 is 5.8 billion. Although rates of growth have fallen and will continue to fall, our numbers are increasing by more than 86 million persons annually. According to United Nations projections, annual increments are likely to remain above 86 million until the year 2015. While it took 123 years for world population to increase from 1 billion to 2 billion, succeeding billions took 33 years, 14 years and 13 years. The next billion is expected to take only 11 years and to be completed by 1998. World population will pass 6 billion in 1998.

During the remaining years of this critical decade, the world's nations by their actions or inactions will choose their demographic future. Looking ahead 20 years, United Nations population projections range from a low of 7.10 billion people in 2015 to a high of 7.83 billion. The difference of 720 million people in the short span of 20 years is nearly equivalent to the current population of Africa. Further into the future, the projections diverge even further. By the year 2050, the United Nations low projection shows a world population of 7.9 billion people, and the high projection a population of 11.9 billion people.

In an already largely urban world the growth of cities will be the single largest influence on development in the first half of the 21st century. Urban population is 2.6 billion, 1.7 billion in developing countries. Urban population is growing faster than world population as a whole. Some cities are experiencing the fastest rates of population growth ever seen. Within ten years, more than half the people in the world will be living in cities, 3.3 billion of the 6.59 billion total.[1]

Nearly all the urban population increase will be in today's developing countries. They will account for 92.9 per cent of a 2.06 billion increase in the global urban population between 1970 and 2020. Two out of three urban dwellers live in developing regions; by 2015 it will be more than three out of four; by 2025, nearly four out of five. Much of this growth will come in the world's poorest countries, and many of the new urban dwellers, particularly women and their children, will be among the poorest people in the world.

A higher proportion of the world's people live in the biggest cities. There were 83 cities or city systems with populations of more than 1 million in 1950, 34 of them in developing countries. Today there are over 280 and this number is expected to almost double by 2015. All the new million-cities and 11 of the world's 15 biggest cities are in developing countries. In 1950, only the biggest city in the world (New York) had more than 10 million people; today 14 of the biggest have more than 10 million and Tokyo, the largest, has 26.5 million.

People living in rural areas will be increasingly affected by the urban dynamos. Rural populations will be more involved in meeting urban needs, responding to urban priorities and capitalizing on the opportunities the cities present. To a great extent in their daily lives, in their expectations of life, in their social organization and in their value systems they will become urbanized themselves.

One of the features of this process will be increasing mobility. Migration accounts for some 40 per cent of urban increase. Migrants learn quickly and transfer the habits and values of their hosts to their own societies. Although the volume of international migration is insignificant by comparison with internal movement, its effects are profound. International migrants have an impact on their adopted society out of proportion to their actual numbers.

The urban future carries many risks for the physical environment and natural resources, for social cohesion and for individual rights but it also offers vast opportunities. The experience of large cities as concentrations of human creativity and the highest forms of social organization suggests that the future will open new avenues for human development. Cities provide capital, labour and markets for entrepreneurs and innovators at all levels of economic activity. Cities already account for 60 to 80 per cent of the gross national product of many developing countries.

Cities also speed social transformation. Indicators of health, literacy and social mobility are all higher in urban areas. Among these the key indicators of movement towards the equality and autonomy of women, such as closing the gender gap in education, access to

reproductive health services including family planning and sexual health, and fairly-paid waged employment are also higher.

The challenge of the urban future will be to sustain progress in social development in the face of unprecedented pressure. The assumption that urban growth will power development has held in many countries in Asia and some in Latin America. But even as urban-based economies grow, they are in danger of being overwhelmed by the sheer numbers of the poor and the dispossessed.

Poverty has not risen in step with population growth: in a number of countries in Asia the numbers of the poor have actually declined since the mid-1980s. But overall, the absolute number of the urban poor is still increasing. There are now an estimated 600 million people in urban areas in developing regions who cannot meet their basic needs for shelter, water and health from their own resources. Half the populations of cities in some of the world's poorest countries are living below official poverty levels. Poverty will present itself increasingly as an urban problem.

The new urban masses' success in finding livelihoods will determine the viability of cities and nations. It is not only a matter of creating employment opportunities: in the long term it will require larger and more effective social investments: in health, especially for reducing infant and maternal mortality; improving reproductive health, promoting family planning and sexual health, and controlling the spread of infectious diseases; in education, especially for girls and women; and in promoting autonomy and equality for women by these and other means. Releasing the potential of the female half of the urban population will be one of the keys to both social cohesion and economic progress.

The demands of the urban future will test the pledges made by the world's governments at the series of global conferences on social development which started in 1992 and conclude in June 1996 with the International Conference on Human Settlements (HABITAT II) in Istanbul. Meeting their universally agreed goals is vital for the future of cities and for all prospects for human development.

Among the most specific goals are those of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The ICPD goals of providing universal primary health care including reproductive health care, family planning and sexual health by 2015, closing the gender gap in education and providing education for all by 2015, and ensuring equality and autonomy for women are essential for dynamic urban growth.

Reproductive health care includes both younger and older women as well as those of child-bearing age, and men as well as women. The services offered must include prenatal and postnatal care, consultations and referrals for complications, and trained attendants in childbirth, in addition to family planning and sexual health care. Reproductive health care also provides protection and screening against sexually transmitted diseases including HIV/AIDS, teaches responsible sexual behaviour and the elimination of harmful practices such as female genital mutilation. These services are more likely to be available in urban than in rural settings; they are likely to be of higher quality, and urban dwellers are more likely to take advantage of them. The challenge is to improve their range as well as their quality and maintain these in the face of mounting demand and pressure on resources.

Education, particularly the education of girls and women, is one of the keys to social and economic development. Research has shown that the education of girls and women is a powerful ally in the eradication of poverty. Educated women are better able to care for their own health and that of their families. Educated women marry later, have their first child later, and have fewer and healthier children. They are in a better position to secure employment and command higher rewards for their work. Women with families are very likely to use additional income on better food, health and education for their families, thus generating further investment in economic and social development.

Cities historically present fewer obstacles to women's education and tend to be less bound by traditions that work against women's interests. Compared with rural areas they have higher enrolment ratios and more schools offering all grades. The challenge will be to open urban schools to the children of shanty towns and informal settlements on the outskirts of every city in the developing world, while maintaining the advantages of education for girls.

Equally important for the urban future is the ICPD goal of **empowerment:** equality and autonomy for

women. Women need to have decision-making power in their own lives and to participate in community and governmental institutions. They need to be able to make their own decisions concerning marriage and child-bearing, employment outside the home and the disposition of their income. Women heads of household are becoming an important factor in the urban community. Today, their families are much more likely to be poor. A viable future requires that they have the means to escape from poverty. It is no accident that women in industrialized countries and the more successful developing countries enjoy relatively higher levels of autonomy and equality, including access to health care and education.

Finally, reducing the pressure of numbers and progress towards the ICPD goal of stabilizing world population growth will be essential for a successful transition to an urban world.

A key element for success in this aim will be to meet rapidly growing demand for social investment. Though the market will meet some of this demand, ensuring that all needs are met must remain a responsibility of government as part of its monitoring of planning and policy.

Increasing urbanization has the potential for improving human life or increasing human misery. The cities can provide opportunities or frustrate their attainment; promote health or cause disease; empower people to realize their needs and desires or

QUANTITATIVE GOALS OF THE ICPD

The ICPD Programme of Action sets out 20-year goals in three related areas: expanding the availability of education, particularly for girls; reducing mortality rates; and increasing access to quality reproductive health services, including family planning.

Education

All countries should strive to ensure complete access to and achievement of primary education by both girls and boys as soon as possible and before 2015. The goal of universal access by the year 2000 was agreed at the 1990 World Conference on Education for All, held at Jomtien in Thailand.

In view of education's importance in improving women's status, countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher education, vocational education and technical training; and to improve the quality and relevance of that education. [para. 4.18]

With a view to closing the gender gap in primary and secondary education by 2005, countries should take affirmative steps to keep girls and adolescents in school by building more community schools, training teachers to be more gender sensitive, providing scholarships and other incentives and by sensitizing parents to the value of educating girls. Also, pregnant adolescents should be enabled to continue their schooling. [para. 11.8]

Mortality Reduction

Specific infant and child mortality-reduction goals aim to reduce the gap between developed and developing countries as soon as possible:

- Countries should strive to reduce infant and under-5 mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000. [para 8.13]
- By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under-5 mortality rate below 60 deaths per 1,000 births.
- By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000.
- Countries achieving these levels earlier should strive to lower them further. [para. 8.16]
- Maternal mortality should be reduced by one half of the 1990 levels by the year 2000, and a further one half by 2015:
- Countries with intermediate mortality levels should aim to achieve a maternal mortality rate below 100 per 100,000 live births by 2005 and below 60 per 100,000 live births by 2015.
- Countries with the highest levels of mortality should aim to achieve a maternal mortality rate below 125 per 100,000 live births by 2005 and below 75 per 100,000 live births by 2015.
- All countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. [para. 8.21]

Reproductive Health and Family Planning

Recognizing the importance of reproductive health care for human health and well-being, the ICPD urged countries to make such care accessible through the primary health care system to all individuals of appropriate ages as soon as possible and no later than 2015. [para. 7.6] In addition, it urged countries to act to meet their populations' family planning needs as soon as possible and to seek to provide universal access to a full range of safe and reliable family planning methods within reproductive health services in accord with their laws and practices by 2015.

The aim should be to assist couples and individuals to achieve their reproductive goals and enable them to exercise the right to have children by choice. [para. 7.16] Public, private and non-governmental family-planning organizations should seek to remove all programme-related barriers to family-planning use by 2005 through the re-design or expansion of information and services, to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases. [para. 7.19]

impose on them a simple struggle for basic survival. Which of these represents the urban future is a matter for us to decide.

A successful urban future depends as much as anything else on engaging all members of the community, especially women and the poor, in a constructive political process. Governments, in this view, are important partners in civil society, helping create and support the conditions under which all actors participate.

The process has an international dimension. Using the forum provided by the United Nations system, the large series of conferences of the 1990s have produced an agenda for social development in the 21st century and a framework for realizing its goals. International organizations such as UNFPA can offer leadership and coordination.

Especially in those countries where poverty is greatest, discrimination against women most severe and population pressures felt most keenly, national efforts cannot succeed unaided. The causes and effects of global urbanization cross national boundaries: so too must cooperation and compassion.

A DIFFERENT VIEW OF DEVELOPMENT

The opportunities and obstacles on the path to sustainable development are both greater than ever before. Though access is uneven, new technologies and global markets offer the prospect of broader and more rapid economic growth and social progress; though environmental stress is deepening, so is understanding and agreement on the issues; though population numbers are ever greater, there are good prospects for stabilization within the next two generations; though chasms divide North and South, rich and poor, the Cold War no longer stands in the way of solutions.

The fate of nations, enterprises, families and individuals for good or ill is increasingly affected by external decisions. But development, if it is to be worthy of the name, increases rather than reduces autonomy.

In the 1990s a series of international conferences has articulated a common vision for social development through meeting human needs and enabling the contribution of each individual, family and community.

First, everyone needs to play an active role in the development process. The capacities, perspectives and contributions of women in particular have long been undervalued or ignored. Women have too often been valued primarily for their reproductive role, but even in that role their views and perspectives have not been respected. This has limited women's opportunities for education, employment, and recognition of basic rights and responsibilities such as autonomy in person and property, rights to land ownership and inheritance, access to credit, participation in political life and decision-making authority within the family and their communities.

The role of women should not be narrowly defined by the burdens, joys and risks of child-bearing and child-raising. It follows that a fundamental condition for social transformation is the basic human right of individuals and couples freely and voluntarily to determine the number and timing of their children and to have the information and means to do so. This exercise of reproductive rights must be free of coercion and violence, encourage recognition of male and female responsibilities and foster full partnerships in the making of decisions.

Second, lives should not be truncated by avoidable morbidity and premature mortality. Improvements in basic health (of which reproductive health is one important component) will improve the quality of life, increase productivity and extend the duration and the security of the support which family members can give each other throughout their lives. It will allow decisions about family formation and family life to be more responsive to the desires of parents, their capacities for support and hopes for their children's futures than to their worries about their own. Access to healthy and safe shelter, to water, sanitation and to productive livelihoods are as important as health services in realizing these possibilities.

Third, the full exercise of personal capacities requires quality basic education and the opportunity for further advancement. Access to and promotion of education for all, and especially girls and women, are vital components of any sustainable development strategy. Education creates and strengthens capacities for informed decision-making. These basic conditions of empowerment, health (including reproductive rights and health) and education work together to create a positive dynamic for development.

CHAPTER 2:

CONDITIONS OF LIFE IN URBAN AREAS

CONDITIONS OF LIFE IN THE CITIES, ESPECIALLY FOR THE MOST VULNERABLE GROUPS, ARE EITHER POORLY DOCUMENTED OR THE DATA ARE DIFFICULT TO ACCESS, AND ARE UNDERANALYSED AND UNDERUSED. THERE IS AN URGENT NEED FOR IMPROVED INDICATORS FOR MEASURING THE QUALITY OF INDIVIDUAL LIVES.

THE MOST SERIOUS PROBLEMS IN ALL SECTORS ARE EXPERIENCED BY THE URBAN POOR. IT IS STILL DIFFICULT TO ASSESS THE NATURE AND SERIOUSNESS OF URBAN POVERTY AND SUGGEST SPECIFIC POLICY SOLUTIONS. BUT IT IS NOT HARD TO CONCLUDE THAT MORE ATTENTION TO THE PROBLEM IS NEEDED. BETTER BASIC SERVICES, EDUCATION AND HEALTH, WITH EMPHASIS ON EQUAL OPPORTUNITIES FOR GIRLS AND WOMEN, WILL IMPROVE THE COMPETITIVE ADVANTAGE OF THE URBAN POOR.

Poverty casts a deep shadow over the urban future. Urban areas cannot meet the basic needs of a vast number of people, who are relegated to inadequate and unhealthy living conditions. These Egyptian families live close to a major cement factory. *Jørgen Schytte, Still Pictures*

URBAN POVERTY

For all the relative advantages of city life, widespread poverty casts a shadow over the urban future. Difficult questions remain concerning the definition of poverty, but it cannot be denied that a vast number of people in urban areas cannot adequately provide for their basic needs in shelter, employment, water, sanitation, health (including reproductive health) and education. Such poverty may affect a third of all urban dwellers directly, but its indirect effects are felt by the whole society. The ability to meet the challenge of eradicating extreme poverty and providing basic needs will define and to some extent determine the viability of urban centres and the economies which they increasingly dominate. A large proportion of the poorest are women. Collectively, women form a resource of great size and crucial importance. Their individual ability to provide for themselves and their families will determine whether the potential of that resource is realized.

Various estimates of the proportion of urban populations living in poverty are available; different definitions are used. One global estimate suggests that 27.7 per cent of the developing world's urban population lives below official poverty lines. Regional variation is considerable: sub-Saharan Africa, 41.6 per cent; Asia, 23 per cent; Latin America, 26.5 per cent; and the Middle East and North Africa, 34.2 per cent. Urban poverty has been increasing faster than rural poverty.

According to national studies up to half the population of several cities in some of the world's poorest countries are living below official poverty lines.[1] Even this may be an underestimate: official poverty lines are often set unrealistically low, below the levels required to meet basic needs, and standard income-based definitions do not usually take into account the higher cost of liv-

DEFINITIONS OF POVERTY

A variety of ways to define urban poverty are available, each with their own strengths and deficiencies:

- ***income-based definitions:*** This approach seeks to specify a level of income per capita in a household below which the basic needs of the family cannot be satisfied. It shares the difficulties of the next class of definitions of imposing an official's or observer's view of necessities. It does not acknowledge variation in costs of similar goods for different consumers. The vital importance of non-market household production and non-monetarized exchanges in poor families is not taken into consideration.
- ***basic needs approaches:*** A set of minimal conditions of life, usually involving the quality of the dwelling place, degree of crowding, nutritional adequacy and water supply are specified and the proportion of the population lacking these conditions is used to estimate the degree of poverty. The advantage of this approach is that different conditions can be specified appropriate to different settings. However, this reduces the comparability of estimates undertaken in different sites. Similarly, it does not take into account the willingness of people to accept various tradeoffs deliberately (e.g., a lower quality dwelling in return for reduced transportation time and expense in getting to work).
- ***participatory definitions:*** In this approach, respondents from communities are themselves invited to identify their perceptions of their needs, priorities and requirements for minimal secure livelihood. Some sacrifice of comparability of estimates in different communities or at different times is traded for better information on the identified demands of the individuals themselves. At times such analyses supplement and reinforce the more quantitative measures; at other times they reveal a very different experienced reality. A study in Rajasthan, India, identified 32 conditions which individuals felt necessary for a satisfactory minimal lifestyle. Comparison of interview results over a decade revealed that despite reductions in income of the residents, and little change in living conditions of the kind generally surveyed in basic needs estimates, significant improvements had occurred in experienced quality of life.

The International Conference on Population and Development emphasized the importance of incorporating beneficiaries' perspectives into the design of programmes of social intervention.

ing in the cities. In 1990 "at least 600 million urban dwellers in Africa, Asia and Latin America live in 'life and health-threatening' homes and neighbourhoods because of the very poor housing and living conditions and the inadequate provision for safe and sufficient water supplies and for sanitation, drainage, the removal of garbage, and health care".[2]

Some individuals and families move out of poverty and others fall into it. Social status, including poverty and near poverty, is not static but dynamic. The relatively poor, however, do share a particular vulnerability to life's shocks: even minor illnesses and lost opportunities can lead to deeper poverty and misery. Many millions of people never get access to the skills, resources or opportunities required to escape from poverty's grasp. The frequency of mobility out of poverty in rural and urban areas is poorly understood.

Though urban poverty has its special characteristics, the same structural factors underlie poverty in both urban and rural areas.

Shelter

Bad housing with poor or non-existent services is a characteristic of poverty, with homelessness as its most extreme expression. Social disruption, environmental disaster and the effects of bad urban planning can quickly expose the vulnerability of the poor. Free space in urban areas tends to be on marginal lands such as steep hillsides, ravines and watercourses. Home-made shelter is little protection against wind, flood or landslide, as on two occasions a few weeks apart in 1995, when a hurricane in the Caribbean and typhoons in the Philippines destroyed thousands of poorer homes. Better-built housing on more secure land was relatively undamaged.

The evidence of inadequate provision of infrastructure to the poor is overwhelming. In a study of eight mega-cities, the ILO estimated slum populations at between 12 per cent (Seoul) and 84 per cent (Cairo) of the populations.[3] (Other cities were: Shanghai, 20

URBAN COMPARED WITH RURAL POVERTY

- Urban workers' livelihoods depend on access (both social and physical) to jobs.
- The ability of the informal urban sector to absorb the unemployed is limited.
- The urban poor are more vulnerable to changes in market conditions.
- Female-headed households, the most vulnerable of the poor, are more common in cities.
- The urban poor tend to pay more for services.
- City dwellers tend to favour higher quality or more convenient foods, which are generally more expensive.
- The urban poor share fewer communal assets that could shield them from individual circumstances (such as health conditions, employer decisions, etc.).
- Urban exchange is more monetized, making assets and credit availability more important.
- Exposure to environmental risks (pathogens and toxins) is greater in cities.

per cent; Mexico City, 25; Rio de Janeiro, 34; Bombay, 57; and Lagos, 58.) National studies in Asia show large percentages of the urban population in slum or squatter settlements: Bangladesh, 47 per cent; India, 36; Sri Lanka, 21; Malaysia, 15; Thailand, 15; and Indonesia, 54.[4]

In Rio de Janeiro, residents on the periphery were three times more likely than those in the wealthier city centre to lack access to electricity. Eight times as many peripheral buildings (41.8 per cent) lacked running water than buildings in the centre (5.2 per cent); 64 per cent of poor households (those with income less than three times the minimum wage) in the periphery lacked adequate running water compared to 30 per cent of poor households in the central district. Sewerage was lacking in 35 per cent of the periphery and only 14 per cent of the central area. The number of health professionals per capita in the periphery was one third that of the centre.[5]

While many aspects of Rio's infrastructure improved during the 1980s, comparisons consistently showed large disadvantages for poorer populations. By the end of the decade, more than a third of the poor lived in dwellings lacking piped water while only one eighth of the non-poor did so. Nearly a third of the poor lacked sewerage service compared to less than a tenth of the non-poor. Half of the poor lived without garbage collection, compared to a quarter of the non-poor.[6]

Poor housing affects the whole community. Overcrowded, ill-ventilated and poorly drained settlements are breeding grounds for infectious diseases of all kinds. Inadequate housing is a major contributor to social breakdown, with domestic violence, unintended pregnancy and high rates of single-parent families only some of the many consequences. A high level of violent crime and illegal drug use is associated with poor housing.

Poor housing has a drastic effect on the whole community and the whole family, but women often bear the brunt of the burden. This rubbish recycler and his family live amid the raw material of their trade near the dump in Bogotá, Colombia.
Paul Harrison, Still Pictures

Estimates of actual homelessness in northern industrial states vary considerably. In the United States, estimates range from about 250,000 to over 3 million people.[7] Despite social safety nets, European homelessness is estimated conservatively at 2.5–5 million.[8] Outside the industrialized countries, figures are hard to come by and confused by the informal nature of much housing: homelessness by the same measure as industrialized countries would give a figure of 200 million for the less developed world.

Employment and sustainable livelihoods

A variety of studies in diverse settings have shown that unemployment is two to three times greater among the poor than among the middle- or higher-income groups and correspondingly higher among the very poor compared to the relatively poor.[9] It is not merely that employment prevents poverty, but that poverty restricts access to skills, attitudes and opportunities for further advancement.

In all regions of the world, women in the larger cities are most likely to be found in the lower ranks of clerical, sales and service occupations rather than in production and manufacturing. The proportion of women in such occupations far exceeds that of men. In Asia, the proportion of city women in production jobs reaches a high of 33 per cent, compared to 50 per cent for men. While the proportion of women in

administrative, technical and managerial positions has been increasing, educational and social barriers still trap many women in low-skilled and low-paying work.[10]

Many developing countries have sought to generate employment and attract industry by creating export promotion zones in which duties and taxes are significantly reduced or waived as an incentive for foreign investment. Also waived are labour regulations which protect wages, hours, and conditions of work. Women in particular are recruited for low-skilled and low-paid employment in such activities as textile, garment assembly and other small-scale manufacturing activity. Journalists' reports and systematic studies[11] indicate that such employment opportunities frequently also involve opportunities for exploitation rather than for empowerment. While providing some income, they have little effect on poverty and may even contribute to it in the long run.

Women migrants have fewer opportunities than men. Though many migrants of both sexes often find their first employment in occupations lower than their aspirations, after a period of time upward mobility is stronger for men.[12] Men are more likely to enter formal-sector jobs, jobs with clear career progressions such as apprenticeships, and to advance in their positions or switch to jobs closer to their initial preferences.

Income distribution

Cities draw migrants with the promise of higher living standards, but the wealth produced in cities does not necessarily translate into prosperity for all. The best opportunities are open to those with entrepreneurial skills, influence and access to services and support. Two issues are important: the relative degree of income inequality, and the changes in these conditions over time.

Studies of selected megacities show that in the late 1980s the proportion of the urban population under the poverty level was roughly comparable to national poverty levels in Korea, Brazil and Egypt; in Nigeria, a higher proportion were poor in Lagos than in the

A PLAGUE OF URBAN VIOLENCE

Guatemala City (WFS) – Like many children in this sprawling urban centre, 12-year-old Marcos Fidel Quisquinay worked several jobs to help support his family. In the mornings, he washed laundry. In the afternoons, he helped on a garbage truck. At night, he washed and guarded cars.

But Quisquinay's short working life recently came to a sudden, violent end. As the ragged boy was guarding cars near a restaurant, two men approached him and handed him a bag, as if offering food. Moments later, a bomb inside the bag exploded in his hands, blowing the child to bits.

Although Guatemala's 33-year civil war has officially ended, violence still besets the capital of this Central American nation. A spate of vicious armed robberies, muggings and kidnappings – which have frequently ended in the victims' death – have earned Guatemala City a reputation as the most violent urban centre in the region.

"Night of Urban Terrorism: Boy Dies," a newspaper headline screamed the morning after the child's death. But within a few days, media attention had turned to frightening new incidents. "Ten Gun Deaths This Weekend," "Kidnappers Free Six Students" and "Youth Gangs Terrorize City."

An average of 10 to 15 people are killed every day in Guatemala, according to Police Chief Salvador Figueroa. Between May and October of 1994, 573 people were killed in violent crimes. An increasing number of victims are women whose bodies, dumped on the outskirts of the capital, show clear signs of rape and torture.

Much of the crime has been attributed to youth gangs from the vast ring of shanty towns surrounding Guatemala City, population 1 million. The endless rows of wooden shacks without potable water or electricity are the base for more than 60 separate armed gangs.

Violence has long permeated Guatemalan society, often sponsored by the state itself. During the civil war, Guatemala's military government was responsible for the death of at least 100,000 of its own citizens. Many of those killed were peasants and workers in rural areas whom the government suspected of supporting the insurgency.

Now, although a civilian government is in power, the culture of violence lingers. Analysts say that years of political killings underlie the barbarity of today's urban crime. "These practices cultivate the violence that plagues our citizens," says Human Rights Ombudsman Jorge Garcia Laguardia.

However, the motive now is usually gang members' enrichment. Assaults occur on the streets, on buses, in shopping centres and even in restaurants. For frightened city residents, nowhere seems safe anymore. But police officers say they do not have enough agents or other resources to combat the problem.

"We have only 4,000 agents to provide security for 10 million people throughout the country," says Interior Minister Danilo Parinello. "There's nothing more we can do."

Citizens have responded by stockpiling weapons to defend themselves. The Department for the Control of Arms and Munitions has issued gun licenses to 300,000 Guatemalans for self-defence purposes. The department's director, Col. Alfonso de Leon Tarzo, estimates that another 1 million citizens own guns illegally.

Copyright 1995, Women's Feature Service

country as a whole.[13] Data from China suggest that income differentials in urban areas have become lower than in rural areas, in contrast to the usual situation. It is clear that income distributions became more skewed (i.e., the proportions of both poor and wealthy increased) in Brazilian metropolitan areas during the 1980s.[14] In Asia, urban poverty has been decreasing proportionally since the mid-1980s in a number of countries.[15]

However, even with this success, income inequality is increasing. Opportunities for the more advantaged are increasing at a faster rate than those available to the disadvantaged. Access to services, particularly health and education, for all, including the poor and disadvantaged, will be essential to reduce these biases and prevent their perpetuation in the next generation.

Water and sanitation

Providing adequate water supplies for burgeoning urban populations is both difficult and expensive. Many cities in developing countries have already tapped all existing water supplies and must now bring water from great distances or reprocess used water. Better management and reduction of losses from leaks and diversions could effect large savings. However, expanding the distribution system is out of the question for cities which cannot afford to maintain the present one. Newly-settled sections are far from the centre and on difficult terrain.

Private water vendors fill the gaps, supplying an estimated 20 per cent or more of the urban population of developing regions.[16] But this service provides water of uncertain quality at a premium price. A review of water costs in a variety of cities indicates that private vendors charge from four to 100 times the cost charged by public utilities. The result is to place an additional burden on the poor, who pay high prices for bad service and at the same time subsidize cheap water for the better-off through their payment of taxes.

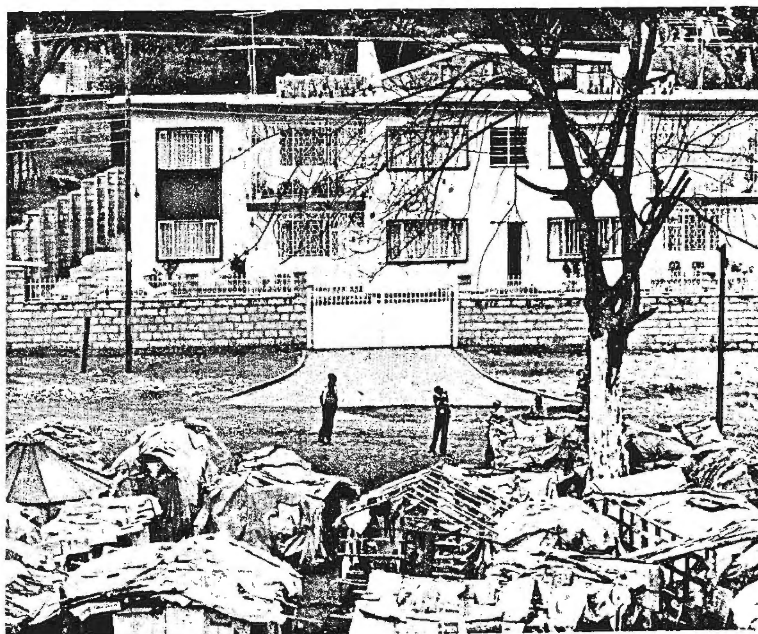
Expensive and poor-quality water is an additional tax on poor urban women, who are still performing their traditional role of finding water and fuel. They may spend hours waiting in line for a stand-pipe which is turned on for a few hours a day.

It seems nevertheless that urban water supplies are still better overall than rural[18], and that both have improved, though there are some questions about the quality of information and the usefulness of definitions associated with these findings.[19]

Power

Power for lighting, cooking and other household amenities has become more widely available in both urban and rural areas over the past decade. About three quarters of the urban population had access to the power infrastructure at the start of the 1990s. However, the poor in both urban and rural areas are seriously underserved. The richest 20 per cent of populations have access to the best available sources; only a small fraction of the poorest 20 per cent have similar access. For example, electricity is accessible to 99 per cent of the richest quintile in Mexico, but to only 66 per cent of the poorest. In Côte d Ivoire, the corresponding access levels are 75 and 13 per cent. The poor generally have less access in urban centres as well.[20]

Where power supplies are not available, as is usually the case in informal settlements, it is the women who



In many countries, urban poverty has been falling since the mid-1980s. However, income inequality is increasing and opportunities for the "haves" are increasing faster than those for the "have-nots". The differences are visible here in Nairobi. *Mark Edwards, Still Pictures*

CLEANER STREETS AND HEALTH AWARENESS

A UNFPA-supported project in Bamako, Mali, has helped to improve living conditions in the city's old central quarters by building awareness of hygiene and health issues. Poor drainage, an accumulation of uncollected garbage, and a lack of potable water and sanitation facilities were among the consequences of runaway population growth in these neighborhoods. These conditions resulted in a proliferation of flies and mosquitoes and rampant malaria, diarrhoeal diseases and other illnesses, especially in the rainy season.

To ameliorate these conditions in the Medina Coura district, a Women' s Cooperative for Education, Family Health and Sanitation was created with support from UNFPA and UNIFEM. It involved secondary school graduates in organizing efforts to collect household garbage and clean up sewage ditches, combined with public education campaigns on health, family life and hygiene. Informal discussion groups and film showings aimed at women and adolescents focused on topics like the importance of sanitation, proper waste disposal, and protection and treatment of drinking water. They also pointed out the risks of too-early and too-closely spaced pregnancies, and provided information about family planning.

The outcome was an increased environmental awareness and changes in household behaviour, leading to improved living conditions. Residents proved willing to pay for garbage collection and cleanup efforts; these modest fees helped to sustain the project. More favourable attitudes regarding contraceptive use also resulted. The success of this project generated interest in creating similar services in other neighbourhoods. UNFPA is now supporting a similar project in the Sabalibougou quarter.

search for fuelwood or other local materials (e.g., animal waste) for heating and cooking, though men may buy and carry kerosene. Household pollution from low quality fuel sources is a common contributor to respiratory disease, particularly for women.

In urban squatter settlements, electricity is often diverted from power grids. This practice makes it difficult for utilities to finance the expansion of services to underserved areas. Where power prices are subsidized, most benefit goes to middle- and upper-income families who can best afford pumps and consumer appliances; such policies further constrain prospects for extending systems and reforming pricing policies.

HEALTH

Individuals' sense of well-being and security as well as productivity is directly affected by their state of health and their expectations of a healthy life for their families and communities. It is so vital a component of national capacity and so clear an indicator of development status that it has been used by the International Conference on Population and Development, the Fourth World Conference on Women and other international conferences for the formulation of short- and medium-term goals of national progress.

Over the past 30 years life expectancies have increased in all regions of the developing world, with those in East Asia and the Caribbean nearing the levels of the developed regions. In many countries infant and child mortality rates have declined and maternal mortality rates have improved. These indicators reflect the variety, frequency and intensity of the disease burden. National indicators alone, however, do not illuminate the role of urban growth in shaping health risks and opportunities.

Understanding the dynamics of disease helps to illuminate the relative risks of urban populations. Health depends directly on the resistance of the population to disease, on the virulence of the disease-causing pathogens or disease agents, on lifestyles and social interactions, and on the nature of the responses of the health delivery system. Each of these is different in cities than in more rural areas, and is different for the poor than for the better-off.

Better nutrition, reflecting higher incomes, is usually assumed to have enhanced resistance to disease in the developed regions as they underwent urbanization.[21] However, any close inspection reveals a vastly more complex situation.

Cities – the healthy alternative?

Urban-rural health differences have not always favoured urban populations. Infant and child mortality in Holland in the late nineteenth century was lower in a sample of rural communities than the corrresponding figures in some cities. Only the urban rich had lower infant and child mortality rates than the rural poor. Even the rural poor had lower rates than the urban middle class. Data from England as recently as 1910–1912 indicate that mortality from several of the commonest diseases was lower among farm labourers than among better-paid urban professional and salaried workers.[22]

Today, in both developed and developing countries the urban poor have the highest health risks. Lower income and poor living conditions are usually

associated with poorer health status and increased mortality. At higher income levels the rural-urban balance of populations and the distribution of health services become more important than income alone.

Recent developments point to increased risks in urban areas: from pollution and other factors in environmental health; lower public expenditures in the health sector; the emergence of new diseases; the reappearance of more virulent or drug-resistant strains of older scourges; the quicker spread of infectious disease; and the interactions of viral and bacterial infections (including sexually transmitted diseases and HIV/AIDS).

Demographic, social and environmental health risks

Demographic, social and environmental conditions in cities have an affect on the incidence of both infectious and chronic diseases.

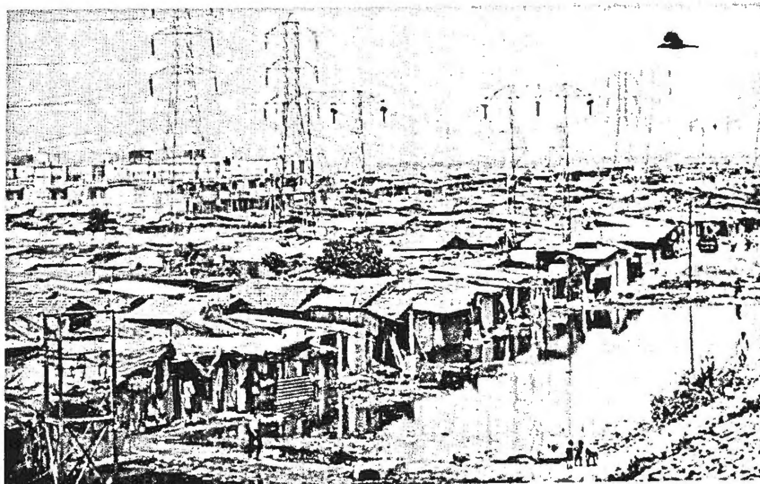
Demographic: Fertility rates continue to fall due to the impact of effective reproductive health and family planning programmes, the decline in mortality and improvements in economic conditions, while the age structure of populations continues to change, with proportionally more of the population in the older age groups. People over the age of 65 are the most rapidly increasing group in many countries.

Countries which have had the most rapidly changing age structures, particularly in East Asia, are finding a growing demand for services for chronic diseases, which affect older people more than young ones.

Social: Population densities in urban settlements generally exceed those in rural areas. Crowding is an important element in disease transmission, particularly of airborne infectious agents. The incidence of tuberculosis cases fell in the more developed countries of the world in part because of reductions in the density of populations in urban areas, though its re-emergence has more to do with drug-resistant bacteria and infections which weaken the immune system such as HIV than with population density.

In most parts of the world, women are bearing fewer children, but that does not necessarily mean less crowding in societies where the nuclear family is the exception rather than the rule. Providing shelter and support for elderly parents and poorer relatives is not only customary but an essential part of the social security system in many countries. This may be changing, in East Asia for example, where incomes are rising and there is a trend towards the nuclear family. A trend towards nuclear families can worsen environmental stress since the household is a basic unit of consumption. The continued spread of shanty towns and other informal settlements around major cities clearly indicates that local population densities continue to rise even as household sizes decline.

Environmental: Cities harbour threats to health unknown in rural settings. Most important is the pollution of air and water as a result of industrial activity, transportation and cooking exhausts. In the larger megacities, particulate concentrations are direct hazards to health. Mexico City and São Paulo, for example, are afflicted with excessive levels of carbon monoxide, ozone and particulates that lead to increases in respiratory and cardiovascular diseases.[23] In Mexico City, lead poisoning caused by emissions from cars and trucks is thought to be the cause of 140,000 children requiring remedial education, and of hypertension in 46,000 adults of whom 330 die yearly from heart attacks. In Cairo, lead concentration in the air is five to six times greater than global norms and



Urban areas involve threats to health unknown in the rural areas from which many migrants come. These threats are always most serious in the shanty towns and marginal slum dwellings, such as these in Bombay most often inhabited by migrants. This makes health care doubly crucial in the alleviation of urban problems. *Mark Edwards, Still Pictures*

DIRTY CITIES, DEADLY CITIES

Manila (WFS) The tons of garbage spewed out by Filipino cities is taking its toll on children's lives. Recently, one-year-old Irison Solis died of pneumonia and four-year-old Lovelyn Najera died of meningitis. The children they played with survived but with big stomachs, dry hair and symptoms of malnutrition.

These children and their parents live on a 24-hectare garbage dump site at Katmon, Malabon, a marginalized town in the Metro Manila area where several thousand migrants from the rural areas come in search of food, jobs and security. But with not enough jobs, garbage becomes the means of livelihood for many. At the five open dump sites in Metro Manila, scavengers and nearby residents battle scores of filth-borne diseases that prove fatal with alarming regularity.

"The pollution and the offensive odor of the dump could have contributed to the high incidence of respiratory diseases in the area," says Dr. Raymundo Vicente, physician at the Department of Health (DOH) Centre in Katmon. Centre records indicate from June 1992 to January 1993, respiratory diseases constituted 37 per cent of all diagnosed illnesses.

The other problem is constant exposure to excrement. "Many houses here don't have private toilets. There's no space for them," says Wilmer Najera, 21, who lives near the Katmon site. A study by the Environmental Management Bureau of the Department of Environment and Natural Resources says that by the end of 1986, only 63 per cent of households at the Katmon site had sanitary toilets; 15 per cent had unsanitary toilets; and 16 per cent had no toilets at all.

"We just wrap it (excreta) and throw it," says Leonila Parel, 45, who lives near the Katmon dump. Like in many other developing countries, this waste often finds its way into canals and rivers and contaminates food and water.

Besides human waste, garbage remains a massive problem. Despite decentralization of the collection system in 1992, garbage continues to spill over the streets of Metro Manila, causing scores of filth-borne diseases including diarrhoea. "Many of my neighbors suffer from diarrhoea. Ever since they were small, all my three children have repeatedly had colds and sometimes fever during the nights," says Najera of the Malabon dump site.

According to the DOH, diarrhoea plagues an average of 770,000 Filipinos annually. In 1991, 5,403 people died of related complications. It was the second leading cause of morbidity from 1986-1991 and seventh in terms of mortality.

It is, however, just one of the more than 35 filth-borne diseases identified by Dr. Metodio Palaypay, a public health professor at the University of the Philippines. The others include typhoid fever, cholera, dysentery, tuberculosis, anthrax, ophthalmia, intestinal worms and poliomyelitis. DOH identifies other filth-borne diseases like skin disorders, pneumonia, parasitism, tuberculosis and malaria as five out of the top 10 leading causes of morbidity from 1986 to 1991.

DOH also reported a 69 per cent increase in the number of typhoid cases in Metro Manila in 1992 over the previous year. During 1990–91, DOH hospitals in Metro Manila admitted the highest number of people suffering from cholera, dengue fever, hepatitis A, poliomyelitis and typhoid. DOH hospitals in other areas had fewer such cases.

Dr. Baquilod, a doctor at the Environmental Health Service of DOH, says that mosquitoes, cockroaches and rats in the area are also responsible for contaminating water, food and soil. This results in diarrhoea, amoebiasis, dysentery, viral hepatitis, cholera, typhoid fever and parasitism.

Copyright 1994, Women's Feature Service

the blood of children has lead content levels three to five times higher than children in rural Egypt.[24]

In settings where infectious diseases remain serious health threats, often compounded by malnutrition, faulty sanitation, unsafe water and pollution, and where chronic disease and disability are also rising, different segments of the population find themselves pitted against each other in competition for public resources and for institutional priorities. Governments and local authorities have to choose among conflicting demands–the needs of the old versus the young, the poor versus the better-off, the acute and pressing versus the long-term and systemic. These are hard choices and made no easier by shortages of resources for what are and must largely remain public services, paid for from taxes and revenues on the productive sectors of the urban economy.

The case for meeting the needs of the poor is frequently drowned out by the clamour of the better-off, who claim that they are the productive members of society and should have first call on resources. But failure to meet the needs of the poor will both prevent them from becoming productive and drive the already productive to locate in more congenial surroundings. This is the public policy dilemma faced in one form or another by all cities in the modern world.

Public health and the cities

Better health overall since World War II has been attributed to better drugs and medical technology, to better public health, including infectious disease prevention and control, to better nutrition and to improvements in the availability of clean water and sanitation. The extent of the improvement in water and sanitation is frequently overestimated in official statistics, however, particularly for the urban poor. Improved nutrition has helped some populations to live more healthy lives.

Nevertheless, for the poorest members of the population, both rural and

urban, these amenities and services remain the exception. In both industrialized and developing countries poverty and ill-health are connected. Where improvements have been noted, they are largely the result of public health intervention measures, especially infectious disease prevention and control, and maternal and child health including family planning. On both fronts there is room for both optimism and concern as the urban future unfolds.

Increasing urbanization will affect the future course of many infectious diseases:

Tuberculosis and respiratory diseases: Acute respiratory infections, tuberculosis and other airborne infections are a major source of death and ill-health in rural and urban areas in the developing world. Tuberculosis afflicts about 20 million people and is responsible for around 2.7 million deaths per year. Acute respiratory infections take the lives of 4 to 5 million infants and children. These diseases tend to be more prevalent in urban areas. The highest incidence tends to be in the poorest, most-crowded areas.[25] Overcrowding and poor ventilation can lead to multiple members of families being infected.[26] The emergence of diseases of the immune system, particularly HIV/AIDS, has increased the prevalence of tuberculosis, which is a common opportunistic infection of affected populations.

Malaria: In general, malaria is less common in urban areas, because urban development reduces densities of the carrier anopheles mosquito. This is still true in sub-Saharan Africa, but in South Asia the mosquitoes have adapted to urban life.

Malaria is the fifth most common cause of ill-health in the world, causing an estimated 2 million deaths a year. This makes it imperative to spray mosquito sites, as seen here in Maroua City, Cameroon. Some mosquitoes, however, have adapted to urban habitats and drug-resistant strains of malaria have emerged and spread rapidly. *Mark Edwards, Still Pictures*

Fewer mosquitoes and better availability of anti-malarial drugs have lowered mortality. This improvement may not continue because of the emergence and rapid spread of drug-resistant strains, helped by increased contact between urban and rural populations and between countries.

About 400 million people are currently infected with malaria. It is the fifth most common cause of ill-health in the world, and causes an estimated 2 million deaths per year. Nearly half of these deaths are among children under 5, some of whom succumb to malaria in combination with nutritional deficiencies and respiratory disease.[27]

Vaccine development has been slower than hoped; further progress depends as much on the complexity of disease dynamics and the adaptability of disease organisms as on the ingenuity of researchers. Insecticide-treated bednets and other low-tech approaches

can be effective among an aware population with resources to spend on such items. Public health information and prevention campaigns were highly successful in the 1950s and 1960s and could again yield benefits, but depend on a commitment to spending which many poorer communities are unable to make.

Cholera: Spread by contaminated water, cholera is endemic in many countries in Africa, Asia and Latin America. It also affects many other countries (including 27 in Europe). On a global basis, 377,000 new cases were reported in 1993. Cholera has reappeared recently in a wide variety of settings from which it had previously been eliminated: overcrowded settlements where there is a lack of basic sanitation and safe water create the opportunity for epidemics. Refugee camps and the poorer areas of cities have been the sites of some of the more dramatic recent outbreaks. In 1992, a new strain appeared in Asia and spread rapidly through Bangladesh, China, India, Malaysia, Nepal and Pakistan.[28]

Cholera can be successfully treated in most cases, and incidence has declined from its peak in 1991, but the future is uncertain. It depends in the first place on the ability of the public health services to handle a continuing high case-load, but ultimately on safe and dependable water supplies for urban populations.

Emerging viruses: Haemorrhagic fever viruses have been implicated in infections and deaths in a variety of locations around the world. In haemorrhagic fevers, patients develop high fevers followed by an agonizing general deterioration in health during which bleeding often occurs. In the most serious cases, patients die from massive superficial and internal bleeding or from multiple organ failure.

Different families of these viruses have been identified: filoviruses (which include Ebola and Marburg), arenaviruses (which include Lassa, Junín, Machupo, Guanarito and Sabià), flaviviruses (which cause dengue fever), and bunyaviruses (one of which causes Rift Valley Fever). Most of these viruses have been around for long periods of time, perhaps millions of years, in animal populations. Changing environmental conditions, both artificial and natural, have allowed them to multiply and spread. Dengue fever, and its more serious haemorrhagic form, has been spreading through Latin America in recent years and is carried by insects readily found in cities. As a virologist at the Pasteur Institute has written, "The expansion of world population perturbs ecosystems that were stable a few decades ago and facilitates contacts with animals carrying viruses pathogenic to humans." [29]

The 1995 outbreak of Ebola virus in the Zairean town of Kitwit galvanized international attention. The World Health Organization helped coordinate a local response and an international assistance effort which succeeded in ending the epidemic within six months and in limiting the number of individuals infected to only 316 of whom 245 died.[30] This highly fatal disease had previously appeared only in relatively small and isolated communities in Zaire and the Sudan. The spread of these outbreaks has so far been limited in part because the virus kills too quickly to be spread without human assistance such as poor medical hygiene or rapid transport and because transmission involves contact with bodily fluids which can be prevented by isolating patients and by the rapid burial of the unwashed bodies of the dead.

The appearance of the disease in a large settlement with easy transport access to the capital of Kinshasa and the wider world raised the spectre of such an infection establishing itself in a large urban settlement and spreading. This could occur due to increased contact between isolated areas of disease and urban centres. If a mutation or genetic combination with other viruses were to make a virus like Ebola capable of airborne transmission, it could cause a global catastrophe, a scenario which is already the subject of novels, movies and epidemiologists' nightmares.

Antibiotic-resistant infections: The widespread use of antibiotics has contributed significantly to better health in the past 40 years. However, medical practitioners worldwide have become very reliant on antibiotic drugs, even for treating relatively benign infections. They are also used heavily in industrialized countries as prophylaxis against possible infection after injury or in hospitals after operations, and on animals and crops used for food. In combination with other factors, such as patients' natural tendency to discontinue taking medications when they feel their health improving (especially when drugs are expensive and incomes low) but before the infection is eliminated, this reliance has created the conditions for the rapid evolution of drug-resistant strains of infections.

Common and harmless bacteria such as *E. coli* can become dangerous when

antibiotic-resistant strains develop and spread by exposure to waste and by the unsanitary preparation and storage of food. Staphylococci and streptococci infections, long routinely controlled by antibiotics, can seriously complicate recovery from wounds, surgery and respiratory infections, especially in already weakened patients. The development of strains resistant to common antibiotics has forced doctors to switch to less common drugs, which are becoming less effective in their turn. The biology of bacterial resistance to antibiotics poses additional problems: direct exchange of genetic material, including antibiotic resistance, between diverse strains of bacteria has been observed by researchers.

The effectiveness and low cost of routine antibiotics encouraged the belief that bacterial disease could be defeated altogether and discouraged research on new antibiotic compounds; but common infections are regaining strength. Urban life, with its dependence on modern medicine and its constant interaction with a wide variety of people, creates ideal conditions for easy transmission. Urban areas, especially crowded poor urban areas, provide the opportunity for people with multiple infections to serve as incubators for new resistant strains.

Whether future medical ingenuity can outpace the evolutionary adaptation of bacteria remains to be seen. Making new countermeasures available in poor urban areas will be a challenge but will be necessary if bacterial resistance is not to deepen and spread still further afield. Still more necessary are public health intervention measures in all countries to limit the use of antibiotics and encourage their effective use, as well as limiting the transmission of infection. This must include better health facilities, better and less-crowded housing, cleaner food and water, and more efficient waste disposal. Otherwise the health crisis of the urban poor could rapidly become a global crisis.

STDs/HIV/AIDS: Sexually transmitted diseases (STDs), including HIV/AIDS, account for more than 10 per cent of the disease burden for both men and women on a worldwide basis.[31] The World Health Organization recognizes that sexually transmitted diseases are most frequent in sexually active young people aged 15–24 and that these high incidences are continuing. The highest rates for notifiable STDs are generally seen in the 20–24 age group, followed by those aged 15–19, then those aged 25–29. However, in most of the world the age peak of infection is lower in girls than in boys.

Two STDs, gonorrhoea and chancroid, are now reported to be resistant to inexpensive antibiotics.[32] The relative prevalence of STDs in urban and rural areas is not well documented. Anecdotally, however, STD risks to teenagers are higher in cities than in rural areas. Traditional barriers to early sexual activity are more likely to have broken down in urban settings.

According to WHO, an estimated 20 million people globally have been infected by the HIV/AIDS virus; 18.5 million adults and 1.5 million infants. The annual number of deaths has been increasing as those infected in earlier years progress to AIDS. It is estimated that the death toll will exceed 8 million per year by 2000. While other diseases have higher annual death rates, the tragedy of AIDS is compounded by the fact that it causes many of its deaths in the prime years of family formation and productive work life. Its impact on families and society is therefore not in proportion to its relative incidence.

STDs are a frequent co-factor for the accelerated transmission of the HIV/AIDS virus. This is reflected in the historical epidemiology of the disease. In both developed and developing countries, urban areas initially demonstrate the highest levels of HIV incidence. Over time the epidemic diffuses to rural areas, generally spreading over heavily used road networks and then to the general population. Even small groups of people who engage in high-risk sexual behaviours in urban centres – such as intravenous drug users, prostitutes, transport workers and migrants separated from their spouses – may suffice to fuel successive waves of the infection into the population at large.[33]

Those at highest risk for STD/HIV/AIDS infection include individuals with large numbers of sex partners (including prostitutes) and drug users, and their sexual contacts. The AIDS epidemic in a single country has been described as an intersection of different epidemic episodes in different risk groups followed by the diffusion of the disease into transmission via heterosexual intercourse through the larger population.[34]

The groups at highest risk, particularly in the earliest stages of the epidemic, are present in disproportionate numbers in urban populations. Young women are often either already at risk or are taken to be desirable sexual partners by older male members of

high risk groups, including those infected. It is estimated that half of HIV infections have been contracted by people under 25 years of age. Up to 65 per cent of infections in females are believed to occur by age 20.[35] STDs in general are more treatable in urban areas with their higher concentration of health facilities and better public health services, but the challenge is also greater here.

The HIV/AIDS epidemic spreads from urban centres during the early stages of the epidemic. A noteworthy portion of poor women migrants turn to prostitution to support their families in the village. In sub-Saharan African samples, estimates range as high as one half of migrants, in Indonesia around one third. Higher proportions may be observed elsewhere in East Asia. In Thailand, a large proportion of the migrants to cities are young women, and prostitution, voluntary and coerced, has been tolerated. It is a common source of income and remittances, but also ensures a steady flow of HIV-infected women back to their villages. The high return of prostitution compared with other employment is a strong incentive for some poor young women seeking to support themselves and their family members, but it is also highly dangerous for these women and coerced women, for their clients and their clients' other partners.[36]

Migration will have serious implications for the course of the AIDS pandemic. Returnees to rural areas tend to have more sexual partners than those who stayed at home, and they may also have picked up other high-risk habits such as drug use. Better roads and easier transport point to increased transfer of disease risks, including HIV/AIDS, between rural and urban populations.

As AIDS is most predominantly a disease of young adulthood, it exacts a heavy toll in cities on highly skilled and educated early and mid-career workers – precisely those most needed for development, and those in shortest supply. The immediate economic effect of the loss of such workers, the cost of replacing them and the long-term effects of losing so many men and women in their most productive years has yet to be fully experienced; but it may have serious effects in some rapidly developing countries. Social costs include the damage to young families of the loss of one or both parents, and the creation of a generation of orphans. Some of the rural families hardest hit by AIDS are already making their way to join the ranks of the urban poor.

Diseases migrate too

The emerging viruses are only the most dramatic example of rural diseases establishing themselves in urban areas. Chagas fever, for example, is transmitted to humans by beetles which have now adapted to life in the scrap wood used for building in shanty towns. This disease is controllable but difficult to diagnose and has seriously debilitated many sufferers, particularly in Brazil.

Urban environments, particularly in poorer sections of cities without proper water, sanitation and solid waste services, are hosts to rats, mice and insect carriers of disease. Dengue fever has reached epidemic proportions in Central and South America with over 135,000 reported cases in 1995. Dengue is carried by an urban mosquito. It thrives where there is no running water and the larvae of the mosquito can grow in places where water collects, such as barrels and tyres.[37]

The health effects of tobacco use, junk food, drug and alcohol abuse and sexual experimentation are increasingly coming to the attention of health professionals in urban areas of developing countries, partly as a side-effect of exposure to the media and mores of more affluent countries. A WHO conference on the health situations in the United States, Britain, China, Bahrain, India and Kenya took note of this new burden on health systems. Indu Capoor, a health activist from India, noted, "In urban areas we are getting the problems of the West – drugs, sexual experimentation and fast food like chocolate and soda." Dr. David Nyamwaya of the African Medical and Research Foundation in Kenya observed, "We are seeing that kids are copying what they see on television in terms of violence, drug abuse and sexual experimentation."[38]

The international mass media and the spread of a world-wide youth culture may present a threat, but they also present an opportunity to send effective messages about positive and responsible behaviour if the will and the resources exist to do so.

Infant and child health issues

Poverty is a pointer to infant and child as well as adult health problems. In Porto Allegre, Brazil, the infant mortality rate (IMR) in squatter settlements is three times that of non-squatter areas, over 75 deaths per thousand live births.[39] In Quito, Ecuador, in the early

1980s the IMR in upper-class districts was 5 per 1,000 live births, comparable with more developed countries today. At the same time, manual workers in Quito's squatter settlements saw their children die at a rate of 129 per 1,000 live births, a rate slightly below the current global average for less developed regions. Similarly large differentials have been observed in the Philippines, Sri Lanka, England and Wales and elsewhere.

Childhood exposure to many diseases and the incidence of, for example, leprosy, hookworm, diarrhoea, cholera, other parasitic infestations and polio are clearly related to income differentials within urban areas. The higher levels of disease incidence are also tied to malnutrition and lower levels of available or affordable medical care.

Death among newborn children is higher in rural areas, except for a few countries such as Malawi, Panama, Colombia, Tanzania, Turkey and Vietnam. Infant mortality is lower in urban areas except in Namibia, Vietnam and Panama where the differences are very small or non-existent, and Tanzania, a highly urbanized country strongly affected by a weak economy and the effects of structural adjustment policies.

A young mother and her baby receiving treatment for malaria at the Laquintinie hospital at Doula, Cameroon. Death among newborn children is higher in rural areas, but at the same time childhood exposure to disease in urban areas varies greatly according to income differentials and access to medical care. *Mark Edwards, Still Pictures*

Infant survival chances are generally much better in urban areas, except among the poorest groups who have little or no access to regular health care. Squatter and shanty settlements usually have no services of any kind, and residents may be barred or discouraged from using those in nearby neighbourhoods. Even emergency services, which are generally in town centres, may not be readily available to the many who live in settlements on the outskirts.

REPRODUCTIVE HEALTH

Perinatal care

Higher proportions of women receive care during their pregnancies in urban than in rural settings.[40] While over two thirds of women receive prenatal care in rural areas, the corresponding figure for pregnant urban women is nearly 90 per cent. Together with better maternal nutrition, this greatly increases the survival chances of newborn infants. Public medical services are located overwhelmingly in urban settings (particularly district hospitals, teaching hospitals and other tertiary care facilities). Because of better access to medical services, urban women are likely to receive higher levels and better quality maternity care than their rural counterparts. The urban poor, however, often lack access to these services. They are likely to have fewer contacts with the health system during the course of their pregnancies than those more advantaged.

Institutional deliveries are much more common in urban areas of developing countries than in rural. The median proportion of births which take place in an institutional setting in urban areas is over 77 per cent. In rural areas,

the median percentage of births in medical settings is only 35 per cent.[41] The place in which women choose to give birth is the result of a wide variety of considerations. Social, cultural and economic factors all enter into family preferences and into their ability to act on them. Even where non-medical settings are preferred as the place of birth, however, trained birth attendants significantly reduce the health risks of childbirth to both mother and baby. Such help is much more likely to be on hand in an urban setting.

Trained attendants are more often present at births in urban areas than in rural areas. Doctors are more likely to be the attendants in urban settings than in rural settings. Higher attendance by registered nurses and midwives also contribute to the overall advantage of urban settings. Traditional birth attendants generally constitute a higher proportion of the overall percentage of trained personnel in rural areas even in countries where their services are used in both rural and urban settings.[42]

Maternal mortality

Maternal mortality is devastating and almost completely avoidable, although around 585,000 women still die each year in developing countries from complications associated with pregnancy or delivery, or from perinatal infection. Reliable separate estimates of urban and rural maternal mortality ratios are rarely available; where they are, urban maternal mortality is consistently lower than rural.[43] This is probably the result of better medical treatment during pregnancy and, particularly, of greater access to emergency obstetric care in the case of pregnancy and delivery complications. This pattern may not hold for the many poor urban women living in informal settlements on the outskirts of cities, however, since emergency services are usually located in the centre and they have little if any better access to routine pre- and perinatal care than their rural counterparts.

Reduction of maternal mortality in rural areas to urban levels means overcoming problems of transport and distribution of services. Both urban and rural areas will require trained medical personnel, available safe blood and necessary equipment and supplies. The Mother-Baby Package[44], supported by WHO, the World Bank and UNFPA, describes the necessary inputs and priorities for effective intervention to reduce both maternal mortality and early infant mortality. The ICPD Programme of Action calls for the elimination of programme-based differentials in service access by the year 2005 and universal access to reproductive health care services by the year 2015.

Towards better reproductive health

While reproductive health services are more readily available in urban than rural settings, the capacity of existing institutions to expand their outreach and improve their quality in the face of expanding demand and contracting financial resources is uncertain. Public budgets for health services have been shrinking in many countries, particular ly those which have adopted structural adjustment programmes. The energies of non-public sources of reproductive health services must be effectively mobilized. Non-governmental organizations, community-based approaches and private-sector activity will need to supplement public efforts to strengthen the entire health delivery system.

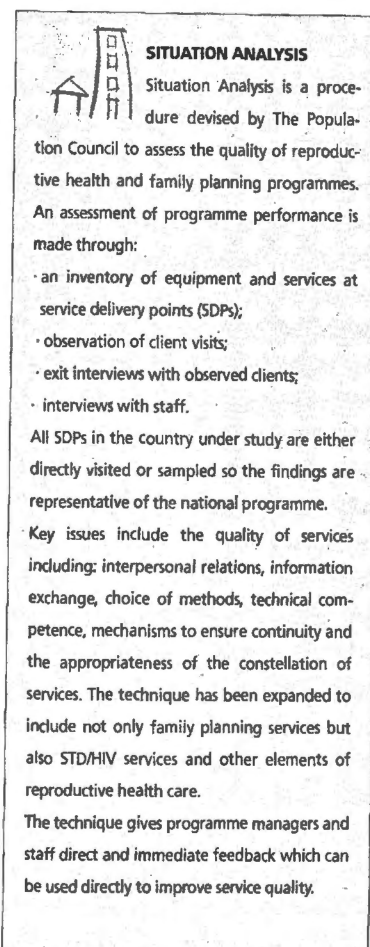
Extending the reach of reproductive health care services has been a historical priority: improving quality is now recognized as equally necessary for effective service. This applies to urban as well as rural settings, though quality is generally better in urban areas.

A Situation Analysis (see box) undertaken by the Population Council in Peru dramatizes the difference. An index was constructed to describe eight important elements of the quality of care: health provider competence, range and freedom of choice, adequacy of coun-

WHAT IS REPRODUCTIVE HEALTH CARE?

A comprehensive reproductive health programme might include the following elements as part of primary health care (with appropriate referrals):

- family planning information and services, including counselling and follow-up, aimed at all couples and individuals;
- prenatal, delivery (including assisted delivery) and post-natal care, with referral for the management of obstetric complications;
- prevention of abortion, management of the consequences of abortion and post-abortion counselling and family planning;
- prevention of reproductive tract infections including sexually transmitted diseases, and treatment of systemic infections;
- prevention of HIV/AIDS;
- prevention of infertility and sub-fecundity;
- routine screening for urinary tract infections, cervical infections, cervical and breast cancer and other women 's reproductive health conditions;
- active discouragement of harmful practices such as female genital mutilation.



SITUATION ANALYSIS

Situation Analysis is a procedure devised by The Population Council to assess the quality of reproductive health and family planning programmes. An assessment of programme performance is made through:

- an inventory of equipment and services at service delivery points (SDPs);
- observation of client visits;
- exit interviews with observed clients;
- interviews with staff.

All SDPs in the country under study are either directly visited or sampled so the findings are representative of the national programme.

Key issues include the quality of services including: interpersonal relations, information exchange, choice of methods, technical competence, mechanisms to ensure continuity and the appropriateness of the constellation of services. The technique has been expanded to include not only family planning services but also STD/HIV services and other elements of reproductive health care.

The technique gives programme managers and staff direct and immediate feedback which can be used directly to improve service quality.

seling and follow-up, privacy and cleanliness, supply availability, attention to a variety of reproductive health needs. Highest quality service delivery points (SDPs) would score eight points. Clinics in urban areas averaged 5.31 compared to 1.64 in rural areas. Differences favouring urban settings were observed for all of the dimensions denoting quality of care.

Even in urban settings, greater attention to the quality of services is needed. Shortcomings were noted in both information and services: for example, information important for proper or informed use of different methods was not regularly provided. Providers imposed restrictions on the services offered based on the marital status, age or parity of the client or the presence or absence of explicit partner consent. Services in rural areas were of low quality on all dimensions. The clinics performed worst in providing information and maintaining cleanliness.

Rural clients also had the fewest contact points offering reproductive health services including family planning methods. Many rural service points did not offer immunization, pap smears or pregnancy tests: many urban service points offered at least two of these.[45]

These differences are clear in Peru which has a moderately well-developed maternal and child health system. In Peru nearly 60 per cent of the women use some method of contraception, nearly 90 per cent of women know a source for family planning services, 60 per cent of births are attended by a trained physician and more than three quarters of one-year-olds have been immunized against TB, diphtheria, pertussis, tetanus and polio. Peru is, however, heavily urbanized (72 per cent of the population) and other social indicators reveal large urban-rural differences. For example, sanitation is estimated as being available to 58 per cent of the urban population but only to 25 per cent of the rural.

Situation analyses in sub-Saharan African countries with health systems at different stages of development[46] and in selected single cities further highlight differences between rural and urban areas. Urban service delivery points in Ghana, Senegal, Kenya and on Zanzibar were more likely to have running water. Only 29 per cent of rural service delivery points in Ghana had running water compared with 52 per cent of urban centres and, in Senegal, 54 per cent as against 96 per cent of urban SDPs. Electricity was widely available in urban SDPs but even less likely to be found in rural settings than running water. Both are essential for hygiene and thus for good quality of care.

The use made of individual SDPs depends on the size of the surrounding population, how much choice they have and local demand for services. It also depends on the effectivness of the SDP's outreach and the quality of services it offers. In Ghana, urban SDPs averaged over 1,000 client visits per year, two to three times more than SDPs in rural or semi-urban settings. In Kenya, urban and semi-urban SDPs averaged over 1,700 family planning visits per year, twice as many as rural SDPs. In Senegal, urban SDPs, with over 2,000 visits per year on average, were more than twice as active as semi-urban SDPs which in turn serviced more than three times as many client visits as rural SDPs. On Zanzibar, urban SDPs account on average for more than 11 times the number of visits of the rural clinics but the total geographical area is relatively small and the urban area is also accessible to many rural residents.[47]

Both urban and rural SDPs with better facilities draw more visits. The difference is greater for rural SDPs: the 29 per cent of Ghana's rural SDPs which had running water accounted for 47 per cent of the annual visits. It is not clear whether better-equipped SDPs generate and sustain more client contacts, or whether client demand encourages investment in better facilities: the

THE ICPD ON QUALITY OF CARE

At the 1994 International Conference on Population and Development all members of the international community agreed on standards for quality of care in reproductive health and family-planning programmes. The ICPD Programme of Action says (para 7.23): Among other measures, programmes should:

Recognize that appropriate family planning methods for couples and individuals vary according to their age, parity, family size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective methods in order to enable them to exercise free and informed choice;

Provide accessible, complete and accurate information about various family-planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases;

Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continuous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured;

Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling;

Ensure appropriate follow-up care, including treatment for side effects of contraceptive use;

Ensure availability of reproductive health services on site or through a strong referral mechanism;

In addition to quantitative measures of performance, give more emphasis to qualitative ones that take into account the perspectives of current and potential users of services, through means including effective management information systems and survey techniques for the timely evaluation of services;

Emphasize breast-feeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival.

answer is probably some combination of the two. In any case improvement in all settings, and particularly in poorly-equipped rural SDPs should be an important priority.

In other respects, the study found that differences between rural and urban services are neither clear nor consistent. There is no evidence of urban bias in programme capacity or in the services offered.[48] IUD insertion, which requires trained personnel, is generally more available at urban SDPs, which also usually have somewhat better equipment and stocks. Supervision of staff, a key to service quality, varies little between urban and rural settings within countries but differs considerably between countries. Better supervision is often seen in clinics in urban areas with larger numbers of annual visits, but again it is hard to say whether better supervision encouraged more visits or vice versa.

Overall, programme effort and capacity was distributed relatively evenly between rural and urban SDPs[49], with broadly similar training levels, logistics management, completeness of examinations, quality of the interaction between provider and patient, and attention to broader reproductive health concerns (especially STD/HIV information and services).

Continued improvement in the quality and coverage of services is a national challenge: infrastructure improvement needs more attention in rural areas, but better management, logistics, supervision, and counselling is a universal requirement.

Reproductive health in the cities Examples from Africa

Situation analyses in individual African cities[50] revealed needs more clearly. In Mombasa, Kenya, for example, demand for family planning services may increase by 200 to 700 per cent over the next 20 years, but even the current demand cannot be met. Most SDPs lack the equipment and commodities to provide a full range of contraceptive methods, and some lack laboratory facilities and running water. Existing services are not well advertised and information about family planning methods is selectively given. Staff training in STD/HIV information and in communicating with clients need improvement. On the positive side, clients were given adequate information to facilitate follow-up and were well instructed about their future needs. Most clients were satisfied with the services they received. Reproductive health services other than family planning were available at many SDPs but were not well integrated with family planning activities.

A particular problem in Bulawayo, Zimbabwe, is that most public SDPs are located in outlying residential districts and are closed during the evening. Most private SDPs and pharmacies are in the city center. The working population that leaves the residential areas during the day but relies on public facilities (which supply nearly two thirds of the city's needs) is therefore poorly served in the evening hours. An adjust-

ment in either the hours of availability of public services or the location of private services could increase the ability of the system to meet current and future unmet demand.

In Blantyre, Malawi, unmet need for long-term family planning methods is high, but there are alternatives to the government-provided SDPs – for example pharmacists, some of whom are known to be interested, or medical clinics in industrial plants, which currently do not offer family planning or other reproductive health services. Better education of staff and clients could allow these facilities to address the demand.

Education is essential for the process of sustainable development. However, the quality of education is just as vital as the numbers being educated. Under-resourced schools, like this one at Ngora in Uganda, produce under-educated children. *Carlos Guarita/Reportage/Still Pictures*

Financing reproductive health and family planning in the cities

As national economies and personal incomes grow, the market can play a larger part in reproductive health services including family planning. In Thailand, for example, pills account for nearly 30 per cent of contraceptive use: in the cities over 70 per cent of users get such pills from private sources rather than government clinics, but in the poorer rural areas the proportions are reversed. Except for condoms, private sector family planning is more expensive – for clinic methods between two and five times more expensive.[51]

The ability to pay is only one factor. In some places relatively poor people would rather spend money on contraceptives than be seen in a government clinic; elsewhere relatively affluent people queue up with the rest. Some users will pay for services if they are sure that their money will go towards better reproductive health services. Others will pay to assure a regular supply or better quality. In Bolivia, a private voluntary organization has been gaining clients from the Ministry of Health though their rates are the same. The difference involves the clients' perception of quality, even though experts found no difference.[52]

Cost recovery and insurance schemes can be successful in urban areas, but the poor may lose their access to services unless careful attention is paid to subsidies and means-testing, with guaranteed supplies for the poorest. In Cebu, the Philippines, for example, nearly two thirds of subsidies were found to benefit the better-off[53] and the poorest quarter of the population realized only 17 per cent of the benefits. Most subsidies for permanent methods were directed to the poorest quarter.

However, it is fair to note that the proportion of subsidies going to upper-income groups for public services such as hospitals and higher education in developing countries is typically far greater than for family planning. Some spillover of benefits to the better-off may be the necessary cost of programmes to benefit the poorest. On the other hand, the collection of some contribution, however small, may actually enhance the perceived value of services among the poor. Both can help mobilize support across income groups.

EDUCATION

Education, and especially education for girls, is widely recognized as essential for sustainable development. This fundamental fact has been recognized by all the recent international conferences: at the International Conference on Population and Development in 1994, at the World Summit on Social Development in 1995 and the Fourth World Conference on Women in 1995. In general, urban areas have the advantage over rural areas in proportions of primary schools which offer all grades, the num-

ber of schools available, and enrolment ratios.[55] These advantages are further magnified at the secondary and tertiary levels. Decisions on the placement of schools in rural areas depend on a wide variety of considerations. The location of the population and ease of access for the largest number of students are frequently not decisive.[56]

Investment in schooling is a substantial proportion of social sector investment in many developing countries.[57] Nevertheless, given the growth of school-age populations, reaching the international goals of universal primary education and universal literacy will call for unprecedented creation of new places in schools. To keep up with needs, creation of new primary school places by the end of this decade must exceed the average of the 35 years since 1960 in 58 of 81 countries assessed. In about a quarter of them the pace will have to be more than five times greater than the historical average. Sub-Saharan Africa will need to create spaces for new primary school students at more than 3.5 times the previous average annual rates; even though recent trends ominously show worsening enrolment rates. By 2025, it is expected that falling fertility will have reduced significantly the numbers of school-age children, but long-term fertility decline depends on the development process. The need for a more educated labour force cannot be deferred without making existing problems worse and creating new ones.[58]

The quality of education is as vital as the number of students to be educated. Overcrowded schools with inadequate supplies and facilities and failing physical conditions cannot educate effectively. Such stratagems as increasing class size and multiple shifts in the same facilities do not make up for shortages of chairs, desks, books, chalk, writing materials and paper. They reduce personal attention and accelerate the deterioration of physical plant.

Drop-out rates in primary school are high. In many developing countries, particularly in the least developed, only a small proportion of those who complete elementary school go on to secondary education. This may be a family decision encouraged by poverty or a low perceived value for education, but it may also, particularly in urban areas, be enforced by an overstrained school system which can only make room for a small proportion of secondary students. In these circumstances, there is a heavy bias against the children of poor families. The bias is greater against girls when difficult decisions are being made on priorities for allocating scarce family resources. The assumption is that girls will benefit less from education and will return less of the investment to the family. Girls are assumed to be needed at home, and education is seen as a luxury which poor families cannot afford. This has created a gender gap in education which varies from country to country but is highest among the poor.

The International Conference on Population and Development recognized both the gender gap and the need to eliminate it, agreeing that women were the strongest untapped human resource for any developing country. There is an equally strong and well-recognized connection between women's education and their ability to bring up smaller, healthier and better-educated families.

Smaller age groups coming into the education system have enabled many of the faster-growing economies to re-allocate resources to quality rather than quantity in education and build a firmer base for further economic and social advance.[59] This is the aim that has been accepted by the international community.

SELF-RELIANT REPRODUCTIVE HEALTH CLINICS

Non-governmental organizations (NGOs) can play an important role in providing health services in urban areas. Since 1981, the Indonesian NGO Yayasan Kusuma Buana (YKB) has successfully operated urban clinics offering family planning information and services for a modest fee. Today it has six clinics, which also provide routine antenatal care, immunization, and general maternal and child health services and information. The programme, started with UNFPA assistance, has been financially self-sufficient since 1992.[52]

The YKB programme targets people of low to moderate income, complementing the government clinics which mostly serve the poor and the private clinics and hospitals used by wealthy Indonesians. Patients are willing to pay for services because the midwife-run clinics offer them quality services, a range of choices (based on surveys of clients' needs), longer service hours and a clean and friendly atmosphere. Delayed payment plans are available for those who need them. The NGO programme also provides follow-up home visits.

CHAPTER 3:

URBAN POPULATION DYNAMICS

IMPROVING SOCIAL AND ECONOMIC CONDITIONS FOR ALL PEOPLE AND PROMOTING SUSTAINABLE DEVELOPMENT IS INCREASINGLY AN URBAN CHALLENGE. AS CITIES GROW, MAKING THESE IMPROVEMENTS BECOMES MORE COMPLEX.

The urban population is growing at a much faster rate than the population as a whole, and by larger annual increments than ever before. By the early years of the next century, most of the people in the world will live in urban areas. In most developing regions the proportion of people living in the largest cities is also increasing.

Cities are intimately tied to national prospects for sustained economic growth and sustainable development. The ability of cities to function as social, cultural and economic centres is shaped by urban population dynamics. This section will review the current urban demographic situation including: problems in defining urban areas; urban population growth since 1950, and its concentration in developing regions (noting regional differences); sources of urban growth, including natural increase and migration fueled by rural population growth; the world's largest cities (now concentrated in developing countries, especially in Asia); projections of the future size and location of large cities, and the difficulties of projecting accurately; and the continuing growth of rural populations in developing countries, despite outmigration.

"Like people, cities have personalities. Each represents a unique mix of history and natural setting, cultural patterns, and lifestyles. Some are ugly yet attractive, others beautiful but dull. Under such circumstances modelling and theorizing about cities is risky, if even possible."[3]

Urban systems take a variety of forms in different countries, and diverse definitions of "urban" are used for census purposes. This variability makes comparisons and generaliza-

ASIA AND THE PACIFIC[1]

Asia is the world's largest and most diverse region in both area and population. The extent and pace of urbanization vary considerably within the region, as does the capacity to accommodate urban growth. Asia is not highly urbanized by world standards. At nearly one-third urban it is far below Latin America's level and approximately at that of Africa. Southern Asia is only about one-quarter urbanized, though urban growth there could accelerate as a consequence of economic reforms. Larger countries are generally less urbanized than smaller ones, but given their size, even moderate urban growth rates imply extremely large increases in urban populations.

Countries' urban growth rates are related to their levels of development and economic growth rates. Having urbanized rapidly, the more vigorous economies of Eastern and South-eastern Asia are now quickly slowing their urban growth and reorganizing their cities to reduce concentration. In other countries, populations are growing faster than the cities' economies can manage, deepening the persistent problems of "poverty, unemployment and underemployment, inadequate infrastructure and housing, deficient social services, and environmental degradation".[2]

Most Asian countries have long recognized the need to slow or reverse urban concentration and to energize their economic and social development. Finding an effective mix of policies has been difficult, however, and regional experience does not prescribe any single strategy for achieving either objective. Migration controls, land-use planning, investment in satellite cities, special economic zones, controls on industrial location, rural development, urbanization and service provision, fiscal incentives and other schemes have been adopted in different countries at different times. Their impact has varied, depending on the consistency of policies, institutional capacity and coordination, and the available resources. Both natural economic forces and macroeconomic policy reforms have also helped to reduce excess urban concentration under certain circumstances.

The smaller Pacific island states' integration into the international economy and pace of development are limited by the small scale of their production enterprises and by administrative and technical limitations. Urban environmental impacts on fragile local ecosystems also pose special difficulties.

The Central Asian countries of the former Soviet Union, no longer managed by a centralized administration outside their borders, urgently need to develop vital civil societies and to strengthen their capacities for planning and administration. They must also adjust to major changes in their economic systems, trading partners and relations to the global economy dislocations which have intensified conflicts within multi-ethnic communities.

Countries and large states of federal unions frequently accord lower priority to investments in social services and infrastructure than to industrial development. Those that have invested in education (particularly women's education) and basic health services (including reproductive health and family planning) have had striking results; Sri Lanka, India's Kerala State, Bangladesh and countries in East Asia have attained higher levels of education and health than other societies with similar economic status and urban burdens. Levels of women's participation in education, employment and other development activities differ considerably throughout the region.

EASTERN EUROPE[4]

The countries of Eastern Europe and the former Soviet Union are undergoing an economic, political and administrative transition which is reflected in shrinking gross domestic products, high unemployment and declining fertility and life expectancy. While some countries have shown signs of economic stabilization (e.g. reduced rates of inflation and economic contraction), it will take time to establish new institutions and redefine the role of the public and private sectors.

Wasteful consumption and production patterns, long-term neglect and misdirected policies have led to serious environmental degradation. Toxic industrial pollutants affect health and agriculture. The transition to market economies calls for new regulatory and planning regimes to accommodate greater participation by non-governmental organizations and the private sector.

tions difficult. Internationally accepted definitions generally involve some combination of the following:

- administrative units – places incorporated as cities, or seats or capitals of administrative entities such as districts;
- population concentration – localities with clear boundaries whose total population or population density exceeds a specified threshold;
- proportion of the population in non-agricultural occupations (the cut-points used vary considerably in societies at different levels of development);
- availability of infrastructure – paved roads, postal offices, centralized meeting places, etc.

The particular definitions of cities used by different countries vary considerably and unsystematically. Among those countries that base their definitions largely or exclusively on population counts, some define a locality as urban if it has as few as 200 residents (Iceland and Norway, for example); more common cut-off points are 2,000 (Angola, Argentina, Bolivia, Cuba, Eritrea, Ethiopia, France, Gabon, Germany, Guadaloupe, Honduras, Israel, Kenya, Liberia, the Netherlands, Sierra Leone) and 5,000 (Austria, Comoros, Czech Republic, Ghana, Lebanon, Madagascar, Mali, Saudi Arabia), while some countries put the cut-off point as high as 10,000 (Benin, Greece, Italy, Jordan, Kuwait, Portugal, Senegal).

Since national authorities use their own definitions in reporting on cities, it is not possible to apply a uniform definition or set of criteria to all countries. Given their different social conditions, such an exercise would not necessarily be useful. But the incomparability of the data available underscores the need for carefully designed databases for monitoring urban development and dynamics.

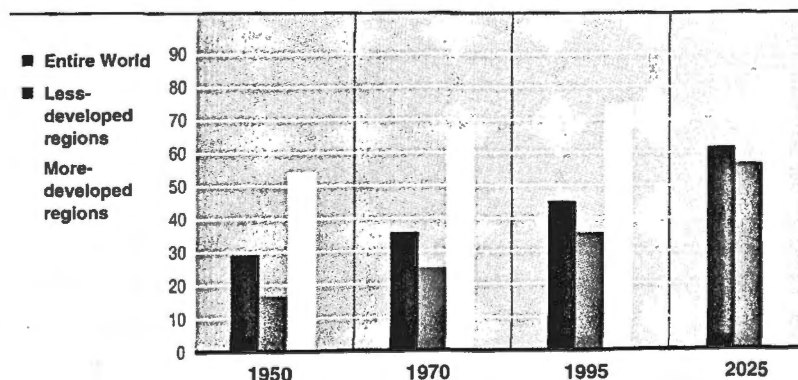
Urban dwellers will soon be a majority of the world's population. Not long after, they will be a majority in all regions of the world.

As the figure below indicates, the percentage of people living in urban areas has increased dramatically during the past half century, particularly in the less-developed regions. The United Nations projects that a majority of the world population will be urban by 2005; in the less-developed regions, that threshold will be crossed before 2015. Of the world's 2.6 billion people currently living in urban areas, over 1.6 billion are in less-developed regions. These regions will include 3.2 billion out of 4.1 billion urban people worldwide in 2015, and over 4 billion out of 5.1 billion in 2025.

The urban population is increasing much faster in developing countries than in the more-developed regions.

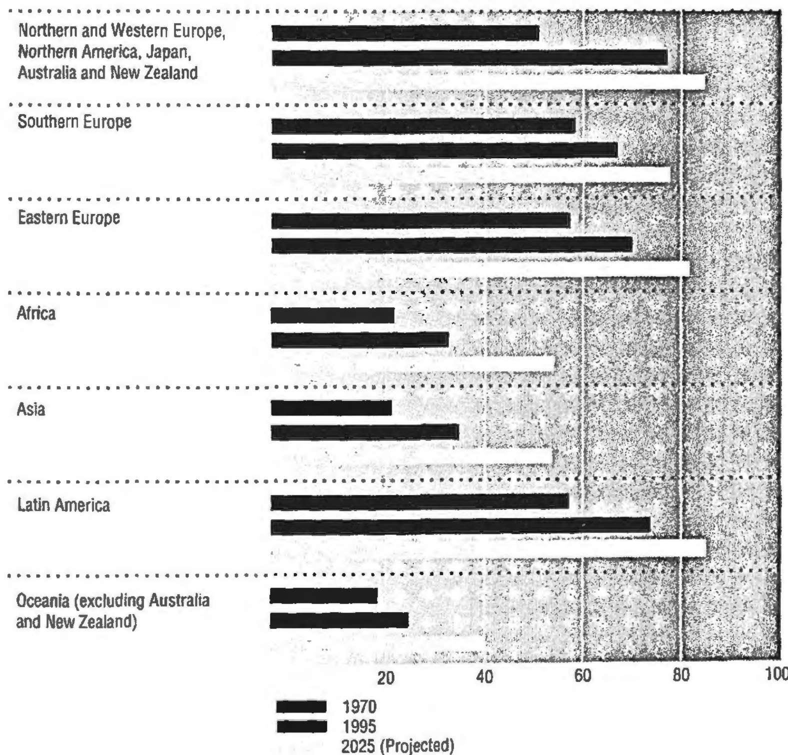
In 1970, there were about as many city dwellers in developing countries as in the more-developed regions. The ratio is nearly two to one today; it will pass three to one by 2015 and approach four to one by 2025. Of the 1.23 billion

Percentage of the population living in urban areas



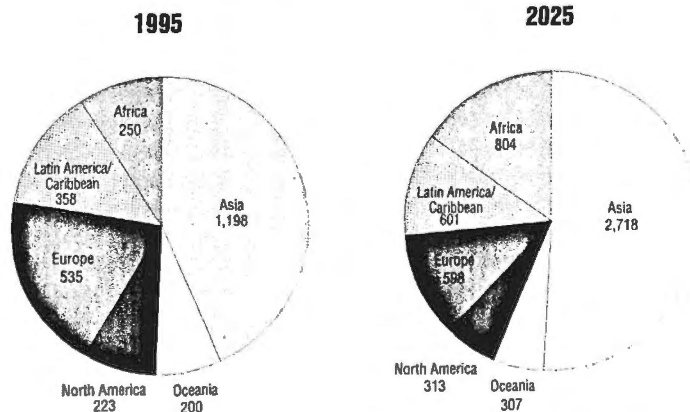
Source: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision*. New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

Levels of urbanization in selected regions



Source: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision*. New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

Regional distribution of urban population



Source: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision*. New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

urban residents added to the world population since 1970, 84 per cent have been in less-developed regions, and this proportion is growing. It is projected that less-developed regions will account for 92.9 per cent of a 2.06 billion increase in the global urban population between 1970 and 2020.[5]

In terms of total population numbers, Asia now accounts for 1.2 billion of the 2.5 billion global urban residents (i.e. about 46 per cent). Europe accounts for 535 million more. By 2025, 23 new urban Asians will be added for every new European urban resident. Latin America and the Caribbean account for about 358 million current urban residents. In 2025, these numbers will be: Asia, 2.7 billion; Europe, 598 million; Latin America and the Caribbean, 601 million; and Africa, 804 million.

There is substantial variation in the level of urbanization within regions. In Africa this ranges from 48 per cent in Southern Africa, 45 per cent in Northern Africa, 36 per cent in Western Africa and 33 per cent in Middle Africa to 21 per cent in Eastern Africa. These differences between African subregions result from historical patterns related to their governance and economic structures dating back to colonial times, and are expected to continue for at least the next 30 years. National levels range from 6.1 per cent in Rwanda[6] to 85 per cent in the Libyan Arab Jamahiriya.

For Asian subregions the levels are: South Central Asia, 28.8 per cent; Eastern Asia, 36.9 per cent (the regional statistic is dominated by China's 30.3 per cent); and South-eastern Asia, 33.7 per cent. National levels vary from under 10 per cent in Bhutan to over 90

per cent in Hong Kong and Singapore. In Western Asia, national levels vary from 13 per cent in Oman to over 90 per cent in Bahrain, Israel, Kuwait and Qatar.

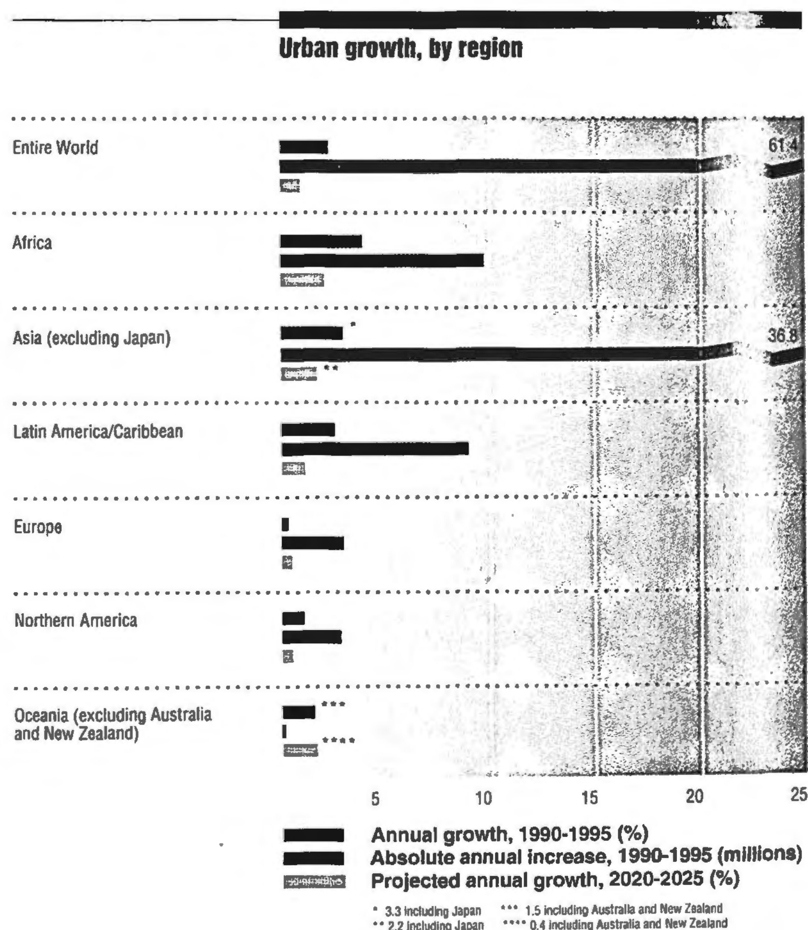
Subregional urbanization levels in Latin America and the Caribbean are 62.4 per cent in the Caribbean, 68 per cent in Central America and 78 per cent in South America. National levels range from 13.8 per cent in Montserrat, 31.6 per cent in Haiti and 41.5 per cent in Guatemala to 90.3 per cent in Uruguay and 100 per cent in the Cayman Islands and Bermuda.

Urban growth in less-developed regions is declining, but annual increments will continue to be very large into the next century.

The global urban population is growing by 2.5 per cent per year (3.5 per cent per year in the less-developed regions and 0.8 per cent in the more-developed regions), or 61 million people – roughly the equivalent of adding six cities the size of Lagos. Annual urban growth in the less-developed regions peaked at 5.1 per cent during 1955–1960. Today's rate of growth is slower because the base population is much larger, but the annual increments are greater. By the period 2020–2025 the global urban growth rate will have declined to under 2 per cent per year, but the urban population will increase by 93 million people – more than the current annual increase in the total world population.

As the figure on this page shows, the highest rate of urban growth is in Africa. Cities in Eastern Africa grew by more than 6 per cent a year between 1960 and 1980, reaching a high of 6.5 per cent during 1975–1980. A gradual decline to 4.1 per cent in 2020–2025 is anticipated. Southern Africa's urban growth rate, now 3.2 per cent, will decline to 2.3 per cent by 2020–2025.

Asia accounts for more than two thirds of the annual increase in the global urban population. Within Asia, urban growth rates are more than 3.6 per cent per year in South-eastern Asia and Western Asia, compared to about 3 per cent in Eastern Asia (less if China is excluded). These subregions are expected to reach 2.2, 2.0 and 1.6 per cent urban growth, respectively, by 2020–2025.



Source: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision.* New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

THE PROCESSES OF URBAN GROWTH

Three different processes fuel urban population growth[7]: natural growth (the excess of births over deaths), migration from rural areas, and cities incorporation of rural surrounds (redefinition of administrative boundaries). The relative importance of each component changes as urbanization proceeds.

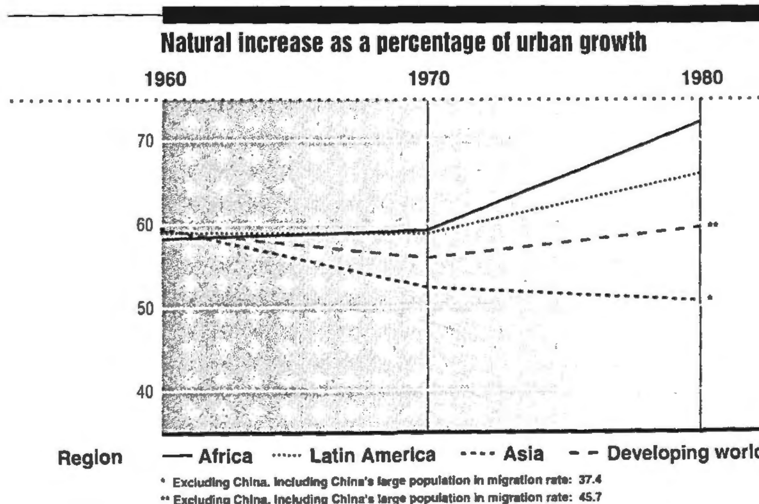
When urbanization levels are low (particularly when rural and urban fertility rates are similar), migration accounts for most of the growth differ-

ence between cities and rural areas. Natural increase becomes more important at higher levels of urbanization.[8] When economic opportunities in the cities expand rapidly, growth from migration may also increase.

Globally, natural increase accounts for nearly 60 per cent of urban growth.[9] The contribution of rural urban migration differs significantly in different regions and over time.[10]

By way of contrast, the rapid urban growth in Europe during the 19th century was largely attributable to migration, fueled by the growing urban manufacturing sector. London's population more than doubled between 1801 and 1851. The 10 largest cities in England during this period increased from 16 to 23 per cent of the total national population. This was also a period of substantial migration to North America. It is estimated that if the population which left the United Kingdom had instead moved to its cities, urban growth would have exceeded 5 per cent a year. At this rate, the urban population would have doubled in 14 years, about the pace of urban growth observed in Africa since 1950.

Natural increase as a percentage of urban growth

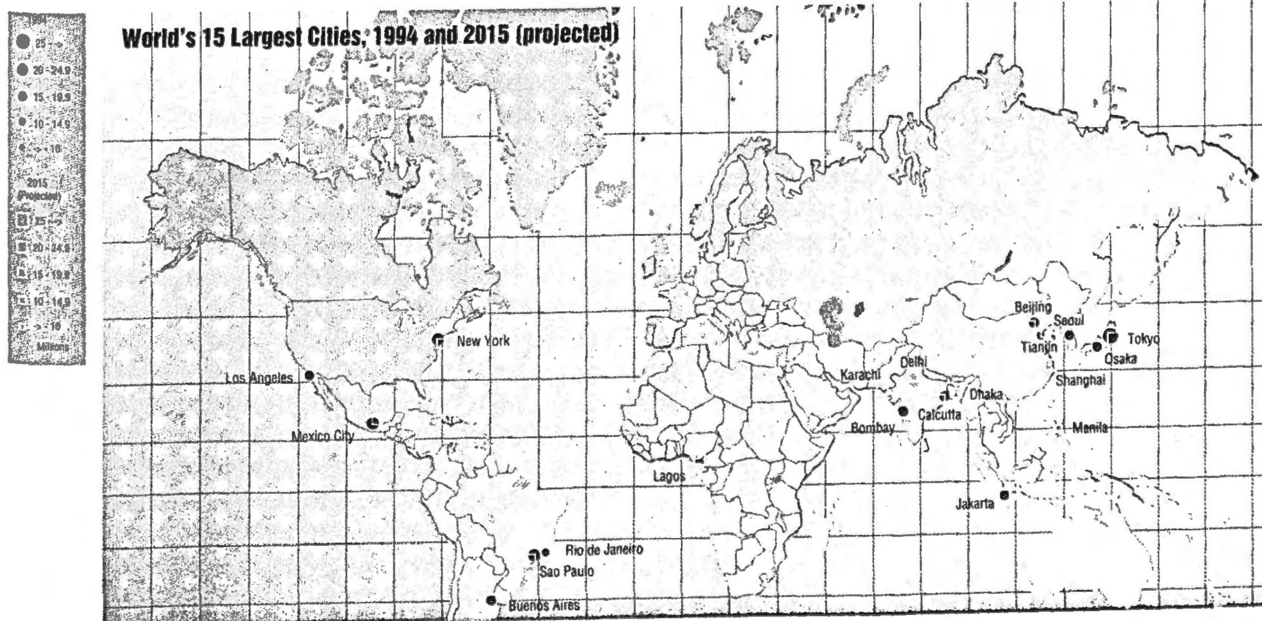


Source: United Nations Population Division. 1996. "Trends in Urbanization and the Components of Urban Growth." Paper for the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, New York, January 1996.

The largest cities

City sizes and growth rates describe only part of the global transformation of where, and how, people live. The distribution of sizes of urban areas is changing dramatically. In 1950, only one

World's 15 Largest Cities, 1994 and 2015 (projected)



Source: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision.* New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

SUB-SAHARAN AFRICA[11]

Cities in Africa are growing faster than in any other region. Most of the increase is the result of migration, reflecting people's hopes of escaping rural privation more than the existence of actual opportunity in the cities. In fact, under the burden of structural adjustment programmes, formal employment in Africa's cities is not growing, while informal-sector job growth is not likely to keep pace with the 5–10 per cent anticipated growth rates in the working-age population.

The quality of life in many African cities is increasingly threatened. Urban infrastructures are already under great stress. Shrinking budgets for social services have left schools overcrowded and ill-equipped, medical services understocked and overburdened, transport less reliable and basic electrical and water supplies increasingly intermittent. Economic pressures and rising school fees have reversed the trend towards higher enrolments for basic education; male primary school enrolment and completion rates have declined in the early 1990s.

The most important African cities were developed as colonial administrative and trading centres, rather than industrial and commercial centres equipped to support large populations. A generation after independence, well-serviced but expensive city cores are surrounded by rings of development supporting most of the population, where the quality of housing and services varies greatly. Urban authorities providing administration and services have been unable to keep up with the explosive growth of squatter communities and shanty towns.

Slow economic growth and poor transport have limited the relocation of industry and industrial suppliers, impeding job growth in secondary cities. This has fuelled continued migration into larger cities by people in search of work.

Economic liberalization has encouraged external assistance in some countries. Tanzania, Zimbawe and Uganda have received assistance for transport infrastructure, for example. Such improvements can stimulate developing markets and help generate employment, offsetting some of the economic effects of structural adjustment. But increases in traffic often worsen travel conditions even as road quality improves, reducing the value of the investment.

Decentralization of authority has accelerated change in the management of basic services, but public and private initiatives alike are hampered by haphazard tax collection and poorly functioning credit markets. A number of countries allow the private sector to supplement or replace overburdened public services such as buses.

As employment stagnates and services deteriorate in many urban areas, social and economic conditions continue to worsen. As a result, crime and homelessness increase and family systems break down, especially under the added strains of internal political turmoil and the ravages of AIDS.

LATIN AMERICA AND THE CARIBBEAN[12]

Latin America is the most urbanized of the developing regions. In most countries, populations are relatively concentrated in the largest cities, usually the capital. Urban growth rates are slowing in the region's larger cities; more remarkable are ongoing political and social changes affecting urban management and development.

Urban growth in Latin America's large cities is largely driven by natural population growth. Migration is increasingly from other cities rather than from rural areas.[13] Migration to large cities including São Paulo and Santiago de Chile has slowed; Mexico City has begun to experience a net out-migration. There is accelerated growth in certain medium-sized cities which are part of urban systems growing around the large centres.

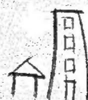
Following the economic crises of the 1980s, economic activity has accelerated, but much of it is in the informal sector. Individuals and families face increasing job insecurity, lower wages and a reduction in essential social services; investment in public works has decreased. Environmental degradation around many of the region's cities is increasing; low-income shanty towns proliferate in the affected areas. Urban road and transport systems do not meet local needs. A large portion of cities' solid waste, industrial waste and sewage goes untreated, contaminating water supplies; cities like Lima and Mexico City which depend on wells are especially burdened.[14] Water rationing is common and quality varies.

Most studies since the 1980s have noted an increase in poverty in the region's metropolitan areas. Latin America is the only developing region with more poor people in cities than in rural areas; although, as elsewhere, poverty is more prevalent in the countryside.

The change from military to civilian regimes throughout the region and the devolution of powers to local authorities have given impetus to grass-roots and local initiatives, creating a climate for a vibrant and diverse network of local and national non-governmental organizations and associations. Increasingly, local and municipal authorities are subject to election rather than appointment by central governments or parties, increasing their accountability and responsiveness to local populations. A review of the new developments concludes:

"In the past ten years more than 12,000 cities, towns and local government units in Latin America have elected mayors and councillors. In many of them new people seem to have established themselves at the grass roots. A study carried out in Colombia, for example, showed that 11 of 16 cities in that country elected outsiders as mayors, not members of the traditional local elites. The newcomers in turn attracted better-educated people to work for them: graduates' share of total municipal employment rose from 1 in 39 in the early 1980s to 1 in 13 now."[15]

Although conditions vary from country to country, there are opportunities throughout the region for progress following a deep and extended crisis. The most stubborn and persistent problem is to address the needs of the urban poor.



ARAB STATES[16]

North Africa is highly urbanized. In Morocco, for instance, growth in the larger cities has slowed but small and medium-sized cities are proliferating.[17] Urbanization has been fuelled by high fertility rates, substantial rural-urban migration, international labour migration and the concentration of economic activity in urban areas. Housing and administrative policies (including city definitions) have also contributed to urban growth.

Infrastructure development has not kept pace with this growth. Rural development activities (like Libya's enormous irrigation plans), often intended to counter urbanization trends, have received priority policy attention instead.

The Gulf States have some of the world's highest rates of labour immigration. Migrants are concentrated in the cities, contributing to this subregion's high urbanization levels.

Elsewhere, high levels of urban unemployment and underemployment have led many young workers to migrate within the region and to Western Europe, but tightening migration controls will reduce this outlet. Violent social movements and periodic unrest are becoming more prevalent. Food and fuel subsidies have eased living conditions, but also produced economic distortions; these subsidies cannot be easily reduced since urban populations rely on them.

Improved life expectancy coupled with high fertility has given the Arab region the world's highest proportion of children under 15. This portends growing difficulties in employment provision, infrastructure development and service delivery, particularly in education and health. Water supplies will be increasingly strained as personal, agricultural and industrial use expand. Urban settlements will encroach on surrounding agricultural land, forcing many countries to rely more on agricultural imports or grants. Traffic congestion will intensify unless public and private mass transport alternatives are developed.

In many of the region's cities, modern districts are set apart from traditional city centres and expanding slum settlements (frequently on the periphery). Historic areas are threatened by expanding development, and preservation efforts often conflict with economic restructuring priorities.

The feminization of poverty in the area is a cause for increasing concern. Armed conflicts and civil disturbances have displaced increasing numbers of women and their children. Such women become the heads of their households with few resources to provide for their families basic needs, and limited opportunities to improve their situation.

city had a population of more than 10 million people. In 1994, there were 14 such cities, only four of which were in more-developed regions. By 2015 there will be 13 more, all in the less-developed regions.

The composition and distribution of the world's largest cities has changed dramatically over the past 45 years.

In 1950, only New York had a population exceeding 10 million. Eleven of the 15 largest cities were in more-developed regions. The 15th largest city, Berlin, had 3.3 million people. In 1970, three cities (Tokyo, New York and Shanghai) exceeded 10 million; seven of the top 15 were in less-developed regions, and the 15th largest had 6.7 million people.

By 1994, 14 of the top 15 cities had more than 10 million people. The largest, Tokyo, had reached 26.5 million (the only city with more than 20 million); 11 were in less-developed regions and the 15th largest city had 9.8 million. By 2015, seven cities will exceed 20 million (Tokyo will still be the largest, at 28.7 million); 13 of the top 15 will be in less-developed regions, and the 15th largest will have nearly 15 million.

Between now and 2010, Asia's share of the 15 largest urban agglomerations[18] will grow from nine to 11, Africa's from zero to one. Latin America will go from having four of the 15 largest cities to two, and Northern America from two to one.

The growth rates of megacities have been changing over the past few decades and will continue to do so. The fastest growing megacities will be in the less-developed regions.

Megacities in the more-developed regions grew, on average, by less than 1 per cent per year between 1970 and 1990. Some, such as Los Angeles, Tokyo and Moscow, grew faster, while others, like New York, experienced negative growth.

In contrast, Bombay, Karachi, Lagos and Dhaka grew by 3.7, 4.7, 6.7 and 7.6 per cent, respectively, between 1970 and 1990. These growth rates will moderate before 2015. However, many of the cities projected to be megacities in 2015 will grow by more than 3 per cent per year between 1990 and 2000 (including Bangalore, Bombay, Dhaka, Delhi, Hyderabad, Istanbul, Jakarta, Karachi, Kinshasa, Lagos, Lahore and Metro Manila).

Six megacities are projected to grow faster than 3 per cent per year during 2000–2015: Dhaka, Hyderabad, Karachi, Lagos, Lahore and Kinshasa. Dhaka's 2015 population is projected to be more than 13 times larger than its 1970 population; Lagos's will be over 11 times larger. Slower growth rates are expect-

MAKING A SHANTY TOWN MORE LIVABLE

Nairobi (WFS) The ledge above Mathare looks down on a staggering beehive of rusted and crumbling corrugated iron roofs, held down by stones. As one descends the precarious footholds and enters the slum by way of a creaky bridge over a stream whose colour suggests pollution, it seems that hell has claimed a new outpost.

Mathare is less than a 30-minute drive from Nairobi's dazzling architectural wonders, well-laid neighbourhoods, clipped hedges and splendid gardens. It is an abject slum settlement wrenched out of a disused quarry on government-owned land. Its sardine-packed, makeshift houses are reportedly home to at least 20,000 marginalized people. "I had nowhere else to go when I came to the city," says one.

However, the story of Mathare is not just one of dirt, squalor, disease and hopelessness. It is also the story of resilience, and the indomitable spirit of a group of people who are trying desperately to brighten their corner of the world. The group is Wapenda Afya Bidi Women/Community Self Help Group (WAB). They are assisted by a Nairobi-based NGO, the Development Alternatives Network (DAN).

WAB's chairperson is Lydiah Nyambura Kinyua, 32, a mother of six. She trained as a nursery school teacher after completing her primary education, and now runs her own nursery in Mathare. Five years ago she and a few other women decided to do something about their dismal situation. They started the self-help group. "If we don't help ourselves nobody else will," Kinyua says simply.

Barefoot children line the narrow, wet tracks separating the hovels of what Kinyua calls "the village." Structures exist wherever there is space, with no thought of access for vehicles or even a breeze. Most of the time a visitor either has to duck or walk sideways.

The only evidence that city authorities have noticed the community's plight are two public toilets whose systems collapsed long ago. The refuse everywhere, the excreta by the stream and the flies hovering over uncovered food items on sale give an indication of the problem at hand. There is no electricity, and the source of clean water is a tap owned by individuals who open it to those who have money. Prices depend on the supply.

With DAN's help, a programme has been put into place to improve sanitation and reduce the incidence of disease. First on the agenda was waste management: every morning women from the self-help group manually clean the two broken toilets. Thanks to the daily clearing, barefoot children have less risk of picking up diseases. The incidence of dysentery, diarrhoea and worms has been reduced by at least 30 per cent in recent months, says Pontianus M. Nthuli who oversees DAN's training wing. A child health monitoring project has improved the chances of survival of children in Mathare. Mothers have learned to weigh their children regularly as a way of monitoring their health.

Among DAN's priorities are a training programme to enable the self-help group to organize itself properly, teach it survival skills, and set its own agenda: water and sanitation; child health, family planning and drug-abuse control.

The NGO's intervention has brought the WAB crucial recognition, Nthuli notes. "They feel recognized, people now know about them." One result is that the traditional chief of the Mathare area has allocated land to the settlement for a community pharmacy, and the City Council has agreed to provide 15 water pumps to be operated by the women.

Copyright 1995, Women's Feature Service

HOW ACCURATE ARE PROJECTIONS OF FUTURE CITY SIZES?

Efforts to predict the size of cities have proven less accurate than projections of national and regional populations. While the world's total urban population has been projected with some accuracy, projections of individual cities' populations and of cities' relative sizes have been much less reliable.

These shortcomings are partly due to the incompleteness of census information prior to the 1980s. But they also reflect the complexity of urban population dynamics. Like national populations, the size of cities depends on fertility, mortality and external migration rates, but it also depends on the differentials between urban and rural fertility and mortality and on migration within countries. Population movements are far more sensitive to regional variations in economic opportunities than are fertility and mortality.

It is also hard to predict changes in the spatial dimension of urban systems. In some cases, the population becomes increasingly less concentrated in central cities and more dispersed into urban systems of varying size with different economic specializations. Such patterns are difficult to predict.

In São Paulo, for example, the 1991 census showed both the population and the growth rate to be much smaller than anticipated. This reflected a large net outmigration, partly due to the relocation of industry to smaller cities, and a lower than expected fertility level.

Other unanticipated economic developments have upset expectations more dramatically. In 1982, Shanghai was the only Chinese city that the United Nations projected to be among the world's 20 largest urban centres in the year 2000, with an expected population of 13.5 million. By 1994, however, Shanghai, Beijing and Tianjin were all projected to be in the top 12 by 2000 (all three are currently in the top 15) and Shanghai's projected population has grown to 17.2 million.

The unreliability of forecasting is clearest in regard to single cities. Of the cities projected in 1982 to be the 15 largest in 2000, the total population was expected to be 233.8 million. This is close to the 1994 projection of 230.1 million in the top 15 cities in 2000. However, the lists are not the same; the 15 cities in the 1982 list are currently projected to total 215 million people by 2000—18 million below the 1982 projection. Some cities were very poorly estimated. The current projection for Tokyo in 2000 is 10.8 million people larger than was projected in 1982; Mexico City's population in 2000 is now expected to be 9.9 million smaller than was projected in 1982.

WILL A TREND AWAY FROM THE CITIES DEVELOP?

In the late 1960s, 1970s and early 1980s the growth of many cities in the more developed regions, particularly in Europe, slowed significantly. Some cities actually became smaller as improved transportation and communications enabled populations to disperse to surrounding smaller "ring cities" and suburbs. These developments, coupled with declining annual growth in megacities, including those in developing countries, suggested that a deconcentration of population would develop as a general trend.

Comparison of data from different decades and different regions, however, does not suggest a general pattern. There is no clear relationship, for example, between migration to cities and urban population density. The role of international migration in the recent revitalization of core city growth also needs to be better appreciated and analysed.

Some problems of large cities, particularly traffic congestion, rising housing and living costs and air and water pollution, intensify with city size; others with rising numbers of people living in poverty, while the incidence of crime and disease worsens with unequal development. This has led to speculation that the economic and social opportunities which draw people to cities will eventually be overwhelmed by the urban disamenities. The cities where growth has slowed, however, have not experienced dramatic shifts in the balance of advantages and disadvantages. And many cities continue to grow even though their disamenities are clearly intensifying.

Selective migration may become an increasingly important factor in population distribution. People with skills and resources can take advantage of new technologies allowing them to leave the denser cities and stand to gain the most by doing so; they will leave behind less economically viable social environments for the poorer populations that remain. But urban opinion polls indicate more people say they want to move away than actually do so. Better understanding is needed of what determines individual mobility and of how to facilitate movements with desirable consequences.

The pattern of forces supporting and countering trends towards population concentration is clearly complex. Many of these are affected by the general economic climate and by local and national government policies. It is quite possible that economic, technological and social changes will result in recurrent cycles of urban concentration and deconcentration.

ed in Istanbul, Lima, Mexico City, São Paulo and Seoul.

The proportion of the population living in the largest cities is increasing.

In 1990, 7.5 per cent of the urban population in more-developed regions was concentrated in the four cities with more than 10 million people; by 2015, these four cities will account for about the same share of the urban total, 7.2 per cent. In the less-developed regions, however, the change will be dramatic: from 98 million people (6.9 per cent of the total urban population) in eight cities of over 10 million in 1990 to 378 million (12.0 per cent) in 23 such cities by 2015.

At the same time, substantial change is expected in the distribution of cities of smaller sizes, particularly in the less-developed regions. The number of cities of 5–10 million people will increase from 15 to 36 between 1990 and 2015, and the population in them will more than double (from 110 million to 226 million), even as the proportion of the urban population in this size class declines slightly. Cities in the range of 1–5 million people will increase from 151 to 352, with their combined populations increasing from 283 to 701 million.

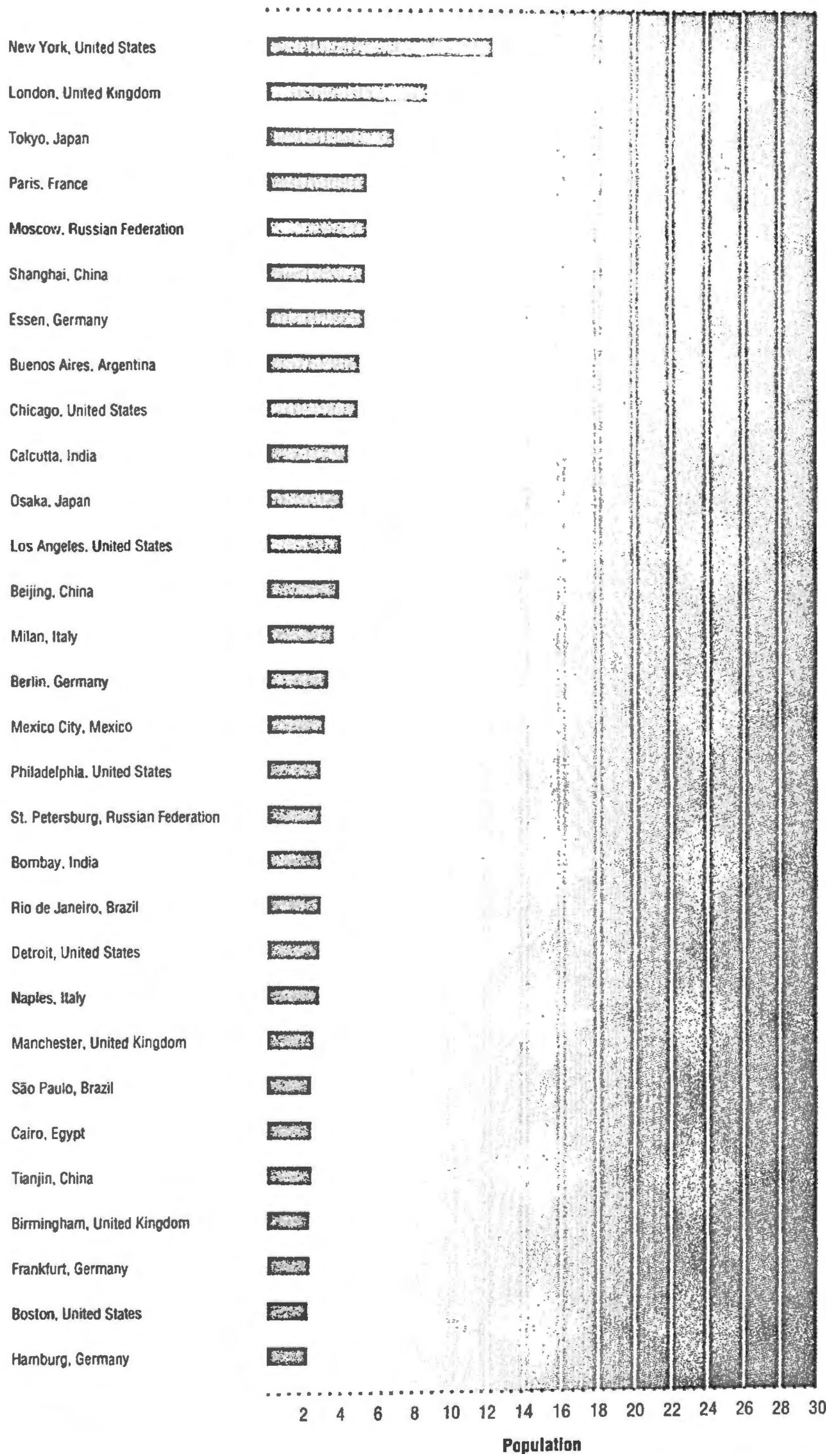
Both the number and population of those in the 500,000 to 1 million range will increase by about 50 per cent.

Cities of fewer than 500,000 people will continue to account for more than half of the urban population at least through 2015. Those in the less-developed regions will contain more than twice as many people in 2015 than in 1990 (1.64 billion compared to 812 million), though their share of the urban total will decrease slightly. In the more-developed regions, the greatest growth in numbers and population will occur in cities of 1–5 million people.

Regional patterns of city size distribution and growth vary substantially. In Africa, the proportion of people living in urban areas grew from 14.7 per cent in 1950 to 34 per cent in 1994. In 1950, 80 per cent of the urban population lived in cities of fewer than 500,000 people; this proportion declined to 60 per cent by 1994 and is expected to fall to 54 per cent by 2015. Africans are becoming increasingly concentrated in larger urban areas. Nearly 19 per cent will live in cities with over 5 million inhabitants by 2015, compared to 8.1 per cent in 1994.

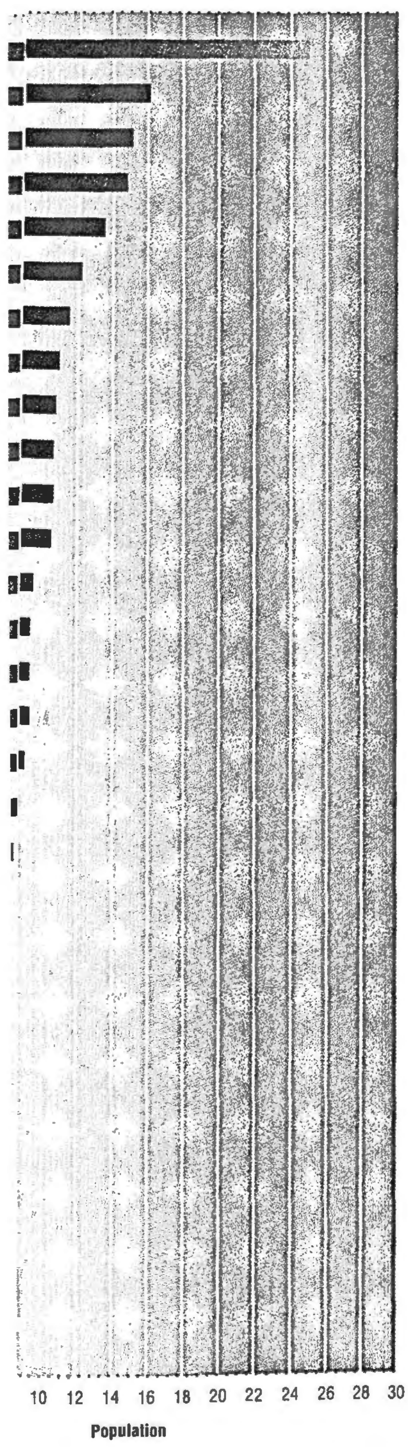
In Asia, the number of cities in each of the size classes over 1 million people will more than double between 1990 and 2015. The greatest proportional growth will occur in cities of over 10 million.

Latin America and the Caribbean is the only less-developed region where cities of 500,000 to 1 million will contain a majority of the urban population by 2015. Cities of 1–5 million will show the largest growth, increasing from 32 to 69 in number, from 61 to 132 million in population, and from 19.4 to 25.2 per

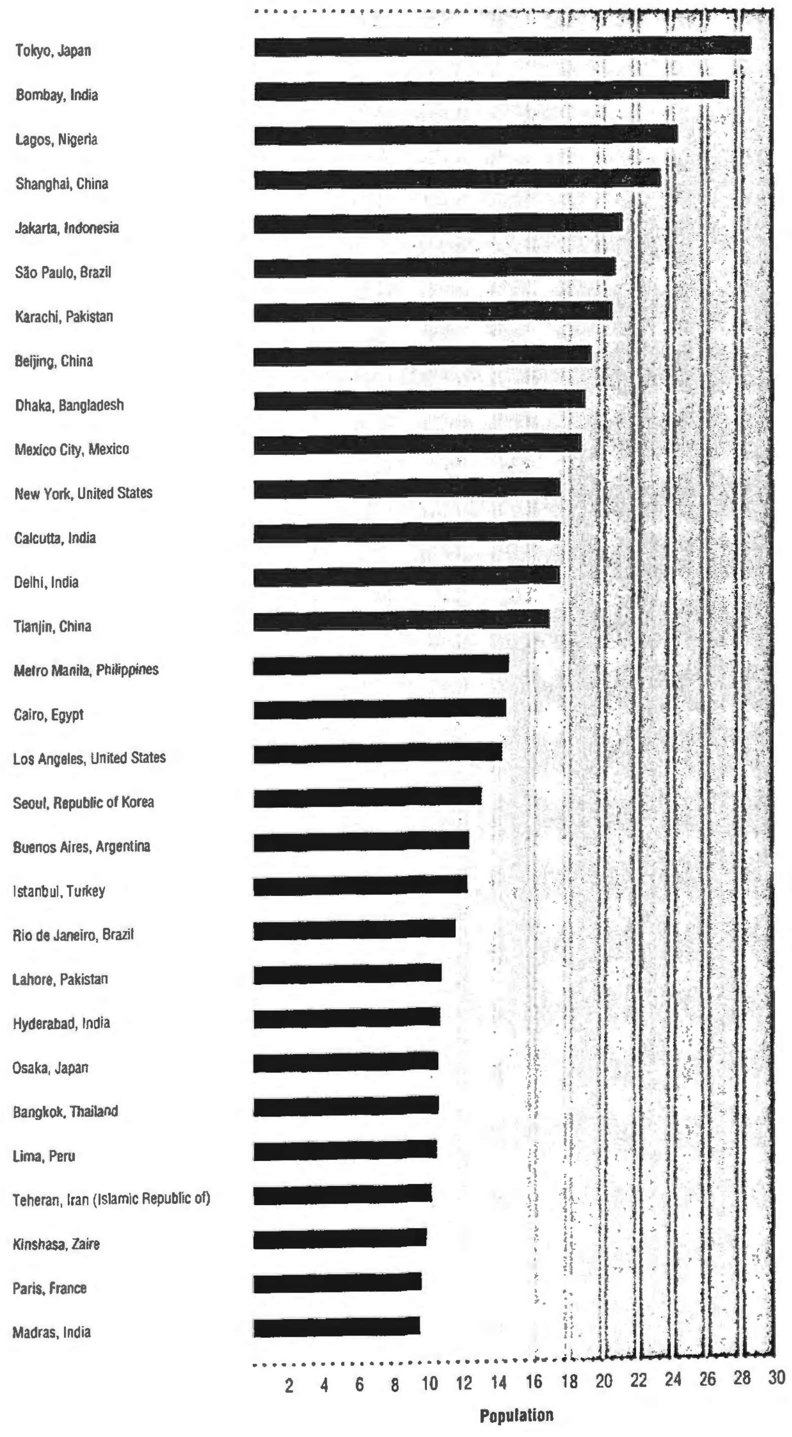

Agglomeration and Country, 1950
New York, United States
London, United Kingdom
Tokyo, Japan
Paris, France
Moscow, Russian Federation
Shanghai, China
Essen, Germany
Buenos Aires, Argentina
Chicago, United States
Calcutta, India
Osaka, Japan
Los Angeles, United States
Beijing, China
Milan, Italy
Berlin, Germany
Mexico City, Mexico
Philadelphia, United States
St. Petersburg, Russian Federation
Bombay, India
Rio de Janeiro, Brazil
Detroit, United States
Naples, Italy
Manchester, United Kingdom
São Paulo, Brazil
Cairo, Egypt
Tianjin, China
Birmingham, United Kingdom
Frankfurt, Germany
Boston, United States
Hamburg, Germany
2 4 6 8 10 12 14 16 18 20 22 24 26 28 30
Population

Agglomeration
Tokyo, Japan
New York, United States
Mexico City, Mexico
São Paulo, Brazil
Shanghai, China
Bombay, India
Los Angeles, United States
Beijing, China
Calcutta, India
Buenos Aires, Argentina
Seoul, Republic of Korea
Osaka, Japan
Rio de Janeiro, Brazil
Paris, France
Tianjin, China
Jakarta, Indonesia
Moscow, Russian Federation
Cairo, Egypt
Delhi, India
Metro Manila, Philippines
Karachi, Pakistan
Lagos, Nigeria
London, United Kingdom
Chicago, United States
Istanbul, Turkey
Lima, Peru
Essen, Germany
Teheran, Iran (Islamic Republic of)
Bangkok, Thailand
Dhaka, Bangladesh
2 4 6 8

...n and Country, 1990



Agglomeration and Country, 2015 (Projected)



Source: United Nations Population Division. 1995. *World Urbanization Prospects: The 1994 Revision* (ST/ESA/SER.A/150). New York: United Nations.

FLOWERS AMONG THE GARBAGE

Cairo (WFS) In the Mokattam Hills southeast of Cairo, 17,000 garbage collectors or *zabbaleen* live in dusty squatter settlements of teeming, narrow dirt lanes. There they sort and recycle the garbage produced by Cairo's burgeoning population.

Among them are Gehan Guirgis, 19, and Shayeda Atteya, 17. At the NGO Forum alongside the 1994 International Conference on Population, they displayed the multi-coloured cotton rag rugs, bags and cushion covers they weave as part of a model project that has changed their lives.

Since donkey-pulled carts were banned from the city's modern section of Cairo, the *zabbaleen* have used pick-up trucks to collect garbage from residences. They sort, separate and recycle garbage for sale, under a programme sponsored by the Association for the Protection of the Environment. The health and well-being of the children of *zabbaleen* families, particularly girls, is a focus of the NGO's activities.

At the Women's Centre in Mokattam, a bright modern building that stands out from its drab surroundings, a rag recycling programme targets the community's most disadvantaged girls – those who come from the poorest families, have not been to school and must help their families sort garbage.

Since 1988, 320 girls have been trained to weave discarded cotton scraps into rugs, using two-pedal hand looms. There is also training in patchwork quilt-making, and a new project to transform scrap paper into stationery, envelopes and embroidered folk art tableaux. After three months of training, the girls receive their own loom or sewing machine and continue to weave or sew from their homes. They are paid by the piece; the Association sells their products at expositions, hotels and a shop in the suburb of Heliopolis.

But this project is more than a cottage industry. By raising the status of young women, it has improved their quality of life and that of their families in unexpected and tangible ways. "Most of the girls come from very large families," explains Samira H. Abou Seif, a volunteer with the Association. "Legally you cannot be married until age 18, but illegal marriage at 15 or 16 or younger is common. The Association pressures the girls who participate to remain single until age 18. If they wait to get married, they receive a gift of 500 Egyptian Pounds and a wedding party."

The programme also provides literacy classes and drama presentations on the dangers of early marriage and child-bearing and the importance of preventive maternal and child health care. The result, Abou Seif says, has been a radical reduction in family size among the women who entered the programme at age 11 or 12 and are now married. "Those who got married four or five years ago have only one child and most of the girls say they want only one or two," she says. "Approximately 75 per cent of the women who have remained involved in the programme use contraception."

Some of the teenage weavers, such as Gehan and Shayeda, have also been trained to be primary health visitors. "We go to visit homes," Gehan explains, "talk about prenatal advice, tell children not to go barefoot in the garbage, give first aid, take children to be vaccinated, talk about family planning and escort women who want to go the clinic."

Gehan, who is from a family of eight children, is engaged to be married. "I want only one child," she says. "My fiancé also agrees. I have seen so many problems in my work as a health visitor, so much misery in the lives of women who have so many children. How can we put ourselves in the same situation?" Shayeda, from a family of seven, says she wants only two children.

"Before I came to the programme I never left the neighbourhood," Gehan says confidently, "I could not meet people and used to be very shy. Now we even go outside the community on field trips, even as far as Greece for a meeting." Shayeda adds, "This has given us a kind of freedom we never had before."

Copyright 1994, Women's Feature Service

cent in their share of the total urban population.

Europe over the next quarter century will see little change in either the numbers of cities or the total populations in the various size groups; nearly two thirds of the population will continue to reside in cities of under 500,000.

In Northern America, the proportional distribution of population among city sizes will change little between 1990 and 2015. Unlike Europe, less than 40 per cent of the urban population is in smaller cities. Oceania's urban population pattern, dominated by Australia and New Zealand, is not expected to change.

CHAPTER 4:

SOURCES OF CITY GROWTH

THE TENDENCY TOWARDS CITY GROWTH, BOTH IN ABSOLUTE TERMS AND AS A PROPORTION OF POPULATIONS, IS INFLUENCED BY DIFFERING PATTERNS OF FERTILITY, MORTALITY AND MIGRATION.

NATURAL INCREASE

The first cause of urban population growth is simply an excess of births over deaths, known as natural increase. Urban fertility is usually lower than rural fertility though the differences vary from region to region. Asia shows smaller differences than Africa and Latin America. In Asia, the difference ranges from about a half to one birth over the reproductive span, in sub-Saharan Africa from one to two; in Western Asia and North Africa, around two; in Latin America between one and three. These differences have emerged relatively recently, particularly in sub-Saharan Africa.[1]

High population growth rates in the rural areas help fuel migration: many of the migrants are in the prime of their reproductive years and their children are added to the city populations. It is a question, however, whether the fertility of migrants follows the pattern of their origin or that of their destination.

The available data suggest that migrants quite quickly adopt their new neighbours' fertility behaviour: urban natives have the lowest fertility, then rural to urban migrants, then urban to rural migrants, with rural natives the highest of all. These differences are more marked than they were a decade ago when urban areas were less advanced in the process of demographic transition.

Differences between regions are the result of circumstances as well as demographic change. Urban migrants in Africa are often separated from their wives or husbands: their fertility is extremely low in the first two years and then increases until the overall rate is about the urban norm after five years. In Latin America the same initial pattern stabilized over time at lower levels; it remains to be seen if this will happen in Africa. Recent analysis suggests that it will, because of better employment and other opportunities and more accessible health services in urban areas.[2]

Women in cities generally tend to marry later, breast-feed less and abstain from sex for a shorter time after a birth; but they also have better access to reproductive health and family planning services and are more likely to use contraception. But within this generalization there are wide variations among individuals and groups, depending on cultural background, economic and social opportunity, education levels, service access and aspirations.

Rural and urban areas differ not only in fertility but in mortality. Overall, urban areas tend to have lower levels of mortality than rural areas, though mortality in poorer urban neighbourhoods can be at least as high as in rural areas. Even in developed countries, high levels of infant and child mortality can be observed in poor urban neighbourhoods. In combination with high levels of adult mortality due to violence and accidents, life expectancies can be extremely low. The mortality rate in the Harlem section of New York from birth to age 65 is estimated to be higher than the national average for Bangladesh.

Overall comparisons of rates of natural increase in urban and rural areas are not readily available. The most systematic attempt to perform the necessary analyses is now over 15 years old.[3]

Over the last three decades of declining mortality and fertility, the relative importance of natural increase has remained at about 60 per cent of urban growth. In the 1960s, this was the level in all major regions of the world. By the 1980s, however, the dynamics of development led to significant regional differences. In Asia, migration and reclassification started to become more important in the 1970s and by the 1980s had reached nearly half.[4] During the difficult decade of the 1980s in Latin America, natural increase accounted for two thirds of urban growth, and in Africa for three quarters.

These regional differences reflect trends in component processes. In Latin America, urban natural increase has been declining while migration has fluctuated (higher in the more successful decade of the 1970s than before or since). In Asia, migration has steadily increased since the 1960s while natural increase grew slightly over time.[5] In Africa, natural increase has remained high, but migration rates dropped by half.

It is hard to draw country-specific policy conclusions from the data available. Generally speaking, since high rural fertility rates help fuel rural to urban migration, reducing unwanted fertility in rural areas will help reduce rates of urban growth. But since natural increase is still the major component of rapid urban growth, information and services are also needed to reduce unwanted urban fertility.

Particular attention should be given to peri-urban and squatter settlements where new migrants tend to be concentrated.

Access to quality reproductive health services, including family planning methods, and the unmet demand for such services vary considerably between regions. Outside sub-Saharan Africa, unmet demand for family planning services tends to be higher in rural areas than in cities.[6] In Latin America and the Caribbean, the urban unmet need is estimated to be low, generally under 15 per cent; in rural areas, unmet need is at least 60 per cent higher. In Asia and North Africa, rural unmet need is generally higher than in cities, but the differential is much smaller than in Latin America. Urban unmet need is as high as 32.5 per cent in Pakistan, 23.4 per cent in the Philippines and 19.9 per cent in Jordan. In sub-Saharan Africa, however, more than half the surveyed countries show higher unmet need in cities than in rural areas. Since contraceptive prevalence is higher in urban areas, this indicates that urban demand has risen and that programmes still must overcome various obstacles – financial, informational and social – to meet this increased demand.

MIGRATION

Migration is difficult to study, since a complete analysis requires information on people and conditions in at least two different places and at various times. Information about communities, families and individuals is needed to understand the context of migratory moves. Many people move seasonally (farmers seeking non-agricultural jobs during the dry season, for example) or temporarily (to gain an education or save a certain amount of money); others make multiple moves in hopes of improving their lives.

Temporary migration is difficult to quantify without specialized surveys or studies, of which there are few; census estimates provide only snapshots of a more dynamic flow of people. Much research and policy attention is focused on rural to urban migration. In parts of the world such as Latin America, however, rural to rural migration is a much larger flow. Migration between cities and from cities back to the countryside further complicate efforts to understand migration based on information on peoples' locations at census times.

Where specialized studies have been undertaken, they have found a much greater volume of migration than census estimates suggest. A survey in Thailand, for example, found that about one person in four migrated within the previous five years, 15 per cent within the previous two years. About one third of all internal migration in the country was temporary. Other studies suggest that Bangkok's population varies by as much as 1 million people in different seasons.[7]

Migration can create both problems and benefits for both the areas that people migrate from and the areas they migrate to. Developing policies that can reduce the problems and maximize the benefits will require better understanding of its causes and consequences.

Why people move

Migration makes a significant contribution to the growth of urban areas. The decision for a family member or an entire family to move is a complex one, affected by both the "push" of conditions at home and the "pull" of life in the city. The mix varies from time to time and place to place; and the influence of different factors also varies according to family size and composition. The discussion here, however, concentrates on voluntary migration. In parts of the world affected by political instability, natural disasters or wars, large numbers of people become refugees within their own countries, frequently moving to cities from unsafe countrysides. In such cases "push" factors predominate as the motivation to move, though the "pull" of the cities may determine the destination.

The hope or expectation of jobs. The primary reason for urban migration has long been understood as the desire for higher wages or the greater expectation of employment. However, the difference between urban and rural wages is minimal in some settings (for example in sub-Saharan Africa). It is also widely recognized that the informal sector now accounts for a substantial portion of employment and employment growth in urban areas. The prospects of work and wages in the informal sector are much less easy to define, especially at a distance, so it is hard to account for the continuing inflow in this manner. However, better and more varied opportunities for the better-educated are reflected in higher migration rates among this group, particularly as regards men.

Low barriers to migration. Physical barriers such as distance and accessibility are reduced by better roads and transport; but lower barriers equally

may encourage seasonal or circular migration. Social barriers are reduced by networks of friends or relatives who provide a context of familiarity, encouragement and support for the would-be migrant. Direct and indirect controls such as taxes, rationing, pass systems and policing slow migration, although they are frequently evaded when motivation is strong. Conversely, freedom of movement can increase migration, although movement is more likely to be temporary if it is free.

Services and amenities are generally better in the city. Educational opportunities – particularly at levels above basic education – and health services are more accessible and of higher quality. Urban life offers the prospect of freedom from gathering wood and carrying water, though many migrants must be sorely disappointed. Life in the favelas, barrios and shanty towns can be every bit as arduous and services just as poor as in the village. The quality of water and air and the risk of disease from inadequate sanitation and overcrowding may even be worse. What is known about conditions in such settlements can hardly be an inducement.

Deterioration of rural life. Rapid population growth among low-income groups in rural areas puts pressure on land, fuel and water. These pressures may be intensified by large-scale resource-intensive agriculture, loss of traditional tenure rights on common land and other policies which reduce the need for labour and the possibility of self-sufficiency. Such developments may loosen social cohesion and the sense of community as they change economic relationships. This together with pollution and degradation of basic resources reduces the quality of rural life and forces migration to the cities.

Population growth puts pressure on land; the marginal land areas on which shanty towns are often built are frequently also particularly vulnerable to natural forces. Such land is often also under pressure from large-scale resource-intensive agriculture. The floods seen here at Ormoe City on Leyte Island in the Philippines were caused by extensive deforestation, and more than 8,000 shanty dwellers lost their lives. *Nigel Dickinson, Still Pictures*

The influence of the different factors is unknown, but the erosion of traditional "pull" factors and the intensification of the "push" out of rural areas points to a generally negative conclusion in many areas, particularly sub-Saharan Africa. The balance may be different in much of Asia, where economic opportunities are generally better.

The gender factor

Studies of migration from the 1960s to the 1980s generally ignored gender issues, but migration decisions are more complex than the individual decision of a male employment seeker. Newer studies show that a growing proportion of rural to urban migration streams is made up of women and that individuals who migrate, men and women, are often doing so as part of a complex family and community process aimed at improving family well-being and survival.[8] Women migrants are particularly disadvantaged by a number of recent developments which the new studies have revealed.

Migration is highly concentrated around the time of entry into the labour force, between the ages of 15 and 24.[9] Recently, a trend among women towards migration at younger ages has developed, concentrated between 10 and 20. There is also a secondary peak among women in their late 50s and 60s, who commonly migrate more frequently than men in the same age group. They are often widows and divorcees moving to join their children, or childless women. The absence of sons or a husband can deny an older woman status in her own community, forcing her to seek the protection of other family members or to strike out on her own.

Studies in Asia and in sub-Saharan Africa suggest that the availability of low-skill domestic work in urban areas increasingly draws younger women. Studies in Latin America and Asia have found young women migrants supporting rural families, saving for future mar-

riage or looking for a husband. Among poor women who migrate, many are currently single with a small number of children to support. Some of these young women return to start married life: however, it is widely believed that permanent migration is increasing for both men and women, together or apart.

Many women migrants report that they moved to accompany or follow a spouse or other family member:[10] globally, about 29 per cent (16 per cent to accompany family and about 13 per cent for marriage); about a third in Asia, higher in South Asia and Africa. Such migration predominates in largely Moslem societies where women are usually married and do not join the labour force. Elsewhere, job and education, support of children and occupational mobility account for the majority. In Latin America and the Caribbean and in the South Pacific, moves for employment are the most common. Changes in economic opportunities in agriculture in rural areas have increased rural—rural migration among women in South Asia and are increasing the proportion of women's overall mobility that is believed to be economically motivated. Whether such change will also be reflected in rural–urban migration remains to be seen, but it is a reasonable response to economic conditions.

In South-east Asia and Latin America, a high proportion of women migrants surveyed cite economic motivations (68 per cent in Bangkok, 70 per cent in Dugupan City, the Philippines, 56 per cent in Malaysia, over 50 per cent in Costa Rica, Guatemala, Haiti and Mexico). The high levels of economically motivated migration in South-east Asia are relatively recent. They are related to many changes, including girls staying longer at school and better opportunities for women's employment in urban areas, especially in service sectors. The greater importance of economic motivation may also be the result of increasing independence in chooisng a mate. Women in many parts of Asia are getting married later in life, so moving in order to accompany a husband or family is less likely.

Some observers have argued that the relatively wealthy and relatively poor are disproportionately represented, particularly among male migrants, but the evidence is far from clear. Women migrants, however, are more likely to be from poorer (and larger) families. Poor rural families are more likely to allow or demand female migration to cities as part of broad survival strategies. The transformation of rural economies has created a demand for cash, but not the jobs to supply it. In this case, the wages of a daughter in an office, shop or domestic job can fill the need. Often the opportunities are easier for women to find than they are for men. Even where this is not the case, experience has shown that daughters are more likely than sons to send money home.

Female migration decisions are the result of a more complex mix of social and economic conditions than male decisions. Women migrants tend to have less education than their male counterparts but this reflects the general difference in women's opportunities, and they have more education than women who do not migrate, even in societies with low levels of female education. Women with more education are more likely to find formal sector employment, and so are favoured in family migration decisions. Nevertheless these women are at a disadvantage when they reach the city, and may find themselves trapped in low-wage employment without the qualifications to advance, but still with too much education for work at home.

For most women there is little change in the type of work they do after they migrate. A third to a half of all female urban migrants find jobs in domestic or personal service. The next most common occupation is sales, either as an independent operator or employed by others. Fewer than one fourth find jobs in blue or white collar formal jobs. Trading unpaid domestic labour at home for the same work (though paid) in the city, or cultivating vegetables in order to sell them does nothing real for the autonomy of these women. The informal sector offers little security and restricted opportunities. Work such as prostitution exploits women with limited education and impoverished backgrounds. The explotation of children – both girls and boys – for their labour is also a problem in cities, among both migrants and other residents. And in poorer families some children are abandoned to their own devices or flee difficult conditions and become "street children", cut off from family support networks and opportunities for education.

Opportunities for advancement depend on the skills which women bring with them to their urban milieu and their resourcefulness in acquiring new skills after they arrive. Though some women are aware of the problem

and manage to avoid it by seeking further education once they arrive in the city, the improvement of both education and employment opportunities for women in rural areas is essential.

Unanswered questions

A broad range of questions about the contribution of migration to urban growth, the dynamics of migration and prospects for the future remain unanswered because of the difficulties of research and the sketchiness of existing data. Conceptual problems and measurement difficulties obscure conclusions on many fundamental issues. For example, the proportion of rural to urban migration which is temporary or targetted to particular short-term ends (such as seeking a marriage-partner or start-up funds) and the scale and impact of return migration are largely unknown. The diversity of factors (within families, within sending areas and within urban areas) which influence migration decisions make generalization difficult. Migration has contributed significantly to the growth of cities but an analytic framework for understanding its dynamics, including its gender aspects, remains elusive.

We know that large numbers of migrants, particularly to the larger cities, facilitate further migration. Groups of migrants once settled ease the transition of their families, associates and neighbours and reduce barriers to their movement. Studies show that a substantial majority of rural to urban migrants in most parts of the world find employment and housing through such connections. Some Asian studies found that some three quarters of migrants had employment leads before they moved.[11] Such networks strengthen links with the rural places of origin, and may assist the transformation to a cash economy and the adoption of urban values. As this proceeds the migration calculus will become more complex and its effects further-reaching.

City dynamics and international migration

International migration also fuels urban growth. In places with low rates of natural increase and modest migration flows, international migration can be a significant contributor to urban growth. Population flows from rural to urban areas reflect demand for labour in urban areas, low rural opportunity and unbalanced patterns of development between rural and urban areas; similarly, international migration flows reflect broader patterns of international imbalances in development. The barriers to international migration are higher – greater expense, longer distances (commonly), greater separation from familiar surrounds, looser ties to familiar persons and practices, varying levels of legal, social and cultural acceptance by the hosts. These barriers vary in intensity, as do the formal and informal mechanisms which can reduce them.

Cities are frequently the starting and ending points of long-distance migration (particularly if it is inter-continental), though international migrants often bypass cities in their own countries. Migration flows within countries far exceed those between nations. This is probably clearest both in countries at the highest and the lowest overall development levels.[12] But many of the same questions remain to be answered. Which international migrants intend permanent settlement and which intend to return to their own countries? How would that change if controls were stiffer or more relaxed? For example, some North African migrants would prefer to come and go between France or Italy and their own countries. Will migration controls keep them out or lock them in? Will older migrants retire in their countries of origin, as many "new Australians" have done?

CONCLUSION

The growth of cities is part of a secular shift in societies and economies, on a scale never before experienced. While the quantitative outline of the future is clear in general terms, the pace and intensity of the evolution and the resulting quality of life and opportunity is not. Responses are required from all sectors of civil society, to meet existing needs and to anticipate new ones, to help to create a cohesive society. Among them will be special attention to the needs and the contribution of women.

The preceding chapters have emphasized the differences between rural and urban areas. It is clear, however, that urban issues cannot be addressed in isolation, because the links between city and country are closer and more comprehensive than ever. The section which follows reviews the growing similarities as both rural and urban areas increase their linkages, respond to each other and to broader trends of an increasingly international economic environment. The final section will call attention to some of the policy responses which will be needed in an increasingly urbanized world.

CHAPTER 5:

URBAN-RURAL LINKS: TRANSACTIONS AND TRANSFORMATION

THANKS TO BETTER COMMUNICATIONS, CLOSER LINKS BETWEEN RURAL AND URBAN AREAS ARE SHAPING THE COURSE OF FUTURE SOCIAL AND ECONOMIC DEVELOPMENT THEY INFLUENCE BEHAVIOUR AND VALUES ON BOTH SIDES OF THE RURAL-URBAN DIVIDE, AND TEND TO BLUR THE DISTINCTIONS BETWEEN THEM.

Trade, migration and remittances, the exchanges of goods, people and money, are the most obvious signs of the relationship between urban and rural areas. Other influences are less tangible: standardized curricula and increased access to education; the growing reach of the mass media; commercial advertising and campaigns by service organizations; the influence of cultural and religious networks, and the spread of urban services to the rural areas all increase the strength and depth of the interactions between them.

The traditional rural family lived on and from the land, which provided food, fuel, water and often clothing and shelter as well. They were secure when their hold on the land was secure, and when the land delivered what it promised. Bad landlords, bad government or bad weather meant deprivation and often famine.

For many rural families those times have gone, for better or worse. Fertilizers, flood control and irrigation remove some of the uncertainties from farming; but the small farmer still finds it hard to survive in the cash economy. Population growth, environmental damage and commercial farming mean that many rural people are landless and depend on cash wages. More and more they look to the cities for a livelihood, by their own efforts or those of their children.

If they stay on the land they look for ways to produce more and sell more. The rural areas around cities, even small cities in predominantly rural areas, offer urban markets. Improvements in transport and the development of intermediate markets provide additional opportunities. Assured sales permit increased risk, such as new and more productive technologies.

In search of security, many farm families are diversifying their sources of income. Employment opportunities in rural areas and small towns are most often in commerce and services, which demand some education and are often open to women. This has encouraged poor rural households to put a greater value on education, especially for girls, and on girls themselves. They may also look again at the value of children and decide in favour of investing in a higher quality of opportunity for a smaller number of children.

The effect of this diversification strategy is closer contact with urban centres and urban values. At the same time, for those who make the move to the city survival in urban areas may depend on rural skills such as finding a small piece of land to grow food or crops for sale. Migrants will also rely on social networks based on their places of origin, intensifying their linkages to their rural families and recreating some of their former social structures.

Remittances are an important form of exchange between urban and rural areas. Money flows in both directions, but the bulk of it consists of urban migrants' support to their families at home. Remittances can amount to as much as 50 to 80 per cent of the families' incomes, highest in lower income families, particularly those who are otherwise dependent on farm income.

Men earn more than women and send more home – but women are more consistent; young women, in particular, more than their brothers.[1] Most women migrants send remittances and if they are in domestic work which provides food and lodging they send more of their cash income. For the poorer migrants remittances can be a large proportion of their total income. Recent migrants have frequently received help with their move, and they are more likely to send money home as repayment. Remittances are thus part of a pattern of linkages, obligations and voluntary mutual help which help forge the links not only among family and community members but between communities at different points on the rural-urban continuum.[2]

The impact of remittances on recipient families in rural areas has been a subject of considerable debate, centring round the distribution of use between consumption and investment. For poorer sending families remittances are part of a variegated survival strategy. They can support immediate basic consumption needs such as improved diets; provide better health care, for example family planning; finance improvements to housing; provide security for risk-taking, such as innovations to increase productivity; or allow long-term investment such as annuities or education costs.

The volume of temporary migration can be substantial and increases as

Temporary migration is a often a major source of income for those in rural areas. These Guatemalan migrant workers and their families spend three months a year picking coffee, most of which is destined for urban consumers. The "ecological footprint" of cities extends over wide areas. *Paul Harrison, Still Pictures*

transport improves. In the case of Thailand, estimates of the number of migrants in the past five years increase by 50 per cent when temporary migration flows are added. People travel between and among urban and rural areas for a variety of reasons, including residence, employment, to distribute money, visit friends and family, and to transport products and goods. As people move, their ideas, values and aspirations are also transported. In many cultures, family and cultural events such as weddings, births, rites of passage and funerals, bring dispersed people together, providing opportunities for exchange of information and goods and for maintaining networks which can encourage further exchanges and migration. Better understanding of this process requires surveys and innovative data collection. For example, a specialized survey in China was able to collect much valuable information on migrants during the Spring Festival, when most circular migrants and many longer-term migrants return to their original homes to visit their families.[3]

URBANIZATION OF THE RURAL AREAS

The economic linkage of urban surrounds

Cities' production and consumption patterns have a wide impact on their surrounding environments. The "ecological footprint" of cities extends over wide areas, not just those immediately affected by pollution and generated waste, but also to the areas which supply them with food, fuel and new residents.

The overall effect is to create less a divide than a rural–urban continuum, along which each different locality finds a place. Prospects for sustainable development depend on the dynamics of the relationship between locations at different points on the continuum, and the effects of policy and market decisions on the relationship. The pull of the cities with their opportunities for employment and other personal advancement is reinforced by a push out of declining rural areas. Both are influenced by creating urban-type opportunities in rural areas, or decisions affecting a wide variety of transfers of goods, services, associations, communications and other exchanges.

Expanding urban markets generate demand for rural products, including raw and processed agricultural products, crafts and other manufactures. This demand invigorates rural regional centres and small cities as collection and distribution points. This can spur improvement in rural economies which generate demand and expand local markets, initially for locally-produced non-farm goods and services, then increasingly for other domestic and for imported products.

The growing national integration of market systems mirrors the increasing global integration of trade. Both within nations and between nations these developments can sustain the structural transformation of economies. Such systemic change offers both great opportunities and challenges to a smooth and equitable course to sustainable development.

Environmental issues for the urban surrounds include airborne pollution, the release of treated or untreated liquid wastes into lands and water systems, and demands for fuel and other supplies. Sprawling squatter communities have arisen around many major cities, dependent on the cities for opportunities yet often independent in administration and adaptation. Surrounding communities provide cities with labour, services and products. In Latin America and Asia, urban systems

linking two or more cities are increasingly common as crowded central cities become less and less viable.[4]

Even small towns and cities impact on surrounding villages and rural settlements. The exchange of goods, cash and services allows small towns and their rural surrounds to stimulate each other's economic and social development. Studies show that 20–30 per cent of the rural labour force is primarily involved in non-farm economic activity.[5] In some settings in sub-Saharan Africa up to one third of household income is derived from non-farm sources. The non-farm income (from agricultural wage labour, employment in town or marketing of rural produce or crafts, for example) of rural families affects agricultural productivity.[6]

Non-farm income is particularly important to landless people and to small landholders. Women, whose land ownership rights are often restricted, are major contributors to non-farm income, exploiting whatever opportunities local conditions allow. The least successful and most vulnerable households are those which depend only on their direct agricultural production and sale of their labour. The most successful households have incomes from both rural and urban activities.[7] Investment in children's education enables families to take advantage of formal employment opportunities and use their available resources more productively.

Communications

The past two decades have seen a dramatic expansion of exposure to mass media in rural areas. Since these are almost by definition urban media and present an overwhelmingly urban portrayal of life and values, their impact on attitudes and behaviour has been profound.

Radio is the medium with the widest coverage. Developing countries as a whole average 176 sets per thousand of population. In Latin America and the Caribbean there are 344 radio sets per thousand of population, in West Asia and Northern Africa 240, East Asia and the Pacific 195, Sub-Saharan Africa 142 and South Asia 79.[8]

These figures underestimate radio's actual reach. For example, Bangladesh is estimated to have 44 radio sets per thousand of population but representative national surveys indicate that in urban areas more than half of the married women of reproductive age have listened to a radio within the last week and in rural areas more than a third.[9] South Asian surveys show that more than half the married women of reproductive age report having a radio in their household.[10] Many people listen to other people's radios or hear them in public places. Studies in India have recently shown high levels of exposure to radio broadcasting both within urban and rural areas, whether or not listeners actually own a set. Nearly two thirds of urban dwellers and more than a third of rural residents listen to radio at least once a week.

The pattern is more pronounced where radio ownership is higher. Studies in Asia and in Latin America and the Caribbean indicate that more than half the women of reproductive age in urban and rural areas live in a household with a radio, in urban areas more than three-quarters. In sub-Saharan Africa, urban radio ownership reaches similarly high levels although rural ownership can be much lower.[11] Increasingly, in more parts of the world, rural and urban people alike are exposed to similar communications from similar sources.

Television, video and films expose viewers to a common window on styles of life and behaviour, an impact increased by the supranational reach of the media. Television is extremely popular where it is available. UNESCO statistics indicate that in the early 1990s there were 56 television sets for every 1,000 persons in developing countries as a whole. Latin America and the Caribbean had 163, West Asia and Northern Africa 112, East Asia and the Pacific 44, South Asia 31 and sub-Saharan Africa 23. In the least developed countries the number was only 10 per 1,000. Television has been spreading at a very rapid pace over the last decade, around 20 per cent per year in developing countries overall.[12]

In Bangladesh, over 60 per cent of the married women of reproductive age in urban areas see television in some form at least once a week. Rural exposure to television was lower by far than radio, reaching only 12 per cent. Again, reach exceeds ownership – in urban areas more than one and a half times the percentage of owners report watching television at least once a week; in rural areas, there are more than three times as many viewers as owners.[13] Data from India similarly show that nearly 70 per cent of urban and nearly 20 per cent of rural married women of reproductive age watch television at least once a week.[14] Television increasingly exposes viewers to a wide range of national, regional and international viewpoints,

Though starting from a lower base, the availability of video cassette recorders (VCRs) has been increasing at an even faster pace, with phenomenal growth in Latin America and the Caribbean and in Asia. In these regions, VCRs doubled or tripled in availability during the last half of the 1980s, reaching a level of one VCR for every seven televisions. Video parlours and other sites for public viewing have also been increasing rapidly.

Illiterate women are less likely than any other group to watch TV, listen to the radio or go to the cinema. In India, for example, only a third of illiterate married women of reproductive age had recent exposure to one or other, compared with 93 per cent of women with high school or higher education. Illiteracy not only prevents women reading; it inhibits their watching and listening as well. The coming of radio and TV has pushed illiterate women, and to a lesser extent the poor as a group, still further out to the margins of society.

The mass media bring change wherever they go; but change does not have to be random. Successful media campaigns have changed attitudes and behaviour in a variety of areas, from basic literacy to health care and family planning. In some countries the only sex education teenagers ever receive is via radio programmes where their questions can be answered.

Convergence of consumption tastes

One effect of easier travel, frequent migration, and the spread of mass media has been to increase rural demand for different foods and a wider range of consumer products. This has long been a feature of higher income in urban households and is now observed when rural incomes increase.[15] The effect over time will be a further blurring of distinctions between urban and rural areas.

One of the marked distinctions between urban and rural areas in developing countries is in consumption expenditures. Urban housing costs are generally higher: frequently twice as high expressed as a share of household expenditure. Urban expenditures are also substantially in cash, compared with rural areas where subsistence production plays a larger role. As urban income increases more is spent on transportation: the distance from the place of work and the availability of transport to work are important considerations in urban areas. In many cities low-income families live as close to work as they can manage or spend considerable time walking or cycling. At low incomes high proportions of total expenditures go to basic needs, particularly food.[16] As income increases households shift to higher quality foods, which often take less time to prepare as well as having higher nutritional value. Recent years have seen the growth of sizeable markets in convenience foods in response to this large demand.

The urbanization of consumption patterns extends to health care, including reproductive health and family planning. Knowledge of modern family planning is almost universal even among illiterate rural populations, and demand is increasing rapidly. From the policy point of view, a rapidly rising demand for family planning, assuming that it results in lower fertility in rural areas, would weaken the link between urbanization and slower population growth, and permit more flexibility in policy. Wider availability of reproductive health and family planning services in rural areas strengthens women's position and helps to secure family and community structures. This will help to slow urban migration and relieve some of the pressure on cities.

RURAL LIFESTYLES IN URBAN AREAS

Urban agriculture

Agricultural skills transferred from rural areas or learned and adapted to urban conditions can play an important role as a survival strategy and income generator in urban areas, particularly in poor communities. Much of a city's fruit and vegetables may be produced in or just outside the city itself. In some cities this is exaggerated by an expansive definition of the metropolitan area, but in many cities it is common to use land near residences, vacant plots and gardens and on marginal or vacant land for household consumption and marketing. A study of six towns in Kenya found that two thirds of the urban households surveyed grew some of their own food or fuel and that half kept some livestock. In Lusaka, Zambia, in some low income areas more than half of all households maintained food plots.[17] Civil servants in Kampala and Dar es Salaam, among others, commonly supplement their meagre salaries by means of their home gardens. The large proportions of migrants from rural areas among urban populations in sub-Saharan Africa have contributed to the scale and visibility of urban food pro-

duction in the region. Such observations have, however, been made in all developed and in some developing countries as well.

The full extent of the contribution of urban agriculture to food needs and its potential for expansion remains to be assessed. A recent United Nations Development Programme publication systematically collates much of the currently available information.[18] Various promoters of "sustainable cities" approaches to urban planning have emphasized the environmental benefits obtainable from further development of agriculture in cities: reduction of organic waste disposal burdens, reduction of water pollution and (with low cost treatment or restriction to non-food crops) use of waste water.

Experience and policy considerations alike point to a blurring of traditional distinctions between urban and rural life. Better communications permit the exchange of populations on a much greater scale than ever before, though the scale is not and may never be completely known. With ease of movement and better communications come exchange of values. The rural extended family still survives in Asian and African cities, where it substitutes in many ways for social security services such as unemployment benefits, old age pensions and subsidized health care.

The urban dependence on the mass media rather than on traditional forms of entertainment is spreading to the village: half the population of India watched all or part of the national TV dramatization of the *Ramayana*. Urban behaviour patterns are close behind, including, for example, the use of cash for wages and purchases, women leaving the home to work and the routine use of modern family planning methods.

Women are a large part of the transformation, whether as urban workers or participants in rural government. A dramatic change in their traditional roles is taking place; whether it will be for their benefit and the benefit of the larger society depends on whether their contribution is welcomed and made a full part of national and international development policies.

CHAPTER 6:

POLICIES, STRATEGIES AND ISSUES FOR IMPROVING CITIES

MAKING CITIES SUSTAINABLE WILL REQUIRE INTEGRATED PLANS THAT LINK BALANCED DEVELOPMENT OF RURAL AND URBAN AREAS TO THE ALLEVIATION OF POVERTY. THE EMPOWERMENT OF WOMEN THROUGH EDUCATION, GREATER INVOLVEMENT IN DECISION-MAKING, PARTICIPATION IN GOVERNMENT AND COMMUNITY INSTITUTIONS, AND BETTER ENTREPRENEURIAL OPPORTUNITIES FOR BOTH URBAN AND RURAL WOMEN MUST BE CENTRAL TO ANY SUCH PLANS. ALSO VITAL WILL BE ENABLING ENVIRONMENTS WHICH ENCOURAGE ALL ELEMENTS OF CIVIL SOCIETY TO PARTICIPATE.

MEETING THE URBAN CHALLENGE

In the most recent United Nations assessment[1] fully three quarters of the 190 governments surveyed were dissatisfied with the distribution of their populations; 110 said they wanted to slow or reverse existing trends. Most of these were concerned about rapid urbanization. This concern has been a consistent feature of national policy and action for the past 20 years, yet the cities have continued to grow.

The more successful policies, however, offer some pointers for the future. In recent decades the dominant strategies[2] have been directed either at the distribution of population between rural and urban areas; or at improving the quality of life in cities and strengthening urban institutions. Preparations for the HABITAT II Conference have further refined these alternatives.

Underlying HABITAT II are aims shared with the other inter-governmental conferences of the 1990s: forging new partnerships; creating the social conditions for accelerated economic development; emphasizing social investments such as health and education, especially for girls and women; alleviating poverty; and mobilizing resources to improve settlements and services.

Particular emphasis is given in current policies to strengthening urban management systems; to promoting national development; and to integrating national economies into the international system of exchange and finance. All the conferences emphasized improving urban management and the financing of services.

Economic constraints and structural adjustment programmes have forced policy changes aimed at limiting public sector expenditure and extracting greater efficiency from what remains. The need for economy has influenced a trend towards administrative decentralization and the concept of "civil society", the mobilization and broad participation in government of the combined forces of business, non-governmental service organizations, and community and advocacy groups.

Policies on population distribution

Strategies adopted to slow urbanization have included investments in rural development; incentives promoting urban alternatives to primary cities; establishment of new towns; and the relocation of ministries and legislatures to new capital cities. These attempts have been hampered by a lack of investment in infrastructure outside the urban centres, and have usually failed to overcome the drawing power of urban magnets.

Newly created urban centres may provide employment and housing but little else, making it difficult to attract and retain skilled labour. Even when workers move, employment does not necessarily follow, as has been the case with the new towns around Cairo which have failed to reduce commuting.

Cities gain their economic advantage from the concentration of skills, capital, industrial activity, manufacturers' suppliers, energy supplies, transport and educational infrastructure. Demand results in competition among suppliers and efficiency. Concentration of suppliers, services and customers within certain districts promotes further efficiencies, stimulating further concentration. New urban centres lack these advantages, which have developed over time in response to diverse market stimuli rather than central planning.

Investing in rural areas so that they may retain population has had only mixed success. It requires vast amounts of financial and human resources because rural infrastructure development is more costly than that in cities. Policies and regulations meant to generate non-farm employment are only beginning to be effective, and are not readily transplanted to new settings.[3]

Rural development is important in its own right. Higher agricultural productivity increases rural incomes and helps meet growing urban demand. Higher rural incomes do not necessarily stem the flow of people to the cities, however, as the experience of sub-Saharan Africa shows. Productivity gains may turn part of the rural population into

ICPD AND URBAN STRATEGIES

The Programme of Action of the 1994 International Conference on Population and Development recognizes that the concentration of population in urban areas is an intrinsic dimension of economic and social development, with both positive and negative aspects. The greatest challenge seen by the programme in this regard is to cope with the enormous strain the rapid urbanization will place on social services and infrastructure in the developing world. Some of the main concerns are:

Families and children. Migrating to cities and adopting urban lifestyles puts strains on families. Parents and children cut off from extended family support become increasingly dependent on assistance from governments or the private sector. Policies need to help families cope with the demands of urban life, or at the least not to worsen them.

Households headed by women are increasing in number. Labour migration and heavy workloads in low-paying informal jobs are breaking down family ties. Compounding these problems for urban families are high levels of poverty, the need to support the elderly or disabled, AIDS and other terminal diseases, substance dependence and domestic violence – abuse against spouses and children.

Millions of urban children and youths, some left to their own devices, are subject to the risk of dropping out of school, of labour exploitation, sexual exploitation, unwanted pregnancies and sexually transmitted diseases. In view of the increasing problem of street children and the vulnerability of urban children, child-care centres and special protection and rehabilitation efforts are needed.

Health and environment. Policies need to protect both ecological systems and people's health in light of increasing pollution and settlement on marginal lands. All countries should give priority to ensuring everyone – especially the poor and disadvantaged – a safe and sanitary living environment, through measures to avoid crowded housing conditions, reduce air pollution, ensure access to clean water and sanitation, improve waste management and increase workplace safety.

Regional and urban-rural differentials in access to reproductive health including family planning and sexual health need to be reduced. An additional health concern is the spread of the HIV/AIDS pandemic from urban to rural areas and its growing impact on economic and agricultural production.

Population distribution. In response to rapid urbanization, governments have paid most attention to rural-urban migration, although rural-rural and urban-urban migration are more prevalent in many countries. Migration to cities both reflects the greater economic opportunities available in urban settings and increases that advantage; it is both a way to seek new life opportunities and a response to inequities – in distribution of resources, access to technologies and useable land – that must be redressed.

Policy issues relate to urban growth rates, distribution of population among cities of various sizes and economic roles, and protection of individuals' rights to live and work in communities of their choice. Conditions in both urban and rural areas must be improved; development should be promoted both in areas sending migrants and in those receiving them.

A balanced distribution of production, employment and population is essential for sustainable development. Policies should encourage sustainable regional development and urban consolidation, the growth of small- or medium-sized cities and sustainable rural development by creating labour-intensive projects, training youth for non-farming jobs and ensuring effective transport and communications. Decentralization of administration, expenditure, taxation and services should be considered to facilitate local development. Infrastructure improvements and environmental protection should be carried out in both urban and rural areas.

Industries and businesses should be encouraged to relocate from urban to rural areas. Infrastructure provision, investments, income-generating projects and other policies should foster rural opportunities; involvement of local communities is imperative. Grassroots organizations like credit, production and marketing cooperatives can improve rural people's livelihood. Expanded international trade – facilitated by reducing restriction on agricultural imports – can benefit both rural and urban areas.

Urban management agencies and planning mechanisms need strengthening and reorientation, ensuring the participation of all population groups. Particular attention should be paid to ensuring economical land use, protecting fragile ecosystems and facilitating the access of the poor to land in both urban and rural areas.

The largest cities are dynamic centres of economic and cultural activity. Strategies to address their problems also need to foster their positive contributions to economic and social development.

High priority should be given to improving the security and quality of life of low-income residents. All citizens, including urban squatters, have needs for personal safety, basic infrastructure and services, the elimination of drugs and criminality, and problems resulting from overcrowding. People living in areas prone to natural and man-made disasters need attention.

Governments should promote the integration of rural migrants into urban areas and improve their income-earning capability by facilitating access to basic education, health services, vocational training, employment, credit, production, marketing opportunities and transportation. Women workers and heads of households should receive special attention.

Effective environmental management requires special attention to water, waste and air management as well as environmentally sound energy and transport systems.

Information technologies can help bridge geographical, social and economic gaps and ensure wide participation in local, national and global-level debates about development issues. Parliamentarians, in particular, need full access to the information needed for decision making.

URBAN ISSUES AT THE WORLD SUMMIT FOR SOCIAL DEVELOPMENT

The World Summit for Social Development gave special consideration to the problems of urbanization. Excerpts follow.

Chapter I. AN ENABLING ENVIRONMENT FOR SOCIAL DEVELOPMENT

13. Ensuring that fiscal systems and other public policies are geared towards poverty eradication and that they do not generate socially divisive disparities calls for:

(e) Re-examining the distribution of subsidies, *inter alia*, between industry and agriculture, urban and rural areas, and private and public consumption, to ensure that subsidy systems benefit people living in poverty, especially the vulnerable, and reduce disparities;

Chapter II. ERADICATION OF POVERTY

21. Urban poverty is rapidly increasing, in pace with overall urbanization. It is a growing phenomenon in all countries and regions, and often poses special problems, such as overcrowding, contaminated water and bad sanitation, unsafe shelter, crime and additional social problems. An increasing number of low-income urban households are female-maintained.

34. Urban poverty should further be addressed by:

(a) Promoting and strengthening micro-enterprises, new small businesses, cooperative enterprises, and expanded market and other employment opportunities and, where appropriate, facilitating the transition from the informal to the formal sector;

(b) Promoting sustainable livelihoods for people living in urban poverty through the provision or expansion of access to training, education and other employment assistance services, in particular for women, youth, the unemployed and the underemployed;

(c) Promoting public and private investments to improve for the deprived the overall human environment and infrastructure, in particular housing, water and sanitation, and public transportation;

(d) Ensuring that strategies for shelter give special attention to women and children, bearing in mind the perspectives of women in the development of such strategies;

(e) Promoting social and other essential services, including, where necessary, assistance for people to move to areas that offer better employment opportunities, housing, education, health and other social services;

(f) Ensuring safety through effective criminal justice administration and protective measures that are responsive to the needs and concerns of the community;

(g) Strengthening the role and expanding the means of municipal authorities, non-governmental organizations, universities and other educational institutions, businesses and community organizations, enabling them to be more actively involved in urban planning, policy development and implementation;

(h) Ensuring that special measures are taken to protect the displaced, the homeless, street children, unaccompanied minors and children in special and difficult circumstances, orphans, adolescents and single mothers, people with disabilities, and older persons, and to ensure that they are integrated into their communities.

The Conference also gave high priority to the related concerns of expansion of productive employment, reduction of unemployment and the promotion of social integration.

surplus labour, ripe for migration. Better social and economic infrastructure in rural areas can stimulate increased economic activity, leading to development in smaller cities. This increases overall urbanization, but may take some pressure off primary cities.

Experience suggests that limited resources are better used to raise rural living standards than to attempt deliberately to counter the attractions of dominant cities.[4] Over the last decade, however, there have been successful efforts in Latin America and in Asia to distribute economic development and populations within complexes of primary and secondary cities. Growth in small and medium-sized cities can help reduce the growth of the biggest ones,[5] although this has more often been a natural consequence of stronger links between large cities and surrounding areas than a result of deliberate policy.

Reproductive health

The biggest factor in urban population growth in most regions and in many countries is natural increase. Reducing this component will require substantial progress in social development. Central to this effort will be the empowerment of women and the guarantee of their human rights, including the right to reproductive and sexual health. Providing high-quality reproductive health services, including family planning, is an essential element. Access to services for both women and men – whether offered by government, private suppliers or NGOs – must be equitable; the disparity between accessibility to the poor and the non-poor urgently needs to be redressed. Better reproductive health for all is a link in a virtuous circle connecting the autonomy and equality of women with slower, more balanced population growth, the viability of urban areas and a better overall quality of life.

In cities, access to quality services is higher than in rural areas. But there is still considerable unmet demand for reproductive health services, including family planning, and fertility levels among the poor are generally higher than among other groups, indicating that barriers to service use persist. In

BEIJING AND URBAN ISSUES

The Fourth World Conference on Women (FWCW), held in Beijing, China, from 4-15 September 1995, addressed poverty alleviation and other issues related to the urban environment in the context of empowering women and improving their economic, political and social status.

The FWCW Platform for Action points out that increased rural to urban migration in recent years has profoundly affected family structures and well-being, with unequal consequences for women and men. It cites problems common to poor urban and rural families, including a lack of food and inequitable distribution of food for girls and women, inadequate access to safe water, sanitation facilities and fuel supplies, deficient housing conditions and environmental health hazards, all of which overburden women and their families and have a negative effect on their health.

Among the relevant recommendations of the Platform for Action :

Increase allocations for social services and health care, especially programmes at the primary level in poor areas, giving special attention to the reproductive and sexual health of girls and women.

Develop and promote employment programmes.

Improve the effectiveness of anti-poverty programmes; provide adequate safety nets to enable those living in poverty to withstand times of economic crisis.

Expand the access of disadvantaged women to financial services, appropriate technologies, transportation, extension services, marketing facilities and credit; ensure that laws and regulations do not discriminate against enterprises owned by women.

Eliminate child labour that is contrary to international standards; protect working children, and street children in particular, by providing appropriate health, education and other social services.

Promote the participation of local communities, particularly women, in identifying public service needs, spatial planning and providing and designing urban infrastructure.

Design and implement environmentally sound resource management mechanisms, production techniques and infrastructure development.

Design structural adjustment programmes to minimize their negative effects on vulnerable and disadvantaged groups and communities; prevent the marginalization of these groups in economic and social activities and devise measures to give them access to and control over economic resources; design economic policies and programmes to take account of their impact on women and girls, especially those living in poverty.

rural areas, unwanted fertility reduces families' ability to provide for their children, and puts stress on local resources and local environments. These conditions help push people into migration.

Employment

Half the new urban jobs in the past decade were in the informal sector , the major source of employment for many city dwellers. Policies in this area seek to improve wages and working conditions; to revise regulations and codes to increase access to services, infrastructure, credit and markets; and to strengthen links to the formal sector.

Many Asian and Latin America countries are using tariff exemptions, tax benefits and other export-driven policies to promote manufacturing, assembly plants and service industries. This approach creates employment, but experience has shown that it can lead to exploitation of the workers, who are often young women desperate for work on any terms. Competition for jobs discourages protest or organization and keeps wages low; employers' attempts to maximize output result in employee dissatisfaction and high turnover. This is not only unjust but also inefficient.

Housing

Tightening public budgets and changing attitudes about government's role in social services have affected national strategies to improve housing. In the 1960s, the emphasis was on public works including housing construction and slum clearance. As understanding of the scale of need increased, Latin America in the early 1970s and, later, countries in Asia began to emphasize organized self-help, encouraging future tenants to build their own homes with materials provided by the public sector. This eliminated overheads and profits, but overestimated both labour's contribution to total costs and the degree to which unskilled workers could replace skilled ones.

In most of the developing world in the late 1970s and 1980s, government's role was further limited to providing land and access to water and waste disposal. This approach overestimated residents' ability or willingness to pay for shelter after meeting basic food and energy needs. Service provision remained outside residents' control, and conditions often deteriorated rapidly. Residents of informal settlements frequently faced eviction due to public and private efforts to use the land more profitably.

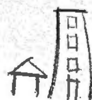
These experiences led increasingly to a belief that government's proper role is an enabling one, mobilizing the particular strengths of various actors, rather than providing inputs directly.

Shelter provision is increasing recognized as a means not only to meet

housing needs but also to generate employment and contribute to economic restructuring. Homes are the site of many informal-sector activities including self-employment. Community involvement in the provision of services and infrastructure can also play an important role in political and social cohesion.[6]

Global economic trends and structural adjustment

Economic shifts and increasing global competition are profoundly restructuring national economies. In the developed countries, changes in the competitiveness of different industries have shifted tens of thousands of workers from manufacturing to other sectors, contributing to temporary or longer-term unemployment. Some service industries are moving from developed countries to developing countries which have increasing technological sophistication and lower wages; the rapid growth of computer software development activities in India, supported by national and



URBAN CONFERENCES OF THE PAST DECADE

Barcelona: International Conference on Population and the Urban Future, 1986.

From 19–22 May 1986, UNFPA convened its second major conference on urbanization (the first was in Rome in 1980). Mayors and planners from large cities took part, along with representatives from Governments, intergovernmental organizations and NGOs. Cosponsors included the Spanish Government, the United Nations Centre for Human Settlements (HABITAT) and the International Union of Local Authorities.

The conference adopted the Barcelona Declaration on Population and the Urban Future, which emphasized the importance of comprehensive national population policies, balanced development, economic growth and social equity. It recommended: integration of urban planning with social and economic development; redesign of city institutions for more effective planning and resource use; decentralized decision-making to increase local and regional governments' responsibility, and better representation of communities and various groups within cities. It advocated public-private partnerships and urban-rural alliances to improve health services and reduce mortality and fertility.

The Declaration stressed the need to develop cost-effective technologies for housing, transport, communications, health, water supply and sanitation. It urged city administrations to promote family planning and programmes to reduce infant and child mortality, to increase recreational facilities, and provide services to underserved groups. And it called for better data collection, research and training to support policy formulation.

Kobe, Japan: Asia Conference on Population and Development of Medium-Sized Cities

UNFPA, the city of Kobe, and Nihon University Population Research Institute jointly organized an 11–14 August 1987 meeting on medium-sized cities' unique problems and potential. It involved representatives of 11 Asian countries, including mayors and local and regional officials, as well as intergovernmental organizations and NGOs.

Their final declaration noted that national policies, budgets, data collection and development planning tend to neglect medium-sized cities, which often lack adequate resources and effective administrations. Migration often places major demands on public utilities and social services, and environmental degradation takes a heavy toll. At the same time, the declaration pointed out that mid-sized cities provide an important link between larger cities and rural areas. They can relieve overcrowding in bigger cities, and have the potential for more efficient use of resources and more equitable distribution of social services.

Participants recommended that such cities: strengthen their capacities for administration and fundraising; consider the impact of planned industrial development on urban services; consult with the people whose lives are affected by development policies; ensure that development plans provide for adequate urban infrastructure; attend to the health and family planning needs of the poor, to employment opportunities and working conditions for women, and to social service needs of children; and give priority to low-cost housing and public utility facilities for the poor.

New York: International Colloquium of Mayors on Social Development

The United Nations Development Programme, in cooperation with HABITAT and The Group of Four Cities' Associations, organized this gathering on 18–19 August 1994 as a preparatory activity for the HABITAT II conference. More than 100 mayors took part. The focus of discussion was on the role of social integration in the development and management of sustainable cities, and the need to expand employment opportunities as part of an overall poverty alleviation strategy.

Participants issued a Mayors' Declaration on Social Development and Sustainable Human Settlements. They noted their concern about poverty, social disintegration, pollution and other urban conditions and made a number of commitments: to promote social development in partnership with communities, civil society, the private sector and government agencies; to work to achieve education, health and shelter for all by 2000; to empower the poor to help themselves to improve their living conditions, by providing infrastructure, shelter and services in their communities; involving local communities in the planning process; promoting harmony among different social groups by recognizing their ethnic, cultural and racial diversity and democratically involving minorities in city governance; ensuring women full access to education, training, health, credit, employment and decision-making; and coordinating various social services more effectively to support families at risk.

international financing, is a recent example.

At the same time, inefficient policies are impeding some countries' participation in international markets. As they seek to revise such policies, many countries have negotiated programmes of assistance with international lending institutions, giving them access to resources and credit. Following economic stagnation and rising debt in the 1980s, lending institutions encouraged governments to undertake programmes of structural adjustment to try to effect economic renewal. These programmes as initially devised and implemented are believed to have seriously affected the quality of life in cities. The elements varied from country to country but generally included:

- Reductions in social-sector budgets including health and education and public-sector employment; less support for social development initiatives such as basic literacy and other programmes aimed at empowering women;
- elimination of subsidies for food and other basic commodities;
- privatization and decentralization;
- imposition of school fees, charges for health services and other cost recovery options;
- liberalization of trade policies to facilitate external investment and encourage manufacture and services for export; and currency revaluations.

These policies fell heavily on urban populations. Public sector investment is concentrated in capital cities and other large cities, and in many countries governments account for a large proportion of formal employment – as much as 10 to 25 per cent in some sub-Saharan African countries; layoffs often exacerbated already severe unemployment.

Increased school fees, combined with governments' earlier retreat from policies guaranteeing employment for all graduates, have eroded confidence in the value of education. UNESCO statistics[7] indicate that in sub-Saharan Africa a decreasing proportion of boys are attending school beyond the earliest grades, and the ratio of girls to boys in education is not growing.

Charges for health services fell especially hard on preventive services such as child immunization and family planning. Many hopeful initiatives aimed at reducing poverty and closing the gender gap were inadequately funded and implemented.

Elimination of food subsidies also fell hardest on the urban poor, who grow less of their food than the rural poor and spend more of their incomes on food than the urban middle class. This has had the effect of increasing malnutrition, especially among those last in line for food and the most vulnerable to shortage – girl children and mothers of young families.

In many developing countries, real wages of urban residents fell in the early stages of the adjustment process, before the anticipated benefits could be felt. Deteriorating economic conditions make low-income families more liable to fall further into poverty, and escape more difficult.[8] Fewer are able to save, diets worsen and housing becomes more crowded with relatives forced to share lodgings and pool dwindling resources.[9] Women must stretch and supplement household income to provide food, water, clothing and basic necessities for children. Conflicts over food, shelter, clothing, education and health intensify. Increasing desperation often leads to domestic violence.

The international financial community understands that reducing investment in health and education cuts away the foundations for long-term development; it recognizes the need to lighten the burden of structural adjustment programmes on the social sector and to include better safeguards for vulnerable populations. Increasing attention is being given to improving access to credit, particularly for women, to facilitate entrepreneurial activity and lessen the shock of disruptions. Some steps are being taken to ensure that essential health and education services remain in place.

Reductions in public sector employment and shifts in the structure of national economies are natural responses to increasing global economic integration. In rapidly growing economies, notably in East Asia, the transformation has been more rapid than elsewhere, and higher incomes and resources have mitigated the impact; in fact, the proportion of people living in relative or absolute poverty has declined.[10] This success reflects substantial earlier public investment in education, health and family planning programmes: today's urban challenge is to maintain these necessary investments in the face of resource contraints and rising populations.

Decentralization

A mass global experiment in decentralization is in progress. Policy making, programme development, implementation and monitoring functions are being

shifted from central governments to local authorities, parastatal organizations or the private sector. Various arrangements for delivering basic services are being explored and tested. "Of the 75 developing and transitional countries with populations greater than 5 million, all but 12 claim to be embarked on some form of transfer of political power to local units of government." [11]

From the brief experience of decentralization to date, despite varying local circumstances, some tentative conclusions may be offered:

(1) Before administrative and financial authority is delegated, the functions and responsibilities at each level should be delineated.[12] Decisions about responsibilities for finances and fund-raising should be made only after the roles of the various actors are defined.[13]

(2) Systems for transferring funds need to be clear, workable, targeted to the most responsive areas, and transparent in operation.[14] People must have assurances that resources are being distributed and used effectively.

(3) Implementers must be accountable to programme beneficiaries and the public.[15] No matter who is executing the programme, the beneficiaries should be fully involved in programme design, implementation and monitoring, and there need to be mechanisms to ensure that shortcomings are corrected. Electoral accountability, public decision making, transparency in financing and administration, and openness to innovations and "bottom-up" management are essential. Non-governmental organizations have an important role to play in monitoring programme performance.

Decentralized approaches to health care programme design. A number of countries, particularly in southern and eastern Africa, now allow health programme priorities to be determined locally. In Zambia, for instance, a district-level consultative process identifies local service delivery priorities, within a central framework specifying minimum service levels which must be maintained. Such flexible strategies maximize the input of local administrators and programme beneficiaries.

The consultations leading up to the HABITAT II conference have stressed the importance of community-based and participatory initiatives. Mayors, local NGOs and the private sector have been actively involved in the process. Regional and international meetings have allowed the sharing of information about successful local programmes.

BEST PRACTICES

In November 1995, as part of the preparations for the HABITAT II conference, an International Conference on Best Practices was held in Abu Dhabi. Participants exchanged information and experiences on successful initiatives to address settlement problems, particularly in urban areas.

Featured programmes in industrialized countries dealt with: pollution reduction (United States); housing planning, addressing renewal, modernization and tenants' rights (Austria, the Netherlands and Sweden); collaborative efforts to improve housing for the immigrant population (France); and overall urban/regional planning involving a wide range of community actors (Finland).

The conference recognized a diverse range of projects in developing countries. Several involve innovative approaches to forging new partnerships which empower women, contribute to education and improve health:

- Aqaba, Jordan: national, regional and municipal authorities joined with local NGOs and community-based organizations to upgrade public housing. Inputs from heads of households, both men and women, were emphasized in determining priorities for interventions.
- Bombay, India: The Society for Promotion of Area Resource Centres, in collaboration with other NGOs, has shown that pavement dwellers, mostly women with children, can save up for better housing and can avert or cope with the demolition of their squatter homes. Working with government, area committees headed by women conducted surveys and planned for alternate settlements. Women collaborated with architects and engineers in the design of new dwellings.
- Kisumu, Kenya: The Citizen's Social Care Centre has reduced the number of street children by assisting those who have run away from home. It trains teenage women and single mothers to be environmental educators, holds counselling sessions with parents and guardians, and presents dramas on the needs of street children and youth.
- State of Orissa, India: The Friends' Association for Rural Reconstruction met with the Government and community-based women's groups to confront alcohol-related problems, because men's drinking was diverting

money from family needs including education and contributing to domestic violence. The resultant mobilization led to a ban on alcohol sales and showed the government the strength of women's organizations.

- Delhi, India: Action for Securing Health for All (ASHA, "hope" in Hindi) has developed an intersectoral, participatory health model to ensure the accessibility of health facilities and improve living conditions in slum areas. Working with the Delhi Development Authority and women's groups, the NGO links training of health workers with service delivery, community health education (including prenatal care), efforts to keep children in school, and income-generating activities.
- São Paulo/Rio de Janeiro, Brazil: Police Stations in Defence of Women, staffed by women, have since 1985 provided specialized attention to female victims of domestic violence, sexual assault and rape, to ensure appropriate counselling, care and requested legal follow-up. Though victims are often reluctant to seek legal remedy, the expansion of the service to more locations is changing public perception of such crimes.

Since programmes must be implemented in a variety of economic, social, political and administrative contexts, successful models need to be adapted to local conditions. Parallel to the HABITAT II process, a wide variety of technical exchanges and cooperative efforts are under way at local levels.

Numerous international organizations support projects aimed at improving human settlements. For example, the Urban Management Programme of the United Nations Development Programme and the World Bank helps local administrations remedy management deficiencies and strengthen local governance mechanisms. UNCHS (Habitat) and the Danish International Development Agency offer a training programme for community participation in improving human settlements. UNDP and the International Labour Organization are collaborating on employment generation in urban works programmes. UNCHS, ILO, UNDP and the United Nations Volunteers support a programme on improvement of living conditions and expanding employment opportunities in urban low-income communities. And UNDP in collaboration with the Netherlands, Sweden and Germany are networking with other programmes and local institutions in the Local Initiative Facility for Urban Environment (LIFE) programme.

International networks of city planners, administrators and researchers have been formed to facilitate the exchange of information and urban management strategies. The MEDURBS programme links participating urban centres in developed and developing Mediterranean countries. Networks funded by the European Community maintain databases, jointly implement and monitor projects, and exchange technical materials on urban issues. Networks of non-governmental organizations are sharing experiences with community action programmes.

UNDERSTANDING URBAN POPULATION DISTRIBUTION AND SERVICE NEEDS

With Mexico's population concentrated in cities and rural shanty towns, the government has been concerned about population distribution since the 1970s. In the past decade rural-urban migration increased (60 per cent of the population is now urban, up from 46 per cent). But recent deregulation and redefinition of government functions have diversified population flows and increased migration from larger to smaller cities, raising the number of cities with more than 15,000 inhabitants from 166 to 309.

The urbanization process and the increased migration towards medium-sized cities seem to be driven by service growth more than industrialization. The recent increase in export-oriented production, however, will benefit not just central cities but also smaller surrounding cities. These effects will be strongest along the frontier with the United States, where there are infrastructure, public services, communications, transport, and a labour environment favourable to production.

Much of this analysis is based on two UNFPA-funded studies. The first examined migration to 16 Mexican cities and included a U.S. Government survey of undocumented workers on the frontier. The second studied the potential for development in shanty towns.

An additional series of studies in collaboration with local authorities and the private sector is looking at ways to increase general employment, raise the quality of life and offer alternatives to migration. Another project will improve baseline data in micro-regions to promote sustainable development to stem migration. A third project will study the evolution of Mexican cities in this century and provide basic information about migration.

UNFPA AND THE URBAN FUTURE

The United Nations Population Fund, in collaboration with the rest of the United Nations system, continues to play an important role in addressing urban problems and urban–rural balances and encouraging sustainable

development and settlement policies. Its programme activities aim to eliminate urban bias and gender bias in development efforts, to foster participation and partnership, and to ensure that urban and rural development strategies pay attention to population concerns.

Reproductive health including family planning and sexual health

UNFPA supports governments and collaborates with national and local administrations, NGOs, community organizations and the private sector to promote high-quality reproductive health services including family planning and sexual health, for both men and women. The ICPD Programme of Action calls for universal access to these services, provided through effective primary health care systems, by 2015. Organizations – public, private (including enterprise-based), voluntary and community-based – which can provide such services are being strengthened, and barriers to their efficient functioning removed.

Reproductive and sexual health is more than the absence of disease; it includes the positive exercise of reproductive rights and the enjoyment of healthy and enriching sexual lives. Reproductive rights imply that women's role in reproduction must not be used to deny them other social, economic and political roles at a level equal to those of men.

As the ICPD recognized, promoting reproductive rights and reducing infant, child and maternal mortality and morbidity requires the provision of a broad range of reproductive health services. Making these universally available will entail, among other things:

- Improving education and services for **prenatal care, safe delivery and post-natal care** for both mothers and children, particularly for the rural and urban poor.
- Providing high-quality voluntary **family planning**, including counselling, information, education, communication and services, to all who are interested. Meeting the expressed demand for services to better space and limit births will improve health and further reduce both natural urban growth and the high rural fertility which contributes to migration.
- Improving services for other reproductive and sexual health conditions, including the treatment of **reproductive tract infections and sexually transmitted diseases including HIV/AIDS**.
- Protecting women from **sexual and other violence** and preventing harmful traditional practices such as female genital mutilation.
- **Eliminating disparities** in service coverage and outreach that are related to gender, geographical, social and economic differences. This includes extending quality health services to residents of urban slums and peri-urban areas.

Advocacy

UNFPA will directly and indirectly advocate for the empowerment of women. A

LINKING REPRODUCTIVE HEALTH SERVICES TO COMMUNITY OUTREACH

Over half the people of Nairobi live in densely populated urban slums. Residents are exposed to severe environmental risks, including poor sanitation, lack of potable water, poor drainage and uncollected refuse, resulting in high rates of morbidity and mortality.

A UNFPA-supported project, launched with the Nairobi City Commission in 1993, has sought to improve health conditions by establishing an integrated health and family planning delivery system involving both clinics and community-based outreach. By October 1995, the project had trained 465 residents to distribute contraceptives in their communities and deliver messages on reproductive health, including family planning, pre- and post-natal care, nutrition, immunization, a clean environment and safe sex. The distributors also help with home-based care of people with AIDS.

Trained nurses working as supervisors provide a link between the community and the health centres. They assist the distributors by taking blood pressure and providing counselling in clients' homes. Both supervisors and distributors work to mobilize community education campaigns on family planning and on AIDS. They also carry contraceptive commodities to the market on market day to reach clients who do not have time to go to the clinics.

The project also organizes workshops for health workers on primary health care concepts and family planning technology, and for local officials on community participation in health and development activities.

Two of the slum communities have formed volunteer village health committees to work for a clean environment; the committees manage water kiosks as an income-generating activity. The project has provided cleaning tools and materials for building garbage centres, one public toilet and storm water drainage. UNFPA support will aim to help countries attain all of these goals. The Fund will also support biomedical, social and cultural research to assess reproductive health-related conditions, perceptions and behaviours, to assist in the design of programmes..

cornerstone of this effort will be the expansion of educational access and support for girls and women. Education enables individuals to lead healthier lives, improve their opportunities, assimilate new ideas and play productive social roles. It is also key to improving countries' productive capacity, enabling them to compete in international markets.

The exercise of reproductive rights is fundamental to women's educational progress. Teenage pregnancies, which often interrupt or interfere with women's schooling, can be reduced by providing better family planning information and services to youth, educating men on responsible sexual behaviour and involving families and communities in reproductive health programmes. Together with programmes to discourage female genital mutilation and other harmful practices, advocacy on behalf of women will produce greater discussion and understanding of unequal gender relationships and barriers which impede women's contributions to sustainable development.

Many if not most societies assign less value to girl children than to boys. At its most extreme, this can result in selective abortion favouring boys, to infanticide and abandonment of girl children. Discrimination persists throughout childhood and into adolescence. It helps to perpetuate a secondary status for women, ensuring not only that women are trapped in their reproductive role but that they are offered little support in performing it.

UNFPA's advocacy, in cooperation with all its partners in government and non-governmental organizations, is dedicated to establishing the equality and autonomy of women by ensuring that girl children are welcomed in the family on the same basis as boys; that parents accept the equal value and the special needs of girl children; and that the empowerment of women has the support of teachers, health personnel, political leaders, policymakers, religious and moral leaders and others in authority.

INTEGRATING POPULATION INTO DECENTRALIZED URBAN PLANNING

Rural migrants in San Pedro Sula, Honduras, are rapidly putting up makeshift houses in several fast-growing neighbourhoods where sanitation services are erratic and crime is on the rise. Much of the responsibility for planning and delivering basic services in these sprawling communities has devolved to city authorities, as a result of decentralization moves by the central government in Tegucigalpa. To support San Pedro Sula in managing this responsibility, UNFPA in 1991 helped design a model project to provide socio-demographic information for municipal planning.

Data collected under the project have helped local authorities to understand why infant and maternal mortality remain high despite good hospital coverage, resulting in the creation of reproductive health and family planning initiatives, including a training course for midwives. Useful data have also been provided on the local spread and socio-economic impact of HIV/AIDS. Maps and demographic data are being used to upgrade the telephone system throughout northern Honduras.

The project's underlying assumptions were that: (1) more effective municipal management requires not only more resources and decision-making authority at the municipal level, but also better information on which to base decisions; (2) planning is most effective at the local level, where flexibility and inter-sectoral cordination are easier to achieve than at the federal level; and (3) NGOs and the private sector will implement projects to solve problems identified by the city, allowing officials to concentrate on providing data and analysis to guide policy-making.

In 1992, the project created a municipal statistics unit and funded 6 of its 13 staff members. The unit provided on-the-job training and developed a geographical information system, drawing maps to show, for example, how land was being used. The unit' s first census revealed that the city's population was just half of what authorities had assumed, resulting in a cost-saving scaling-down of plans for a new water supply system. Annual surveys are conducted on population and social indicators; the 1994 survey focused on family health and family planning.

The statistics unit is now an executive department, overseen by the Municipal Institute for Planning and Investigation. A population and development branch carries out detailed studies on reproductive health and family planning, HIV/AIDS, the position of women and the environment; it also maintains a public library. Users of the department's services include the national phone company, the local Chamber of Commerce, UN agencies, the Ministry of Public Health and the National Census Bureau. The department has also provided research assistance to NGOs carrying out women-in-development projects.

Policy support

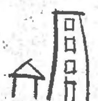
UNFPA will continue to support policy analyses and to strengthen national and international policy institutions addressing urbanization and other population concerns. The fund is working to ensure a consistent flow of reliable information on the conditions of life and on basic demographic and social information. Improving the quality and coverage of gender-sensitive social information is a high priority. Basic data collection and special research efforts assist the design and implementation of programmes, particularly for the rural and urban poor and other dis-

advantaged groups.The United Nations system as a whole is improving its ability to coordinate assistance to governments, for the measurement of progress and the design and implementation of programmes to attain the objectives of the international conferences taking place in this decade.

The changing dynamics of migration and its impacts on both sending and receiving areas are poorly understood. Clearer identification of those aspects of population movement which require policy interventions will prevent futile or counterproductive efforts and help to alleviate hardship among affected groups. A UNFPA-sponsored Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, held in New York in January 1996, helped identify research questions that are key to improved policy advice. UNFPA support of the International Organization for Migration and regional institutions also helps promote improved understanding of internal and international migration and their relation to development.

UNFPA has long supported the Asian Urban Information System of Kobe (Japan) which conducts policy studies on population dynamics and urban conditions and provides technical support to regional and local institutions addressing information needs for urban planners and administrators. Data on population, health and education are needed to monitor progress in improving the quality of life. The Fund assists local and municipal institutions in improving databases related to provision of basic social services.

UNFPA will also continue to support activities to integrate population groups into social development strategies, plans and programmes (particularly those for the delivery of basic social services). It will work with the rest of the United Nations system to effect the efficient mobilization and use of resources for integrated population and development programmes, and particularly those for the improvement of basic social services to urban and rural populations.



REPRODUCTIVE HEALTH FOR THE MARGINALIZED COMMUNITY

A growing number of non-governmental organizations are beginning to address the specific sexual and reproductive health needs of urban slum dwellers. Family Planning Associations belonging to the International Planned Parenthood Federation, for instance, are using a variety of innovative approaches to widen the scope of client groups served, ranging from Brazilian street children to Bombay factory workers.

In Thailand, peer education programmes are training young women to negotiate for safer sex. In Indonesia street outreach is bringing information about sexual health and AIDS to socially marginalized groups. A clinic in densely populated northern Santo Domingo offers maternal and child health care, including family planning and gynaecological services to 300 people each day. A High Risk Project in Nairobi addresses unintended adolescent pregnancies. In Addis Ababa a youth centre provides reproductive health counselling and clinical services to school drop-outs and other adolescents; another project there has involved 20,000 teenagers in family life education discussions, and broadcasts a weekly radio drama dealing with adolescent sexuality and reproductive health.

Technical support

UNFPA will collaborate with governments to strengthen the technical capacities of non-governmental organizations that deliver reproductive health services and information and conduct communication programmes and advocacy efforts. Local NGOs and the international networks in which they participate including the International Women's Health Coalition and the International Planned Parenthood Association are actively working to address needs in all aspects of reproductive health including sexual health and family planning.

As a number of the Best Practices projects have demonstrated, primary health components, including reproductive health care, can be successfully included in local and community efforts to improve settlements and services. Slum improvement programmes may provide opportunities to improve primary health care service delivery.[16] Such efforts can work to ensure that the design, implementation and monitoring of these programmes incorporate women's perspectives.

UNFPA will support institutions which collect, analyse and disseminate basic data on population and social development. It will support research at national and international centres of excellence on population and development linkages to advance the policy dialogue on population issues.

UNFPA will also support programmes of South-South cooperation to ensure that developing countries share successful models and technical capacities in the area of reproductive health and population programmes.

APPENDIX:

FOLLOW-UP TO THE ICPD – IMPLEMENTING THE REPRODUCTIVE HEALTH AGENDA

THE SUCCESS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD) IN CAIRO IN 1994 WILL ULTIMATELY BE MEASURED BY HOW EFFECTIVELY THE ICPD PROGRAMME OF ACTION IS IMPLEMENTED.

INTEGRATING FAMILY PLANNING INTO REPRODUCTIVE HEALTH PROGRAMMES

Many governments have started to reorient and reexamine existing policies. In Guinea, for example, the Ministry of Health has begun reviewing its Safe Motherhood/Family Planning programme with the aim of transforming it into a Reproductive Health/Family Planning programme. Indonesia initiated the shift from family planning to reproductive health even before the ICPD, and will accelerate the transition in its current five-year programme (1995–1999). The Government of Paraguay revised its national plan for reproductive health and family planning, elaborated just before the ICPD, to adjust it to the new focus, principles and recommendations of the ICPD Programme of Action.

The ICPD Programme of Action marks a profound change in the international consensus on population issues; the new approach starts from the point of view that securing human rights and meeting the needs of individuals also addresses global problems.

One of the key elements of the programme of action is its emphasis on reproductive rights and health. The exercise of reproductive rights requires having access to family planning information and services. Family planning contributes both to reproductive and sexual health and to maternal and child health. Experience over the past two decades has shown that family programmes best respond to users' needs when they are integrated with broader health initiatives within the primary health care context.

Experience also shows that women with a full and free choice in the matter of family size tend to have fewer children, and can keep them healthier and better educated.

To assess the ICPD's impact on population policies and programmes around the world, UNFPA invited countries to share their experiences to date in implementing reproductive health interventions. The information below is based on their responses.

OPERATIONALIZING REPRODUCTIVE HEALTH

Since the ICPD, many countries have organized workshops or seminars for planners and health workers on the reproductive health approach and its implications for their national population programmes. In addition, national medical associations have organized forums or symposiums on how to put the concept of reproductive health into operation in their countries.

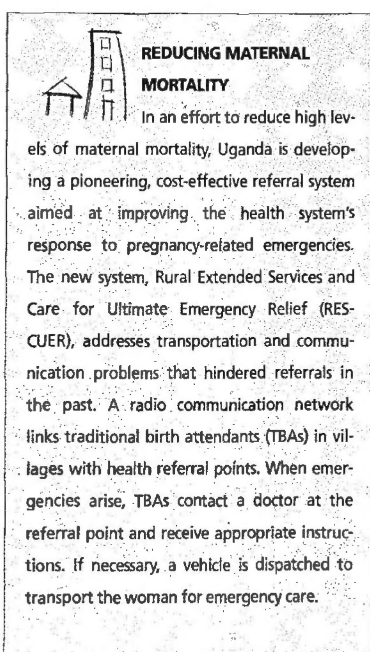
Countries all over the world have responded to the Cairo challenge of adopting a reproductive health approach. Almost two thirds of the countries which responded to the inquiry have taken initial steps to broaden existing family planning and related programmes (maternal and child health, birth spacing, safe motherhood, for example) to include other reproductive health information and services. Many countries are heeding the ICPD's call for increased attention to the quality of care in reproductive health and family planning programmes.

Some sub-Saharan African countries are integrating reproductive health services into ongoing activities under the Bamako Initiative. This initiative, launched in 1987 to revive, strengthen and extend basic health care services, has four key features: the rehabilitation and extension of basic health care delivery systems, particularly for maternal and child health; the provision of affordable drugs; appropriate financing for long-term sustainability, and community mobilization.

The degree to which family planning is integrated into reproductive health programmes seems to depend largely on the current state of health care services and facilities. Countries where the most essential reproductive health services are already available to most people are directing activities to previously underserved groups in society, or are introducing more specific reproductive health services such as the prevention and referral of infertility, and prevention and treatment of reproductive tract infections and sexually transmitted diseases. In most least-developed countries, full integration is expected to take more time. In many of these countries, governments have adopted an incremental approach that will gradually introduce reproductive health services within the primary health care system.

The ICPD Programme of Action calls on governments to decentralize the management of public health programmes to promote community participation in reproductive health care. Several governments have already taken steps in this direction.

Despite these encouraging trends, some countries still legally restrict the access of couples and individuals to reproductive health information and services. Some, for instance, reported having laws prohibiting the provision of family planning information and services.



REDUCING MATERNAL MORTALITY

In an effort to reduce high levels of maternal mortality, Uganda is developing a pioneering, cost-effective referral system aimed at improving the health system's response to pregnancy-related emergencies. The new system, Rural Extended Services and Care for Ultimate Emergency Relief (RESCUER), addresses transportation and communication problems that hindered referrals in the past. A radio communication network links traditional birth attendants (TBAs) in villages with health referral points. When emergencies arise, TBAs contact a doctor at the referral point and receive appropriate instructions. If necessary, a vehicle is dispatched to transport the woman for emergency care.

THE AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES

In most developing countries the full range of reproductive health services is not available to all eligible women and men. Of the different components of reproductive health information and services, the most widely available are family planning counselling, information and services, as well as facilities for prenatal care, safe delivery and post-natal care. In one quarter of the countries responding to the inquiry, the availability of family planning information and services is still considered inadequate. Still unavailable in primary health care facilities in the large majority of developing countries are services for the prevention and treatment of infertility; services for treating the consequences of unsafe abortion; and treatment of reproductive tract infections and cancers of the reproductive system.

Several countries reported that most aspects of the reproductive health concept were available for middle and higher income groups in urban areas, but were unavailable or inadequately available to most of the rural and urban poor. Only a handful of countries reported having all seven components of reproductive health programmes, as described in paragraph 7.6 of the ICPD Programme of Action, available to all women and men through their health system.

FOCUS ON SPECIFIC GROUPS

The ICPD emphasized the needs of particular groups of society. Various initiatives are being undertaken to address the reproductive health needs of adolescents, the issue of women's participation in decision-making, and the role and responsibilities of men in the area of reproductive health.

Adolescents

To address adolescent sexual and reproductive health issues, the ICPD Programme of Action encourages governments to provide appropriate services and counseling. The questionnaire responses indicate that in many countries adolescents' needs and problems in the field of sexual and reproductive health are being taken much more seriously than before the ICPD. Nearly two thirds of the countries responding reported having undertaken initiatives to address adolescents' reproductive health and rights and to put their needs on the political agenda. These initiatives have been undertaken in some cases by Governments, in others in cooperation with NGOs or solely by NGOs.

On the other hand, in more than one third of the responding countries, government or other programmes do not address adolescent reproductive health issues. There are a variety of reasons for this; religious and cultural factors are those most frequently cited.

Governments are taking various steps to address adolescents' special needs. Cambodia, for example, has issued guidelines instructing service providers not to discourage adolescents and unmarried clients from coming to service delivery points and to take special care of them. Ghana has established a National Steering Committee on Adolescent Reproductive Health to strengthen coordination and provide a forum for planning and executing activities in this area.

Where Governments are reluctant to address adolescents' sexuality and reproductive health needs, non-governmental organizations often fill the gap. Many NGOs and other local or community-based organizations are uniquely positioned to work in this area. In India, for instance, several NGOs have established long-term health and education programmes for rural and urban adolescents. Ghana introduced family life education (FLE) programmes in schools during the early 1970s, and the Planned Parenthood Association of

Women's participation in the taking of decisions about all aspects of family life is a crucial aspect of a successful approach to reproductive health care. That women then also participate fully in the implementation and administration of those decisions is equally important. Above, a health clinic near Cairo, Monshiat Naser region. *Jørgen Schytte, Still Pictures*

Ghana and the Young Women's Christian Association established FLE Clubs alongside Youth Counseling and Vocational Centres.

In Sudan, required courses on reproductive health and family planning have been added to the curricula of four schools of the Ahfad University for Women. In line with the ICPD Programme of Action (para. 7.48), many NGOs train peer groups in counseling techniques in order to guide adolescents in matters related to responsible sexual and reproductive behaviour.

Governments and NGOs often work hand-in-hand in addressing adolescent reproductive health issues. For example in Mexico, a pre-ICPD national meeting attended by government and NGO representatives issued the Declaration of Monterrey, which recognizes the needs and demands of adolescents. Activities undertaken since then have led to the establishment of 78 adolescent reproductive health care units in facilities around the country; they provide information and advice and promote reproductive health services and family planning. By the end of 1995, the adolescent care programme covered the entire country and each state had at least two units, one in an urban health centre and another in a general hospital.

A similar form of government-NGO cooperation exists in Morocco, where the Ministry of Youth and Sports and the Moroccan Family Planning Association developed an innovative programme to educate youth about reproductive and sexual health. In youth clubs in five regions, adolescents create their own songs, drama, and puppet shows on topics like family planning, sexually transmitted diseases, HIV/AIDS, communication, and family life and sex education; the best are performed at national festivals.

ADDRESSING ADOLESCENTS' NEEDS

Some countries have found innovative ways to address adolescent sexuality and reproductive health needs. The ICPD Programme of Action notes that health services have largely ignored the reproductive health needs of adolescents. In response, Uganda started a participatory process that led it to form the Programme for Enhancing Adolescent Reproductive Life (PEARL), which aims to enhance the reproductive health of Ugandan adolescents by providing appropriate counseling and services. To ensure sustainability, PEARL calls for young people and community leaders to take a leading role in implementation efforts.

Women's participation

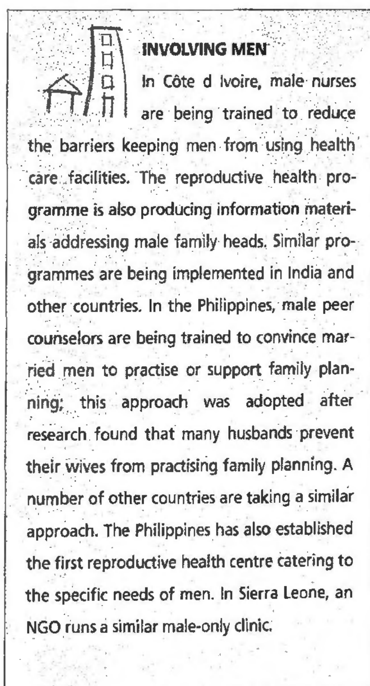
Women's participation in decision-making processes is a crucial aspect of introducing a reproductive health approach in any country. Information received indicates that the level of participation differs considerably from country to country.

Gender concerns are increasingly being taken into account in reproductive health programme designs and implementation. For example, Mexico

WOMEN AND DECISION-MAKING

Having women in decision-making positions advances efforts to meet women's reproductive health needs. El Salvador, for instance, reports that women's health and well-being are taken more seriously since some women in the National Assembly started to speak out on related issues. Togo changed the structure of the Family Health Division in its Ministry of Health last year; women now occupy 8 of 17 decision-making positions.

has established a special unit within the Directorate General of Reproductive Health to advise on the inclusion of gender issues in its programme. Gender training has become a standard components of projects in an increasing number of developing countries. The use of female consultants for project formulation, implementation, monitoring and evaluation is also increasing markedly. In Costa Rica, women consultants and decision-makers actively participate in the formulation and implementation of more than half the current or planned reproductive health projects.



INVOLVING MEN

In Côte d Ivoire, male nurses are being trained to reduce the barriers keeping men from using health care facilities. The reproductive health programme is also producing information materials addressing male family heads. Similar programmes are being implemented in India and other countries. In the Philippines, male peer counselors are being trained to convince married men to practise or support family planning; this approach was adopted after research found that many husbands prevent their wives from practising family planning. A number of other countries are taking a similar approach. The Philippines has also established the first reproductive health centre catering to the specific needs of men. In Sierra Leone, an NGO runs a similar male-only clinic.

The health sector is notoriously vulnerable to economic and social crisis. Since most health workers are female, women's participation in health care, including reproductive health care, often suffers most in economic hard times. In Brazil, women have always been involved in planning and implementing reproductive health programmes, but in recent years overall difficulties in the health and government sector appear to have reduced this involvement somewhat.

Women are most visibly involved in planning and implementing reproductive health programmes through the rapidly growing number of NGOs dealing with reproductive health care. These NGOs are often headed by women, and most or all of their staff are women. As a result of the ICPD, governments are more inclined to collaborate with national and local NGOs and other grass-roots or community-based organizations.

The role of men

The ICPD Programme of Action urges governments to increase the participation of men in all aspects of reproductive health, and to encourage men to share responsibility in matters related to family planning, parenting, gender equality and the empowerment of women. Most countries responding to the inquiry indicate an increased awareness of the need to involve men in reproductive health programmes. Many reported having started programmes specifically directed at male involvement, some of them quite innovative.

In several countries plays have been developed to generate discussions among men on their responsibility in the use of family planning. A number of countries have officially approved vasectomy as a method of family planning. In Nepal, condom boxes have been placed in most health facilities, providing free and unhindered access. Indonesia intends to expand its counselling programme and develop new training materials to emphasize male participation in family planning.

The role of civil society

The ICPD Programme of Action calls for a broad and effective partnership between governments and the non-governmental sector in delivering reproductive health information and services. Governments are encouraged to promote much greater community participation in reproductive health care by decentralizing the management of public health programmes and collaborating with local non-governmental organizations and private health-care providers.

NGO involvement in the reproductive health field differs greatly from country to country. In some countries, NGOs were heavily involved before the ICPD; NGO involvement in others is still only marginal, but in general seems to be growing. The Family Planning Association of Iran, which had been inactive for several years, was reactivated after the ICPD.

In many developing countries, NGOs continue to provide a large volume of reproductive health services, information and education, thereby increasing both demand for and access to these services. However, some countries reported that worsening economic conditions had weakened NGOs' ability to provide services. In some countries, NGOs have not had the resources to reach large segments of society, particularly in rural areas. Some NGOs have had to shift their focus from low-income groups to middle-income groups.

More and more NGOs are participating in national committees or councils

set up by several governments to coordinate national implementation of the ICPD Programme of Action. NGOs are also increasingly collaborating and networking among themselves to expand their influence in project formulation and execution. In Ethiopia, for example, 11 NGOs have established a Consortium of Non-Governmental Organizations in Family Planning.

Traditionally, NGOs have played an important role in providing information and services to segments of society not well-served by official programmes, such as the poor, adolescents, commercial sex workers, unmarried couples, and men. They have also addressed sensitive or controversial issues such as abortion, violence against women, and traditional practices that harm women. NGOs often pioneer innovative approaches to issues related to women's health, reproduction and family planning. The Togolese Family Welfare Association, for instance, operates a model clinic to demonstrate the integrated approach to reproductive health and family planning services; it plans to establish four more such clinics.

The ICPD's emphasis on a comprehensive approach to reproductive health has also influenced the work of NGOs. Traditional family planning NGOs are increasingly including other reproductive health services in their clinics, and are training their staffs in the implications of this new concept of reproductive health.

NOTES

1. Introduction: The Urban Potential

1 Statistics for this chapter were derived from: United Nations. 1995. *World Urbanization Prospects: The 1994 Revision* (ST/ESA/SER.A/150). New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

2. Conditions of Life in Urban Areas

1 Hamid, Tabatabai, and Manal Fouad. 1993. *The Incidence of Poverty in Developing Countries: An ILO Compendium of Data,* A World Employment Programme Study. Geneva: International Labour Organization. Cited in "Urban Poverty." Introduction to *Urbanization and Environment* 7(1).

2 Satterthwaite, David. 1995." Rapid Urbanization and the Urban Environment." Paper presented at the Seminar on Demography and Poverty International Union for the Scientific Study of Population (IUSSP), Liège, 2-4 March 1995.

3 Oberai, A.S. 1993. *Population Growth, Employment and Poverty in Third World Mega-cities,* p.119ff. Geneva: International Labour Organization. The cited estimates refer to around 1988, at the time of an international survey conducted with ILO assistance. The definitions of slum dwellings are not strictly comparable, however. Cairo's high estimate results from a definition stressing informal housing (rather than its quality), Seoul's was based on a local definition of inadequacy, Shanghai's was tied to an administrative criterion concerning housing which needed to be rebuilt. Only in Seoul was the slum population's growth rate negative.

4 Economic and Social Commission for Asia and the Pacific (ESCAP). 1993. *State of Urbanization in Asia and the Pacific 1993,* Table 2.36. New York: United Nations. Statistics were lacking for much of East Asia and for the Pacific. Most data points referred to the mid- to late 1980s.

5 Oberai, op. cit., p.136.

6 Ibid., p.138.

7 United Nations Centre for Human Settlements (UNCHS/Habitat). 1996. *An Urbanizing World: Global Report on Human Settlements 1996* (Draft), pp. 6-47. Nairobi: UNCHS/Habitat.

8 Daly, Mary. 1994. *The Right to a Home: The Right to a Future,* Third Report of the European Observatory on Homelessness. Brussels: FEANTSA. Cited in UNCHS, op. cit.

9 Oberai, op. cit., p. 84ff.

10 United Nations. 1995. *The World's Women 1995: Trends and Statistics,* Series K, No. 12, p. 41ff. New York: United Nations.

11 Cawthorne, Pamela M. 1995. "Of Networks and Markets: The Rise of a South Indian Town: The Example of Tirrupur's Cotton Knitwear Industry." *World Development* 23(1): 43-56; and Findley, Sally, and Lindy Williams. 1991. *Women Who Go and Women Who Stay: Reflections of Family Migration Processes in a Changing World,* World Employment Programme Research Paper. Geneva: International Labour Organization.

12 Findley and Williams, op. cit.

13 Oberai, op. cit., p. 82ff.

14 Ibid., p. 83.

15 Economic and Social Commission for Asia and the Pacific, op. cit., Ch. 2, p. 55ff.

16 The World Bank. 1988. *World Development Report 1988.* New York: Oxford University Press.

17 United Nations Centre for Human Settlements (UNCHS/Habitat), op. cit.

18 The World Bank. 1994. *Infrastructure for Development: The World Development Report 1994,* p. 26ff. New York: Oxford University Press.

19 Satterthwaite, op. cit. Among the questions raised are the appropriateness of definitions of access to community piped water on the basis of physical proximity to taps without consideration of the size of the served community and "effective availability" of sufficient quantities of water, reporting biases for urban populations (particularly in squatter settlements) and lack of consideration of costs incurred and their relation to incomes.

20 The World Bank 1994.

21 Generally measured by data on wage rates since these are more widely available than other indicators of individual and household wealth.

22 Collins, S.D. 1926. *Economic Status and Health: A Review and Study of the Relevant Morbidity and Mortality Data,* Public Health Bulletin No. 165, Treasury Department, US Public Health Service. Washington D.C.: US Government Printing Office. In "The Ranks of Death: Secular Trends in Income and Mortality," by Stephen J. Kunitz and Stanley L. Engerman. 1992. In *Health Transition Review* 2 (Supplementary issue).

23 Country writeups in United Nations. (Forthcoming) *The Challenge of Urbanization: The World's Largest Cities.* New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

24 Mexico and Cairo information from: Serageldin, Ismael, and Richard Barrett. 1993. "Environmentally Sustainable Urban Transport: Defining a Global Policy." Washington, D.C.: The World Bank. Cited in *The Urban Age* 2(1).

25 World Health Organization. 1992. *Our Planet, Our Health,* Report of the Commission on Health and Environment. Geneva: World Health Organization. Cited in United Centre for Human Settlements (UNCHS/Habitat), op. cit.

26 Cauthen, G.M., A. Pio and H.G. ten Dam. 1988. Annual Risk of Tuberculosis Infection. Geneva: World Health Organization. Cited in United Centre for Human Settlements (UNCHS/Habitat), op. cit.

27 World Health Organization. 1995. *The World Health Report: Bridging the Gap.* Geneva: World Health Organization.

28 Ibid.

29 Le Guenno, Bernard. 1995. "Emerging Viruses," *Scientific American,* October 1995.

30 Altman, Lawrence K. 1995. "New Skin Test Will Help Track Ebola Infection in Remote Areas," *The New York Times,* 19 September 1995.

31 UNFPA. 1995. *The State of World Population 1995: Decisions for Development: Women, Empowerment and Reproductive Health.* New York: UNFPA.

32 World Health Organization 1995, p. 15.

33 See: Way, Peter O., and Nancy Stanecki. 1995. *Transmission of HIV/AIDS in Sub-Saharan Africa.* Washington, D.C.: U.S. Bureau of the Census.

34 Fontanet, Arnaud, and Peter Piot. 1994. "State of Our Knowledge: The Epidemiology of HIV/AIDS." In *AIDS Impact and Prevention in the Developing World: The Contribution of Demography and Social Science.* Paper presented at a seminar, International Union for the Scientific Study of Population (IUSSP), Liège, 5-9 December 1993.

35 World Health Organization 1995, p. 15.

36 Intravenous drug users are another group at high risk of infection. In some parts of the world, prostitute populations are also high users of such drugs.

37 Rohter, Larry. 1995. "A Fever, Once in Retreat, Surges in Latin America," *The New York Times,* 23 September 1995.

38 "World's Poor Youths Facing Western Maladies," *The New York Times,* 24 September 1995.

39 Guimaraes, J.J., and A. Fischmann. 1985. "Inequalities in 1980 Infant Mortality among Shanty Town Residents and Non-shanty Town Residents in the Municipalities of Porto Alegre, Rio Grande

Do Sul, Brazil." *Bulletin of the Pan American Health Organization* 19(3): 235-251. In *A Review of Environmental Health Impacts in Developing Country Cities*, Urban Management Programme Discussion Paper No. 6, by David Bradley, Carolyn Stephens, Trudy Harpham and Sandy Cairncross. 1992. Washington, D.C.: The World Bank.

40 Source: recent tabulations provided by the Family Health Division of the Word Health Organization.

41 Calculated using most recent data for 75 developing countries provided by the Family Health Division of the World Health Organization.

42 In Pakistan, trained TBAs constitute nearly even proportions of all births attended in both settings (urban: 18 per cent; rural: 16 per cent). However, they service two thirds of all attended births in rural areas and less than a third of all attended urban births.

43 Data provided by the Family Health Division of the World Health Organization.

44 World Health Organization. 1993. *Safe Motherhood: Maternal Health and Safe Motherhood Programme*. Geneva: Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization.

45 Mensch, Barbara, Mary Arends-Kuenning and Anrudh Jain. 1994. "Assessing the Impact of the Quality of Family Planning Services on Contraceptive Use in Peru: A Case Study Linking Situational Analysis Data to the DHS," Research Division Working Papers No. 67. New York: The Population Council.

46 Miller, Katharine A. 1995. "Special Urban-rural Data Analyses for Ghana, Senegal, Kenya and Zanzibar of the United Republic of Tanzania." Unpublished paper.

47 The number of visits per client in a year varies with the family planning methods which are adopted. No differences were found, however, between the method mixes in rural, urban or semi-urban settings in the sampled SDPs.

48 Differences by each indicator on average, however, do not reveal patterns of available services or equipment at particular SDPs; the proportions of SDPs offering full ranges or various combinations of equipment, staffing and capacity need further analysis.

49 Other regional differences require analysis and appropriate remedial attention as well. Regional programme priorities can be independent of the degree of urbanization.

50 The following reports in the series: The Center for African Family Studies, John Snow, Inc., and Center for Population and Family Health. 1995. *Findings from the Sub-Saharan Africa Urban Family Planning Study.* Arlington, Virginia, and Boston, Massachusetts: SEATS Project, John Snow, Inc., and Center for Population and Family Health, Columbia University: (a) In collaboration with: National Family Welfare Council of Malawi, Blantyre District Health Office, Blantyre Munnicipal Health Department, Southern Region Provincial Health Office. *Blantyre City Report;* (b) In collaboration with: Bulawayo City Health and Zimbabwe National Family Plannig Council. *Bulawayo City Report;* and (c) In collaboration with: Mombasa District Health Office and Mombasa Municipal Health Departmnent, *Mombasa City Report.*

51 Janowitz, Barbara. 1992. "Cost and Cost Recovery Options for Thailand." Paper prepared for "Programme Management Issues and Operational Plans," UNFPA/Thailand

52 UNFPA. 1995. *Report on Family Planning Sustainability*, Technical Report Number 26, p. 26. New York: UNFPA.

53 National Research Council. 1995. *Resource Allocation for Family Planning in Developing Countries: Report of a Meeting.* Washington, D.C.: National Academy Press. It must be noted that comparative information concerning the distribution of the subsidy benefits for other health services and other categories of benefits in general are not available.

54 "Special Report: Exceeding the Breakeven Point." *Integration*, No. 38(December 1993): 2-21.

55 United Nations Educational, Scientific and Cultural Organization (UNESCO). *Education Yearbook 1995.* Paris: United Nations Educational, Scientific and Cultural Organization.

56 Personal communication with staff of United Nations Statistical Office, who assist governments in the design of analyses of relevant census data for use in the planning process.

57 Jespersen, Eva, and David Parker. 1990. *The 20/20 Initiative.* New York: UNICEF; and The World Bank. 1995. *World Development Report 1995.* Washington, D.C.: The World Bank.

58 United Nations Educational, Scientific and Cultural Organization (UNESCO). 1993. *Trends and Projections of Enrolment by Level of Education, by Age and by Sex, 1960-2025*, Current Surveys and Research in Statistics Series No. CSR-E-63. Paris: Division of Statistics, United Nations Educational, Scientific and Cultural Organization.

59 Kelley, Alan C. 1994. "Population Growth and Education, Inquiry "Background Paper No. 3." In *Independent Inquiry in Population and Development*, a Report Prepared for the Government of Australia. 1994. A related analysis outlining alternate policy interventions to facilitate improved universal primary education is available in: Colclough, Christopher, with Keith M. Lewin. 1993. Educating All the Children: Strategies for Primary Schooling in the South. Oxford: Clarendon Press.

3. Urban Polulation Dynamics

1 Sources: United Nations. (Forthcoming) *Population Distribution and Migration, Proceedings of the United Nations Expert Group Meeting on Population Distribution and Migration, Santa Cruz, Bolivia, 18-22 January 1993* (ST/ESA/SER.R/133). New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations; United Nations. 1995. *The Challenge of Urbanization: The World's Largest Cities* (ST/ESA/SER.A/151). New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations; and United Nations Centre for Human Settlements (UNCHS/Habitat). 1996. *An Urbanizing World: Global Report on Human Settlements 1996* (Draft), pp. 6-47. Nairobi: UNCHS/Habitat.

2 Pernia, Ernesto M. (Forthcoming) "Population Distribution in Asia: A Region of Contrasts." In United Nations (Forthcoming).

3 Sachs, Ignacy. "Vulnerability of Giant Cities and the Life Lottery." In *The Urbanization of the Third World*, edited by Josef Gugler. 1988. Oxford: Oxford University Press.

4 See note 1.

5 The statistics presented in the following section are based on: United Nations. 1995. *World Population Prospects 1994.* New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

6 Rwanda's projected estimate does not yet reflect the impact of the tragic internal events of 1994. Neighbouring Burundi, with an estimated 7.5 per cent of the population in urban areas, is the next most-rural African nation.

7 International migration also contributes to city growth, but is much less significant globally than the other three factors. International migration can be an important component of growth in urban areas with low rates of natural increase and

rural-urban migration (as in many countries in Europe).

8 The concentration of migrants in the peak reproductive ages adds to the contribution of natural increase. Other evidence reviewed in this report, however, indicates at least a short-term reduction in fertility among recent migrants.

9 Economic and Social Commission for Asia and the Pacific (ESCAP). "Urbanized in Asia and the Pacific." Cited in "Global Urbanization: Towards the Twenty-First Century," by Terence McGee and C.J. Griffiths. In United Nations. (Forthcoming) *Population Distribution and Migration, Proceedings of the United Nations Expert Group Meeting on Population Distribution and Migration, Santa Cruz, Bolivia, 18-22 January 1993* (ST/ESA/SER.R/133) New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

10 United Nations 1996. "Trends in Urbanization and the Components of Urban Growth." Paper prepared for the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, New York, 24-26 January 1996. New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

11 See note 1.

12 See note 1.

13 Economic Commission for Latin America and the Caribbean (ECLAC). (Forthcoming) "Population Dynamics in the Large Cities of Latin America and the Caribbean." In *Population Distribution and Migration*, Proceedings of the United Nations Expert Group Meeting on Population Distribution and Migration (ST/ESA/SER.R/133). New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

14 Op. cit., p. 430.

15 "Cities, A Survey Report: Citadels of Power," *The Economist*, 29 July 1995.

16 See note 1.

17 Stren, Richard (ed). 1994. *Urban Research in the Developing World: Africa*, vol. 2 of the series. Toronto: Centre for Urban and Community Studies.

18 "Urban agglomerations" are comprised of city centres and adjacent urban concentrations.

4. Sources of City Growth

1 Muhuri, Pradip K, Ann K. Blanc and Shea O. Rutstein. 1994. *Socioeconomic Differentials in Fertility*, Demographic and Health Surveys Comparative Studies Series No. 13. Calverton: Maryland: Macro International Inc.

2 Brockerhoff, Martin. 1996. "Migration and the Fertility Transition in African Cities." Paper prepared for the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, New York, 24-26 January 1996; and Brockerhoff, Martin. 1994 *Fertility and Family Planning in African Cities: The Impact of Female Migration*, Research Division Working Papers No. 68. New York: The Population Council.

3 Preston, Samuel H. 1979. "Urban Growth in Developing Countries: A Demographic Reappraisal." *Population and Development Review* 5(2). Reprinted in revised form in *The Urbanization of the Third World*, edited by Josef Gugler. 1988. Oxford: Oxford University Press.

4 If China, which was not included in the early time periods, is included (63.6 per cent).

5 If China is included, a substantial drop in natural increase occurred in the 1980s, which added to the increased importance of migration.

6 These data are from: Westoff, Charles F., and Akinrinola Bankole. 1995. *Unmet Need: 1990-1994*, DHS Comparative Studies No. 16. Calverton, Maryland: Macro International Inc.

7 Guest, Phillip. 1996. "Assessing the Consequences of Internal Migration: Methodological Issues and a Case Study of Thailand Based on Longitudinal Household Survey Data." Paper prepared for Symposium on Internal Migration and Urbanization in Developing Countries: Implications for Habitat II, New York, 24-26 January 1996.

8 United Nations. 1993. *Internal Migration of Women in Developing Countries: Proceedings of the United Nations Expert Group Meeting on the Feminization of Internal Migration, Aguascalientes, Mexico, 22-25 October 1991*. New York: United Nations; and United Nations. (Forthcoming) *Population Distribution and Migration, Proceedings of the United Nations Expert Group Meeting on Population Distribution and Migration, Santa Cruz, Bolivia, 18-22 January 1993* (ST/ESA/SER.R/133). New York: United Nations.

9 Todaro, Michael P. 1989. *Economic Development in the Third World*, Fourth Edition. New York: Longman.

10 Findley, Sally, and Lindy Williams. 1991. *Women Who Go and Women Who Stay: Reflections of Family Migration Processes in a Changing World*, World Employment Programme Research Paper, p.13. Geneva: International Labour Organization.

11 Petersen, G.E., K. Thomas and P.T.T. Jeffrey. 1991. *Urban Economics and National Development*. Washington, D.C.: Office of Housing and Urban Programs, USAID. In "A Critical Evaluation of Migration-Development Linkages in the Bangladesh Context," by Rita Afsar. Paper prepared for the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, UNFPA, New York, 24–26 January 1996; and Hugo, Graeme. 1983. "Circular Migration in Indonesia." *Population and Development Review* 8(1): 59-84. In United Nations. 1995. *The Challenge of Urbanization: The World's Largest Cities* (ST/ESA/SER.A/151). New York: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations.

12 Individual and family migration in advanced settings such as the United States far exceed the scale observed in other settings (United Nations Centre for Human Settlements [UNCHS/Habitat]. 1996. *An Urbanizing World: The 1996 Human Settlements Report* [Draft]. Nairobi: UNCHS/Habitat).

5. Urban-Rural Links: Transactions and Transformation

1 Studies are reviewed in: Findley, Sally, and Lindy Williams. 1991. *Women Who Go and Women Who Stay: Reflections of Family Migration Processes in a Changing World*, World Employment Programme Research Paper. Geneva: International Labour Organization. The overall level of remittances from men also reflects the higher proportion of male remitters who are sending money to a wife who has been left behind during temporary migration.

2 The World Bank. 1995. *Workers in an Integrating World: The World Development Report 1995*, pp. 88ff. Washington, D.C.: The World Bank.

3 Zhu Junming. 1996. "Multilevel Analysis of Rural Outmigration in Guangdong, China." Paper prepared for the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II. UNFPA, New York, 24-26 January 1996.

4 Gilbert, Alan. 1996. "The Coping Capacity of Latin America s Cities." Paper prepared for presentation at the Symposium on Internal Migration and Urbanization in Developing Countries: Implications for HABITAT II, UNFPA, New York, 24-26 January 1996.

NOTES

5 Baker, Jonathan. 1995. "Survival and Accumulation Strategies at the Rural-urban Interface in North-west Tanzania." *Environment and Urbanization* 7(1): 117-132; and Evans, Hugh E. 1990. "Rural-Urban Linkages and Structural Transformation," Discussion Paper, Report INU 71. Washington, D.C.: Infrastructure and Urban Development Department, The World Bank.

6 Evans, op. cit., section IV.

7 Baker, op. cit.

8 UNICEF. 1996. *The State of the World's Children 1996*, Statistical Table Numbers 4 and 10. New York: UNICEF; based on data provided by UNESCO.

9 Mitra, S.N., M. Nawab Ali, Shahidul Islam, Anne R. Cross and Tulshi Saha. 1994. *The Bangladesh Demographic and Health Survey, 1993-1994*. Calverton, Maryland: National Institute for Population Research and Training (NIPORT), Metra and Associates and Macro International Inc.

10 Robey, B., S. O. Rutstein, L. Morris and R. Blackburn. 1992. "The Reproductive Revolution: New Survey Findings." *Population Reports*, Series M, No. 11. Baltimore: Population Information Program, Johns Hopkins University; supplemented by examination of more recent Demographic and Health Survey reports.

11 Muhuri, Pradip K., and Shea O. Rutstein. 1994. *Socioeconomic, Demographic and Health Indicators for Subnational Areas*. DHS Comparative Studies No. 9. Calverton, Maryland: Macro International Inc.

12 Church, C.A., and J. Geller. 1989. "Lights! Camera! Action! Promoting Family Planning with TV, Video and Film." *Population Reports*, Series J, No. 38. Baltimore: Population Information Program, Johns Hopkins University.

13 Mitra et al., op. cit., pg. 21.

14 *National Family Health Survey (MCH and Family Planning) 1992-1993*. 1994. Bombay: International Institute for Population Sciences.

15 Evans, op. cit.

16 Economic and Social Commission for Asia and the Pacific (ESCAP). 1993. *State of Urbanization in Asia and the Pacific 1993*, pp. 4-19. New York: Economic and Social Commission for Asia and the Pacific, United Nations; tabulations of household food expenditures by income levels in regional publications series: Food and Agriculture Organization (FAO). 1993. *Compendium of Food Consumption Statistics from Household Surveys in Developing Countries*, Economic and Development Paper Series. Rome: Food and Agriculture Organization.

17 Studies cited in: United Nations Centre for Human Settlements (UNCHS/Habitat). 1996. *An Urbanizing World: The 1996 Human Settlements Report* (Draft). Nairobi: UNCHS.

18 United Nations Development Programme. 1996. *Urban Agriculture: Food, Jobs and Sustainable Cities*, Publication Series for HABITAT II, vol. 1. New York: United Nations Development Programme.

6. Policies, Strategies and Issues for Improving Cities

1 United Nations. 1993. *Global Population Policy: Data Base, 1993*. New York: Population Division. Department of Economic and Social Information and Policy Analysis, United Nations.

2 This discussion relies on analyses of: The World Bank. 1991. *Urban Policy and Economic Development: An Agenda for the 1990s*. Washington, D.C.: The World Bank; and Berghäll, Pii Elina. 1995. *HABITAT II and the Urban Economy: A Review of Recent Developments and Literature*. Helsinki: World Institute for Development Economics Research, The United Nations University.

3 Brennan, Ellen M. 1988. "Population Distribution Policies: A Policy Review." *Population Policies in the Third World: Issues and Practice*, Twenty-fifth Anniversary Commemorative Conference, Cairo Demographic Center, Cairo, Egypt, pp. 100-120.

4 UNFPA. 1993. *The State of World Population 1993: The Individual and the World: Population, Migration and Development in the 1990s*. New York: UNFPA; United Nations Development Programme. 1990. *Human Development Report 1990*. New York: United Nations Development Programme; Berghäll, op cit.; and Fuchs, R., E. Brennan, J. Chamie, F. Lo and J. Uitto. 1994. *Mega-city Growth and the Future*. New York: United Nations University Press.

5 This approach has been particularly stressed and analysed in the works of: Rondinelli, D.A. 1983. *Secondary Cities in Developing Countries*. Beverly Hills, California: Sage; 1991. "Asian Urban Development Policies in the 1990s: From Growth Control to Urban Diffusion." *World Development* 19: 791-803; 1994. "Urban Policy and Economic Growth in Sub-Saharan Africa: The Private Sector's Role in Urban Development." In *Urbanization in Africa: A Handbook*, edited by James D. Tarver. 1994. Westport, Connecticut: Greenwood Press.

6 These issues are analysed in: United Nations Centre for Human Settlements (UNCHS/Habitat)/ International Labour Organization. 1995. *Shelter Provision and Employment Generation*. Nairobi/ Geneva: UNCHS/Habitat and International Labour Organization; and International Labour Organization. 1995. *The Future of Urban Employment*. Paper prepared for the International Symposium on the Future of Urban Employment, Turin Centre, Turin, Italy, 5-7 December 1995. Geneva: International Labour Organization.

7 United Nations Educational, Scientific and Cultural Organization (UNESCO). 1993. *Trends and Projections of Enrolment by Level of Education, by Age and by Sex, 1960-2025*, Current Surveys and Research in Statistics Series No. CSR-E-63. Paris: UNESCO.

8 Detailed local studies are presented in: Kanji, Nazneen. 1995. "Gender, Poverty and Economic Adjustment in Harare, Zimbabwe." *Urbanization and Environment* 7(1); and Escobar Latapi, Agustin, and Mercedes González la Rocha, "Crisis, Restructuring and Urban Poverty in Mexico," loc. cit., pp. 57-76. These ethnographic and survey studies cite additional literature confirming the observed effects in other settings.

9 Whether the larger number of members per household increases or reduces family income depends on the local labour market's prevailing opportunities and wages, and on the obligations of the added household members to family elsewhere. Evidence suggests that the effects on household well-being have been, on balance, more positive in Latin America than in sub-Saharan Africa.

10 Economic and Social Commission for Asia and the Pacific (ESCAP). 1993. *State of Urbanization in Asia and the Pacific 1993*. New York: Economic Commission for Asia and the Pacific, United Nations.

11 The World Bank. 1992. *World Development Report 1992*. Washington, D.C.: The World Bank. Cited in *Decentralization and Its Implications for Urban Service Delivery*, Urban Management and Municipal Finance Series, Paper No. 16, by William Dillinger. 1993. Washington, D.C.: Urban Management Program, The World Bank.

12 Dillinger, op. cit., p. 24; and Wiesner, Eduardo. 1995. "Fiscal Decentralization in Colombia: Advantages and Pitfalls." *The Urban Age* 3(3): 9.

13 See also: Peterson, George E. 1995. "What Kind of Financing Systems Support Decentralization?" *The Urban Age* 3(3): 3.

14 Dillinger, op. cit., p. 29ff.

15 Dillinger, op. cit., p. 35ff.

16 Harpham, Trudy, and Carolyn Stephens. 1992. "Policy Directions in Urban Health in Developing Countries: The Slum Improvement Approach." *Social Science and Medicine* 35(2): 111-120.

MONITORING ICPD GOALS – SELECTED INDICATORS

Country	Indicators of mortality				Indicators of education								Reproductive Health indicators			Other Health indicators	
	Infant mortality	Life expectancy at birth		Maternal mortality ratio	Primary enrolment (Gross)		% last year primary		Secondary enrolment (Gross)		% Illiterate (>15 years)		% knowning FP		Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
		M	F		M	F	M	F	M	F	M	F	method	souce			
World Total	57	63.7	67.8												60		
More developed regions (*)	9	71.2	78.6												32		
Less developed regions (+)	63	62.4	65.3												65		
Least developed countries (‡)	102	51.6	53.6												140		
Africa	85	52.7	55.7												136		
Eastern Africa (1)	99	48.6	51.2												151		
Burundi	96	49.4	52.9	1,300	76	62	73	78	8	5	39	60	70	62	60	65	19
Eritrea	94	51.4	54.6	1,400											140		
Ethiopia	107	48.4	51.6	1,400	27	19	26	31	12	11			63		169	45	14
Kenya	66	53.0	55.4	650	93	91			30	24	20	42	96	88	144	19	54
Madagascar	93	57.5	60.5	490	77	74	36	41	15	15	12	27		45	155	65	57
Malawi	136	44.3	45.4	560	84	77	46	37	6	3	48	69	90	80	173	80	55
Mauritius (2)	16	68.3	75.0	120	107	108	97	97	56	57			100		46	100	85
Mozambique	136	45.4	48.3	1,500	69	52			9	6	55	79			131	30	25
Rwanda	105	45.2	48.0	1,300	76	74	50	50	12	10	36	63	98	86	60	60	26
Somalia	112	47.4	50.6	1,600	113	113			68	80	64	86			208	20	2
Uganda	111	42.2	44.3	1,200	78	62			14	8	38	55	82	74	220	70	38
United Republic of Tanzania	81	50.2	52.9	770	71	69	72	74	6	5			74	66	134	73	53
Zambia	99	45.4	46.8	940	90	84	88	75	29	17	19	35	89	81	145	75	51
Zimbabwe	65	49.8	51.8	570	120	117	96	93	53	42	26	40	96	93	102	71	70
Middle Africa (3)	88	50.6	53.8												207		
Angola	112	47.4	50.6	1,500	89	82			16	11	44	72			236	70	15
Cameroon	55	57.0	60.0	550	100	86	69	66	36	25	34	57	72	54	141	15	64
Central African Republic	96	47.8	52.5	700	99	62	65	53	18	7	48	75			161	13	46
Chad	112	47.9	51.1	1,500	80	38	76	56	16	3	58	82			192	30	15
Congo	83	47.8	52.0	890			57	48			30	56			146		
Gabon	85	53.9	57.2	500	126	123	46	41	32	37	27	52			163	87	80
Zaire	86	50.4	53.4	870	79	61	86	44	31	14	16	39			231	50	
Northern Africa (4)	56	62.9	65.8												60		
Algeria	44	67.5	70.3	160	111	96	92	88	66	55	36	55	99		30	90	77
Egypt	54	64.7	67.3	170	102	87			82	68	37	66	100	93	73	99	40.7
Libyan Arab Jamahiriya	56	63.9	67.5	220	88	84			52	70	25	50			110	100	76
Morocco	56	63.9	67.5	610	85	60	75	76	40	29	39	62	99	94	37	60	31
Sudan	71	53.6	56.4	660	61	47			23	19	57	88	71	60	88	70	69
Tunisia	37	68.4	70.7	170	122	111	79	77	53	45	26	44	99	97	23	90	69
Southern Africa	49	62.1	67.9												75		
Botswana	37	65.3	69.2	250	113	120	71	88	49	55	16	35	95	95	100	85	78
Lesotho	69	60.5	65.5	610	94	111	61	39	21	31	38	16	79		85	80	40
Namibia	53	60.0	62.5	370	134	139	32	43	49	61			89	78	107		68
South Africa	48	62.3	68.3	230											72		
Western Africa (5)	90	49.9	52.9												164		
Benin	79	47.2	50.6	990	92	46	42	36	17	7	68	84	40		152	99	45
Burkina Faso	123	45.3	48.1	930	47	30	70	72	11	6	72	91	66	30	165	70	42
Cote d'Ivoire	88	48.6	50.5	810	79	57	75	64	34	17	33	60	26		228	60	45
Ghana	73	56.2	59.9	740	82	70			43	28	30	49	76	70	127	25	59
Guinea	124	46.0	47.0	1,600	57	27	70	59	17	6	65	87			241	32	36
Guinea-Bissau	129	43.9	47.1	910	71	40	8	7	15	7	50	76			189	80	27
Liberia	113	56.0	59.0	560							50	71	72	48	230	34	58
Mali	149	46.4	49.7	1,200	35	22			11	5	59	76	42	30	199	20	32
Mauritania	92	51.9	55.1	930	68	55	75	59	19	10	53	79	61		133	30	40
Niger	114	46.9	50.2	1,200	35	21	83	77	9	4	60	83	76	33	219	48	15
Nigeria	77	50.8	54.0	1,000	104	82	56	60	27	33	38	61	46	34	150	40	37
Senegal	62	50.3	52.3	1,200	67	50	91	78	22	12	48	75	74	44	155	40	46
Sierra Leone	154	39.5	42.6	1,800	59	40			21	12	69	89	78		212	36	25
Togo	77	55.2	58.9	640	149	97	67	44	35	12	44	69	94	81	126		54
Asia	57	64.9	67.7												45		
Eastern Asia (6)	35	69.0	73.1												14		
China	38	68.2	71.7	95	124	117			59	48	16	38			15		94
Democratic People's Republic of Korea	22	68.7	75.2	70											12	100	100
Hong Kong	6	76.2	82.3	7	104	103	96	98	75	79	5	19	98		6		100
Japan	4	76.8	82.9	18	101	101	100	100	99	100					4	100	100
Mongolia	52	64.4	67.3	65	84	88			72	81					37	100	99
Republic of Korea	9	68.8	76.1	130	103	104	99	100	91	90	1	7	100	94	6	100	89

MONITORING ICPD GOALS – SELECTED INDICATORS

Country	Indicators of mortality: Infant mortality	Life expectancy at birth M	Life expectancy at birth F	Maternal mortality ratio	Indicators of education: Primary enrolment (Gross) M	Primary enrolment (Gross) F	% last year primary M	% last year primary F	Secondary enrolment (Gross) M	Secondary enrolment (Gross) F	% Illiterate (>15 years) M	% Illiterate (>15 years) F	Reproductive Health indicators: % knowning FP method	% knowning FP souce	Births per 1,000 women aged 15-19	Other Health indicators: % access basic care	% births with trained attendants
South Eastern Asia	47	63.5	67.6												47		
Cambodia	102	52.6	55.4	900							52	35			131		47
Indonesia	48	63.3	67.0	650	116	112			48	39	16	32	95	93	64	64	36
Lao People's Democratic Republic	86	52.0	55.0	650	119	89			30	18	8	24			51	67	
Malaysia	11	69.9	74.3	80	93	94	95	96	58	62	14	30	99	94	29		87
Myanmar	72	58.5	61.8	580	110	106			25	25	11	28			32	48	57
Philippines	35	66.6	70.2	280	113	110	70	70	76	78	10	11	97	93	28		53
Singapore	5	73.5	78.6	10	108	104	100	100	69	70	7	21	98	95	8	100	100
Thailand	34	65.2	71.6	200	99	98			40	38	4	10	100	99	53	93	71
Viet Nam	37	64.9	69.6	160	111	106			33	31	8	16	95		18	97	95
South Central Asia	74	62.1	63.1												73		
Afghanistan	154	45.0	46.0	1,700	31	16	27	32	10	5	56	86	4		153		9
Bangladesh	96	58.1	58.2	850	94	81			26	14	53	78	100	98	133	38	10
Bhutan	107	51.6	54.9	1,600							49	75			63	65	7
India	72	62.6	62.9	570	112	89	65	58	60	37	38	66	95		64	75	33
Iran (Islamic Republic of)	30	69.0	70.3	120	114	104	92	90	70	53	11	57	91		90	73	70
Nepal	86	56.5	56.5	1,500	130	87			46	23	62	87	93	80	104	10	6
Pakistan	74	62.9	65.1	340	53	28	48	48	32	14	53	79	78	46	64	85	35
Sri Lanka	15	70.9	75.4	140	106	104	98	95	71	78	7	17	99	98	33	90	94
Western Asia (7)	48	66.2	70.2												65		
Iraq	47	66.5	69.5	310	98	83	67	49	53	34	23	51			49	93	50
Israel	8	75.4	79.2	7	95	96	100	100	84	91	3	7			20	100	99
Jordan	30	67.7	71.8	150	94	95	84	91	52	54	25	30	100	95	49	80	87
Kuwait	15	74.1	78.2	29	60	60	90	90	55	55	39	33			41	100	99
Lebanon	29	68.1	71.7	300	117	113			71	76	12	27	91		32	95	45
Oman	25	68.9	73.3	190	90	83	93	88	59	52					122	92	60
Saudi Arabia	23	69.9	73.4	130	78	73	87	89	54	44	27	52			124	93	90
Syrian Arab Republic	33	66.7	71.2	180	112	101			54	43	47	49	78		110	83	61
Turkey (8)	52	66.5	70.7	180	107	98	96	95	74	48	10	29	99	95	43	100	76
United Arab Emirates	15	73.9	76.5	26	111	109	94	95	78	89					84	100	99
Yemen	109	51.9	52.4	1,400			71	55			47	74	60	27	102	40	16
Europe	12	69.3	77.4												27		
Eastern Europe	17	63.7	74.1												38		
Bulgaria	14	67.8	74.9	27	91	88	84	78	68	72					59	100	100
Czech Republic	9	67.8	74.9	15	98	101	93	93	77	79					46		
Hungary	15	64.5	73.8	30	95	94	92	94	79	81					41	62	99
Poland	13	66.7	75.7	19	99	97			81	85					28	100	100
Romania	23	66.6	73.3	130	87	86	95	93	83	82					41	100	100
Slovakia	12	66.5	75.4		101	101			86	90					44		
Northern Europe (9)	7	73.5	79.3												22		
Denmark	7	73.0	78.7	9	98	98	99	99	112	115					10	100	100
Estonia	16	63.8	74.8	41	86	85			90	95					34		
Finland	5	72.7	80.2	11	100	99	99	99	112	135					13	100	100
Ireland	7	73.4	78.9	10	103	103	98	99	101	110					16	100	
Latvia	14	63.3	74.9	40	86	84			84	88					35		
Lithuania	13	64.9	76.0	36	93	90			78	81					32		
Norway	7	74.1	80.6	6	100	100			114	111					19	100	100
Sweden	5	76.2	81.9	7	101	101	100	100	96	97					13	100	100
United Kingdom	6	74.5	79.4	9	103	103			87	90					33	100	100
Southern Europe (10)	10	73.9	80.8												17		
Albania	26	70.0	75.8	65	99	100			65	73					14	100	99
Bosnia & Herzegovina	13	70.5	75.9												33		
Croatia	9	68.1	76.5		86	85			73	81					32		
Greece	9	75.6	80.6	10	103	103	97	98	99	98	2	11			22		97
Italy	7	75.1	81.4	12	98	101	100	100	81	81	2	4			9	100	
Macedonia (Former Yugoslav Republic of)	24	69.8	75.8												41		
Portugal	9	72.1	78.9	15	126	123			66	99	11	19			25	100	90
Slovenia	7	68.8	78.1	13	96	96			88	91					30		
Spain	7	75.3	81.0	7	105	105	97	97	105	115	3	7			12	95	96
Yugoslavia	18	70.3	75.3								3	12			43	100	
Western Europe (11)	6	73.9	80.4												11		
Austria	6	73.9	80.1	10	104	104			110	104					23	100	
Belgium	6	74.1	80.6	10	99	100	76	80	104	105					10	100	100
France	7	73.8	81.3	15	107	105			100	104					9		94
Germany	6	73.5	79.8	22	97	98	98	98	102	100					13	100	99
Netherlands	6	75.1	80.9	12	96	99			126	120					7	100	100
Switzerland	6	75.4	81.7	6	103	104	100	100	94	89					5	100	99

MONITORING ICPD GOALS – SELECTED INDICATORS

Country	Indicators of mortality: Infant mortality	Life expectancy at birth M	Life expectancy at birth F	Maternal mortality ratio	Indicators of education: Primary enrolment (Gross) M	Primary enrolment (Gross) F	% last year primary M	% last year primary F	Secondary enrolment (Gross) M	Secondary enrolment (Gross) F	% Illiterate (>15 years) M	% Illiterate (>15 years) F	Reproductive Health indicators: % knowing FP method	% knowing FP souce	Births per 1,000 women aged 15-19	Other Health indicators: % access basic care	% births with trained attendants
Latin America & Caribbean	41	67.2	72.5												79		
Caribbean (13)	38	68.0	72.6												78		
Cuba	11	74.2	78.0	95	103	102			77	87	5	7	100		92	100	90
Dominican Republic	34	69.0	73.1	110	96	98			64	84	15	18	100	96	91		92
Haiti	77	56.7	60.2	1,000	56	52	40	38	23	22	41	53	81	66	54	45	20
Jamaica	12	72.4	76.8	120	109	108	82	88	62	70	2	1	99		86		82
Puerto Rico	9	72.1	79.8												65		
Trinidad & Tobago	16	70.5	75.3	90	95	95	91	82	77	80	3	5	97	96	60	99	98
Central America	34	68.4	74.1												89		
Belize	30	73.4	76.1		111	107			47	48			95		127	75	
Costa Rica	12	74.5	79.2	60	105	104			45	47	7	7	100	99	93	97	93
El Salvador	39	65.8	70.8	300	78	79	24	23	25	28	24	30	98		131		90
Guatemala	40	64.7	69.8	200	84	74			25	21	37	53	70	64	123	60	87
Honduras	35	67.5	72.3	220	104	109	30	23	29	36	25	29	95		127		81
Mexico	33	68.9	75.0	110	115	111			56	56	11	15	91	72	77	91	77
Nicaragua	45	66.6	70.3	160	100	104			40	44			97		153		73
Panama	21	71.8	76.4	55	107	102	76	82	62	66	12	12	95		91	82	96
South America (14)	44	66.6	71.8												75		
Argentina	22	69.7	76.8	100	104	109			66	74	5	5			61		87
Bolivia	66	59.8	63.2	650	104	95	47	41	42	36	15	29	73	66	82		47
Brazil	53	65.5	70.1	220	115	107			38	49	18	20	100	95	78		81
Chile	14	71.1	78.1	65	99	98	73	80	67	72	7	7			56	95	98
Colombia	34	67.4	73.3	100	116	117	53	59	56	67	13	14	98	94	71	97	94
Ecuador	46	67.3	72.5	150	117	116	63	65	58	61	12	16	89	88	79	80	84
Paraguay	35	69.4	73.1	160	111	108	57	60	34	35	8	12	98	90	92		66
Peru	59	65.5	69.4	280	120	115			69	62	9	21	96	89	60		52
Uruguay	17	69.7	76.2	85	109	107	91	94	72	93	3	4			60		96
Venezuela	21	70.0	75.7	120	95	97			29	41	13	14	98	68	101		69
Northern America (15)	7	73.5	80.2												60		
Canada	6	75.0	81.2	6	106	104	96	96	104	104					27		99
United States of America	7	73.4	80.1	12	104	106	89	87	95	94					64	100	99
Oceania	24	71.3	76.4												28		
Australia-New Zealand	7	75.1	80.9												24		
Australia (16)	6	75.5	81.2	9	108	108	99	100	83	86					21	100	99
Melanesia (17)	53	60.0	62.2												33		
New Caledonia	18	70.9	75.9												53		
New Zealand	8	73.4	79.4	25	103	101	96	97	95	95					35	100	99
Papua New Guinea	62	57.2	58.7	930	80	67			15	10	35	62			23	96	20
Vanuatu	38	65.5	69.5		105	107			23	18					75	80	
Countries with Economies in Transition of the Former USSR				75													
Armenia	20	70.3	76.3	50											61		
Azerbaijan	26	68.0	75.5	22	88	86			93	91					21		
Belarus	17	64.5	75.1	37	96	96			88	95					28	100	
Georgia	18	69.5	77.6	33											51		
Kazakhstan	27	66.5	75.0	80	87	87			81	82					35		
Kyrgyzstan	32	66.5	73.8	110											37		
Republic of Moldova	25	63.5	71.6	60											38		
Russian Federation	19	61.5	73.6	75	84	84			84	91					37		
Tajikistan	43	68.8	74.0	130	87	84			89	84					34		
Turkmenistan	51	63.5	70.0	55											18		
Ukraine	16	64.2	74.2	50	91	90			84	94					43	100	
Uzbekistan	38	67.5	73.2	55											34		

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Country	Total population (millions) 1996	Projected population (millions) 2025	Ave. pop. growth rate (%) 1995-2000	% Urban (1995)	% Urban growth rate (1995-2000)	Population/ ha arable land	Total Fertility Rate (period)	Contraceptive prevalence Any method	Contraceptive prevalence Modern methods	GDP per capita (1993)	% central govt expenditures Education	% central govt expenditures Health	External population assistance ($,000US)	Under 5 mortality M	Under 5 mortality F	Per capita Energy consumption	Access to safe water
World Total	5,804.1	8,294.3	1.5	45	2.5		2.98	57	49				(776,624)				
More developed regions (*)	1,170.7	1,238.4	0.3	75	0.7		1.71	71	51								
Less developed regions (+)	4,633.4	7,055.9	1.8	38	3.3		3.29	53	49								
Least developed countries (‡)	591.8	1,162.3	2.7	22	5.2		5.37	20	15								
Africa	748.1	1,495.8	2.7	34	4.3		5.35	19	15				161,500				
Eastern Africa (1)	233.7	494.6	2.8	22	5.3		5.98										
Burundi	6.6	13.5	2.8	8	6.4	234	6.28	9	1	157			3,984	185	165	24	37
Eritrea	3.6	7.0	2.6	17	4.7		5.34						209	211	190		
Ethiopia	56.7	126.9	2.9	13	5.1	66	6.51	4	3	118	9.9	3.0	9,269	216	194	23	18
Kenya	29.1	63.4	2.8	28	5.6	47	5.76	33	27	218	20.1	5.4	16,909	110	95	99	28
Madagascar	15.2	34.4	3.1	27	5.6	26	5.65	17	5	265	17.2	6.6	6,471	160	141	34	30
Malawi	11.4	22.3	1.8	14	4.6	215	6.69	13	7	189	10.4	7.8	2,376	238	215	35	53
Mauritius (2)	1.1	1.5	1.1	41	1.6	211	2.28	75	49	3,009	14.6	8.1	616	25	20	391	100
Mozambique	16.5	35.1	3.4	34	7.1	26	6.06			94			2,744	283	269	43	24
Rwanda	8.2	15.8	2.6	6	4.7	423	6.00	21	13	198			3,904	206	185	27	64
Somalia	9.5	21.3	3.1	26	4.7	15	6.51			106			312	205	186	7	56
Uganda	22.0	48.1	2.9	13	5.4	174	6.72	5	3	182			9,270	216	194	23	21
United Republic of Tanzania	30.5	62.9	2.8	24	5.7	57	5.48	20	13	85			8,336	158	139	35	52
Zambia	9.7	19.1	2.6	43	3.3	17	5.50	15	9	404	6.2	5.3	3,707	187	167	146	59
Zimbabwe	11.5	19.6	2.1	32	4.4	93	4.53	48	22	526	15.7	5.1	4,349	66	53	471	36
Middle Africa (3)	84.9	189.1	3.0	33	4.5		6.02										
Angola	11.5	26.6	3.3	32	5.6	21	6.69						1,281	220	198	96	50
Cameroon	13.6	29.2	2.8	45	4.7	47	5.30	16	4	885	15.3	4.3	3,098	124	109	87	34
Central African Republic	3.4	6.4	2.4	39	3.5	38	5.29	24	4	391			1,721	183	163	29	12
Chad	6.5	12.9	2.8	21	4.1	9	5.51			199			1,501	216	194	16	
Congo	2.7	5.7	2.7	59	4.2	14	5.87			1,018			1,108	175	157	165	20
Gabon	1.4	2.7	2.8	50	4.2	16	5.70			5,413			260	162	143	953	72
Zaire	45.3	104.6	3.0	29	4.3	113	6.24	8	2	242			453	156	138	48	34
Northern Africa (4)	164.1	268.6	2.1	46	3.1		3.73										
Algeria	28.6	45.5	2.2	56	3.5	16	3.41	47	43	1,862			1,503	80	66	955	78
Egypt	64.2	97.3	1.9	45	2.6	820	3.44	46	45	697	13.4	2.8	12,730	93	80	576	90
Libyan Arab Jamahiriya	5.6	12.9	3.3	86	3.9	4	5.92			4,990			21	91	76	1,883	97
Morocco	27.6	40.7	1.8	48	2.9	30	3.10	50	42	1,027	18.2	3.0	8,475	84	69	299	61
Sudan	28.9	58.4	2.7	25	4.7	13	5.37	8	7	231			2,597	171	152	68	
Tunisia	9.1	13.3	1.7	57	2.6	20	2.75	60	51	1,693	17.5	6.6	3,268	63	51	576	68
Southern Africa	48.5	82.8	2.2	48	3.3		3.92										
Botswana	1.5	3.0	2.9	28	6.3	2	4.46	33	32	2,722	21.0	4.7	1,212	49	37	388	56
Lesotho	2.1	4.2	2.6	23	5.8	61	4.86	23	19	390	21.9	11.5	2,467	73	61		46
Namibia	1.6	3.0	2.6	37	5.3	1	4.90	29	26	1,753	22.2	9.7	1,156	92	79		
South Africa	42.4	71.0	2.2	51	3.0	6	3.81	50	48	2,882			169	77	63	2,399	
Western Africa (5)	216.9	460.6	2.9	37	4.9		6.08										
Benin	5.6	12.3	2.9	31	4.6	127	6.60	9	1	418			1,663	193	172	20	50
Burkina Faso	10.6	21.7	2.5	27	8.9	59	6.06	8	4	288			3,409	205	186	16	67
Cote d'Ivoire	14.7	36.8	3.2	44	4.7	42	6.88	11	4	700			5,292	138	121	109	83
Ghana	18.0	38.0	2.9	36	4.4	101	5.53	20	10	370	25.7	9.0	6,631	138	120	96	56
Guinea	6.9	15.1	2.9	30	5.5	65	6.51	2	1	503			3,593	237	213	66	33
Guinea-Bissau	1.1	2.0	2.1	22	4.6	55	5.42			235	2.7	1.4	574	248	224	37	25
Liberia	3.1	7.2	3.2	45	4.5	31	6.33	6	5		11.0	5.1	428	223	201	38	54
Mali	11.1	24.6	3.0	27	5.4	24	6.60	5	1	288	9.0	2.1	6,485	212	189	20	49
Mauritania	2.3	4.4	2.5	54	4.3	4	5.03	3	1	438			760	207	186	105	66
Niger	9.5	22.4	3.3	17	5.8	57	7.10	4	2	260			5,504	218	196	38	59
Nigeria	115.0	238.4	2.8	39	4.8	103	5.97	6	4	271			12,899	192	174	141	46
Senegal	8.5	16.9	2.7	42	4.0	111	5.62	7	5	709			3,787	113	98	115	55
Sierra Leone	4.6	8.7	2.3	36	4.4	94	6.06			164	2.1	1.5	1,094	253	229	72	42
Togo	4.3	9.4	3.0	31	4.8	105	6.08	12	3	345			959	145	127	47	71
Asia	3,513.2	4,960.0	1.5	35	3.2		2.89	58	54				165,574				
Eastern Asia (6)	1,438.3	1,745.8	0.9	37	2.9		1.92										
China	1,234.3	1,526.1	1.0	30	3.6	155	1.95	83	83	361			13,694	43	32	632	78
Democratic People's Republic of Korea	24.3	33.4	1.6	61	2.3	349	2.23						1,079	32	26	1,701	
Hong Kong	5.9	5.9	0.3	95	0.5	798	1.21	81	75	20,004				9	7	2,278	99
Japan	125.4	121.6	0.2	78	0.4	132	1.50	59	53	33,667			(83,227)	7	5	3,642	
Mongolia	2.5	3.8	2.0	61	2.9	1	3.27			267			1,062	88	73	1,089	66
Republic of Korea	45.4	54.4	0.9	81	2.1	418	1.80	79	70	7,497	16.2	1.2	1,237	18	13	2,863	93

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Country	Total population (millions) 1996	Projected population (millions) 2025	Ave. pop. growth rate (%) 1995-2000	% Urban (1995)	% Urban growth rate (1995-2000)	Population/ ha arable land	Total Fertility Rate (period)	Contraceptive prevalence Any method	Modern methods	GDP per capita (1993)	% central govt expenditures Education	Health	External population assistance ($,000US)	Under 5 mortality M	F	Per capita Energy consumption	Access to safe water
South Eastern Asia	492.8	713.4	1.7	34	3.7		3.03										
Cambodia	10.5	19.7	2.5	21	5.6	166	4.86			232			27	178	160	52	
Indonesia	200.6	275.6	1.5	35	4.1	240	2.63	55	52	844	9.8	2.8	13,442	98	82	330	42
Lao People's Democratic Republic	5.0	9.7	2.8	22	5.7	184	6.03	19	15	290			300	168	149	39	29
Malaysia	20.6	31.6	2.0	54	3.4	110	3.24	48	31	3,325	19.6	5.9	1,333	20	14	1,545	79
Myanmar	47.5	75.6	2.1	26	3.7	192	3.81	17	14	1,238	17.4	6.8	1,201	108	91	39	32.5
Philippines	69.0	104.5	2.0	54	3.7	321	3.57	40	25	839	15.0	4.1	15,901	56	44	328	81
Singapore	2.9	3.4	0.8	100	0.8	257	1.73	74		20,486	22.9	6.2	125	7	6	5,563	100
Thailand	59.4	73.6	1.0	20	2.8	138	2.10	66	64	2,157	21.1	8.1	4,342	36	26	673	72
Viet Nam	76.2	118.2	2.1	21	3.5	611	3.51	65	44	181			6,000	50	38	77	50
South Central Asia	1,409.7	2,196.3	2.0	29	3.4		3.77										
Afghanistan	21.5	45.3	5.6	20	7.7	27	6.37	2	2				206	254	230	145	21
Bangladesh	123.1	196.1	2.2	18	5.2	823	3.90	46	39	208	11.2	4.8	39,575	127	132	59	80
Bhutan	1.7	3.1	2.3	6	6.3	0	5.44				10.7	4.8	231	187	195	33	32
India	953.0	1,392.1	1.8	27	3.0	301	3.42	41	36	279	2.1	1.6	21,884	104	108	243	75
Iran (Islamic Republic of)	68.7	123.5	2.1	59	3.0	26	4.52	65	45	1,782	11.9	4.2	2,087	88	81	1,235	89
Nepal	22.5	40.7	2.5	14	6.5	404	4.95	23	22	180	10.9	4.7	6,726	139	145	22	36
Pakistan	143.5	284.8	2.8	35	4.6	248	5.59	12	9	422	1.6	1.0	15,028	142	129	226	56
Sri Lanka	18.6	25.0	1.2	22	2.8	387	2.29	66	44	578	10.1	4.8	1,888	24	19	110	60
Western Asia (7)	172.5	304.6	2.4	66	3.4		4.13						52,510				
Iraq	21.0	42.7	3.0	75	3.7	39	5.25	14	10	2,692			138	76	62	1,103	93
Israel	5.8	7.8	1.5	91	1.6	36	2.65			13,362	11.1	4.4	103	13	10	2,607	
Jordan	5.7	12.0	3.3	72	4.1	20	5.13	35	27	1,373	12.9	5.2	1,591	41	32	922	99
Kuwait	1.5	2.8	3.2	97	3.4	18	2.90	35	32	13,601	13.7	6.0	243	19	15	4,217	100
Lebanon	3.1	4.4	1.8	87	2.3	71	2.75	53	23	1,955			568	47	36	727	98
Oman	2.3	6.1	3.9	13	7.4	59	6.67	9	8	5,721	11.0	5.7	351	28	20	2,408	64
Saudi Arabia	18.4	42.7	3.5	80	3.9	7	5.94			7,431			30	38	29	4,552	95
Syrian Arab Republic	15.2	33.5	3.3	52	4.3	23	5.36	36	28	1,396	8.6	1.9	2,334	50	38	798	79
Turkey (8)	63.1	90.9	1.8	69	3.5	68	3.04	63	34	3,027	20.0	3.5	8,958	72	66	983	92
United Arab Emirates	1.9	3.0	2.0	84	2.5	0	3.88			19,592	15.0	6.9	395	27	22	16,878	100
Yemen	15.1	33.7	3.2	34	5.9	39	7.14	7	6	322			1,975	162	144	285	
Europe	727.7	718.2	0.1	74	0.5		1.59	72	45				4,975				
Eastern Europe	308.2	299.4	-0.1	70	0.5		1.63										
Bulgaria	8.7	7.8	-0.4	71	0.3	16	1.50	76	8	1,246	22.7	2.1	111	22	17	1,954	
Czech Republic	10.3	10.6	0.1	65	0.4		1.83	69	45	3,026			69	14	10		
Hungary	10.1	9.4	-0.3	65	0.4	17	1.71	73	64	3,769	3.3	7.9	63	21	15	2,385	99
Poland	38.4	41.5	0.2	65	0.9	35	1.88	75	26	2,241			72	20	14	2,390	89
Romania	22.8	21.7	-0.2	55	0.6	26	1.50	57	14	1,141	10.0	9.2	587	32	24	1,785	
Slovakia	5.4	6.0	0.4	59	1.2		1.92	74	41	2,081			62	18	13		77
Northern Europe (9)	93.8	98.6	0.2	84	0.4		1.85										
Denmark	5.2	5.1	0.1	85	0.2	8	1.70	78	72	26,077	9.3	1.0	(29,473)	9	7	3,861	
Estonia	1.5	1.4	-0.5	73	-0.1		1.61			2,619			57	18	13		
Finland	5.1	5.4	0.4	63	1.0	14	1.92	80	78	16,629	13.9	3.2	(8,781)	9	7	5,635	100
Ireland	3.6	3.9	0.3	58	0.8	8	2.10			13,495	12.2	13.0		7	6	3,016	
Latvia	2.5	2.3	-0.7	73	-0.2		1.64			2,145				25	17	1,717	
Lithuania	3.7	3.8	0.0	72	0.7		1.83			1,231			5	23	16	2,596	
Norway	4.4	4.7	0.4	73	0.7	22	2.00	76	72	24,060	9.4	10.3	(42,852)	9	7	5,096	
Sweden	8.8	9.8	0.4	83	0.5	10	2.10	78	71	21,320	9.3	0.8	(37,005)	8	6	5,385	
United Kingdom	58.4	61.5	0.3	90	0.4	6	1.81	82		16,255	13.2	13.8	(47,177)	10	8	3,718	100
Southern Europe (10)	144.2	139.3	0.2	65	0.6		1.41										
Albania	3.5	4.7	1.0	37	2.2	142	2.66			330			897	42	37	455	
Bosnia & Herzegovina	3.5	4.5	4.5	49	6.1		1.60						332	27	19		
Croatia	4.5	4.2	-0.3	64	0.9		1.65			2,445				17	12	1,109	
Greece	10.5	9.9	0.2	65	1.0	23	1.40			7,053			42	12	9	2,160	
Italy	57.2	52.3	0.0	67	0.2	19	1.27	78	32	17,356	5.5	7.5	(17,547)	12	9	2,697	
Macedonia (Former Yugoslav Republic of)	2.2	2.6	0.8	60	1.5		1.97			821				40	30		
Portugal	9.8	9.7	0.0	36	1.4	39	1.55	66	33	8,611	12.0	8.0	68	13	10	1,781	58
Slovenia	1.9	1.8	0.0	64	1.2		1.46			6,015			13	12	9	1,531	
Spain	39.7	37.6	0.1	76	0.4	12	1.23	59	38	12,122	5.3	7.0	(578)	11	9	2,373	98
Yugoslavia	10.9	11.5	-0.3	57	0.9	31	2.03	55	12	-			23	38	29	2,353	75
Western Europe (11)	181.5	180.9	0.2	81	0.4		1.52										
Austria	8.0	8.3	0.4	56	0.7	10	1.60	71	56	23,159	9.4	13.0	(803)	11	9	3,277	
Belgium	10.1	10.4	0.3	97	0.3		1.71	79	75	20,957	10.2	1.4	(2,281)	13	10	4,989	92
France	58.2	61.2	0.4	73	0.5	8	1.74	75	68	21,779	6.1	14.1	(13,422)	11	8	4,031	100
Germany	81.8	76.4	0.0	87	0.3	14	1.30	75	72	23,679	0.5	13.8	(50,657) [12]	9	7	4,170	
Netherlands	15.6	16.3	0.6	89	0.6	26	1.61	80	77	20,237	10.8	13.9	(37,490)	9	7	4,533	100
Switzerland	7.3	7.8	0.8	61	1.3	11	1.67	71	65	32,919			(6,146)	9	7	3,491	

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Country	Total population (millions) 1996	Projected population (millions) 2025	Ave. pop. growth rate (%) 1995-2000	% Urban (1995)	% Urban growth rate (1995-2000)	Population/ ha arable land	Total Fertility Rate (period)	Contraceptive prevalence Any method	Modern methods	GDP per capita (1993)	% central govt expenditures Education	Health	External population assistance ($,000US)	Under 5 mortality M	F	Per capita Energy consumption	Access to safe water
Latin America & Caribbean	490.4	709.8	1.7	74	2.3		2.83	59	49								
Caribbean (13)	36.2	49.6	1.2	62	2.0		2.66										
Cuba	11.1	12.7	0.6	76	1.2	32	1.82	70	67				1,476	15	11	839	97.7
Dominican Republic	8.0	11.2	1.6	65	2.7	72	2.80	56	52	1,261	10.2	14.0	3,486	54	49	340	67
Haiti	7.3	13.1	2.1	32	4.1	283	4.60	18	14	211			2,340	160	141	47	41
Jamaica	2.5	3.3	0.8	54	1.7	152	2.10	62	58	1,696			1,691	19	15	1,096	72
Puerto Rico	3.7	4.6	0.8	73	1.4	0	2.10	70	62	9,909			139	18	14	2,018	
Trinidad & Tobago	1.3	1.8	1.1	72	1.8	70	2.25	53	44	3,654			436	21	15	4,696	96
Central America	129.1	197.5	2.0	68	2.6		3.12										
Belize	0.2	0.4	2.6	47	2.6	60	3.66	47	42	2,595	16.8	6.6	187	58	45	426	73
Costa Rica	3.5	5.6	2.1	50	3.2	26	2.95	75	65	2,337	19.1	32.0	2,359	19	15	558	94
El Salvador	5.9	9.7	2.2	45	2.9	145	3.59	53	48	1,382	12.8	7.5	4,486	52	47	222	43
Guatemala	10.9	21.7	2.8	42	4.1	148	4.90	23	19	1,128			7,326	84	76	159	61
Honduras	5.8	10.7	2.8	44	4.3	69	4.30	47	35	629			4,215	70	57	180	70
Mexico	95.5	136.6	1.8	75	2.4	26	2.80	53	45	4,064	13.9	1.9	14,490	49	37	1,439	78
Nicaragua	4.6	9.1	3.1	63	4.0	22	4.50	49	45	437			2,462	75	68	241	53
Panama	2.7	3.8	1.6	53	2.4	26	2.63	58	54	2,587	16.1	21.8	577	28	23	599	83
South America (14)	325.1	462.7	1.6	78	2.2		2.74										
Argentina	35.0	46.1	1.2	88	1.5	2	2.58			7,633	9.9	3.0	573	38	33	1,351	
Bolivia	7.6	13.1	2.3	61	3.8	11	4.36	45	18	762	16.6	8.2	3,591	115	106	310	66
Brazil	164.4	230.3	1.5	78	2.3	15	2.65	66	57	3,242	3.7	6.9	7,786	76	70	666	87
Chile	14.5	19.8	1.4	84	1.6	9	2.44			3,302	13.3	11.1	1,807	24	18	911	86
Colombia	35.7	49.4	1.5	73	2.2	19	2.49	66	55	1,515			4,600	29	21	661	92
Ecuador	11.7	17.8	2.0	58	3.1	41	3.10	57	46	1,303	18.2	11.0	2,759	64	51	561	70
Paraguay	5.1	9.0	2.5	53	3.8	9	3.92	48	35	1,452	12.7	4.3	1,517	49	38	214	34
Peru	24.2	36.7	1.9	72	2.5	26	3.11	59	33	1,796			7,404	75	61	332	58
Uruguay	3.2	3.7	0.6	90	0.8	3	2.25			4,174	6.8	5.0	562	28	20	715	84
Venezuela	22.3	34.8	2.0	93	2.4	9	2.98	49	38	2,869			262	43	35	2,369	89
Northern America (15)	295.7	369.6	0.9	76	1.2		2.06	71	67								
Canada	29.8	38.3	1.0	77	1.2	1	1.93	73	70	18,982	2.9	5.2	(24,728)	10	8	7,821	
United States of America	265.8	331.2	0.9	76	1.2	1	2.08	71	67	24,279	1.8	16.0	(366,562)	12	9	7,918	
Oceania	29.0	41.0	1.4	70	1.4		2.45										
Australia-New Zealand	21.9	29.0	1.2	85	1.2		1.91										
Australia (16)	18.3	24.7	1.2	85	1.2	0.2	1.87	76	72	16,444	7.0	12.7	(6,347)	10	8	5,316	
Melanesia (17)	5.9	10.1	2.2	21	3.6		4.31										
New Caledonia	0.2	0.3	1.5	62	2.2	26	2.53							24	17	3,398	
New Zealand	3.6	4.4	1.0	86	1.3	2	2.10	70	62	12,530	13.9	12.1	(756)	11	8	4,299	97
Papua New Guinea	4.4	7.5	2.2	16	4.0	538	4.63			1,248	15.0	7.9	617	78	64	238	34
Vanuatu	0.2	0.3	2.5	19	3.9	42	4.36			1,019	14.8	7.6	159	64	51	280	71
Countries with Economies in Transition of the Former USSR																	
Armenia	3.6	4.7	1.2	69	1.6		2.40			643			6	29	21	897	
Azerbaijan	7.6	10.1	1.1	56	1.7		2.30			636				44	33	2,470	
Belarus	10.1	9.9	-0.1	71	0.8		1.65			2,679				21	15	3,427	
Georgia	5.5	6.1	0.3	59	1.1		2.10			606			298	27	19	891	
Kazakhstan	17.2	21.7	0.7	60	1.4		2.37	59	47	1,502			600	43	32	4,435	
Kyrgyzstan	4.8	7.1	1.6	39	2.4		3.30			829			365	52	40	965	
Republic of Moldova	4.4	5.1	0.3	52	1.8		2.10			851				32	23	1,345	
Russian Federation	146.7	138.5	-0.2	76	0.3		1.53	21	13	2,214			260	28	20	4,411	
Tajikistan	6.3	11.8	2.7	32	3.2		4.50			416			285	70	57	634	
Turkmenistan	4.2	6.7	2.1	45	2.5		3.62			1,347			248	78	64	2,268	
Ukraine	51.3	48.7	-0.2	70	0.6		1.64			2,126				25	17	3,960	
Uzbekistan	23.3	37.7	2.1	41	2.8		3.54			998			600	59	47	2,033	

SELECTED INDICATORS FOR LESS POPULOUS COUNTRIES/TERRITORIES

MONITORING ICPD GOALS – SELECTED INDICATORS

Country	Indicators of mortality				Indicators of education				Reproductive Health indicators	Other Health indicators	
	Infant mortality	Life expectancy at birth		Maternal mortality ratio	Primary enrolment (Gross)		Secondary enrolment (Gross)		Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
		M	F		M	F	M	F			
Bahamas	19	69.9	78.7	100	93	96	95	95	54	100	
Bahrain	16	71.1	75.3	60	109	111	97	101	25	100	97
Barbados	9	73.6	78.7	43	109	107	97	89	54	100	98
Brunei Darussalam	8	73.3	77.3	60	108	102	65	73	26	96	
Cape Verde	41	65.5	67.5		122	119	26	26	22	81	50
Comoros	79	57.5	58.5	950	78	70	20	14	166	82	24
Cyprus	7	75.6	80.0	5	101	102	93	96	36	95	98
Djibouti	106	48.7	52.0	570	39	30	13	10	31	37	79
East Timor	135	46.7	48.4						47		
Equatorial Guinea	107	48.4	51.6	820					192		58
Fiji	20	70.6	74.9	90	128	127	64	65	36	100	96
French Polynesia	15	68.6	74.1						77		
Gambia	122	45.4	48.6	1,100	79	56	25	13	171	90	80
Guadaloupe	11	72.1	78.9						39		
Guam	7	73.7	79.1						88		
Guyana	42	64.4	69.5		122	122	67	70	61	96	
Iceland	5	76.3	81.3	0	104	100	104	98	29	100	
Luxembourg	6	72.8	80.3	0	88	94	74	75	13	100	
Maldives	49	65.7	63.3						71	75	
Malta	8	74.6	79.1	0	116	100	87	81	12	100	
Martinique	7	73.8	80.1						31		
Micronesia (18)	35	67.5	71.7						64		
Netherlands Antilles	17	71.5	76.4						34		
Polynesia (19)	37	67.3	71.8						80		
Qatar	17	70.0	75.4		91	86	82	86	66	100	99
Reunion	7	70.9	78.7						67		96
Samoa	58	67.5	71.1	35					80		
Solomon Islands	23	69.7	73.9		97	83	19	12	99	80	
Suriname	24	69.0	74.0		129	128	56	67	62	91	91
Swaziland	65	57.7	62.3	560	120	114	54	52	79	66	55

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Country	Total population (millions) 1996	Projected population (millions) 2025	% Urban (1995)	% Urban growth rate (1995-2000)	Population/ ha arable land	Total Fertility Rate (period)	Contraceptive prevalence		GDP per capita (1993)	Under 5 mortality		Per capita Energy consumption	Access to safe water
							Any method	Modern methods		M	F		
Bahamas	0.3	0.4	87	1.9	0	2.00	62	60	11,444	33	28	6,900	90
Bahrain	0.6	0.9	90	2.7	0	3.42	53	30	8,530	41	31	11,925	100
Barbados	0.3	0.3	47	1.7	43	1.83	55	53	6,273	14	11	1,381	100
Brunei Darussalam	0.3	0.4	58	2.2	1053	2.75			14,570	11	8	7,687	
Cape Verde	0.4	0.7	54	5.5	0	3.95			837	56	44	305	74
Comoros	0.7	1.6	31	5.6	398	6.50			532	135	118	30	
Cyprus	0.8	0.9	54	1.9	88	2.35			8,930	15	12	2,517	100
Djibouti	0.6	1.1	83	2.6	0	5.39			835	203	182	975	43
East Timor	0.8	1.2	8	1.7		4.32							
Equatorial Guinea	0.4	0.8	42	5.2	0	5.51			413	206	185	82	
Fiji	0.8	1.2	41	2.5	92	2.76	41	35	2,210	32	23	525	80
French Polynesia	0.2	0.3	56	2.2	54	2.98				31	22	1,439	71
Gambia	1.2	2.1	26	5.3	270	5.21	12	7	346	234	211	57	77
Guadaloupe	0.4	0.6	99	1.6	67	2.22	44	31		16	13	627	
Guam	0.2	0.2	38	2.4	0	2.96				14	11	9,471	94
Guyana	0.8	1.1	36	2.9	10	2.32	31	28	572	69	55	349	83
Iceland	0.3	0.3	92	1.2	1	2.23			23,075	8	6	5,025	
Luxembourg	0.4	0.4	89	1.4		1.72			31,590	12	9	9,879	
Maldives	0.3	0.6	27	4.3	3593	6.13			952	80	66	139	70
Malta	0.4	0.4	89	0.9	99	2.05			6,766	13	10	2,107	
Martinique	0.4	0.5	93	1.3	66	1.95	51	38		14	11	649	
Micronesia (18)	0.5	0.9	43	3.2		4.10				50	38		
Netherlands Antilles	0.2	0.2	70	1.3	0	2.10				17	13	10,678	
Polynesia (19)	0.6	1.0	41	2.6		3.41							
Qatar	0.6	0.8	91	2.1	0	3.96	32	29	14,188	36	26	16,196	91
Reunion	0.7	0.9	68	2.3	102	2.10	67	62		10	8	671	
Samoa	0.2	0.3	21	2.4		4.00							
Solomon Islands	0.4	0.8	17	6.3	160	4.98			703	62	49	164	69
Suriname	0.4	0.6	50	2.5	77	2.39			1,005	51	39	1,877	98
Swaziland	0.9	1.6	31	5.7	37	4.46	20	17	1,179	169	156	283	30

NOTES

Data for small countries or areas, generally those with population of 200,000 or less in 1990, are not given in this table separately. They have been included in their regional population figures.

(*) More developed regions comprise North America, Japan, Europa, Australia-New Zealand and the former Union of Soviet Socialist Republics.

(+) Less developed regions comprise all regions of Africa, Latin America, Asia (excluding Japan), and Melanesia, Micronesia and Polynesia.

(‡) Least developed countries according to standard United Nations designation.

(1) Including British Indian Ocean Territory and Seychelles.

(2) Including Agalesa, Rodrigues and St. Brandon.

(3) Including Sao Tome and Principe.

(4) Including Western Sahara.

(5) Including St. Helena.

(6) Including Macau.

(7) Including Gaza Strip (Palestine).

(8) Turkey is included in Western Asia for geographical reasons. Other classifications include this country in Europe.

(9) Including Channel Islands, Faeroe Islands, and Isle of Man.

(10) Including Andorra, Gibraltar, Holy See and San Marino.

(11) Including Liechtenstein and Monaco.

(12) More recent reports suggest this figure might have been higher. Future publications will reflect the evaluation of this information.

(13) Including Anguilla, Antigua, Aruba, British Virgin Islands, Cayman Islands, Dominica, Grenada, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Turks and Caicos Islands, and United States Virgin Islands.

(14) Including Falkland Islands (Malvinas) and French Guiana.

(15) Including Bermuda, Greenland, and St. Pierre and Miquelon.

(16) Including Christmas Island, Cocos (Keeling) Islands, and Norfolk Island.

(17) Including New Caledonia and Vanuatu.

(18) Comprising Federated States of Micronesia, Guam, Kiribati, Marshall Islands, Nauru, Northern Mariana Islands, Pacific Islands (Palau), and Wake Island.

(19) Comprising American Samoa, Cook Islands, Johnston Island, Pitcairn, Samoa, Tokelau, Tonga, Midway Islands, Tuvalu and Wallis, and Futuna Islands.

This issue of The *State of World Population* report continues the revised format for its statistical tables. The International Conference on Population and Development adopted a variety of quantitative and qualitative goals for population and development efforts during the next 20 years. The primary quantitative goals in the areas of mortality reduction, access to education and access to reproductive health services (including family planning) are, therefore, given special attention in our presentations. Relevant indicators are reported to help track the processes which generate these vital outcomes. As the follow-up to the ICPD stimulates the development of improved monitoring systems and better process measures, different measures will be included periodically in The *State of World Population* report for various concerns. (Improved monitoring of the resources being made available by governments, non-governmental organizations and through the private sector for implementation of the Programme of Action should also allow better periodic reporting of expenditures and resource mobilization efforts in the future.) The State of *World Population* report will serve as a reference source for evaluating on-going progress towards the attainment of ICPD goals. The sources for the indicators and their rationale for selection follow, by category.

Monitoring ICPD Goals

Indicators of mortality

Infant mortality, Male and Female Life Expectancy at Birth: Source: United Nations Population Division, *World Population Prospects: the 1994 Revision* (United Nations publication). These indicators are measures of mortality levels, respectively, in the first year of life (which is most sensitive to development levels) and over the entire life span.

Maternal Mortality Ratio: Source: UNICEF/World Health Organization working group analysis (1996). This indicator is a measure of the level of women's mortality related to pregnancy and delivery. It presents the number of deaths to women per 100,000 live births which result from conditions related to pregnancy, delivery and related complications. Previous editions of The *State of World Population* report and reports of UNICEF and WHO used estimates of this quantity based on a combination of national, small area and clinical data which were subject to considerable uncertainty. New estimates have been produced based on analyses which take account of the quality and availability of data which use a statistical model (which takes into account regional variation, data types and the proportions of births with a trained attendant) in many countries where civil registration systems do not provide adequate coverage. Precision is difficult, though relative magnitudes are informative. Estimates below 50 are not rounded; those 50–100 are rounded to the nearest 5; 100–1000, to the nearest 10; and, above 1000, to the nearest 100. Most estimates are for around the year 1990.

Indicators of education

Male and female gross primary enrolment ratios, per cent reaching final grade of primary education, male and female gross secondary enrolment ratios, male and female adult illiteracy: Source: UNESCO, *Trends and Projections of Enrolment by Level of Education and by Age, 1960–2025 (as assessed in 1993)*, 1993; *World Education Report 1993*, 1993. Gross enrolment ratios indicate the number of students enrolled in a level in the education system per 100 individuals in the population who are in the age group appropriate to that level. It does not correct for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition. Illiteracy definitions are subject to variation in different countries; three widely accepted definitions are in use. Insofar as possible, data refer to the proportion who cannot, with undertanding, both read and write a short simple statement on everyday life. Adult illiteracy (illiteracy rates for persons above 15 years of age) reflects both recent levels of educational enrolment and the history of past education attainment.

Indicators of reproductive health

Contraceptive access/knowledge

Source: United Nations Population Division. These indicators are derived from sample survey reports and estimate the proportion of women having knowledge of a method of family planning and knowing a source from which contraceptives can be obtained. All contraceptive methods (medical, barrier, natural and traditional) are included in the first indicator; source information is more relevant to medical and barrier contraceptives and to modern periodic abstinence methods. These numbers are generally but not completely comparable across countries due to variation in populations surveyed by age (15–49 year old women being most common) and marital status (e.g., currently or ever married women; or, all women) and in the timing of the surveys. Most of the data were collected during 1987–1994.

Births per 1,000 women aged 15-19: Source: United Nations Population Division, *World Population Prospects: the 1994 Revision*, (United Nations publication). This is an indicator of the number of births in a single year per 1,000 women aged 15–19. It is an indicator of the burden of fertility on young women. Since it is an annual level summed over all women in the age cohort, it does not reflect fully the level of fertility for women during their youth. Since it indicates the annual average number of births per woman per year, it could be multiplied by five to approximate the number of births to 1,000 young women during their late teen years. The measure does not indicate the full dimensions of teen pregnancy as only live births are included in the numerator. Pregnancy wastage due to stillbirths and spontaneous or induced abortion are not reflected in the indicator.

Other health indicators

Access to basic care: Source: *The World Tables 1995*, The World Bank, 1995, derived from World Health Organization sources. This indicator measures the proportion of the population who can reach local health services by the usual means of transportation within one hour. It is sensitive to the distribution of services in relation to population (including urban concentration).

Births with trained attendants: Source: UNICEF/WHO working group adjustment of estimates originally published in *Coverage of Maternity Care: A Tabulation of Available Information*, Third Edition, World Health Organization, 1993. Some estimates differ from prior publications. This indicator presents estimates, based on national reports, of the proportion of births attended by a doctor, a registered nurse or midwife or a trained midwife or traditional birth attendant. Data are from the period 1985–1993.

Demographic, social and economic indicators

Total population 1995, Projected population 2025, Average annual population growth rate for 1995–2000. Source: United Nations Population Division, *World Population Prospects: the 1994 Revision* (United Nations publication). These indicators present the size, projected future size and cur-

rent period annual growth of national populations. Annual growth rates reflect levels of fertility, mortality and migration.

Percent urban, urban growth rates: Source: United Nations Population Division, *World Urbanization Prospects: the 1994 Revision,* (United Nations publication). These indicators reflect the proportion of the national population living in urban areas and the growth rate in urban areas projected for the period 1995–2000.

Agricultural population per hectare of arable land: Sources: (agricultural population) FAO, *The State of Food and Agriculture 1993,* 1994; (arable land) FAO, *Production Yearbook, 1991,* 1992. This indicator relates the size of the agricultural population to the land suitable for agricultural production. It is responsive to changes in both the structure of national economies (proportions of the workforce in agriculture) and in technologies for land development. High values can be related to stress on land productivity and to fragmentation of land holdings. However, the measure is also sensitive to differing development levels and land use policies.

Total fertility rate (period; 1995–2000): Source: United Nations Population Division, *World Population Prospects: the 1994 Revision* (United Nations publication). This measure indicates the number of children a woman would have during her reproductive years if in each five year age interval from ages 15–49 she had the number of children that women of that age currently have in the population as a whole. The data refer to the average projected for the period 1995–2000. Some countries may reach the projected level at different points within the period. This projection is based on data available as of 1993; new projections will be prepared in 1996, taking account of more recent data.

Contraceptive prevalence: Source: United Nations Population Division, World Population Monitoring 1996: Selected aspects of reproductive health (draft, United Nations publication, ESA/P/WP.131). This indicator is derived from sample survey reports and estimates the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. These numbers are roughly but not completely comparable across countries due to variation in populations surveyed by age (15–49-year-old women being most common; slightly more than half of the database), in the timing of the surveys, and in the details of the questions. All of the data were collected 1975 or later. The most recent survey data available are cited; nearly 80 per cent of the data refer to the period 1987–1994.

Gross Domestic Product per capita: Source: The World Bank. 1995. *World Tables 1995.* This indicator measures the total output of goods and services for final use produced by residents and non-residents, regardless of allocation to domestic and foreign claims, in relation to the size of the population. As such, it is a an indicator of the economic productivity of a nation. It differs from Gross National Product by not adjusting for income received from abroad for labour and capital by residents, for similar payments to non-residents, and by not incorporating various technical adjustments including those related to exchange rate changes over time. This measure does not take into account the differing purchasing power of currencies. Future editions of *The State of World Population* report may include purchasing power parity adjustments of "real GDP" as the data become available.

Central government expenditures on education and health: Source: The World Bank. 1995. *World Tables 1995,* These indicators reflect the priority afforded to education and health sectors by a nation through the proportion of government expenditures dedicated to them. They are not sensitive to differences in allocations within sectors, e.g. primary education or health services in relation to other levels, which vary considerably. Direct comparability is complicated by the different administrative and budgetary responsibilities allocated to central governments in relation to local governments, and to the varying roles of the private and public sectors.

External assistance for population: Source: UNFPA, *Global Population Assistance Report 1993,* 1995. This figure provides the amount of external assistance expended in the year 1992 for population activities in each country. External funds are disbursed through multilateral and bilateral assistance agencies and by non-governmental organizations. Donor countries are indicated by their contributions being placed in parentheses. Future editions of this report will provide other indicators to better provide a basis for comparing and evaluating resource flows in support of population and reproductive health programmes from various national and international sources. Reported regional total include both country-level projects (in table) and regional activities (not elsewhere in table). Some less populous recipient countries are also not reported here.

Under-5 mortality: Source: The World Bank. 1995. *World Tables 1995,* based on information from UNICEF. This indicator relates to the incidence of mortality to infants and young children. It reflects, therefore, the impact of diseases and other causes of death on infants, toddlers and young children. More standard demographic measures are infant mortality and 1–4 year of age mortality rates, which reflect differing causes of and frequency of mortality in these ages. The measure is, therefore, more sensitive than infant mortality to the burden of childhood diseases including those preventable by improved nutrition and by immunisation programmes. Under-5 mortality is expressed as deaths to children under 5 per 1,000 live births in a given year.

Per Capita Energy Consumption: Source: The World Bank. 1995. *World Tables* 1995. This indicator reflects annual consumption of commercial primary energy (coal, lignite, petroleum, natural gas and hydro, nuclear and geothermal electricity) in kilograms of oil equivalent per capita. It reflects the level of industrial development, the structure of the economy and patterns of consumption. Changes over time can reflect changes in the level and balance of various economic activities and changes in the efficiency of energy use (including decreases or increases in wasteful consumption).

Access to Safe Water: Source: The World Bank. 1995. *World Tables 1995,* based on WHO reports. This indicator reports the percentage of the population with reasonable access to a safe water supply (and includes treated surface waters or untreated but uncontaminated water such as that from springs, sanitary wells, and protected boreholes). It is related to exposure to heath risks, including those resulting from improper sanitation.

The State of World Population 1996 report
Editor: Alex Marshall
Research and Writing: Stan Bernstein
Managing Editor: William A. Ryan
Editorial Assistant: Phyllis Brachman

Cover photo: São Paulo, Brazil, Still Pictures
Title page photo: Dhaka, Bangladesh, Still Pictures