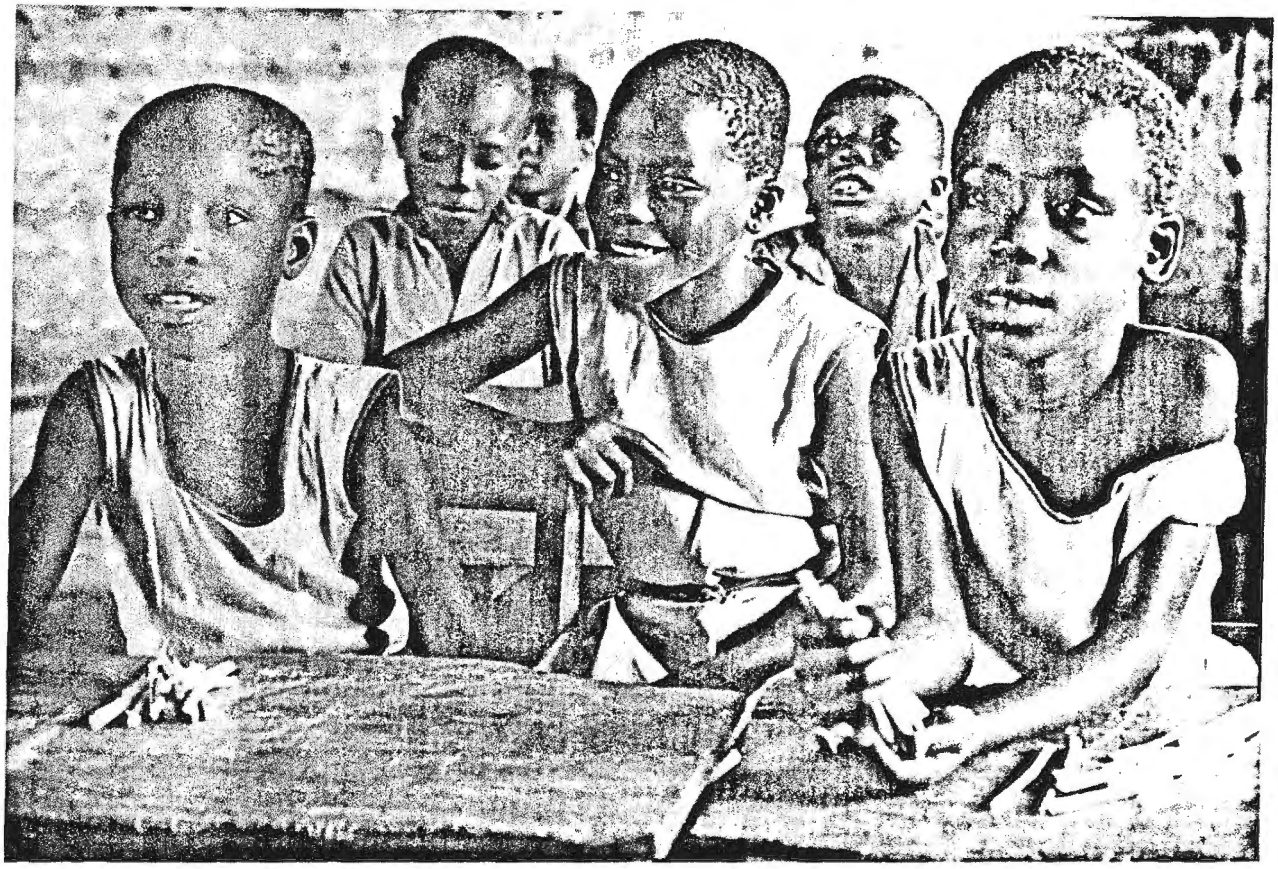
THE STATE OF WORLD POPULATION 1995



DECISIONS FOR DEVELOPMENT: WOMEN, EMPOWERMENT AND REPRODUCTIVE HEALTH

United Nations Population Fund
Dr. Nafis Sadik, Executive Director

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FOREWORD

THE empowerment of women and reproductive health and family planning are crucially related tasks for the world community. These concepts were central to the landmark agreement reached in Cairo at the International Conference on Population and Development (ICPD); their importance was reiterated in Copenhagen at the World Summit for Social Development; and both themes will be discussed further at the Fourth World Conference on Women in Beijing this September. This year's report on *The State of World Population* focuses on all these related themes.

The issues addressed by this continuum of world conferences are crucial to creating a new approach to development, complementing the General Assembly's consideration of "An Agenda for Development". Unemployment and poverty, as well as inadequate expenditures on health, education and basic services, are major causes of social stress in the world today. These persistent conditions point to the need to strongly emphasize social development within overall development efforts. It is imperative, as the Cairo Conference affirmed, that development issues be addressed in the context of population concerns.

Ending poverty and improving human well-being demands a broader range of choices in life, and greater equality between women and men. The Programme of Action adopted in Cairo states that investing in health, education and productivity is the most effective strategy for achieving sustained economic growth and sustainable development. Clearly, there can be no sustainable human development, nor any successful population programme, without the full and equal participation of women.

The involvement of civil society will be crucial. The ICPD Programme of Action emphasizes the need for a "broad and effective partnership" between governments and non-governmental organizations in formulating, implementing, monitoring and evaluating population and development activities.

This report on *The State of World Population* by the United Nations Population Fund illustrates the value of a comprehensive approach to development. It demonstrates the urgent need for action towards gender equity and equality and the empowerment of women.

It is my hope that this report will advance the critical work of building political support in both developing and developed countries for implementation of the ICPD Programme of Action.

Boutros Boutros-Ghali
Secretary-General

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SUMMARY

THE International Conference on Population and Development (ICPD) at Cairo in September 1994 was the start of a new era in population and development. The ICPD Programme of Action, the landmark agreement reached at the Conference, explicitly places human beings, rather than human numbers, at the centre of all population and development activities. It encourages the international community to address global problems by meeting individual needs, while maintaining the responsibilities and sovereignty of governments.

Investing in people, in broadening their opportunities and enabling them to realize their potential as human beings, is the key to sustained economic growth and sustainable development, as well as to balanced, sustainable population growth.

Empowering women is an important end in itself, as well as a key to improving the quality of life of everyone. Without the full and equal participation of women, there can be no sustainable human development. The Programme of Action emphasizes the need for gender equity and equality and the support of men for the empowerment of women. It enunciates the right to universal, comprehensive reproductive health care, including family planning, and it points out that for women, a context which also includes education and access to resources is essential as the basis for empowerment.

These principles are at the core of the ICPD Programme of Action. The Programme of Action spells out an integrated response to population and development challenges in the decades ahead. This new approach is based on the achievements of population and development programmes, but it also reflects the need for action in the coming years. For many countries, action has already begun.

BACKGROUND

In the past 30 years, developing countries have made significant gains in providing better and more comprehensive primary health care, including maternal and child health and family planning and other elements of what is now called reproductive health care, resulting in lower birth and death rates, increased life expectancy and reduced infant mortality. This progress is linked to higher levels of education and income, a narrowing "gender gap" in health and education, increased political commitment to population policies, and changes in individual attitudes about family planning. Contraceptive use has increased four-fold since 1965-70.

Nevertheless, there continues to be great diversity among countries and regions. Maternal death rates are 15 to 50 times greater in the developing world than in most developed countries. Half a million women die each year as a consequence of pregnancy and childbirth; most of these deaths could be prevented with quality prenatal examinations, referrals and emergency obstetric care. Many more women – a much larger number than was previously thought – suffer from illness or impairment related to pregnancy and childbirth.

While levels of education have risen and the gap between males and females has narrowed, there are still nearly 960 million illiterate persons in the world, two thirds of them women; some 130 million children, including over 90 million girls, are denied access to primary schooling.

Women have been entering the labour force in record numbers, many of them in non-traditional economic roles. But women are often the principal or only source of support for themselves and their children. And women still have less access than men to training, credit, property, natural resources and better-paid jobs.

The ongoing shift of rural populations to urban areas is placing growing strains on the resources of developing countries. At the same time, migration between countries continues to rise. In many countries, longer life expectancy and declining birth rates are increasing the proportion of elderly people in the population.

Access to family planning, contraceptive use and average family size vary widely among countries and regions. World-wide, some 350 million couples lack access to a full range of modern family planning information and services; an estimated 120 million women would practise family planning if a modern method were available, affordable and acceptable to their partners, families and communities.

The world population is currently 5.7 billion. According to United Nations projections, annual population increments are likely to remain above 86 million until the year 2015. Projections for 2015 range from 7.1 billion to 7.8 billion, and for 2050

from 7.9 billion to 11.9 billion; the actual totals reached will largely be determined by action taken during the rest of this decade.

ICPD Programme of Action

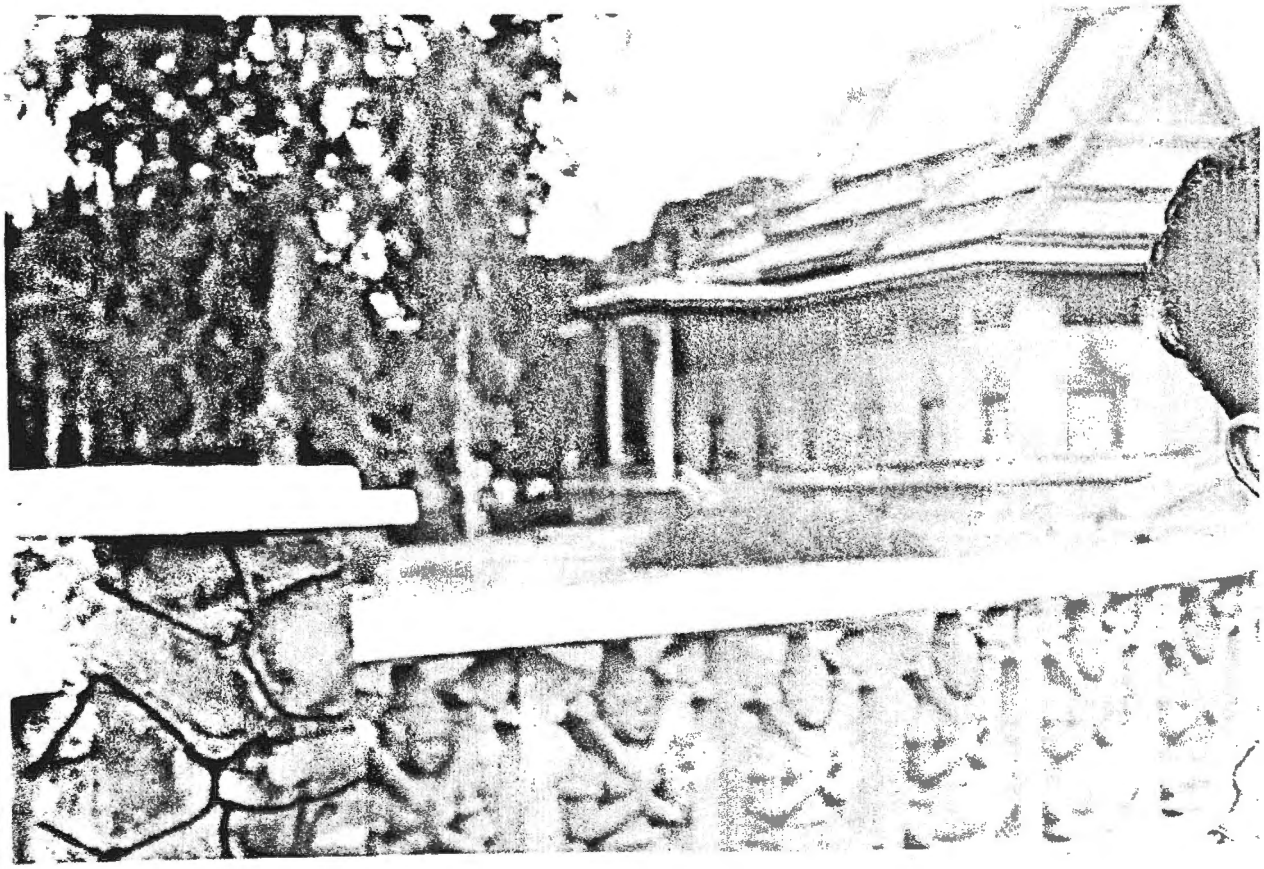
The Cairo Conference agreed on a Programme of Action for the next 20 years in the field of population and development. Recognizing the crucial contribution that early stabilization of the world population would make towards the achievement of sustainable development, the Programme also recognizes that stabilization can be achieved only by taking individual people's perspectives into account, and by ensuring the full and equal participation of women in all aspects of development. It moves away from a focus on fertility towards a comprehensive approach that integrates family planning with reproductive health and addresses a wider range of concerns, particularly economic status, education and gender equity and equality.

The document reaffirms the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. It emphasizes that men have a key role to play in bringing about gender equity and equality, in fostering women's full participation in development, and in improving women's reproductive health. Goals are set out in three related areas: expanded access to education, particularly for girls; reduced mortality rates; and increased access to quality reproductive health services, including family planning.

Many recommendations are aimed at strengthening and supporting families. The Programme recognizes that both married and unmarried adolescents need sex education and counselling services to protect them from unwanted pregnancies and sexually transmitted diseases, and that these efforts should involve parents. Special attention is paid to internally displaced persons and international migrants, among others, and to easing the pressure that rapid urbanization puts on social infrastructure and local environments.

The ICPD Programme of Action urges all countries to make reproductive health care and family planning accessible through the primary health care system to all individuals of appropriate ages no later than 2015; the financial resources required for this effort in developing countries and those with economies in transition is estimated at $17 billion for the year 2000, increasing to $21.7 billion by 2015. Developing countries will continue to meet up to two

Special attention will be needed for the internally displaced: father and daughter in Cambodia.



UN PHOTO 159745 / J. ISAAC

thirds of the cost themselves; approximately one third – $5.7 billion in 2000 and $7.2 billion in 2015 – will have to come from external sources.

The ICPD was one of a series of United Nations conferences which will set the world's social development agenda for the 21st century. In particular, its emphasis on reproductive rights and the centrality of women in development were reaffirmed by the World Summit for Social Development in Copenhagen in March 1995 and are expected to be reiterated at the Fourth World Conference on Women in Beijing in September.

Gender Equity, Equality and Empowerment of Women

Women in most societies have many roles, but often only one, their role in reproduction, is recognized; and even in that they can expect little support. They must struggle to reconcile activities outside the home with their traditional roles. They cannot participate fully in economic and public life, have limited access to positions of influence and power, and have narrower occupational choices and lower earnings than men. Too often, they have little or no voice in decisions made in or outside the household; and too often, even their reproductive health is ignored. These inequities must be redressed to fulfil women's human rights and enable countries to progress towards sustainable development.

Towards this end, all forms of discrimination should be outlawed and opposed in civic life; traditional laws and practices which enforce women's subordination must be challenged. Also important is enacting and enforcing laws setting a minimum age at marriage to protect young women from the dangers of early child-bearing and allow them to take advantage of options beyond motherhood. While public attention to gender-based abuse has increased dramatically in recent years, laws need to be reformed to better protect abused women and punish violent perpetrators.

Though progress is being made, women continue to be grossly underrepresented in the political process; barriers to their participation must be removed.

In the developing countries, women grow up to 80 per cent of all food produced. World-wide, they constitute one third of the wage-labour force. In most countries, women work longer hours than men. Income earned by women tends to effect family welfare more directly than that earned by men. Much of women's work, however, is unpaid and is not included in economic statistics. Women usually

dominate the "informal sector" of the economy. In the formal sector, they tend to be in low-wage positions, and occupy only a small percentage of managerial positions. Working women are disproportionately affected by occupational hazards and also face the risk of sexual harassment in the workplace and rape.

Key contributions to women's empowerment will be in education and health, including reproductive health and family planning.

EDUCATION

Together with health care, education is the most important intervention to break the vicious cycle of low status, poverty and large families. There is a direct connection between education for girls and women's ability to escape from poverty; education also encourages later marriage and greater use of contraception. It is associated with lower maternal mortality, with smaller, healthier families, and better reproductive health for the next generation.

While girls have edged nearer to parity with boys in primary school enrolment in much of the world, parents still tend to give preference to educating their sons. In most countries, the higher the level of education, the lower the proportion of women to men. Numerous innovative programmes are helping to increase and sustain female educational achievement; these need to be maintained and expanded.

The long road to development: students in Ethiopia.

MARK EDWARDS / STILL PICTURES

REPRODUCTIVE HEALTH, FAMILY PLANNING AND REPRODUCTIVE RIGHTS

While health issues related to reproduction and sexuality affect women and men of all ages, women bear most of the associated burden of ill-health. Essential aspects of reproductive health include family planning, safe motherhood, and prevention and treatment of reproductive tract infections and sexually transmitted diseases. A central achievement of the ICPD was its promotion of a comprehensive approach to meeting the totality of people's reproductive health needs, particularly those of women and girls.

To promote reproductive rights the ICPD Programme of Action calls on all countries to provide universal access to a full range of high-quality reproductive health services – including safe, effective, affordable and acceptable methods of family planning – through their primary health care systems by 2015 or sooner.

Being able to exercise choices in regard to fertility has a strong impact on women's reproductive health and allows them to participate in social, political and economic activities. Making family planning available also reduces maternal morbidity and mortality, and helps to prevent the transmission of reproductive tract infections (RTIs), sexually transmitted diseases (STDs), and human immuno-deficiency virus and acquired immune deficiency syndrome (HIV/AIDS).

Lack of information or opportunity prevents many women from using existing family planning services. In many countries, women need their husbands' consent for contraception or sterilization. Eliminating these obstacles would remove a serious threat to women's lives and health.

Need for Comprehensive Services

Experience around the world has shown that to address people's reproductive and sexual health needs, family planning services need to be integrated into a wider framework which addresses their overall health and well-being. Comprehensive reproductive health care can be built on the foundation of family planning programmes which already exist in the primary health care systems of some 155 countries, generally combining family planning with maternal and child health care.

Even with limited resources, such programmes can provide information, education and counselling on STDs and HIV/AIDS, and barrier methods of contraception. Others may additionally offer pregnancy testing, pregnancy and infertility counselling, and prevention and management RTIs and some STDs such as syphilis. Where there is sufficient infrastructure, staff and funding, programmes may provide still wider services including information for the prevention of abortion and management of abortion complications, post-partum maternal care and breast-feeding advice, HIV prevention and counselling, and screening and outpatient services for other reproductive health conditions.

In the effort to expand health and family planning services in poor areas, attention has generally been focused on issues of quantity, accessibility and distribution of services. In recent years, however, it has become apparent that the *quality* and acceptability of care provided are also of crucial importance and deserve increased attention. This recognition has given rise to new indicators of quality.

Critical to how women experience services and whether they continue with medical care are the exchange of information between provider and client and the quality of interpersonal relations, provider competence, and mechanisms to encourage follow-up visits. Also crucial are programme quality standards which are acceptable and achievable in the country's specific conditions. Information efforts are needed to increase women's knowledge about contraceptives and where to obtain them, and to address their concerns about health and side-effects associated with contraceptive use.

Involving Men

Men play a major role in reproductive health and family planning, particularly in decisions about contraceptive use. But they have been largely invisible as a target group in family planning programmes, contributing to low levels of contraceptive prevalence and wasting the potential offered by primarily "male methods" of contraception.

The ICPD Programme of Action states that men should be encouraged to take responsibility for their sexual and reproductive behaviour and for household obligations, to allow women to become equal partners in public and private life. Reproductive health care programmes can take a number of steps to increase male involvement, including education, encouraging better communication between partners, making services more "male friendly", and promoting community-based distribution of condoms.

Meeting the Needs of Adolescents

Married or not, very young women face higher risks in pregnancy and childbirth than those who delay child-bearing until after age 20. They are less likely to continue their education, and are more likely to have lower-paying jobs or to be jobless. They have a higher rate of separation and divorce.

Young women today are marrying later than in the past, in part because they stay in school longer. As the interval between the onset of sexual maturity and marriage increases, so does their exposure to the consequences of high-risk sexual relations – unwanted pregnancy, HIV/AIDS, and other sexually transmitted diseases.

Migration to cities, deteriorating economic conditions and other lifestyle-changing factors are undermining traditional customs and family ties that have discouraged pre-marital sex. Providing sex education in schools can help protect teenagers from the risks of sexual activity. Various innovative means are also being used to reach out-of-school youths. Young people need access to counselling on family planning, gender relations, violence, prevention of STDs including HIV/AIDS, and prevention and treatment of sexual abuse and incest. In addition, they need access to reproductive health services appropriate for their age and their community.

Elements of Reproductive Health and Family Planning Programmes

One third of the illness among developing country women aged 15-44 is related to pregnancy, childbirth, abortion, HIV and RTIs. High levels of maternal mortality and poor maternal health are closely related to the low social and economic status of women. Preventing unwanted pregnancy or protecting themselves against disease is difficult or even impossible for many women. Certain traditional practices compound women's poor health status.

Safe Motherhood

Three fourths of maternal deaths world-wide can be attributed to haemorrhage, infection, pregnancy-

related hypertension, obstructed labour, and complications of unsafe abortion; the vast majority are preventable. For every woman who dies, perhaps as many as 200 or 300 more survive to suffer from chronic illness or physical impairment; the number varies from country to country. The major factor in preventing maternal morbidity and mortality is access to appropriate health services, including family planning.

Unsafe abortion is a major threat to the health of women. World-wide, it is estimated that women have more than 40 million abortions each year. Between 26 and 31 million are performed legally, and some 20 million are performed under unsafe conditions, accounting for an estimated 67,000 deaths. An even larger number of women suffer long-term complications such as infection, pain and infertility. In some countries, adolescents account for as much as 60 per cent of those hospitalized with abortion complications. One of the achievements of the Cairo Conference was to acknowledge the danger of unsafe abortion and agree that action was necessary to deal with its consequences. While stating that "in no case should abortion be promoted as a method of family planning", the ICPD Programme of Action called on governments to deal with unsafe abortion as a major public health concern and to reduce recourse to abortion through expanded and improved family planning services.

Pregnancy can be made much safer with technologies currently within reach of all countries. Emergency obstetric care, in particular, can save countless lives. Providing high-quality family planning, prenatal and delivery care for all women are among the goals of the Safe Motherhood Initiative, a global effort to improve women's health and to reduce maternal mortality by half by the year 2000.

RTIs, STDs and HIV/AIDS

Both women and men are vulnerable to a variety of reproductive tract infections; most are transmitted via sexual intercourse. Biologically, women are more vulnerable than men to sexual transmission of infections; their low status in many countries plays a major role in the prevalence of RTIs. If untreated, RTIs can cause infertility or even death. This danger is greatest where services for diagnosis and treatment are limited, and where health workers and the public are not well-informed about RTIs.

The world-wide incidence of sexually transmitted diseases is increasing. Some 250 million people contract an STD each year, including one in 20 teenagers. Infected women are often left untreated, leading to ectopic pregnancy, chronic pain, genital tract cancer, and complications during pregnancy and delivery.

By the end of 1994, more than 1 million AIDS cases had been officially recorded, and the actual total including undiagnosed cases was estimated at 4.5 million. A cumulative total of 19.5 million people had been infected with HIV since the late 1970s, including 1.5 million children. Between 13 and 15 million of those infected are believed to be still alive. The number of HIV-positive people is estimated to reach 40 million by the year 2000.

An estimated 1.5 million people became infected with HIV in the second half of 1994, the vast majority in less developed countries. About the same numbers of men and women were affected, but the number of infections among women is increasing faster than among men. The AIDS epidemic has placed a serious strain on the already overstretched health care systems in several developing countries.

To better coordinate efforts to help developing countries respond to the HIV/AIDS pandemic, six UN agencies and organizations, including UNFPA, are establishing a joint and co-sponsored UN Programme on AIDS, scheduled to start in January 1996. The new programme will provide policy, strategic and technical guidance and assistance.

Early diagnosis and treatment of lower reproductive tract infections is the cheapest and most effective way to prevent upper tract infections. Without much additional cost, family planning and primary health care programmes can include routine RTI screening and treatment.

Male condoms are currently the most effective method for protection against many STDs. Female condoms, although not yet widely available, may also be very effective. Consumer research and social marketing techniques can greatly increase the acceptance and use of condoms, as can improvements in condoms themselves.

Family Planning

In the past 20 years, many countries have dramatically expanded the availability of family planning services, accelerating a decline in fertility rates. An estimated 57 per cent of couples in developing countries now use contraceptives compared to around 14 per cent in 1965-1970. The total fertility rate in developing countries has declined from 6.1 children per woman in the 1950s to 3.7 today. Female sterilization, oral contraceptives and IUDs account for most use of modern methods.

Practising family planning significantly reduces pregnancy-related mortality, primarily by reducing the overall number of pregnancies and related complications. Reducing unwanted pregnancies also reduces maternal deaths by reducing the recourse to abortion. Enabling women to control their fertility gives them greater control of their lives, allowing young women to continue their education without,

ANTÓNIO MAZIVE / CFF

Empowerment begins with winning equality, autonomy and respect for women within the household. An urban family in Mozambique.

for example, having it interrupted or terminated by a pregnancy.

Over 95 per cent of people in the developing world live in countries that directly support family planning programmes. The average distances that women must travel to the nearest clinic providing family planning services vary greatly, ranging from 1 kilometre in Egypt to 19 in Uganda. In general, women have much better access to family planning services in urban areas than in rural areas.

Experience shows that family planning programmes work best when they are part of, or closely linked to, broader programmes which address closely related health needs, and when women are fully involved in the design, delivery, management and evaluation of services. While governments have an interest in making family planning services available, their use must be completely voluntary; as the ICPD Programme of Action makes clear, coercion has no part to play.

Women's ability to improve their reproductive health also depends on their ability to make decisions in other aspects of their lives, and to participate fully in the life of the community. In addition to enhanced health services, improving women's health requires better living conditions and stronger roles in decision-making at all levels.

Conclusions

The international community is responding to the recommendations made in Cairo. A large number of activities have already been started to raise awareness of issues addressed by the Programme of Action. In addition, numerous countries are reviewing their policies and programmes to ensure that they conform with the ICPD recommendations. National committees have begun to delineate country implementation strategies.

In a number of countries discussions are under way and institutions are being restructured in response to the Programme of Action – including its recommendations to integrate maternal and child health and family planning programmes, and to increase the role of NGOs and community groups in formulating population and development initiatives. Financial, political, institutional and personal resources are being mobilized.

Within the United Nations system, many of the specialized agencies and organizations are formulating and implementing strategies in response to the ICPD

Programme of Action. An Inter-Agency Task Force will focus on policy development and inter-agency coordination in this regard. The Population Commission of the United Nations is being revitalized as a Population and Development Commission.

The United Nations Population Fund is reviewing and revising institutional structures, policy guidelines, policy research priorities and operational policies. The aim is to increase and focus assistance in order to improve national capacity to implement programmes in population and reproductive health. The Fund is supporting a wide variety of global, regional and national initiatives to put the Programme of Action into operation. ■

I. PROGRESS IN POPULATION AND DEVELOPMENT

THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

FROM 5 to 13 September 1994, more than 10,000 people from 180 countries gathered in Cairo at the International Conference on Population and Development (ICPD). The event brought together the views, ideas and experiences of almost all countries of the world.

The Cairo Conference agreed on a comprehensive and detailed strategy for population and development in the next 20 years, the ICPD Programme of Action[1]. The Programme of Action was the culmination of more than three years of intense deliberation and negotiation not only among governments, but also including NGOs, community leaders, technical experts and interested individuals; its success was in part the result of this inclusiveness. Some 60 per cent of official delegations included NGO representatives, a record for an intergovernmental meeting.

ICPD PROGRAMME OF ACTION: MAIN FEATURES

A New Paradigm on Population and Development

The ICPD Programme of Action marks the evolution in perception of population issues over the past two decades. It places human rights and well-being explicitly at the centre of all population and sustainable development activities. The Programme of Action moves discussion and action beyond population numbers and demographic targets: its premise is that development objectives – including early stabilization of population growth – can be achieved only by basing policies and programmes on the human rights, the needs and the aspirations of individual women and men. Human-centred development – in the sense of investing in people generally, and particularly in health, education and building equity and equality between the sexes – is seen as a firm basis for sustained economic growth and sustainable development.

The Programme of Action establishes that population issues cannot be addressed in isolation, but must be seen in a broader context of sustainable development. The Programme of Action asserts that population concerns are an intrinsic part of development and recognizes the need for action by a variety of institutions: public, non-governmental, private and community, to create options and encourage participation.

Gender Equity and Equality and Empowerment of Women

The ICPD Programme of Action recognizes that bringing women into the mainstream of development is an important end in itself and a key to improving the quality of life of everyone: there can be no sustainable human development without the full and equal participation of women. Hence the emphasis on gender equality and equity throughout the Programme of Action. For the first time, the empowerment of women is acknowledged as a cornerstone of national and international population and development policies.

Integrating Family Planning into Reproductive Health

The Cairo Conference broke new ground in all areas of reproductive health and rights, especially for women. The Programme of Action looks beyond family planning and fertility towards a comprehensive view, in which family planning is part of the wider context of reproductive health, and reproductive health is seen as an essential part of primary health care.

The document reaffirms the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so, a right first affirmed in the 1974 World Population Plan of Action. Reproductive health and family planning services are to be provided on a completely voluntary basis: coercion, whether moral or physical, has no part to play. Reproductive health care programmes should be designed to serve the needs of women and men, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services.

For the first time in the international arena, unsafe abortion is recognized as a serious health risk. The Programme of Action clears the way for governments, non-governmental organizations and international organizations to take action to minimize the incidence of unsafe abortion and to deal with its consequences. Abortion is in no case recognized as a means of family

planning; it is recognized on the contrary that adequate reproductive health and family planning services will help minimize the incidence of abortion.

Men's Responsibilities

The Programme of Action emphasizes the key role of men in bringing about gender equity and equality. In most societies, the balance of power in nearly every sphere of life rests with men, from personal decisions regarding family affairs to policy-making at all levels of government. The document urges action to emphasize men's shared responsibilities in sexual and reproductive behaviour, including family planning, and in parenthood.

The Programme of Action also recognizes the need for men to encourage the full participation of women in development, to help include women's perspectives in development strategies and programmes, and to ensure equitable treatment in employment, wages, credit access and other life opportunities. According to the Programme of Action, male responsibilities in family life should be part of the education of children from the earliest ages.

Adolescent Reproductive Health Needs

Existing family planning services largely ignore the reproductive health needs of adolescents as a group. The Programme of Action recognizes that adolescents need information and services to help them make responsible decisions. In particular, sex education and counselling services should be provided in a manner that can help them understand their sexuality in order to protect them from unwanted pregnancies, sexually transmitted diseases (STDs) and subsequent risk of

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

With regard to education, the Programme of Action urges all countries to strive towards ensuring complete access to and achievement of primary education by both girls and boys, as soon as possible and in any case before the year 2015. The goal of universal access by the year 2000 was agreed at the World Conference on Education for All, held at Jomtien, Thailand, in 1990.

In view of the importance of education in improving the status of women, the Programme of Action urges all countries to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education. [para. 4.18]

In addition, with a view to closing the gender gap in primary and secondary school education by the year 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 appropriate 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

With the aim to reduce the gap between developed and developing countries as soon as possible, the Programme of Action spells out specific infant and child mortality-reduction goals:

- Countries should strive to reduce their 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, with appropriate adaptation to the particular situation of each country. [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].
- The Programme of Action calls for significant reductions in maternal mortality by the year 2015, a reduction in maternal mortality by one half of the 1990 levels by the year 2000, and a further one half by 2015. The document further specifies that:
- Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births.
- Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births.
- 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 information and services for human health and well-being, the Programme of Action urges all countries to strive to make reproductive health care accessible through the primary health care system to all individuals of appropriate ages as soon as possible and no later than the year 2015. [para. 7.6] In addition, all countries should take steps to meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services in accord with their laws and practices.

The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. [para. 7.16] And, it should be the goal of public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways 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]

infertility. Such programmes should involve parents, recognizing their rights and responsibilities and the needs of adolescents.

The Basic Unit of Society: the Family

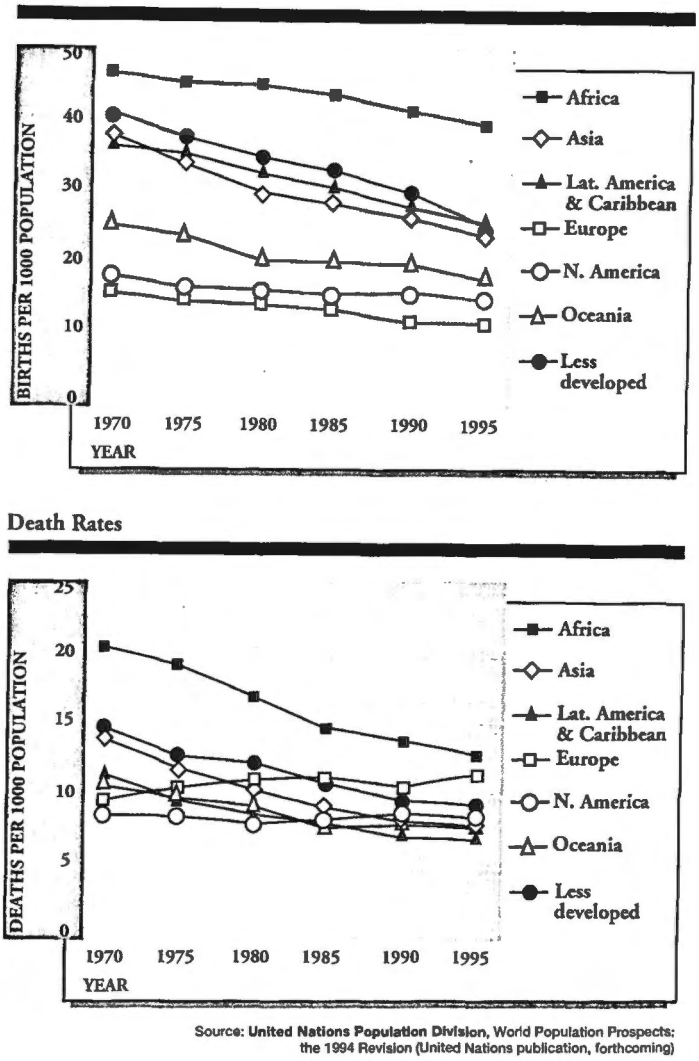
The Programme of Action explicitly reaffirms that the family is the basic unit of society and as such should be further strengthened and protected. Many recommendations are aimed at strengthening and supporting families. The Programme of Action also recognizes that there are various forms of the family in different social, cultural and political systems all over the world.

Migrants

According to the Programme of Action, the process of migration, including urbanization, is an intrinsic aspect of development which brings many benefits to both the migrants themselves and society in general. While building on these positive elements, attention should be given to easing the tremendous pressure of rapid urbanization on social infrastructure and local environments, by improving urban management and by emphasizing rural development strategies.

The Programme of Action also underlines the importance of root causes of international migration such as low levels of economic development, absence of peace and security, poverty and environmental degradation and the lack of democratic institutions. The Programme of Action pays special attention to the situation of internally displaced persons as well as to documented and undocumented migrants. The aim of most recommendations is to offer adequate protection and assistance to persons displaced within their own countries, particularly women, children and the elderly, and to international migrants.

CRUDE BIRTH AND DEATH RATES BY REGION (1970-1995)



Source: United Nations Population Division, World Population Prospects: the 1994 Revision (United Nations publication, forthcoming)

Resource Mobilization

The goals of the Programme of Action can be achieved only if sufficient financial resources are available. New and additional financial investments in the areas of population and reproductive health care and family planning services, as well as in the related areas of the social sector, will be necessary.

The ICPD Programme of Action estimates the required financial resources for a comprehensive package of reproductive health care and family planning services, programmes for the prevention of STDs including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), and population data collection, analysis and dissemination, up to the year 2015. The cost of the full population package in the developing world and for countries with economies in transition is estimated to be $17 billion (in 1993 U.S. dollars) per year by the year 2000, increasing to $21.7 billion per year in 2015. The Programme of Action recommends that these estimates be reviewed and updated regularly. [para. 13.15]

Up to two thirds of the cost will continue to be met by developing countries themselves; approximately one third will have to come from external sources – $5.7 billion in 2000 and $7.2 billion in 2015. [para. 13.16]

THE CURRENT SITUATION AND RECENT PROGRESS

Developing countries have made rapid progress in the last 25 years towards better and broader-reaching primary health care, including reproductive health care and family planning. Better health is reflected in longer life expectancies and lower birth and death rates; better health is also linked to higher education and income levels, including improvements in the educational and economic status of women.

Important shifts in attitude among individual

women and men in favour of family planning have accompanied stronger political commitment to population policies and better reproductive health care, including family planning programmes. Both create new opportunities for addressing population and development issues. The successes provide a reason for optimism about what all countries can accomplish – but they also point to many reproductive health needs that remain unmet.

Reproductive Health and Family Planning: Achievements and Needs

There has been much progress in family planning (see below), but systematic programmes to address a broad spectrum of reproductive health needs are still in their early stages. Cost-effective approaches will need considerably more conceptual development and operational and medical research. Data in many areas of reproductive health – for example maternal mortality, or male involvement – are still inadequate.

Pregnancy and Delivery Care

It is estimated that in the developing world as a whole, 59 per cent of pregnant women receive prenatal medical care. (Unfortunately, data are not available to assess how this has changed over time, since the collection of such data has only recently been made a priority.)

Among regions and subregions coverage rates vary widely, from 35 per cent in Southern Asia to nearly 90 per cent in Southern Africa, Eastern Asia and the Caribbean. Variation within nations and subregions is also considerable.

Only an estimated 37 per cent of deliveries take place at medical institutions. More important (since the site of birth can vary according to cultural and social expectations and preferences) only an estimated 55 per cent of births take place in the presence of a trained delivery attendant. (This compares to earlier estimates of 48 per cent for the mid-1980s made from less complete data.) Regional variation is also high in this regard. Only around a third of deliveries occur with a trained birth attendant in Eastern Africa, Western Africa and Southern Asia; over three quarters are attended by trained personnel in Latin America, Eastern Asia and Southern Africa. Variation within regions and within countries is also sizeable. Where data are available, they indicate some improvement within regions in the proportion of births attended by a trained deliverer.

Sexually Transmitted Diseases

Minimum estimates of the yearly incidence of common sexually transmitted diseases are 120 million for trichomoniasis, 50 million for chlamydial infections, 30 million for human papilloma virus, 25 million for gonorrhoea, 20 million for herpes simplex

Female Genital Mutilation

Female genital mutilation is a major public health issue: an estimated 80 million women world-wide have undergone the procedure. It is practised, in one form or another, in around 40 countries, mostly in East and West Africa and parts of the Arabian Peninsula. As a result of migration from these areas it is now also practised in Europe and North America.

Genital mutilation is frequently referred to as "female circumcision"; this is misleading, as it implies that the procedure is similar to male circumcision, which involves only the removal of skin. For women, the procedure is far more invasive and dangerous, and has many different variations.

There are three main forms of genital mutilation. In the "mildest" form, the tip of the clitoris is cut off. In the second form, the entire clitoris and part of the outer genitalia are removed. In its extreme form, known as infibulation, the procedure involves the removal of the external genitalia and stitching up of the two sides of the vagina to leave only a tiny opening for the passage of urine and menstrual blood.

The procedure is usually performed on young girls or adolescents, and sometimes when a woman has just given birth. Because it is generally performed outside the medical system, it can have grave health consequences. It is typically performed without anaesthesia, using unclean instruments. The girl risks immediate death from shock or severe bleeding, or death from infection which often follows. If she survives, she may permanently suffer pain during sexual intercourse, serious complications during delivery, and psychological trauma.

There are various theories about the origin of this practice. The underlying rationale often is that it attenuates sexual desire, thereby "saving" the woman from temptation and infidelity. Other theories hold that the practice is intended to enhance male sexual pleasure. Where the practice is prevalent, an uncircumcised woman may be considered unmarriageable.

Several countries have enacted laws forbidding female genital mutilation. A 1994 amendment to Ghana's criminal code makes anyone who performs the procedure liable to three years' imprisonment. Burkina Faso and Niger in 1990 established committees to formulate and implement strategies to progressively abolish female genital mutilation and other harmful practices, and to educate the population about these practices. However, the tradition remains deeply rooted. To eradicate it, more national and community education programmes need to be created.

The ICPD was the first international conference to squarely address the issue of female genital mutilation. The ICPD Programme of Action calls on the international community to eliminate the practice, underscoring that it violates basic human rights and constitutes a major lifelong risk to women's health. Paragraph 4.22 of the Programme of Action states: "Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices."

Sources: Fathalla, Mahmoud F. 1992. "Reproductive Health in the World: Two Decades of Progress and the Challenge Ahead." Discussion Note. Expert Group Meeting on Population and Women, Gaborone, Botswana, 22-26 June 1992; Arkutu, Anamie A. 1992. Your Health, Your Pregnancy: A Guide for the African Women. *New York: Family Care International; Boland, Reed (Annual Review of Population Law, Harvard Law School). January 1995. Personal communication.*

virus and 3.5 million for syphilis. Sexually transmitted diseases are an important co-factor facilitating the spread of HIV, which causes AIDS. They are also implicated in infections of infants and as a cause of premature birth and low birth weight.

Cancers of the cervix take the lives of 300,000 women per year, second only to breast cancer in the incidence of female cancers. A strong link has been found between the disease and infection of the cervix by the human papilloma virus. In the poorer countries, most cases are diagnosed in women over age 35, but the disease usually begins to develop at a much earlier age. Only about half of the 900,000 women believed to be suffering from the disease have been diagnosed.

The HIV/AIDS pandemic continues to intensify. It is estimated that 6,000 new HIV infections occur each day and that 17 million people have already been infected, 4 million of whom have developed AIDS. While sub-Saharan Africa has had the highest regional rate of prevalence of HIV, with about 12 million infected, significant increases have been noted in South and South-eastern Asia, with an estimated 2.5 million currently infected. The toll exacted by the disease continues to increase.

Unsafe Practices

Unsafe abortions pose a significant public health risk. It is estimated that maternal deaths due to unsafe abortions are now around 67,000 per year. Reduction of the number of abortions and proper care and counselling for survivors of unsafe abortion procedures are urgently required.

Female genital mutilation is a practice that damages the health and lives of an estimated 85 to 114 million girls and women. Each year it is estimated that about 2 million or more girls undergo the practice. Most female genital mutilation creates some health complications which may occur immediately or shortly after the practice is performed. Some complications can occur years after the initial event. Women's organizations, human rights groups, and national and international media are focusing increased attention on the practice. The ICPD was the first international conference to speak out plainly against it.

Family Planning

Over the past three decades contraceptive use in the developing countries of Africa, Asia and Latin America has increased from around 14 per cent to 57 per cent; birth rates have fallen by 45 per cent and family size (total fertility) by nearly half.

These international trends, while highly encouraging, conceal great diversity among countries and regions. In Western Europe, North America and much of East Asia, access to family planning is almost universal, contraceptive use is between 65 and 80 per cent, and average family size is near or below replacement-level fertility of roughly two children per couple. By contrast, in most sub-Saharan African and some Pacific Island countries, a few of which have made rapid progress recently, family planning services are not yet widely available, contraceptive use is below 15 per cent, the desired family size has declined modestly, and women bear an average of six or more children.


UN PHOTO 152,240 / JOHN ISAAC

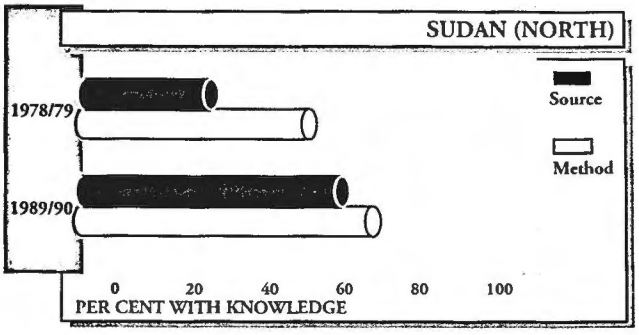
Examining a child at a clinic in Egypt.

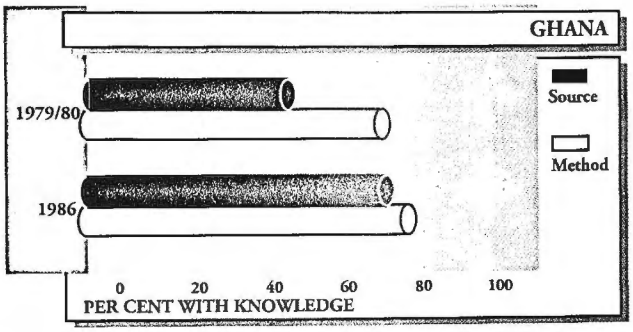
At the global level, an estimated 350 million couples do not have access to a full range of modern family planning information and services. At the same time, an estimated 120 million women would be practising a modern family planning method, if it were available, affordable and acceptable by her husband, family and community. (One indication of the large unmet demand for more and better family planning services is the more than 40 million abortions performed every year, an estimated 20 million of which are carried out under unsafe conditions.[2])

Greater attention is being paid to the improvement of the quality of family planning services and of their responsiveness to the perspectives of clients. Many national programmes have diversified their service delivery systems in order to involve public institutions, non-governmental organizations, the private sector and community organizations.

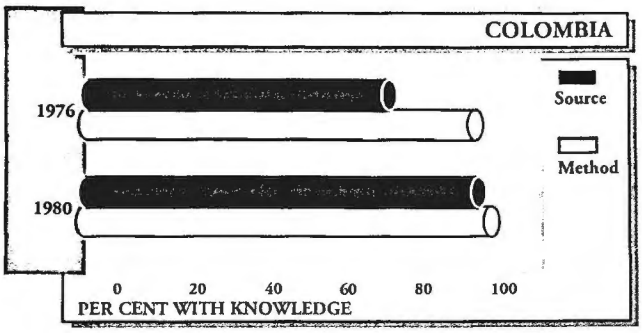
GROWTH IN KNOWLEDGE OF CONTRACEPTIVE METHODS AND SOURCES

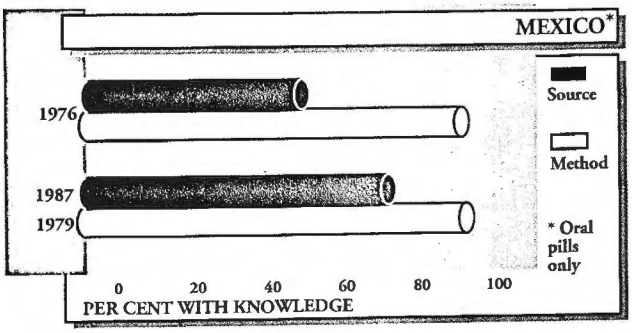
Sub - Saharan Africa



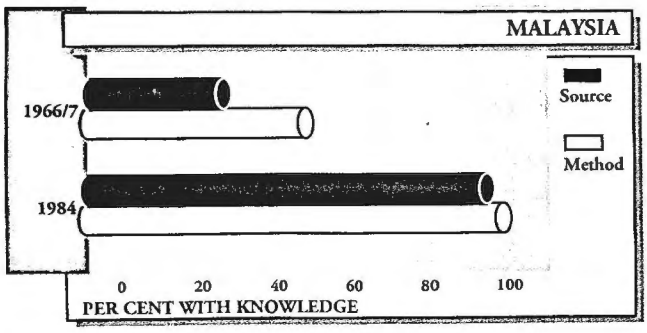


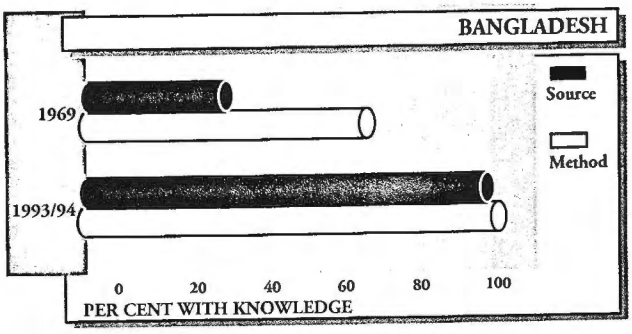
Latin America and the Caribbean



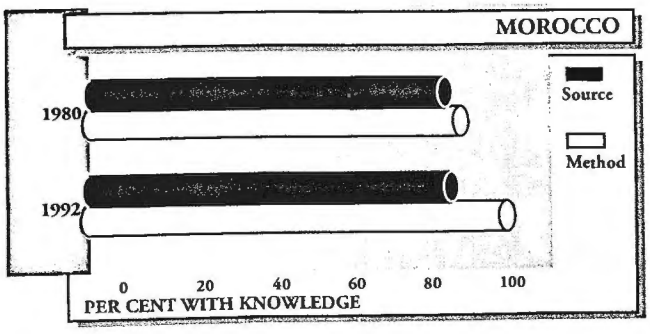


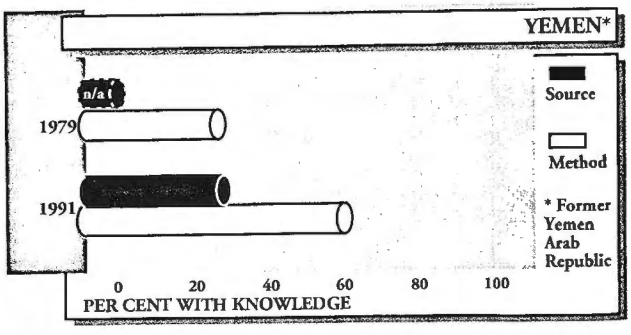
Asia





West Asia / North Africa





Source: **United Nations Population Division**, Levels and Trends of Contraceptive Use as Assessed in 1994 (United Nations publication, forthcoming)

Maternal Mortality: Fewer Women Die

Though fewer women are dying as a result of pregnancy and childbirth, maternal death rates are 15 to 50 times greater in the developing world than in most developed countries. Average maternal mortality in developing regions is about 420 deaths per 100,000 live births, compared to just 30 deaths per 100,000 live births in developed regions. At least half a million women die each year as a consequence of pregnancy and childbirth, with 99 per cent of those deaths occurring in developing countries.

Almost all of those deaths could be prevented with quality prenatal examinations, proper medical referrals and emergency obstetric first aid and referral care. In a few countries, as many as half of maternal deaths may result from unsafe abortions; in many countries, they result from the absence of the most basic antenatal, maternity and post-natal care.

Maternal Morbidity: The Hidden Scourge

Evidence is coming to light that illness and injury as a result of pregnancy are much more prevalent than was previously thought. For each death, hundreds of women may fall ill or suffer injury, some of them for life.

Better reproductive health is one of the bases for social and economic development, as experience in Singapore, the Republic of Korea, Malaysia, Thailand and an increasing number of developing countries has shown. These countries invested heavily in education, health care and special programmes for women from an early stage in their development, and have emphasized information and services on maternal and child health care, including family planning.

OTHER INDICATORS

Over the past 20 years, average life expectancy has increased by 3.5 years in the developed regions, from 71 to 74.6 years, and by 8 years in the developing countries, from 54.5 to 62.4 years. These gains are a major accomplishment. But further gains may be jeopardized in many parts of the world by prolonged economic recession, poorly designed structural adjustment programmes that have reduced already low levels of public health expenditure, and recent dislocations in the health infrastructures of most countries with economies in transition. In many parts of the world growing environmental health problems, the increasing prevalence of substance abuse and the AIDS pandemic are all contributing to high levels of morbidity and mortality.

Infant Mortality Rates Drop

Remarkable, albeit uneven, progress has been made over the past 20 years in reducing levels of morbidity and mortality, especially high death rates among young children. Infant mortality for the world as a whole has dropped by one third, from 92 to 62 deaths per 1,000 births. But much remains to be done both in further reducing both infant and child morbidity and mortality levels and in narrowing the large gap between developing and developed countries (infant mortality is currently 69 and 12 deaths per 1,000 births in developing and developed countries, respectively).

Education on the Rise

Levels of education have risen considerably during the past few decades and in many parts of the world the gap in educational attainment between males and females has narrowed. None the less, the estimated number of illiterate persons in the world, two thirds of them women, is almost 960 million. Some 130 million children, including over 90 million girls, are denied access to primary schooling. The large remaining shortfalls in basic education and adult literacy, particularly among girls and women, continue to be major obstacles in many countries to progress in every sphere of their development.

Women's Roles are Changing

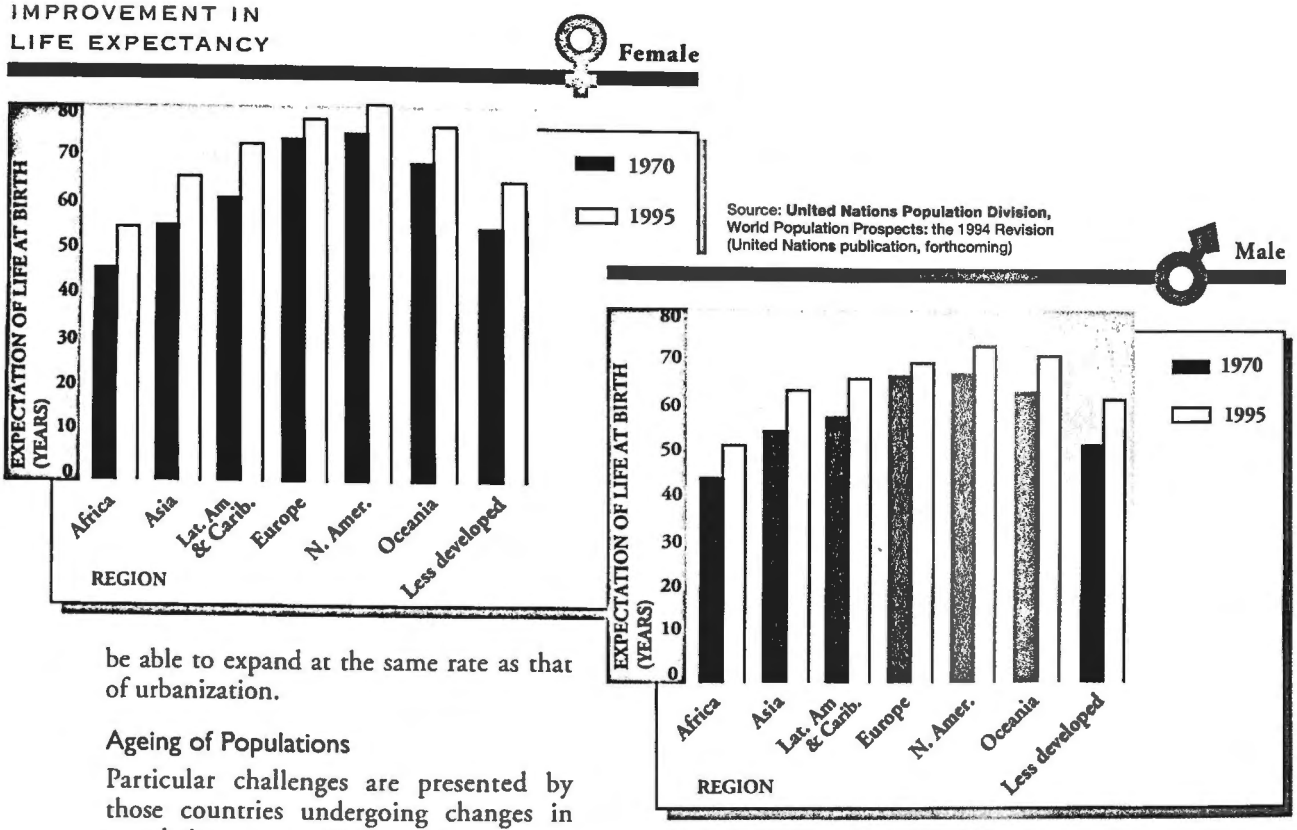
Significant changes have occurred in the roles and status of women in many countries. In addition to gains in education, women have been entering the labour force in record numbers, many of them in non-traditional economic roles. In many countries, women's monetary incomes are an important source of support for families.

But not all recent trends have been positive for women and their families. In some communities the movement of men in search of employment and the failure of men to meet their family responsibilities means that women are left as the principal or only source of support for themselves and their children. Often these households are the poorest of the poor in part because women have less access than men to training, credit, property, natural resources and better-paid jobs.

Growing Urbanization

The decades ahead are destined to produce a further shift of rural populations to urban areas as well as continued high levels of migration between countries. These migrations are an important part of the economic transformations occurring around the world. But they also present serious new challenges. By the year 2015, nearly 56 per cent of the global population is expected to live in urban areas, compared to under 45 per cent in 1994. The most rapid rates of urbanization will occur in the developing countries. The urban population of the developing regions was just 26 per cent in 1975, but is projected to rise to 50 per cent by 2015. This change will place enormous strain on existing social services and infrastructure, much of which will not

IMPROVEMENT IN LIFE EXPECTANCY



Source: **United Nations Population Division,** World Population Prospects: the 1994 Revision (United Nations publication, forthcoming)

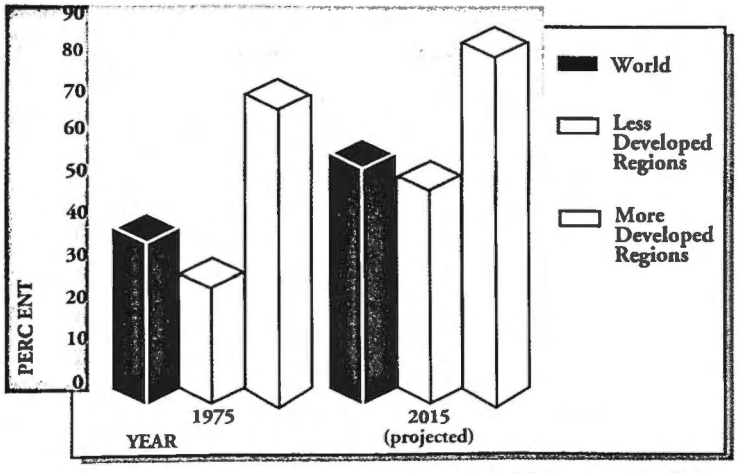
be able to expand at the same rate as that of urbanization.

Ageing of Populations

Particular challenges are presented by those countries undergoing changes in population composition, resulting in an increased proportion of elderly people due to increased life expectancy coupled with declining birth rates. In 1950, there were nearly 12 people aged 15-65 for every person aged 65 and older; today there are fewer than 10 and it is expected that there will be fewer than 7 in 2025. In developing countries this ratio is expected to decline from nearly 13 today to just over 8 by 2025. This includes both countries with very low fertility rates and countries with high fertility rates.

Included in the latter category are those developing countries that are undergoing very rapid demographic transition and, as a result, will need to accommodate in the near future large numbers of elderly persons, often with limited national resources to draw upon. These changes have major implications for every area of social and economic activity.

INCREASE IN POPULATION LIVING IN URBAN AREAS (1975-2015)



Source: **United Nations Population Division,** World Urbanization Prospects: the 1994 Revision (United Nations publication, forthcoming)

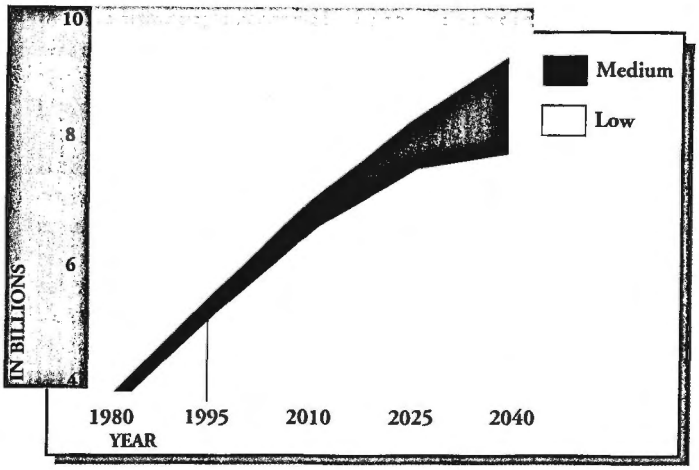
Population Growth Remains High

Although rates of growth have fallen and will continue to fall, world population is 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 increments of 1 billion took 33 years, 14 years and 13 years. The transition from the fifth to the sixth billion is expected to take only 11 years and to be completed by 1998. At mid-1995, world population was 5.75 billion.

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 7.1 billion people in 2015 to a high of 7.8 billion. The difference of 720 million people in the short span of 20 years is nearly equivalent to the

current population of the African continent. 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.

ACTUAL AND PROJECTED WORLD POPULATION GROWTH



Source: **United Nations Population Division,** World Population Prospects: the 1994 Revision (United Nations publication, forthcoming)

THE UN SOCIAL DEVELOPMENT AGENDA FOR THE 21ST CENTURY

The ICPD Programme of Action contains a series of recommendations for immediate follow-up at the national and international levels.

At the international level, population assistance will be greatly affected by the outcome of the Conference. In order to be able to assist developing countries in achieving adequate and acceptable levels of implementation of the Programme of Action, follow-up activities at the international level will be centred around four issues: adjusting international population policies and programmes, mobilizing financial resources, international coordination and monitoring.

The Cairo Conference was one in a series of international conferences organized by the United Nations in the first half of the 1990s, starting in 1990 with the World Summit for Children, followed by the 1992 United Nations Conference on Environment and Development, and the 1993 World Conference on Human Rights.

By putting people in the centre of the discussion on development at ICPD, the tone was set for two major conferences which the United Nations convenes this year, the World Summit for Social Development, and the Fourth World Conference on Women. The World Summit for Social Development took place from 6-12 March in Copenhagen and addressed three core issues: the enhancement of social integration, particularly of disadvantaged and marginalized groups; the alleviation and reduction of poverty; and the expansion of productive employment.

From 4-15 September the international community will gather in Beijing for the Fourth World Conference on Women: Action for Equality, Development and Peace. The participants will review and appraise the progress of women since the 1985 Nairobi Forward-looking Strategies for the Advancement of Women to the Year 2000. A Platform of Action will be adopted, emphasizing some fundamental obstacles to the advancement of women. It will include key issues such as decision-making power, literacy, poverty, health, violence, refugees and technology.

Next year, the Habitat II Conference in Istanbul

UNFPA RESPONSES TO THE ICPD

The United Nations Population Fund is vigorously responding to the instructions of the international community outlined in the ICPD Programme of Action. This response is on many levels including changes in institutional structures, policy guidelines, operating procedures and collaborative activities.

INSTITUTIONAL CHANGES

These include:

- Establishing a new coordinating Task Force on ICPD Implementation to ensure a rapid and coordinated response by governments (donors and recipients), international and national non-governmental organizations and regional and international financial institutions.
- Establishing the Reproductive Health/Family Planning Branch (formerly the Maternal and Child Health/Family Planning Branch) to emphasize the expanded focus on reproductive health.
- Establishing the Gender, Population and Development Branch (formerly the Women, Population and Development Branch) to fully reflect the variety of gender-sensitive concerns which need to be implemented in programmes, including male participation and recognizing male responsibilities.
- Strengthening the Interregional and NGO Programme Branch and working on mechanisms for more effective collaboration with non-governmental organizations.

The recommendations of the ICPD have become the touchstone for the evaluation of institutional arrangements, procedures and policies in the Fund.

POLICY REVIEWS

The categories of activities which the Fund will support within the broad thematic directions of the ICPD are being re-evaluated. Policy Guidelines inform national governments (including donor governments) of the priorities for UNFPA funding.

All existing guidelines are under review and will be reissued in the coming year, made fully consistent with ICPD priorities. New guidelines are under development in the areas of:

- Reproductive health
- Gender, population and development
- Population and sustainable development
- Information, education and communication (IEC)
- Non-governmental organizations (NGOs)

will address world needs for improvements in housing. It will address a range of issues associated with habitable living spaces – including infrastructure, clean water, sanitation, transportation, land use planning, the urban environment and safety – and sustainable economic and social development.

Common to the series of United Nations conferences is a call for social development which expands opportunities for individual women and men and their families. Such development would empower people to participate in the attainment of their social, economic, political and cultural aspirations. It is through such a human development perspective that the goal of achieving truly sustainable development may be achieved.

The keystone of the ICPD Programme of Action is the chapter on Gender Equality, Equity and the Empowerment of Women (Chapter IV). It is crucial for any international meeting on social development to acknowledge that improving women's status depends in the first instance on their personal autonomy, especially in the area of sexuality and reproduction. This means that they must have access to reliable information, to quality family planning services, and to the other services necessary for full reproductive health. The ability to make free and informed decisions on the number and spacing of their children is the first step in enabling women to exercise other choices. It is the first step towards acknowledging that women have many roles other than reproduction. ■

WORLD SUMMIT FOR SOCIAL DEVELOPMENT

The World Summit for Social Development (WSSD), held in Copenhagen from 6-12 March 1995, adopted a Declaration and Programme of Action which reiterate and build upon many of the agreements reached at the 1994 International Conference on Population and Development and earlier conferences.

For example, the Declaration states, "We acknowledge that social and economic development cannot be secured in a sustainable way without the full participation of women and that equality and equity between women and men is a priority for the international community and as such must be at the centre of economic and social development."

In Chapter 2 on the **Eradication of Poverty, the WSSD Programme of Action** restates goals articulated in Cairo in regard to access to education; life expectancy; and infant, under-five and maternal mortality.

It calls on governments to make reproductive health care universally accessible through the primary health care system no later than 2015 and to ensure that people living in poverty and low-income communities have access to affordable, quality health care services. It states that governments and non-governmental organizations should cooperate to develop comprehensive national strategies for improving reproductive and child health care — including education about and services for family planning, safe motherhood and pre-natal and post-natal care, and the benefits of breast-feeding.

In committing to promote and attain "universal and equitable access to quality education, the highest attainable standards of health, and the access of all to primary health care", the conference pledged "to rectify inequalities relating to social conditions" and to act "without distinction as to race, national origin, gender, age, or disability; respecting and promoting our common and particular cultures.... The purpose of these activities is to eradicate poverty, promote full and productive employment and to foster social integration."

Chapter 3, **The Expansion of Productive Employment and the Reduction of Unemployment**, calls on governments to safeguard and promote respect for basic workers' rights, including equal remuneration for men and women for work of equal value, and non-discrimination in employment.

Chapter 4, **Social Integration,** affirms that the family, as the basic unit of society, should be strengthened and should receive comprehensive protection and support; marriage must be consensual, and husbands and wives should be equal partners.

For the first time in a United Nations document, the Copenhagen agreements call for an increase in official development assistance (ODA) "both in total and for social programmes". They endorse a version of the "20/20 initiative", calling for "a mutual commitment between interested, developed and developing partners to allocate, on average, 20 per cent of ODA and 20 per cent of the national budget, respectively, to basic social programmes".

Source: United Nations. March 1995. Adoption of the Declaration and Programme of Action of the World Summit for Social Development. *New York: United Notions.*

THE CONCEPT OF EMPOWERMENT

In many, if not most, societies, women are still considered less valuable than men. Their many contributions in the home, the workplace, and the community are overlooked and undervalued. Women often derive status only from child-bearing and child-rearing; yet even in these roles they are given minimal support. All too often, women have little or no voice in decisions made either within or outside the household, starting with the crucial decision on the size and spacing of the family. This weaker position is directly connected with the perception of women only as child-bearers and child-rearers, whatever else they may do. Power to make decisions within the family is the basis for the power of decision in other areas. Empowerment begins with winning equality, autonomy and respect for women within the household.

In most societies, and particularly in the developing world, women's access to positions of influence and power is limited; their occupational choices are narrower, and their earnings lower than those of men; and they must struggle to reconcile activities outside the home with their traditional roles. While many men, particularly among the poor, also find themselves disfranchised, it is a far more common experience among women. This experience is rooted in failure to value women for anything but their reproductive role.[1]

The ICPD Programme of Action states that the empowerment of women and the improvement of their political, social, economic and health status are not only important goals in themselves; they are also essential for the achievement of sustainable development. [para. 4.1]

THE ROLE OF WOMEN'S EDUCATION

THE IMPACT OF WOMEN'S EDUCATION

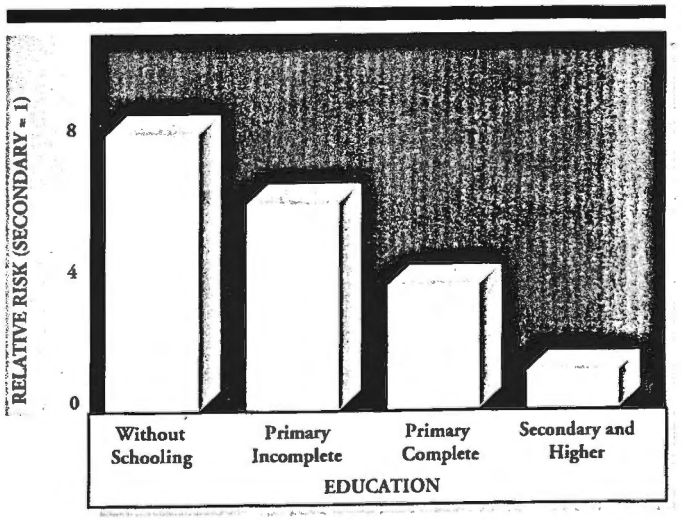
According to the ICPD Programme of Action, education, together with reproductive health (the subject of Chapter III of this report), is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in the development process. Promoting the education of women and girls contributes to postponement of the age of marriage, and to a reduction in the size of families.

Education enables women to respond to opportunities, to challenge their traditional roles, and to change their life circumstances, eroding resignation and substituting for it "a degree of confidence, an awareness of choice, a belief that decisions can be made, circumstances changed, and life improved."[2] One of the best measures of women's current and future status is the proportion of women relative to men in tertiary-level academic institutions, from which future leaders are most likely to arise.[3]

Educated women are more likely to enter the paid labour force.[4] They are also more receptive to new ideas regarding health, nutrition, family planning, technology, marketing, the environment, and political participation.[5] Educated women pass on their knowledge to their peers and other family members, particularly their daughters, thereby multiplying the effects of their own education many-fold.

While education is essential for both boys and girls, the benefits of educating girls tend to be greater. Female education has been found to have a more significant impact on poverty reduction and the promotion of sustainable development, by influencing

EDUCATIONAL ATTAINMENT AND MATERNAL MORTALITY, MEXICO (1990)



Source: Lozano, Rafael, Bernardo Hernandez, and Ana Langer. "Factores Sociales y Económicos de la Mortalidad Materna en México." In *Maternidad sin Riesgos en México*, María del Carmen Elu and Ana Langer (eds.), 1994. Mexico City: IMES/Comité Promotor de la Iniciativa por una Maternidad sin Riesgos en México.

family size and female labour force participation.[6] The effects of women's education on fertility are well documented: it encourages later marriage and greater use of contraception. In Benin, for example, women with no education marry at an average age of 16.9, while those with seven or more years of education marry at an average age of 24.1.[7] Women's education is strongly associated with contraceptive use, even when controlling for income and class.[8]

Education also enhances a woman's sense of her own health needs and perspectives, and her power to make health and family planning decisions. It enables her to be more assertive and questioning in her dealings with health care and family planning personnel, with commensurate personal and family benefits. Studies in Indonesia, Cameroon, and India have found that mothers with higher self-esteem play more assertive roles in child feeding and act more swiftly when children are ill.[9]

Moreover, because they are more likely to seek appropriate care and have fewer children, and are less likely to begin bearing children when they are very young, educated women are less likely to die or suffer ill-health during pregnancy and child-bearing. In Mexico, for example, the risk of maternal mortality is eight times higher for uneducated women than for women with at least some secondary education.[10]

An example from sub-Saharan Africa also illustrates this relationship. If 1 million uneducated women began child-bearing while still young and had the typical average of six births, 50,000 of them would die from pregnancy-related causes. In comparison, 14,000 maternal deaths would occur per million better-educated mothers who began bearing children later and typically averaged only four births each.[11]

Despite the near-universal advantage of female education, however, parents tend to prefer to educate their sons, given women's role in the household economy and the perceived disadvantage of investing in a girl child who will marry into another family and take with her the advantages she has gained.[12] As stated by the ICPD Programme of Action, the value of girl children to both the family and society must be expanded beyond their role as potential child-bearers and reinforced through educational policies that encourage their participation in the development of the societies in which they live. [para. 4.17]

WOMEN'S EDUCATIONAL STATUS

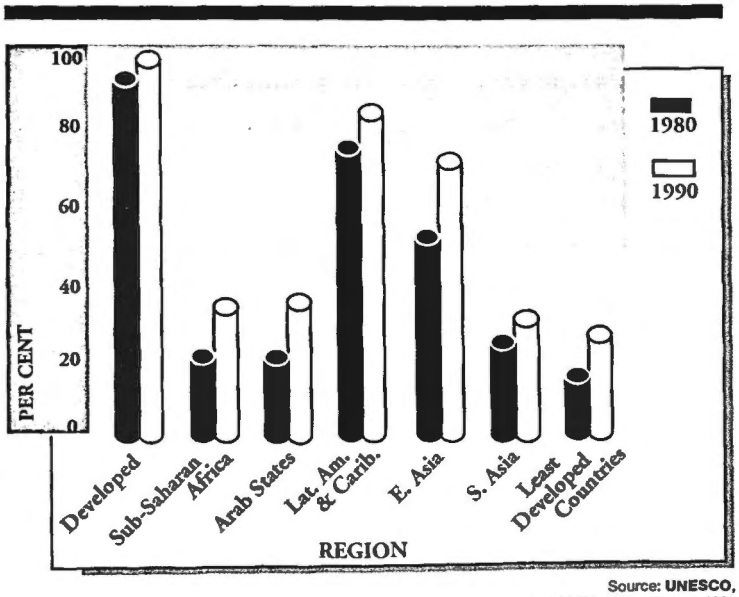
Although the spread of radio and television is providing an increasing amount of information to a growing number of people at an ever-decreasing cost, print puts power in the hands of the reader in a way that radio and television do not. As the ICPD Programme of Action notes, it is urgent for education programmes to reach the 960 million illiterate adults in the world, two thirds of whom are female. [para. 4.2]

Literacy rates are going up. It should again be noted, however, that regional averages mask significant intra-regional variations. While female literacy in the Arab world is around 60 per cent, for example, in Egypt, Morocco, and Algeria it remains below 50 per cent, and in the Sudan it is only 11.7 per cent.[13] There are numerous countries where the literacy rate among 15-24 year-old women remains below 80 per cent: in Haiti, for instance, 51 per cent of 15-24 year-old women are literate; in Nepal, the corresponding figure is 14.9 per cent.[14] In addition, rural women remain particularly disadvantaged. In Africa, for example, only 25 per cent of rural women are literate, compared to more than 50 per cent of their urban counterparts.[15]

Moreover, the gender gap in literacy persists; again, this is particularly true in rural areas. In India, literacy rates are 39 per cent among women, and 64 per cent among men. Significant intra-country differences also persist: literacy remains particularly low in the four large northern states of Bihar, Uttar Pradesh, Rajasthan, and Madhya Pradesh, at around 25 per cent in 1991 compared to an average of 48 per cent in other Indian states.[16] The gender gap also remains wide in Egypt: while literacy rates have increased from 30 to 50 per cent over the last 25 years, 27 per cent of females are literate, compared to 63 per cent of males.[17]

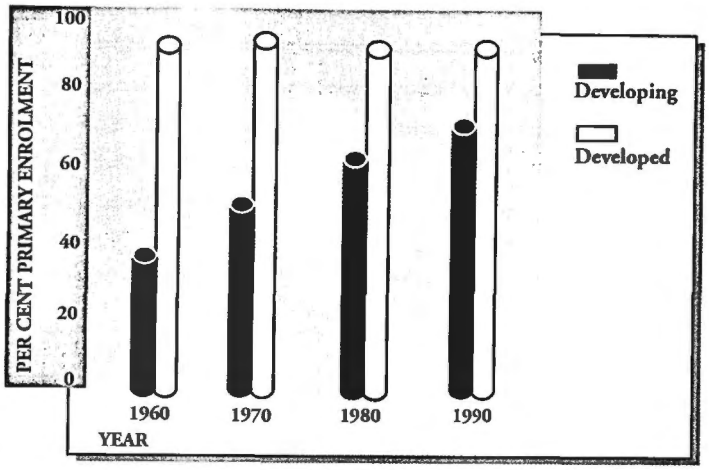
Girls and boys have edged nearer to parity in primary school enrolment around the world, except in Africa, especially south of the Sahara,

GROWTH IN FEMALE LITERACY LEVELS



Source: UNESCO, *World Education Report 1993*

INCREASE IN ENROLMENT RATIOS FOR GIRLS AGED 6-11



Source: **UNESCO,** *Trends and Projections of Enrolment by Level of Education and by Age, 1960-2025 (as assessed in 1993)*

and in Asia, especially South Asia.[18] In most regions, the higher the level of education, the lower the proportion of women to men.

Even in parts of the industrialized world, the ratio of women to men enrolled in higher education is unusually low: in Austria, 80 women per 100 men are enrolled at the tertiary level; in Belgium, 78; in Japan, 63; in Switzerland, 53; and in Luxembourg, 52.[19] In some countries, while boys and girls have roughly the same chance of entering school, girls are less likely to remain in school. A survey in India, for example, found that while approximately 60 per cent of rural children were enrolled in school, only 15 per cent of girls remained after five years, compared to 35 per cent among boys.[20]

There are signs of significant progress, however. In Kuwait and Bahrain, for example, women's secondary school enrolment is exactly the same as men's, and more women are enrolling in universities than men.[21] Among university students in the Philippines and Cuba in 1990, there were 143 and 136 females, respectively, per 100 males.[22]

Even in countries where girls have increasing access to education, they are often channelled into traditionally "female" fields of study that enhance their traditional roles in society.[23]

As the ICPD Programme of Action states, countries must also recognize the importance of eliminating gender bias in all types of educational materials that enforce – and reinforce – existing inequities. The stereotypical portrayal of women in such materials undermines girls' self-esteem and hinders their educational advancement. Teachers' attitudes and practices, school curricula, and facilities must reflect a commitment to eliminate gender bias. [para. 4.19]

Access to education alone is insufficient. The quality of the education – what girls learn and how they learn it – determines the impact of education on behaviour.[24]

Programmes to Enhance Women's Education

Given the multiple benefits of women's education, numerous innovative programmes have been instituted by governments, bilateral and multilateral agencies, and NGOs to help increase and sustain the enrolment of females in education, often with significant results.

The ICPD Programme of Action makes a range of recommendations for improving women's educational status, including: ensuring equal access to education, through efforts to enhance both enrolment and retention; according the highest development priority to the eradication of illiteracy among women; improving access to vocational and technical training, and to continuing education; and developing non-discriminatory education and training programmes.

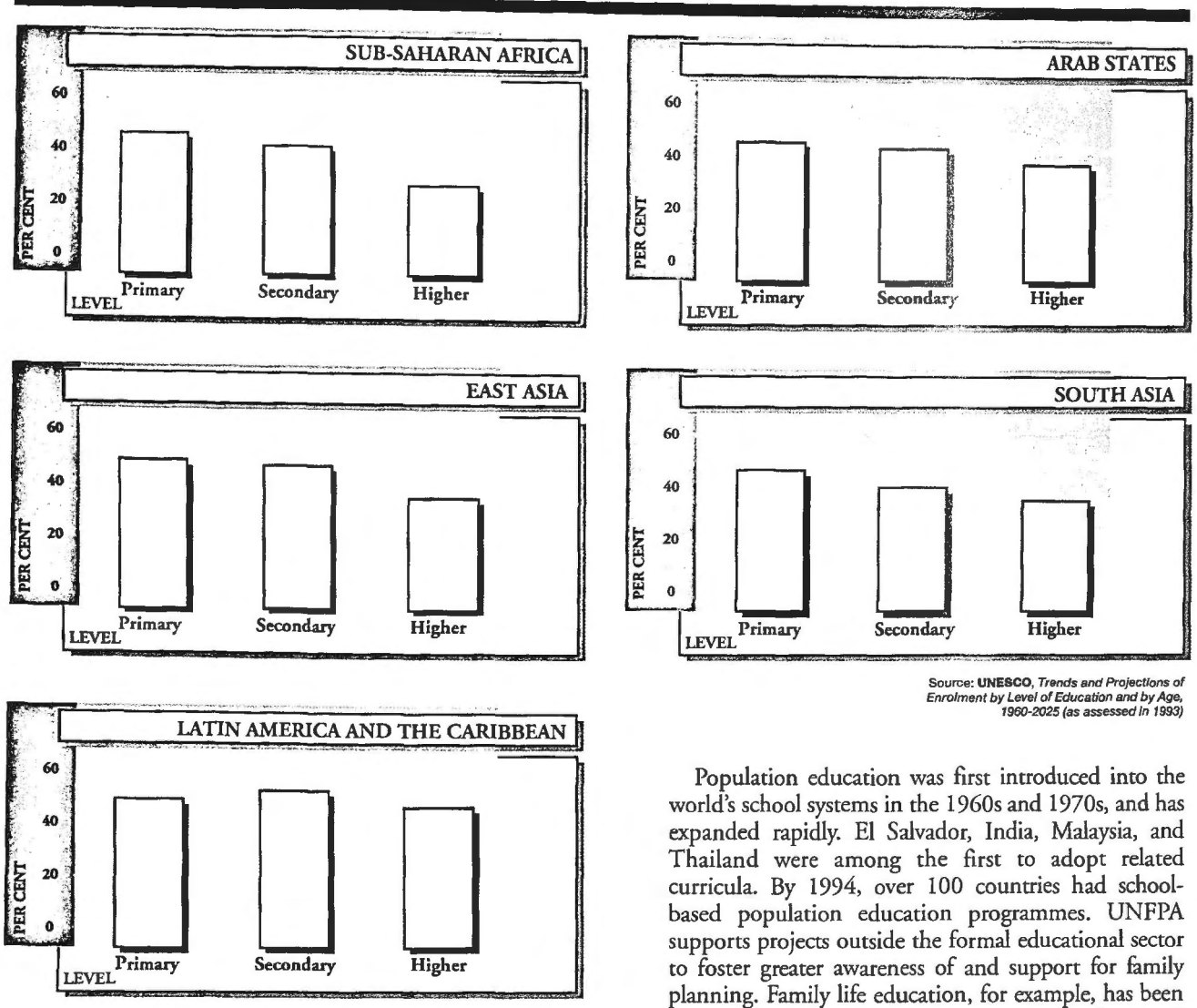
It is also important not to steer women towards a "women's curriculum". Between 1970 and 1985, efforts to expand opportunities resulted in more women entering traditionally male-dominated fields of study in several countries.[25]

Scholarships and other financial support for female education are particularly necessary in situations where girls are undervalued. In Bangladesh, for example, a United States Agency for International Development project provided secondary school scholarships to girls living in project areas, increasing enrolment by nearly 50 per cent; significant delays in age at marriage and increases in contraceptive use among the women involved were also noted.[26] Various NGOs are spearheading efforts to increase female educational enrolment in the Arab world.[27]

In Peru, a study found that girls were three times more likely to enrol in school if textbooks were provided free of charge; no corresponding changes in male enrolment were noted.[28] Innovative and often cheaper alternatives may also increase female enrolment and enable girls to remain in school once they have begun. These include flexible school hours and calendars which make it possible for girls to continue with their education while keeping up with their responsibilities in the home; school-based child care for younger siblings, for whom older daughters are often responsible; and situating girls' schools closer to their villages.

The Government of Jamaica, with assistance from

PERCENTAGE OF FEMALE ENROLMENT BY LEVEL OF EDUCATION AND REGION (1991)



Source: **UNESCO**, *Trends and Projections of Enrolment by Level of Education and by Age, 1960-2025 (as assessed in 1993)*

the International Planned Parenthood Federation and the Pathfinder Fund, established five centres to help young mothers finish school. The centres help young mothers catch up with school work after giving birth, provide family planning services, and help finance school uniforms and tuition. Between September 1985 and June 1987, 55 per cent of the young mothers in the programme returned to school, compared to only 15 per cent of those not enrolled.[29]

The Zimbabwe National Family Planning Council launched a project to improve women's access to education, as well as income-producing opportunities and family planning. Each local women's group involved in the project chooses a member to be trained as a "teacher". These women then offer literacy workshops, and provide training and counselling in health, family planning, bookkeeping, marketing, and a range of other areas.[30]

Population education was first introduced into the world's school systems in the 1960s and 1970s, and has expanded rapidly. El Salvador, India, Malaysia, and Thailand were among the first to adopt related curricula. By 1994, over 100 countries had school-based population education programmes. UNFPA supports projects outside the formal educational sector to foster greater awareness of and support for family planning. Family life education, for example, has been integrated into the educational programmes of workers' unions, national cooperatives, and adult literacy courses in almost all regions where UNFPA is active.[31]

Women and Decision-Making

If the power of decision about pregnancy and childbirth does not belong to a woman, then her power of decision in other areas in jeopardized. The health aspects of this question are dealt with more fully in Chapter III on Reproductive Health and Family Planning. Crucial interventions concern communications within couples, and initiatives to gain the support of men for women's empowerment.

Strengthening women's position in both written and customary law will help to create an enabling environment for individual decision-making. It will be assisted by the presence of women policy makers in politics, national and local administration, the legal system, and the economy.

CRITICAL ALLIANCES: GETTING MEN INVOLVED

Critical alliances between men and women are beginning to emerge in the reproductive health arena. It is clear, for example, that women cannot adequately "protect their sexual and reproductive health in the context of power imbalances with their male partners...." Male-female collaboration in this area is essential to the development of more caring, responsible sexual relationships and to redress gender power imbalances.[32] "Men must be involved because they share the responsibility of reproductive health, and both men and women do not understand their own and each other's bodies."[33]

Men's roles as fathers tend to be unspecified and unsupported by policies and programmes, though their commitment to their children is integral to the quality of family life, and to the prospects of the next generation. It is imperative, for example, to provide boys with different images of what it means to be "male" – that is, caring, informed, and responsible.[34] As the ICPD Programme of Action states, more efforts need to be made to collect information on and support the preparation of boys for effective fatherhood, responsible masculinity, more equal participation in decision-making regarding contraception and fertility, and fuller participation in caring for children. This will be helped by legislation favouring male responsibility – for example family leave for fathers. [para. 4.26]

The "Father Project" in Colombia seeks to teach men that they are responsible, along with their partners, for their children's development. The project utilizes pamphlets about fathering and values, television spots about communication, and the distribution of children's books about fathering in its efforts to promote male participation in pregnancy, childbirth, and the rearing of children, and to encourage them to become full partners in their families, as fathers, husbands, and friends.[35]

Fathers have generally been excluded from the provision of care to their partners in the period following childbirth, for example, although this is a critical time during which they can provide support to their partners, as well as bond with their children.[36] Programme experience in countries as diverse as the United States, Jamaica, and Cameroon have shown that men respond very well to efforts to involve them in the post-partum period.[37] Additional work being undertaken by the Population Council in collaboration with local NGOs is under way to explore the role of men in post-partum care in other countries, including Chile and Turkey.[38]

HASIK (Harnessing Self-Reliant Initiatives and Knowledge), an NGO in the Philippines, collaborated with other NGOs to develop a model of gender sensitivity training for men in response to the need to work with both men and women in improving understanding of gender relations. Through workshops, HASIK deals with such manifestations of gender bias as marginalization, subordination, gender stereotyping, double workloads, and violence against women. The group works with men to discuss the problems and their causes, and to develop plans of action to combat them.[39]

In the United States, men's groups are mobilizing in an effort to change attitudes and behaviour related to male sexuality and gender roles. One of these groups, "Men Acting for Change," which comprises students, faculty, and alumni, was formed by male students at Duke University in response to their concerns regarding violence against university women.[40] The Oakland Men's Project in California, a non-profit, multiracial organization of both men and women, aims to eradicate male violence, among other social

A WOMAN'S DAY OR A MAN'S DAY?

Which would you prefer if you could choose? The Swedish International Development Agency outlined a typical day for a man and a woman in a family that grows both cash crops and its own food supply, in its journal, *Striking a Balance*. The family lives "somewhere in Africa".

The woman's day does not change if she is pregnant. There is little time to spare to visit a medical centre for regular prenatal care.

A WOMAN'S DAY	A MAN'S DAY
rises first	
kindles the fire	
breast-feeds the baby	
fixes breakfast/eats	rises when breakfast is ready
washes and dresses the children	eats
walks 1 kilometre to fetch water	
walks 1 km home	walks 1 km to field
gives the livestock food and water	
washes cooking utensils, etc.	works in the field
walks 1 km to fetch water	
walks 1 km home	
washes clothing	walks 1 km home
breast-feeds the baby	
walks 1 km to field with food for husband	
walks 1 km back home	eats when wife arrives with food
walks 1 km to her field	
weeds field	works in the field
breast-feeds the baby	
gathers firewood on the way home	
walks 1 km home	walks 1 km home
pounds maize	rests
walks 1 km to fetch water	
walks 1 km home	
kindles the fire	
prepares meal/eats	eats
breast-feeds the baby	walks to village to visit other men
puts house in order	goes to bed
goes to bed last	

problems. The group helps men examine popular definitions of masculinity, male socialization, and how the male sex role often sets men up to be dominating, controlling, and abusive.[41]

"Male involvement" has been most explored in the area of family planning. The Zimbabwe National Family Planning Council, for example, produced a biweekly soap opera called "You Reap What you Sow," addressing such issues as the importance of male participation in family planning, contraceptive methods for both men and women, misconceptions about family planning, indicators of high-risk pregnancies, and the health benefits of family planning. The show also told listeners where they could obtain additional information. Follow-up studies found that 61 per cent of listeners had changed their attitudes about family planning, and 30 per cent had taken action as a direct result of the drama. The programme's popularity led the council to fund an additional three months of production.[42]

Efforts to develop better contraceptives for men, to encourage their support for female methods, and to improve our understanding of masculinity, male sexuality, and male perspectives on gender and family roles, are key to empowering *men* in this arena, and to involve them more fully in empowering women. Researchers and activists who work with men report that male-only counselling groups on these topics are most effective, and that it is essential to have a facilitator who is able to encourage men to confront such issues as *machismo*, power, control, and violence. It is also critical to note that very different approaches are needed to reach men of different ages.[43]

In an initiative by the Population Council, women's health advocates have joined (mostly male) programme planners and scientists in the development of a female-controlled microbicide to protect against sexually transmitted infections. The International Women's Health Coalition also collaborated with WHO to sponsor a dialogue between scientists and women's health advocates on the development of contraceptive technology.[44]

Decision-making and the Law

The Convention on the Elimination of all Forms of Discrimination Against Women had been ratified by 138 countries as of 3 November, 1994. These countries have thereby declared their intention to work towards equal rights in all fields, and their opposition to "any discrimination, exclusion or restriction made on the basis of sex...."[45] They are obligated to report data on related legislation and actual conditions – given the vast discrepancies that tend to exist between the two – to an international commission.[46]

The ICPD Programme of Action states that countries should act to empower women as soon as possible by establishing mechanisms for women's equal participation in and equitable representation at all levels of the political process and public life and enabling women to articulate their concerns and needs. [para. 4.4]

Customary and Formal Law

The empowerment of women calls for both reform and enforcement of the law, whether customary or formal. This will also have a significant impact on the number of children women have, and when they choose to have them. In Botswana, as in many other countries, a dual formal-customary legal system has evolved. The institution of *bogadi*, or bride price, grants men almost complete control over their wives; it transfers, in effect, a woman's reproductive rights and children to her husband's family.[47] In parts of the Islamic world, interpretations of traditional *Shari'a* law prohibit women from leaving the home unless accompanied by a man.[48] In northern Cameroon, for example, even women themselves say they would prefer to die rather than seek health care in their husbands' absence.[49]

In countries where the minimum legal age at marriage is low or remains unenforced, women are exposed to the dangers of early child-bearing and prevented from taking advantage of options beyond motherhood. In Paraguay

Legal Services for Women in Colombia

Colombia ratified the Convention on the Elimination of All Forms of Discrimination Against Women in 1981, and incorporated it into national law in 1990. Profamilia, the Colombian Family Planning Association, worked with women's organizations to incorporate the Convention's principles into the 1991 Constitution, including the right to decide freely and responsibly the number of one's children.

The Ministry of Health has used the Convention to introduce a gender perspective in its health policy. A recent Ministerial Resolution requires all health institutions to guarantee women the right to decide all issues that affect their health, their lives and their sexuality, as well as the right to information. The new policy mandates the provision of a full range of reproductive health services, including contraceptives, services for infertility, and treatment for abortion complications. Special emphasis is placed on services to high-risk women such as adolescents and victims of violence.

Legal Services for Women, a programme started by Profamilia in 1987, provides legal aid to women so they can exercise their rights and make their own decisions about sexuality and fertility. In six family planning centres, women are given information and counselling help is given to women whose rights have been violated. Recently, the programme also started offering women legal help in regard to household work, violence in the family, sex education, and equal rights.

Source: Cook, Rebecca J., and Maria Isabel Plata. 1993. "Women, Human Rights and Reproductive Matters." Background Paper for the Roundtable on Women's Perspectives on Family Planning, Reproductive Health and Reproductive Rights, Ottawa, 26-27 August 1993. New York: UNFPA.

and Panama, for example, the minimum legal age at marriage remains as low as 12 for females, and 14 for males.[50]

Laws and regulations that limit the availability of contraceptives deny women their reproductive rights and increase the prevalence of unwanted pregnancy.[51] When family planning services in Ethiopia dispensed with the requirement that a woman's spouse consent to her use of services, utilization increased 26 per cent in a few months.[52] In Malawi, recent legal changes have similarly led to increased access to reproductive health services.[53]

Of women surveyed in various countries, between 20 and 60 per cent report having been beaten by their partners.[54] Few legal systems provide adequate protection for abused women or sanctions against violent perpetrators.[55] Gender-based abuse includes sexual abuse by a male partner, sexual abuse of female children, marital rape, sexual assault, trafficking in women, and forced prostitution.[56] In addition to being an abhorrent and endemic human rights problem, it has a negative impact on efforts to promote reproductive health and family planning. Abuse contributes to early sexual activity and inhibits contraceptive use.[57]

Many women are still denied other rights – to enter into a contract, gain access to credit, own property, secure an education, take maternity leave, and be assured of protection from dismissal due to pregnancy. Fortunately, progress is being made – if only slowly – to ensure that women gain positions of power or influence, in the public, private, and non-governmental sectors, to help change the status quo. Men have also become increasingly active in working towards reform.

Women in Decision-Making Positions

While women comprise more than half of the electorate in almost all countries where democratic elections are held and have demonstrated leadership and a distinctive approach to decision-making, both the judicial and legislative branches of government remain dominated by men. In addition, women represent only 10 per cent of elected legislators worldwide, far from the 30 per cent target suggested by the United Nations Economic and Social Council. Even in the United Nations, 50 years after its creation, women are underrepresented at high levels. Women do not fare much better in the private sector.

Women in Politics and the Judiciary

Though progress is being made, women's participation in public life remains limited, which in turn limits their ability to ensure that legislative and administrative decisions are made in a way that recognizes and meets their needs and those of their families.

Empowerment has a special meaning in South Africa.

In 1946, the 17 women delegates of and advisers to the first United Nations General Assembly wrote an open letter to the women of the world, encouraging them to play leadership roles in their respective countries and in the global community.[58]

Since then, there have been only 24 female heads of state or government, although there were more at the end of 1994 than ever before.[59] While the proportion of women in parliamentary positions remains low, in 21 countries women constitute at least 20 per cent of parliamentarians. Yet, in 1994, the average percentage of women in the lower houses of parliaments was less than 11 per cent, and less than 9 per cent in the upper chambers; in eight countries, there were no female parliamentarians. While there have been significant recent increases in the proportion of female parliamentarians in some countries, regional data show only modest increases overall.[60]

The criminal justice system continues to be dominated by men, though this is changing as greater numbers of women enter the legal profession. While global data on the proportion of female judges are not available, the International Association of Women Judges has affiliates or members in 53 countries, and in some countries membership is high: 1,069 in the United States and 200 in the Philippines, for example.[61] In the Arab world, women in six countries have been holding judiciary positions for many years; with the exception of Morocco, where women can only become civil judges, these women hold judiciary positions at all levels.[62]

Women and Economic Decision-Making

In the majority of countries, women comprise 10 to 30 per cent of managers, and occupy less than 5 per

cent of the very highest economic positions.[63] In the United States, while women occupy 8 per cent of executive positions in the 1,000 largest corporations, they are almost exclusively in third-level executive positions; at the top, they occupy the same proportion of positions as the remainder of the world's women – 1 per cent. Somewhat surprisingly, the participation of Nordic women in the private sector is similar, despite their significant presence in the public sector.[64]

It should be noted, however, that women are playing increasingly important roles as entrepreneurs and leaders of small- and medium-sized companies in growth sectors. In addition, there have been significant improvements in the percentage of females among managerial and administrative workers. Individual countries report significantly higher percentages: in the United States, Botswana, and Guatemala, for example, women constitute 40, 26, and 32 per cent of these positions, respectively.[65]

Women tend to be underrepresented in the trade union movement in comparison to their participation in the labour force, though they have constituted the greatest source of new union membership in recent years. Again, the percentage of women in leadership positions in this movement is far lower than in the workforce.[66]

The economic advancement of women is integrally related to population growth, sustainable development, and economic advancement. There is a strong correspondence between countries where women have advanced and those where economic growth has been steady, and between those where women's participation is hindered and those where there has been stagnation.[67]

WORKING FOR CHANGE

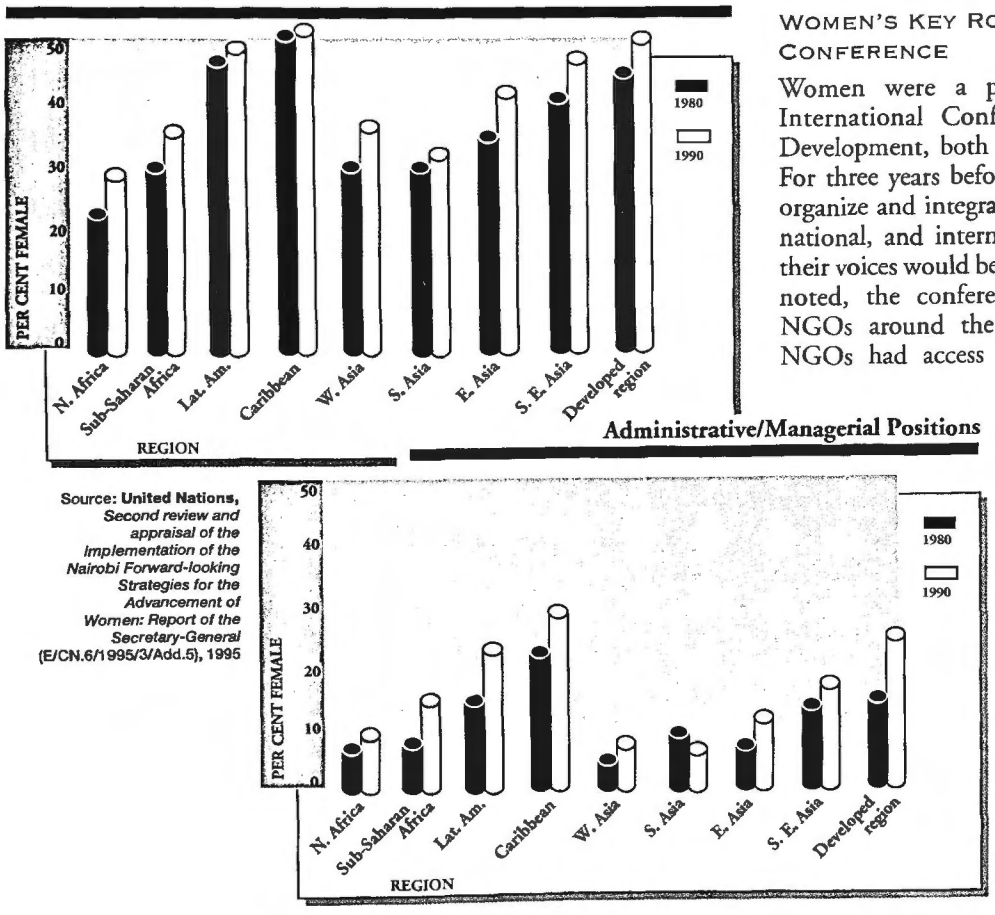
Both men and women are working to change the status quo, in both their public- and private-sector roles. The role of NGOs has grown and become increasingly recognized and accepted. NGOs can be effective agents of change by bringing pressure to bear on decision makers to meet women's needs, and by making women aware of their rights and available services. NGOs also provide smaller-scale experience from which national and international programmes can learn, as well as providing access to settings where new programme approaches can be tested and new services implemented.

WOMEN'S KEY ROLE IN THE CAIRO CONFERENCE

Women were a powerful force behind the International Conference on Population and Development, both before and during the event. For three years beforehand, efforts were made to organize and integrate women at the community, national, and international levels, to ensure that their voices would be heard. As one NGO observer noted, the conference "catalysed women and NGOs around the world. For the first time, NGOs had access to the international policy-making process."[68] Women attended in large numbers, as heads of state, ministers, official delegates, and representatives of NGOs.

The ICPD Programme of Action represents thousands of hours of drafting, negotiating, and consensus building by citizens and governments – and women played a key role in this process. The fact that women's empowerment was identified as one of the principal factors essential to sustainable development and to ensuring the success

IMPROVEMENT IN WOMEN'S SHARE IN SELECTED OCCUPATIONS



Source: **United Nations,** *Second review and appraisal of the implementation of the Nairobi Forward-looking Strategies for the Advancement of Women: Report of the Secretary-General* (E/CN.6/1995/3/Add.5), 1995

of efforts to improve reproductive health is due, in large measure, to women's efforts.

Much of this success stems from the efforts of women's NGOs to serve as "bridges and buffers" within broad-based, interdisciplinary groups, many of which had never worked together before or who were unable to do so directly.[69] Numerous NGOs involved in women's issues were engaged in efforts to mobilize and integrate southern women into the Cairo process. Women – both researchers and those whose lives they were working to understand – played a key role in new research which influenced the ICPD process. This research stemmed in large part from a shift of women into decision-making positions in governments, social services, academic research, funding organizations and NGOs.

WOMEN AND THE ECONOMY

The Extent and Impact of Women's Economic Contributions

In the developing countries women grow up to 80 per cent of all food produced, but rarely hold the title to the land they cultivate. World-wide, they constitute one third of the wage-labour force. Much of their work, however, is unpaid. If global calculations of gross domestic product included household work, they would increase by 25 per cent. In most countries, women work longer hours than men. In Uganda, for example, women work more than twice as many hours as men. In Madras, India, women contribute 46 per cent to family income, compared to 42 per cent for men. Moreover, women head an increasing number of households world-wide.

Because women are more likely to spend their earnings on their families' basic needs, their income tends to have more positive effects on family welfare than does income earned by men. In Guatemala, for example, it takes 15 times more spending to achieve a given improvement in child nutrition when the income is earned by the father. Profits from women's income-producing projects are also more likely to be used to improve community welfare. In Kenya, women who established a bakery cooperative used some of their profits to build latrines to improve community health.

National data collection systems do not accurately record the extent or impact of women's work. A valuable opportunity is thereby lost to enhance the relevance and impact of development plans for society as a whole. Women face a range of constraints in increasing their economic participation; meanwhile numerous socio-economic factors foreshadow increasing female economic responsibility.

The Nature of Women's Work

In most of the developing world, women dominate the "informal sector" of the economy. They are also disproportionately represented in low-wage positions in the formal economic sector.

In addition to their wage-earning activities, women are responsible for a range of household responsibilities that are critical to family survival. Women who head households shoulder an even greater burden, which often results in their opting for lower paying jobs or working fewer hours for pay.

The use of part-time and temporary workers is becoming increasingly common world-wide, and 65-90 per cent of these workers are women. This has had short-term benefits by increasing the availability of jobs that can be handled along with household res-ponsibilities. There are long-term disadvantages to this type of employment, however, including diminished job security, retraining oppor-tunities, and fringe benefits.

Women are disproportionately affected by a range of occupational hazards. They face the risk of sexual harassment and rape in the workplace. They are more likely than men to be employed in unsafe, unregulated industries, and are less able to afford protective clothing and equipment. They may also be disproportionately affected by exposure to toxic chemicals.

The Impact of Economic Crisis and Transition

Structural adjustment programmes, economic restructuring, and the transition from command to market economies in Eastern Europe have taken a heavy toll on both men and women.

In many developing countries, structural adjustment has so eroded earnings that men are migrating in large numbers to cities and, if they find no adequately paid work, women are left to fend for themselves and for their families. Women's dominance of the informal economic sector has been challenged by displaced male workers. According to available estimates, their informal sector earnings have declined sharply. Anecdotal evidence from women in the former Soviet Union indicates that in many sectors, companies have tended to lay off women first and to re-employ them in the lower-paid sectors, such as textile manufacturing. Men have moved into newly profitable sectors, displacing the women who had previously held those jobs. Around the world, women continue to be the last to benefit from job expansion and the first to suffer from job contraction.

Cuts in public spending – or, in the case of the former Soviet Union, the privatization of previously free social services, such as day care – have diminished access to critical services. Care needs to be taken to cushion vulnerable sectors of the population from these changes. Women should be given particular consideration in programmes to ameliorate the impact of adjustment policies on health and nutrition.

It must be said that women in many countries have "adjusted to adjustment". A study in Guayaquil, Ecuador, for example found that the decline in wages resulted in an increase in women's employment as households worked to maintain their income levels. In addition, women worked to compensate for health service cutbacks by filling service gaps. Their increased income and independence resulted in increased respect from male family members.

Sources: Sadik, Nafis. 1994. In Report of the Nordic Women Parliamentarians Meeting to the International Conference on Population and Development (Copenhagen, 3-4 March 1994), *organized by the Danish Women's Parliamentarian's Group in Collaboration with UNFPA; World Bank. 1994.* A New Agenda for Women's Health and Nutrition. *Washington, D.C.: World Bank; UNDIESA. 1991.* "The World's Women: Trends and Statistics, 1970-1990." *Contribution in* The Health of Women: A Global Perspective, *edited by Marge Koblinsky, Judith Timyan, and Jill Gay. 1993. Boulder, Colorado: Westview Press; Bruce, Judith, and Lawrence Haddad. 1994. "Women Do the Caring, Fathers Do the Earning?" Paper presented at Neglected Subjects in the Family: A Policy Dialogue. International Center for Research on Women; World Bank. 1993.* World Development Report 1993: Investing in Health. *New York: Oxford University Press;* Mothers and Children *6(2). 1987. Washington, D.C.: Clearinghouse on Infant Feeding and Maternal Nutrition. In* Safe Motherhood: Action Kit, *by Family Care International (FCI). 1992. New York: Family Care International; Buvinic, Mayra, and Geeta Rao Gupta. 1994.* Targeting Poor Woman-Headed Households and Woman-Maintained Families in Developing Countries: Views on a Policy Dilemma. *New York and Washington, D.C.: The Population Council and International Center for Research on Women; United Nations. 1995.* Second review and appraisal of the implementation of the Nairobi Forward-looking Strategies for the Advancement of Women: Report of the Secretary-General *(E/CN.6/1995/3/Add.5), New York: United Nations; Hovell, M.F. et al. 1988. "Occupational Health Risks for Mexican Women: The Case of the Maquiladora along the Mexican-United States Border."* International Journal of Health Services *18(4). Cited in World Bank, 1994; Rovner, Sandy. 1993. "Many Toxins Target Women Specifically."* Washington Post Health Magazine. *In World Bank, 1994; Chen, Marty. 1994. Introduction to SEEDSII: Supporting Women's Work around the World. In SEEDSII (Draft), edited by Ann Leonard. 1995. New York: The Population Council; UNICEF. 1990.* Economic Crisis, Adjustment, and the Bamako Initiative: Health Care Financing in the Economic Context of Sub-Saharan Africa. *Bamako Initiative Technical Report and background document for the Pan-African Conference on Community Financing in Primary Health Care, Kinshasa, Zaire, June 1990; Maser, Caroline. 1991. Presentation at the 18th Annual Conference of the National Council on International Health (Arlington, Virginia). In Koblinsky et al., 1993.*

GENDER INEQUALITY AND THE ENVIRONMENT

Women, population, and environment have become increasingly recognized as being closely interlinked.

In the developing countries demand for fuelwood, which is usually cut by women, is often blamed for both the high carbon emission and the felling of trees. These women, however, have little choice if they and their families are to survive, unless they are trained and challenged to find alternatives. In addition, according to FAO, studies have found that "high population growth, pressure on limited resources, and environmental degradation increasingly reflect the gender-asymmetries that disfavour women in social, economic, and technological conditions for agricultural production and rural life generally."

The fact that women in some settings are not allowed to hold assets as individuals rather than as wives and trustees for minor children has an impact on the environment. They may be unable to use environmentally sound technologies due to insecurity of land tenure, the absence of rights to grow trees, and an inability to initiate land improvements without the permission of men.

Without time-, labour-, and energy-saving technologies, rural women expend vast amounts of time and energy in their efforts to support family welfare. As land becomes more and more degraded, they have to walk further in order to acquire such necessities as fuel and water. Having larger families provides them with the additional manual labour necessary to compensate for increasing environmental degradation and male out-migration in meeting the family's basic needs.

UNFPA has conducted a series of case studies on women, environment, and population in Kenya, Malaysia, and Mexico, and is planning a fourth in Morocco. The results of the completed studies indicate that women are, indeed, on the front line of exposure to the impact of environmental change, through greater exposure to health hazards or increased work effort to maintain food production, for example. The studies also found that gender-based asymmetries and restrictions over the control of resources may result in less than optimal management of environmental resources. In Kenya, for example, women are particularly exposed to the consequences of environmental degradation, but property and land use rights limit their ability to take remedial action.

There is additional evidence that certain environmental problems have had a disproportionate impact on women, in so far as their search for fuel and water has become more difficult, and their workload has thereby increased. This can be particularly problematic for pregnant women, since heavy work during pregnancy may lead to premature labour and, when not compensated by increased food intake, to low-birth-weight infants. Many women farmers are regularly exposed to pesticides without the necessary safeguards.

The fact that women are not consulted in the development of programmes can also lead to failure. In a reforestation project in the Dominican Republic, for example, only men were consulted in the planning stages, as it was assumed that women and men used wood for the same purposes. In reality, men used trees for timber, while women used them for fuelwood, as well as for basket-making. In addition, the scarcity of fuelwood had forced some women to cease cassava bread processing due to time constraints. Women were consulted during a mid-project evaluation, at which time it was realized that their needs were not being met. Since these differentials were not recognized earlier, however, technical and staff expertise to solve the problem were not available.

Fortunately, there is increasing recognition of the need for a shift from "women in development" to "gender and development." Women are an essential part of development strategy in all respects. This change in thinking has occurred due in large part to the efforts of women at the grass-roots level, who are laying claim to their right to participate in development processes.

In numerous, creative ways, women themselves have taken steps to deal with environmental problems. In India, for example, a woman began experimenting with stove designs that would reduce the amount of smoke in the kitchen. Her efforts were emulated by other village women, and, ultimately, a prototype for the *Nada chulha* stove was developed; it saves time in cooking, cleaning, and fuel gathering, while also reducing internal smoke emissions that affect women disproportionately. The stoves can be constructed and maintained by the women themselves. They cut down on fuel consumption in rural areas, many of which are rapidly becoming denuded, and whose soils are being deprived of nutrients because animal dung is being burned instead of being used as fertilizer.

Also in India, rural women have organized for change in the use of natural resources by developing an innovative approach to the rehabilitation of wastelands. With the assistance of SARTHI (Social Action for Rural and Tribal Inhabitants of India), they are developing ways to meet their needs for biomass in a more efficient and ecologically sound manner, and becoming empowered in the process by learning how to assert themselves in this and other areas.

The income-producing project of the Makiwo women's group in Kenya provides another example. The group combined their revenue with a grant from CEDPA to solve the local water supply problem by buying and installing pipes and selling water to the community; women who used to walk four kilometres to collect water now sell it in the village, and receive a small commission. The balance is used to pay the family planning clinic's monthly utility charges.

Sources: Food and Agricultural Organization (FAO). 1990. Women in Agricultural Development - FAO's Plan of Action for Integration of Women in Development. *Rome: FAO; FAO. 1991a.* The den Bosch Declaration and Agenda for Action on Sustainable Agriculture and Rural Development, FAO/Netherlands Conference on Agriculture and the Environment, 'S-Hertogen Bosch, Netherlands, 15-19 April 1991. Rome: FAO; South Commission. 1990. The Challenge of the South: The Report of the South Commission. *Geneva: The South Commission; UNFPA. 1991.* Population, Resources, and the Environment: The Critical Challenges. *New York: UNFPA. In FAO. 1992.* "Rural Women: The Closing Link Between Population and Environment." *Discussion Note from the Expert Group Meeting on Population and Women, Gaborone, Botswana, 22-26 June 1992; FAO. 1991b.* Report of the Expert Consultations on Women in Agricultural Development and Population in Asia, *Penang, Malaysia, 5-9 February 1991. Rome: FAO; FAO. 1991c.* Report of the Regional Workshop on Women, Population and Sustainable Agricultural Development, *Koriba, Zimbabwe, 3-9 December, 1991. Rome: FAO; FAO. 1991d.* Women and Population in Agricultural and Rural Development in Sub-Saharan Africa, *Women in Agricultural Development Series, Number 5. In FAO, 1992; Joekes, Susan, Noeleen Heyzer, Ruth Oniang'o, and Vania Salles. 1993. "Gender, Environment and Population (DRAFT)." Geneva: United Nations Research Institute for Social Development; Moser, Caroline. "From Nairobi to Beijing: The Transition from Women in Development to Gender and Development." In* SEEDS II, *1995; Sarin, Madhu. "Wasteland Development and the Empowerment of Women: the SARTHI experience." In* SEEDS II, *1995; Sarin, Madhu. 1984.* Nada Chulha: A Handbook. *Voluntary Health Association of India. In* Safe Motherhood: Action Kit, *by Family Care International. 1992. New York: Family Care International: CEDPA. 1992.* Conference of Women Leaders. *In Family Care International, 1992.*

Women are also acting to ensure that the Programme of Action moves from words to reality. The NGOs accredited at ICPD included 210 women's groups from all over the world. These included local groups and those affiliated with regional and international networks. For example, the Centre for Development and Population Activities (CEDPA), one such association, is setting up networks to promote and monitor the implementation of the Programme of Action. One of these, the Africa Women's Network, has expanded its ranks and is bringing the ICPD consensus on women's empowerment to hundreds of NGOs throughout the continent. In collaboration with UNFPA, CEDPA developed *After Cairo: A Handbook on Advocacy for Women Leaders.* The booklet, which aims to help women strategize to promote their priorities, was distributed at the Dakar meeting.[70]

After Cairo, the president of the International Women's Health Coalition, another global association of NGOs, stated: "We women have returned to our home countries to use the language of the document to hold our governments accountable as they restructure budgets and design programmes. We will be equal partners at the policy table and active participants in creating programmes. None of this will happen overnight. None of this will happen easily. But women will write the history of Cairo by translating words into action."[71]

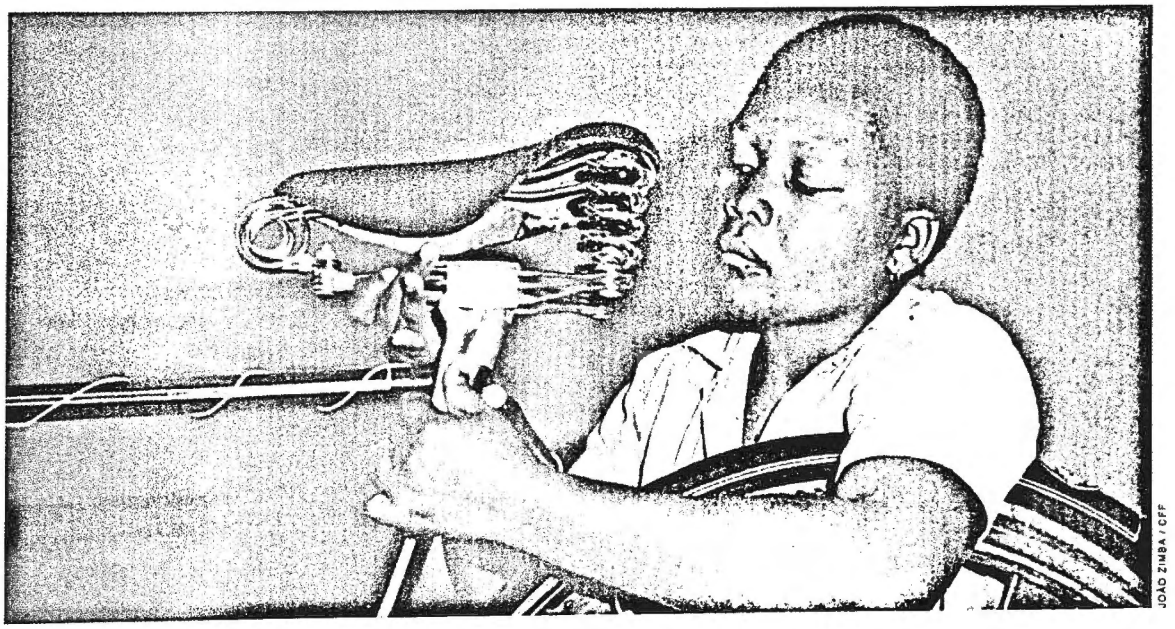
The Key Role of Women's NGOs in Promoting Empowerment

Numerous NGOs have been established to ensure enforcement of the law and promote women's legal awareness. The Ecuadorian Centre for Women's Action and Promotion, for example, developed a paralegal training programme and opened women's rights centres to increase women's access to legal services.[72] In Malaysia, the University Women's Association organized a national seminar on Muslim and non-Muslim family law for leaders of women's organizations, and translated its papers into Mandarin and Tamil to expand readership. The publicity generated by the seminar helped lead to the passage of a law disallowing polygamy among non-Muslims.[73]

In India, while 90 per cent of women participate in agricultural activities, government efforts in this area have largely benefitted men. Laws granting women access to land and credit have not been passed, and the agricultural extension system tends to bypass women, who constitute 40 per cent of self-employed cultivators.[74] The Self-Employed Women's Association has mobilized women to change both law and policy. Moreover, in response to their lack of access to credit, the group established a cooperative bank to provide women with small loans.[75]

Many NGOs have mobilized against gender-based abuse. A recent directory published by ISIS International, a Chile-based women's resource centre, lists 379 projects working on this issue in Latin America alone.[76] Some women's movements, including those in Mexico, India, and Ecuador, have organized nationally for legal reform. Movements in Brazil, Papua New Guinea, and Malaysia have also succeeded in generating government support for related education and services, in addition to legal reform.[77]

Making bicycles in Mozambique.



The National Association of Nigerian Nurses and Midwives developed a communication programme to advocate the elimination of female genital mutilation, and succeeded in including it in nursing and medical school curricula.[78]

In Kenya, the *Maendeleo ya Wanawake* Organization, a women's group, also developed a communication programme to educate community leaders and families.[79] In India, activists have used street theatre to raise women's awareness of issues related to dowry, wife-beating, and other issues.[80] In Peru, the *Movimiento Manuela Ramos*, which provides a range of services related to women's empowerment, helped bring about a modification of the penal code, waiving the penalty for abortion in the case of rape; they were also instrumental in the President's institution of a national plan endorsing family planning.[81] ■

INFORMATION FOR AND BY WOMEN

Information is crucial if women are to achieve good reproductive health. When developing programmes or material for women, the involvement of women is a key ingredient of success, as the following examples illustrate.

Kali for Women, India
This group has produced a booklet portraying a woman's life, beginning with her birth and childhood, through marriage and motherhood. It covers the menstrual cycle, sexuality, marital relations, gender relations, domestic violence, pregnancy and menopause. Male and female reproductive systems are illustrated by drawings of fully clothed men and women with flaps that lift up to reveal the reproductive organs, a discreet presentation that women appreciate. The booklet also includes a folk song which says "When do I think about my health? When do my family, society, the health care system think about my health?" On another page a poem reads "My body is my first home. Let me have full command over it."

Women's Lives' and Health in Egypt
This book for women with higher education and health professionals was produced by the Cairo Women's Book Collective, a group of more than 20 women from different social classes and age groups. It contains 16 chapters on subjects ranging from Egyptian women's perceptions of life, to marriage and sexual relations, violence, and menopause. The book takes a feminist approach, while endeavouring not to offend religious feelings. It includes quotations from the Koran emphasizing the importance of protecting women's health, and equality in marriages.

Videos for Women's Health in Brazil
The multidisciplinary Women's Health Research Group in São Paulo, Brazil, creates both educational videos for women and training material for health professionals. The videos deal with issues such as reproductive rights, family planning, mental health, female mortality, AIDS prevention and breast-feeding.

"Healthy Love Parties" in the USA
The Atlanta-based group Sisterlove organizes "parties" to educate women about safer sex. A group of women are invited to a friend's home to hear a trained facilitator talk to the women about their bodies and sexuality, risks and prevention of STD and HIV infection, and the meaning and practice of safer sex. The approach is participatory, involving questions and answers, games, role-playing and group discussions. The women are invited to return to a subsequent party to discuss their successes and problems encountered in applying what they have learned.

Source: Berer, Marge, 1993. Women's Groups, NGOs and Safe Motherhood *(WHO/FHE/MSM/92.3). Geneva: Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization.*

III. REPRODUCTIVE HEALTH AND FAMILY PLANNING

Reproductive Health and family planning: A Comprehensive Approach

Introduction

Sefernesh, from Ethiopia, was given in marriage at age 10, and was pregnant at 13. She returned to her mother's house to give birth, where she suffered six days of agonizing labour. On the seventh day her husband finally sought medical assistance from the town's private clinic. The health assistant delivered her dead child; Sefernesh was left with an obstetric fistula, a serious reproductive health complication.[1]

Jeannette, a woman in her thirties from Burkina Faso, recalls being genitally mutilated at age five with her friend Rosalie. "I can still hear Rosalie's screams" Jeannette says. "She fought like a devil, and had to be held down by at least seven women." Afterwards she bled horribly, and her wound took months to heal. "The whole thing was monstrous." [2]

Health issues related to reproduction and sexuality affect women and men of all ages in all countries. Individuals who have good reproductive health can enjoy healthy sexual relations. They have the ability to reproduce and the freedom to decide if, when and how often to do so.

As noted in Chapter II, reproductive health is determined by social and economic development levels, lifestyles, women's position in society, and the quality and availability of health care. It is determined, crucially, by women's power to make choices. For social as well as genetic reasons, therefore, women bear most of the burden of ill-health associated with reproduction. As well as premature and excessive child-bearing, women may be at risk from domestic violence, rape and genital mutilation. They are more vulnerable to reproductive tract infections (RTIs) and sexually transmitted diseases, including HIV/AIDS.

Improving reproductive health is essential for improving health generally; it is the basis for women's empowerment, and one of the foundations of social and economic development. Good reproductive health is essential for the early stabilization of world population: couples and individuals who can make the choice have on the whole smaller families than those who cannot.

As the ICPD Programme of Action notes, enjoying the highest attainable standard of health, including reproductive health, is an internationally recognized human right (Principle 8). To exercise this right, women and men must have access to comprehensive reproductive health care. The picture in most developing countries is one of mixed progress and problems.

In these regions motherhood is safer now than ever before, as reductions in maternal mortality indicate. Nevertheless, it continues to be a serious and often neglected area of reproductive health. Maternal death rates remain high, and there is growing evidence that the extent of maternal morbidity (illness or injury related to pregnancy and childbirth) may have been seriously underestimated.

The ability of parents to choose the number and spacing of their children is an essential component of reproductive health. The number of couples using family planning has risen dramatically in recent years. At least 350 million couples world-wide, however, lack access to a full range of family planning methods. Surveys indicate an additional 120 million women would be using family planning if more accurate information and affordable services were easily available, and if partners, extended families and the

What reproductive health entails

Paragraph 7.6 of the ICPD Programme of Action states:

"All countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding, infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in Paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases and HIV/AIDS should always be available, as required. Active discouragement of harmful practices such as female genital mutilation should also be an integral component of primary health care including reproductive health care programmes."

THE WORLD HEALTH ORGANIZATION AND REPRODUCTIVE HEALTH

Within the United Nations system, the role of the World Health Organization (WHO) involves providing long-term strategic and policy guidance, establishing norms and standards for care and defining indicators for assessment, monitoring and programme evaluation. WHO's role in reproductive health is based on its expertise in health and health systems in general and its technical cooperation with countries.

The Organization's work in this regard includes: **advocacy** of measures to improve health; **developing guidelines** based on the relevant norms, standards and country experience; **training**; **research** promotion, support and coordination; direct **technical support**; and **resource mobilization**.

WHO has established a number of programmes to address various aspects of reproductive health, including the Special Programme for Research, Development and Research Training in Human Reproduction, which is cosponsored by UNDP, UNFPA and the World Bank; the Adolescent Health Programme; and the Maternal Health and Safe Motherhood Programme.

WHO collaborates closely with other UN agencies involved in reproductive health, particularly UNFPA, UNDP, UNICEF and the World Bank.

community were more supportive; this number does *not* include the growing numbers of sexually active unmarried individuals.

At the same time, the world-wide incidence of sexually transmitted diseases (STDs) is increasing, and millions of men and women suffer the consequences. About half a million women die each year from preventable pregnancy-related causes, and many times that number suffer illness or injury, often permanent. The AIDS pandemic is causing suffering and death to an increasing number of men, women and children.

ICPD Programme of Action

A central achievement of the International Conference on Population and Development was agreement on a comprehensive approach to all these issues. The ICPD approach is based on meeting the totality of people's reproductive health needs, particularly those of women and girls.

The ICPD Programme of Action defines reproductive health as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters related to reproductive systems, functions and processes. [para. 7.2]

One of the Programme's guiding principles (Principle 8 in Chapter II), based on a number of international legal and human rights documents, states:

"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

To promote these reproductive rights the Programme of Action calls on all countries to provide a full range of high-quality reproductive health services – including safe, effective, affordable and acceptable methods of family planning – through their primary health care systems. The goal is universal access by 2015 or sooner to services that are acceptable and convenient to all users. [paras. 7.6, 7.16 and 7.22]

To obtain the political support necessary to meet this and other ICPD objectives, policy makers,

THE MARIE STOPES CLINIC IN SIERRA LEONE

Sierra Leone has one of the world's highest infant mortality rates, 150-200 per 1,000 births, and one of Africa's higher maternal mortality rates, some 450 per 100,000 births. Women on average have 6 or 7 children in their lifetime.

In 1986, with assistance from Marie Stopes International, the Marie Stopes Society of Sierra Leone began providing inexpensive, high-quality reproductive health care to poor women and their families. The major goal is to reduce maternal morbidity and mortality associated with unwanted pregnancy and sexually transmitted diseases.

The Society seeks to recover its costs by charging modest fees for services, and is financially self-sufficient. In addition to service delivery, it promotes family planning and reproductive health through media campaigns.

Two main clinics and nine smaller ones (one of which is based in the Waterloo refugee camp) offer a wide range of high-quality reproductive and sexual health services, including family planning, diagnosis and treatment of STDs, Pap smears, pre- and post-natal counselling, immunization, and gynaecological and general medical consultations. The clinics also undertake health education and community-based distribution of contraceptives.

A males-only clinic in Collegiate provides services and counselling for family planning, male contraceptives, STDs and AIDS. The staff also conduct health education in workplaces and other sites where men gather.

A project providing credit to women market traders has been very successful, with a high rate of loan repayment. The loans allow women to pay school fees, invest in their businesses and increase earning capacity. The recipients also promote family planning and the services of the Society.

The group's clinics saw approximately 70,000 clients in 1994, 42 per cent of whom came for family planning. More than 100,000 men participated in male health education and motivation sessions; 7,500 of them were referred to the clinics.

Source: Haworth, Caroline (South and West Africa Programmes Administrator, Marie Stopes International, London). January 1995. Personal communication.

planners, parliamentarians and the public need to be better informed on reproductive health issues. Both non-governmental organizations and the private sector must be actively involved in implementation efforts.

The Need for Comprehensive Programmes

The concept of reproductive health care is the outcome of an evolution in thinking about health and family planning. The experience of countries all around the world has shown that to meet people's reproductive and sexual health requirements, family planning services need to be integrated into a wider framework which addresses their overall health and well-being.

To move towards this goal, basic health services need to be strengthened, and links between different components of the health system need to be established or improved. This would allow better coordination and, when necessary, facilitate referrals from one type of service to another.

As recognition of the value of an integrated approach has grown, family planning programmes in all regions of the world have begun adding additional reproductive health interventions to the services they already provide.

For example, the Bangladesh Women's Health Coalition, at the request of its clients, has broadened the package of services it offers. Started in 1980 to provide family planning and menstrual regulation services, the coalition now offers care for STDs, infertility counselling, and expanded primary health and child care. The organization's goal is to empower women by teaching them to manage their reproductive health and the health of their children.[3]

A programme in Tunisia's Sfax maternity hospital integrates post-partum care, family planning and infant care. By tradition, a Tunisian mother exclusively cares for her newborn and abstains from sexual relations for 40 days after childbirth. On the 40th day, a new mother in Sfax is encouraged to bring her baby to a health centre, where both are examined and the infant is immunized. At that time, a health worker discusses the importance of breast-feeding with the woman and gives her information about family planning and contraception.[4] In 1987, 83 per cent of post-partum women in the city came to the clinic; 56 per cent of these women adopted a method of family planning, a high rate of success for a post-partum project.[5]

The Brazilian Government, in cooperation with the women's movement, in 1983 initiated the Comprehensive Programme for Women's Health Care. Going beyond existing maternal and child services, the programme strives to empower women by offering a broad array of services and information which address reproductive health but also mental and occupational health. It serves women of all ages, from adolescents to post-menopausal women.[6]

And Costa Rica in 1989 established an integrated health programme which includes services for maternal and child health, early detection of cervical and breast cancer, monitoring of pregnant women and women who have just given birth, and family planning. Another decree the same year created a National Council of Women's and Family Health to facilitate the implementation of maternal and child health policies, and to formulate and put into effect a national health plan for mothers and newborns.[7]

Reproductive Health and Family Planning for Refugees

Wars, natural disasters and other crises pose particular dangers to women during pregnancy, childbirth or post-partum recovery. They also expose women and adolescents to greater risks of sexual exploitation, abuse and violence.

For various reasons, many women refugees are at high obstetrical risk: those under 18 and over 40; those weakened by trauma and deprivation; women suffering from diseases such as malaria and tuberculosis; and those with poor nutritional levels.

While prenatal care and trained birth attendants are available in many refugee sites, other important reproductive health needs are not being met in most settings, including sex education, family planning information and services, treatment for complications of abortion, AIDS education and prevention, and diagnosis and treatment of other STDs and gynaecological conditions. Programmes to assist the victims of sexual abuse and forced prostitution are also urgently needed.

UNFPA support in emergency situations aims to safeguard people's reproductive rights. In 1994, the Fund established an Office for Emergency Operations, based in Geneva. Working closely with United Nations agencies – particularly WHO, UNICEF and the United Nations High Commissioner for Refugees – and other organizations, UNFPA focuses on providing reproductive health counselling, information and education, and clinical services within the health care mechanisms developed during relief operations. UNFPA provides financial and technical support for safe motherhood, prevention and treatment of sexually transmitted diseases and HIV/AIDS, sexual abuse and gender violence, family planning, adolescent reproductive health, information and education, and special programmes for men. Funding is also provided for equipment, supplies and drugs needed for the delivery of these services. This support may be extended by technical assistance, training and salaries for reproductive health providers at field level.

In the wake of the 1994 crisis in Rwanda, UNFPA is supporting projects to provide maternal and child health and reproductive health services for Rwandese refugees in Burundi and Tanzania, and emergency rehabilitation of maternal and child health and family planning services in Rwanda itself.

Amid the continuing conflict in Bosnia and Herzegovina, local health services lack the supplies to meet essential reproductive health care needs. The scarcity of contraceptives has led to a substantial rise in abortion rates. Since May 1993, Marie Stopes International has operated emergency field projects in Bosnia and Croatia, providing mental health care and social support services to refugee and displaced Bosnian women through women's support groups. Plans for the project's second year called for distribution of reproductive health kits, training of service providers, and the development of a health education strategy.

Sources: Pierotti, Daniel. 28 February 1995. "UNFPA Support for Emergency Relief Operations in Reproductive Health". New York: UNFPA; Marie Stopes International. 1993. "Emergency Reproductive Healthcare Project for Sarajevo, the Eastern Enclaves and Bihac." London: Marie Stopes International; Women's Commission for Refugee Women and Children. June 1994. Refugee Women and Reproductive Health Care: Reassessing Priorities. *New York: International Rescue Committee.*

Comprehensive reproductive health care can be built on the foundation of existing family planning programmes. Some 155 countries have government-supported family planning programmes, generally combined with maternal and child health care and integrated in primary health care systems.

Broadening the Scope of Programmes

Financial and staffing constraints may prevent some family planning programmes from providing a wider range of health services; but a broader package of services may attract more clients. When adding services to existing family planning programmes, the priorities should be affordability, benefit for the most women and impact on public health.

Even the most basic programmes can now offer information, education and counselling on STDs and HIV/AIDS, and barrier methods of contraception for clients at risk. They may also provide diagnosis, selected services and referrals for STDs. Better-equipped and broader-based programmes may additionally offer pregnancy testing; counselling for infertility; and diagnosis and treatment for locally prevalent reproductive tract infections.

An additional tier of service would include: information for the prevention of abortion, management of the consequences of abortion, and post-abortion counselling; maternal care including post-partum care, breast-feeding advice and family planning services for new mothers; diagnosis and treatment of various RTIs; HIV prevention and counselling; screening for other reproductive health conditions such as cervical cancer; advocacy efforts against harmful traditional practices such as female genital mutilation; and outpatient care for women with treatable cervical injuries.

Quality of Care

In the effort to expand health and family planning services in poor areas, most attention has been paid to quantity, accessibility and distribution of services. In recent years, recognition that *quality* and acceptability of care are also of crucial importance[8] has led to the development of new indicators of quality.

Four factors are critical:

- **Provider-client information exchange.** Clients should receive information on diagnoses, treatment options, therapeutic regimes, and contra-indications and side-effects of medications and drugs. In regard to family planning, this means providing information on a number of different available contraceptive methods and their appropriateness for the potential user, and instruction on how to use the method selected. Service providers need to listen to clients to learn their backgrounds, medical histories and preferences for treatment.
- **Provider competence.** This includes knowledge about the disease or condition being treated, technical proficiency in providing clinical treatment, and awareness of referral procedures for cases that cannot be managed properly. Providing family planning methods such as IUDs, implants and sterilizations requires technically skilled service providers, the observance of medical protocols, and hygienic conditions.
- **Interpersonal relations.** Responsive treatment of women should be private, confidential and

Care for Women of All Ages in the Philippines

The Women's Health Care Foundation (WHCF), established in the Philippines more than a decade ago, believes that comprehensive reproductive and other health care should be available to all women, throughout their life cycle. Most of the country's maternal and child health and family planning clinics focus more narrowly on reproductive-age married women who are pregnant or have young children.

WHCF's initial priority was to make information and clinical services available to all young women, particularly students and sex workers. It set up three clinics in different Manila neighbourhoods. These offered obstetrics and gynaecological consultations and care, including family planning; management of reproductive tract infections, including STDs; laboratory tests; counselling; and referral. The clinics are open six days a week, from 8 a.m. until 6 p.m., making the services available to many working women.

After operating a clinic-based programme for several years, the staff realized there was a need to reach women where they live and work. In 1983, WHCF established the Institute for Social Studies and Action to expand its health information programme and conduct training and research.

The three clinics, which receive no external funding, treat each client with respect and privacy — regardless of her ability to pay, motive, profession, social and marital status, age or health condition. Every client's complete medical history is taken, followed by a thorough medical and physical examination. An efficient patient flow minimizes the time clients spend in the clinic; throughout their stay, the emphasis is on making them feel at ease. Discounts and staggered payment arrangements are available for those unable to pay in full.

Each clinic has a medical officer, a paramedic (nurse or midwife) and a medical technician. All staff members are women, and before they start work they are trained on WHCF's goals and philosophy. Ongoing staff training is conducted locally and abroad. Staff members regularly evaluate all activities to improve policies and procedures.

In 1991, with UNFPA support, WHCF set up a new clinic and an attached outreach programme. Field staff conduct focus-group discussions in poor communities with women and adolescent girls and boys. Seminars are conducted on topics selected by the participants. For the future, WHCF plans to place more emphasis on information and communication for women, especially in reproductive health, and to expand its research and outreach programmes.

Source: Tadia, Florence M. March 1993. "Accessible to Young Women." Integration.

respectful, with limited waiting time and adequate time spent with each client; women's participation in decision-making should be encouraged.

- **Mechanisms to encourage continuity of medical care** should include information about where and when to return, and specific follow-up procedures.

An additional element[9] is the "constellation of services" provided in a single facility. These might include maternal and child health initiatives, post-partum services, comprehensive reproductive health services and employee health programmes, depending on circumstances and context.

It is impossible to develop universal standards for quality of care. Standards in a country or province should be acceptable and achievable in the local medical system, cultures and economic conditions.

A study in Nigeria found that training family planning providers in interpersonal relations and counselling led to increased client satisfaction and a higher opinion of the quality of care provided. Nurses trained in counselling were more likely to listen to their clients, and clients counselled by trained nurses were more likely to feel comfortable during sessions. Clients of trained nurses said their providers were polite and gave clear explanations, and were more than twice as likely to return for a follow-up visit than were clients of untrained nurses.[10]

Lack of access to service points may not be the main reason women do not make use of family planning services.[11] A study (using data from 13 demographic and health surveys from Africa, Asia and Latin America) found that non-use was due principally to a lack of knowledge about contraceptives or where to obtain them, secondly to concerns about health and side-effects associated with contraceptive use, and thirdly to husbands' disapproval.

Providing high-quality services should be the aim of every reproductive health programme, even those with limited resources and staff; treating clients with respect and kindness is what matters most.

ICPD Programme of Action on Quality of Care

The ICPD Programme of Action emphasizes that sexual and reproductive health care providers' motivational and counselling efforts should be free of coercion. It makes eight specific recommendations on improving the quality of care in all reproductive health programmes [para. 7.23]:

- Ensure that men and women have information and access to the widest possible **range** of safe and effective family planning methods (appropriate to their age, parity, family size preference and other factors), to enable couples and individuals to exercise free and informed choice.
- Provide accessible, complete and accurate **information** about various family planning methods, including their risks and benefits, possible side-effects and effectiveness in preventing the spread of STDs and HIV/AIDS.
- Ensure services that are **safer** and more **affordable, convenient** and **accessible** to users.
- Expand and improve **training** in sexual and reproductive health care and family planning, including in interpersonal communications and counselling.
- Ensure appropriate **follow-up** care, including for side-effects of contraceptive use.
- Ensure availability of **related services**, on site or through referral.
- In addition to measuring performance quantitatively, emphasize **qualitative indicators** through surveys, evaluations and information systems which take into account the perspectives of potential and actual users.
- Include education and support services for **breast-feeding** as a method of child spacing and to improve child health and survival.

GAUGING MEN'S ATTITUDES ON FAMILY PLANNING

In 1992, a demographic and health survey found that contraceptive use in Namibia's North-west and North-east Health Regions was less than half the 52 per cent prevalence rate in the South; in the Central Health Regions the rate was 32 per cent. Countrywide, women had an average of 6.7 children.

Recognizing that men played key roles in decisions about family planning and women's use of contraceptives, the Government decided to conduct a knowledge, attitudes and practices (KAP) survey among men. The data will be used to design strategies to increase male contraceptive use and male encouragement of female contraceptive use.

The survey, carried out in 1994, found that:

- Most respondents knew about a few methods of family planning (condoms, the pill and injectables). They most often learned about these methods from friends, followed by radio, health workers and written media. Most felt there was little cultural, religious, or peer group pressure not to use family planning, and in fact felt that cultural factors encouraged family planning.
- Seventy per cent stated that, to their knowledge, they had never used family planning. Use of family planning was higher in urban than in rural areas. Most who had used family planning had used condoms (mostly with casual partners, to prevent AIDS and STDs), followed by the pill and injectables (generally with wives to prevent pregnancy).
- Over 80 per cent favoured teaching teenage boys and girls about sex and family planning.
- Many respondents, especially in rural areas, did not think women should have control over family planning decisions. A significant minority felt that "family planning gives women control over men".
- Although they were aware of potential health problems for women who bear children too early or too late in life, or bear too many children, most respondents wanted many children, and many had concerns about the use of contraceptives.

Source: Directorate, Northwest Health Region, Namibia. 1994. Male Knowledge, Attitudes and Practices Towards Family Planning: Northwest Health Region.

Special Target Groups for Reproductive Health and Family Planning

Involvement of Men[12]

Men's attitudes on gender-based issues affect all aspects of women's lives, including those related to reproductive health. Men have a stake in reproductive health through their multiple roles as sexual partners, husbands, fathers, family and household members, community leaders, and gatekeepers to health information and services. Community support for the improvement of opportunities for women and men and for promoting gender equity and equality, responsible sexual behaviour, safe motherhood and supportive fatherhood – and especially the engagement of young men and boys in positive gender-related actions – must necessarily involve men. Encouragement of joint decision-making in the family and male support for their partners' choices related to reproduction are vital components of an empowering and participatory orientation to reproductive health.

In the area of service delivery for reproductive health, programmes have traditionally focused primarily on women. This approach has neglected "male methods" of contraception – condoms, vasectomy and withdrawal.

The past orientation of many service providers placed the responsibility for contraception decisions solely on women[13] and impeded efforts to promote male responsibility in family planning decisions. The provider bias favouring female methods may have also deterred contraceptive use by women,

Reaching Men in Ghana and Zimbabwe

Ghana

Motivating rural men to share decision-making with their partners and to practise family planning is the aim of a project run by the Planned Parenthood Association of Ghana (PPAG) since 1980. The project, part of a family planning information and education programme implemented by PPAG and the Health Education Division of the Ministry of Health, seeks to mobilize men through "Daddies' Clubs" in the workplace, the involvement of hotel and bar managers and transportation unions, and functional literacy programmes.

At weekly meetings of the Daddies' Clubs in various factories and workplaces, a PPAG field worker and a nurse organize talks about family planning, sexuality and reproductive health, followed by group discussions and occasional video showings. The clubs also organize games during lunch breaks and after work. Some club members are trained to distribute condoms and other non-prescription contraceptives, which they sell to the workers and in their communities.

Participating hotel and bar managers receive non-prescription contraceptives to sell to their clientele. The association organizes contests and exhibitions to update participants' knowledge of available contraceptives and their use, and to promote sales.

In metropolitan Accra, field workers meet with drivers of privately owned taxis and vans during work breaks to answer questions about family planning, using various audio-visual support materials. A few representatives of the drivers serve as distribution agents of contraceptives, especially condoms. These agents also organize lectures and talks. At the drivers' regular weekend meetings, the association arranges short lectures by doctors and other resource persons, followed by discussion; topics include sexuality and reproductive health, STDs/AIDS and family planning.

At the National Vocational and Training Institute, the association organizes seminars and video showings on family planning and STDs/AIDS to enable trainers to incorporate these topics into adult education and vocational training activities. Some facilitators also organize educational rallies in their communities and serve as distributors of non-prescription contraceptives.

These community activities have been complemented by Ministry of Health posters, leaflets, three radio programmes and a television drama, reinforcing the key messages on male involvement. The campaign also included community competitions, boat regattas and raffles. Using local languages, and supported by regional and local health units, the campaign has reached a wide audience in the rural areas.

In target regions, virtually all men surveyed reported having seen or heard at least one message; 96 per cent had heard the campaign theme song and seen the poster after the campaign had run for 19 months. The impact has been tangible: 47 per cent of the men exposed to the campaign said they had discussed family planning with their partners, and 26 per cent reported that they or their partners were using a modern method of contraception.

Zimbabwe

The Zimbabwe National Family Planning Council has conducted two major motivational campaigns for men. The first, in 1988-89, promoted condom use and joint decision-making between partners regarding contraceptive use and family size. The campaign included a 52-episode radio drama; information meetings at mines, farms, factories and villages; and the publication of two pamphlets.

An evaluation survey found that 41 per cent of men aged 18-55 had heard the radio drama at least once, 11 per cent had attended an information meeting and 5 per cent had received a pamphlet. Of those aware of the campaign, 53 per cent talked to their partners about family planning, 15 per cent visited a clinic, and 7 per cent started practising family planning.

The second campaign, in 1993-94, continued to encourage discussion among partners but emphasized long-term contraceptive methods and smaller families. It utilized two radio dramas, billboards, posters, radio and television spots, and newspaper and magazine advertisements. There were also concert parties, a roving entertainment group, puppet shows, entertainment, banners and other promotional materials, and competitions including a soccer tournament which reached large numbers of men.

After the campaign, an increased number of men and women reported that they talked regularly with their partners about family planning and agreed that decisions on the use of family planning should be made together. Clinic data indicate that contraceptive use also rose as a result of the campaign.

Sources: UNFPA. 1995. Male Involvement in Reproductive Health, Programme Advisory Note. *New York: Technical and Evaluation Division; Kim, Young Mi, et al. 1992. "Family Planning IEC Project in Ghana: Impact on Ghanaian Males." Paper presented at the Annual Meeting of the American Public Health Association, Washington, D.C., November 1992; UNFPA Ghana. 1994.* Male Involvement in Reproductive Health and Family Planning *(PRO 300/FPA 11444), a Report of the Planned Parenthood Association of Ghana to the UNFPA Country Director, 26 August 1994; Kim, Young Mi, Caroline Marangwanda, and Bendict Dlodlo. 1994. "Zimbabwe Male Motivation and Method Expansion Project: Evaluation Report." Paper presented at the Annual Meeting of the American Public Health Association, Washington D.C., October 30-November 3, 1994; Mayo, Josephine et al. 1994. "The Male Motivation Campaign in Two Urban and Three Rural Areas of Zimbabwe." Paper presented at the Annual Meeting of the National Council for International Health, Arlington, 27 June 1994.*

particularly in cultures where men dominate reproductive decision-making.[14] (Where partners disagree on the number of children or the use of contraceptives, the man's views will usually prevail.[15]) The bias also constrained the use of modern methods of periodic abstinence.

Male Methods and Cooperation

Until about 30 years ago, the few contraceptive methods available were primarily male methods. One third of all couples using family planning still rely on male methods or methods that require male cooperation – 40 per cent in sub-Saharan Africa, where many people lack access to family planning services and overall contraceptive use is low, but 25 per cent in Asia and the Pacific, where family planning programmes are more widespread.[16]

While studies indicate that in general men are more favourable to family planning than has been widely assumed, these attitudes must be translated into support and cooperation in decision-making. The development and use of male methods of contraception which are safe, effective, reversible and acceptable would expand the options for both men and women, attract additional users and improve reproductive health. Male cooperation and responsible sexual behaviour will be required to counter the AIDS pandemic and rising STD rates, since the male condom is the most widely available barrier to disease transmission.

The balance of use among various methods of contraception should be determined through informed joint decision-making from among a range of safe and appropriate methods, sensitive to both medical requirements and to social and cultural values.

ICPD Programme of Action on Male Participation

The ICPD Programme of Action recognizes that if women are to become equal partners in public and private life, joint decision-making by men and women regarding sexuality and reproductive health issues must be improved and their joint responsibilities recognized. It states that men should be encouraged to take responsibility for their sexual and reproductive behaviour, and for their social and family roles. [paras. 4.24 and 4.25]

Greater gender sensitivity, responsible sexual behaviour and equity in relations between women and men will help to ensure that all people have the information and means to achieve good sexual health and exercise their reproductive rights and responsibilities.

The document outlines actions to promote equal participation of men and women in all household responsibilities, including family planning, child-rearing and housework, through education and employment legislation. Governments and employers are urged to enable women and men to combine parenting with participation in the work force. [para. 4.26]

SUNIL GUPTA

India: learning how to be a man.

Male Support for Women's Health

Integrating men into reproductive health care programmes will require many of the same changes needed in programmes for women. Men also require accessible and quality information and services and a wide choice of methods, widely distributed, available at all times and offered free or at minimal cost. In addition, reproductive health programmes need to encourage men to share the responsibility for family planning and child care.

Motivating men to improve their own reproductive health and that of their partners does not necessarily require substantial resources. Existing reproductive health services can be made more "male-friendly", and the participation of both partners can be encouraged.

Men can also support women's decisions regarding reproductive health and help address the problem of violence against women, including sexual violence.

How to Increase Male Involvement

McCauley et al (1994) suggest several steps reproductive health care programmes can take to increase male involvement:[17]

INCREASING MALE AWARENESS IN THE DOMINICAN REPUBLIC

In 1991, the Dominican Family Planning Association (Adoplafam) in cooperation with UNFPA, formulated a project to increase men's awareness on responsible fatherhood and sexually transmitted diseases including AIDS. It targeted the 110,000 men aged 15 and above in the country's eastern and northern districts.

The first step was to train Adoplafam's trainers and technical staff on family planning, STDs and AIDS. The staff then trained 140 barbers to serve as resource persons. Their barbershops became condom distribution and information centres for their clients. The barbers also receive specially developed educational materials on family planning, responsible fatherhood, vasectomy, STDs and AIDS.

The barbershops serve as referral points to health centres. Physicians in health centres in the barbers' districts have received refresher courses on family planning and STDs/AIDS so they can respond adequately to requests for information and services.

The project also involves community organizations in its educational activities. Members of 100 community organizations have been trained to act as resource persons on family planning, responsible fatherhood and STDs/AIDS. There have been thousands of meetings where men discuss the importance of responsible fatherhood and STD prevention.

As a result of the project, men's attitudes have already begun to change, as evidenced by a significant increase in the demand for condoms. The media have played an important role in supporting the project, providing free radio and television time to air messages promoting responsible fatherhood and STD/AIDS prevention.

Sources: UNFPA. 1994. "Responsible Fatherhood and Prevention of STDs in Men, DOM/94/P03." Project Document. New York: Latin America and the Caribbean Division, UNFPA.

Inform men about family planning and reproductive health. Studies in countries as diverse as Malaysia, Nigeria, Peru, Tunisia and Turkey show that men want to learn more about family planning. Men need information about contraceptives – for women as well as for men. Well-informed men can use a method themselves or support their partners in using a method.

Information about STDs and strategies aiming at behaviour change are of particular importance for the health of women and men, since men play a major role in the spread of STDs, including AIDS. At the same time men control condom use, currently the only effective method of preventing STD infection apart from abstinence.

Encourage joint decision-making by spouses. Men can support their partners' choices and empowerment if couples talk about reproductive health and family planning (see Chapter II). National surveys in seven sub-Saharan African countries found that contraceptive use and continuation were much higher among couples who had discussed family planning in the previous year than among those who had not.

Six studies in Kenya and Zambia in the late 1980s found that it was important to women to be able to talk to their husbands about contraception; encouragement and advice from the men helped the women choose which method to use and to persevere when side-effects occurred. Women who didn't have their husbands' support were mainly concerned with choosing a method that would not show or have side-effects that the husband might notice.

A 1993 study in Addis Ababa, Ethiopia, compared two groups of couples. In one, the wives were given a health talk on their own; in the other, the husbands were included. After two months, 25 per cent of the couples from the second group were using contraceptives compared to 15 per cent of the first group; after 12 months the difference widened to 33 per cent versus 17 per cent.[18]

When promoting male involvement in reproductive health and family planning decisions, care needs to be taken not to promote male domination.

Provide contraceptive choices. Vasectomy and condoms are the only contraceptive methods available to men; neither is widely used in most developing countries, although condom use is on the rise due to the AIDS pandemic.[19] There is some evidence that neglect by policy makers and providers may partly explain the low prevalence of vasectomy. Research indicates that where the procedure is accessible and promoted, men tend to use it. In Colombia, for example, the annual number of vasectomies performed by Profamilia rose by 77 per cent after the organization opened its first two men-only clinics in 1985.

Design convenient, appealing services. Men are reluctant to go to facilities that offer services primarily for women. Programmes can be made more attractive to men in several ways:

- **Modifying existing clinics** at little cost, to make men feel more welcome and to offer a broader constellation of services. This could involve making the decor more gender-neutral, establishing separate entrances and/or waiting areas for men, or initiating special clinic hours for men.
- **Separate clinics for males.** This approach has been proven successful in Asia and particularly in Latin America (Brazil, Colombia, Guatemala, Honduras, Mexico and Peru).
- **Services in the workplace.** In India, Kenya, the Philippines, Turkey, and other countries, employers and trade unions provide family planning services to workers, often as part of a broader health care package.
- **Community-based services** for men, such as distribution of condoms and information. The Family Planning Association of the Dominican Republic, for example, uses barbers to distribute condoms and information to customers and others.[20]

EDUCATION INITIATIVES IN LATIN AMERICA

Bolivia

In 1990, the Bolivian Ministry of Education requested UNFPA support to introduce formal and non-formal population education. The project was set up in consultation with labour unions, women's and community organizations, UNESCO and UNICEF.

The project focuses on training educators and social communicators through discussions on such themes as: the family and sexuality, women's status; gender roles; health; and population, migration and the environment. A documentation centre provides information and support.

In the first phase of the project, a central team of 272 people was trained. They in turn trained 9,000 educators — 8,000 of them women — who then educated a large number of students. The school curriculum has since been reformed to incorporate the project's approach. In the non-formal sector, three groups of educators have been trained: 70 social communicators drawn from the ranks of government and NGOs; 50 popular communicators, mainly media professionals; and 380 grass-roots communicators.

A major reason for the project's success has been its participatory approach and an underlying respect for the beliefs of the groups involved.

Brazil

In Brazil, UNFPA supports a programme to train some 2,700 teachers in five Northeastern states in sex education, adolescent reproductive health, and prevention of drug abuse, STDs and AIDS. The project, executed by the *Centro de Sexologia de Brazilia*, aims to implement the Ministry of Education's *Programa de Valorizacao da Vida* (Programme to Value Life). Sex education topics have been integrated into several parts of the school curriculum.

An evaluation has indicated that adolescents like the project. Specifically, they appreciate discussing subjects such as homosexuality, abortion, sexual rules, adolescent pregnancy and contraceptives. Materials used in these discussions are based on research into adolescents' attitudes and sexual behaviour.

In the state of Bahia, the Health Secretariat has observed a marked increase in adolescents' demand for medical and psychological assistance since the education project began in 1992. In response, the Secretariat plans to provide specialized training in adolescent reproductive health for physicians, nurses and social assistants.

Sources: UNFPA. 1994. "BOL/92/P02 – Population IEC through Educational Discussion Groups. Project Information." New York: Latin America and the Caribbean Division, UNFPA; UNFPA. 1994. "BRA/92/P04 – Training Programme in Sex Education for Teacher Schools in Five States of the Northeast." Project Information. New York: UNFPA.

- **Commercial and social marketing.** This involves selling condoms through commercial outlets, at subsidized prices.

Promote positive images of men and women. Mass media and schools can help change people's attitudes about reproductive health and gender issues by, for instance, presenting images of couples discussing family planning and making joint decisions. Family planning messages and educational programmes can counter gender stereotypes, for example, by portraying women as professional, competent and strong, and men as caring and involved in family life.

ADOLESCENTS' NEEDS AND CHOICES

"When I was expelled from school I was 12 years old. Teachers told me I was pregnant, but I did not know what pregnancy was," says a young woman at a rehabilitation centre for teenage mothers in Dar es Salaam. When another resident was asked why she had not used contraceptives, she answered that she did not know what contraceptives were. [21]

Today, more than half the world's people are below age 25. About a third are between ages 10 and 24; some 80 per cent of these live in developing countries. This means that world-wide, large numbers of young people are in need of education and training, jobs, health care and housing. At the same time, all these young people have needs related to their physical and emotional development, particularly as they become aware of their sexuality, and in many cases, become sexually active.

In much of the world, girls have traditionally married young and started to bear children at an early age. Today, 18 per cent of girls in Asia, 16 per cent in Africa and 8 per cent in Latin America are married by age 15.[22] In general, however, girls today are marrying later, in part because they stay in school longer.

At the same time, recent improvements in nutrition and health care have reduced the age at which puberty occurs. Consequently, many young people have a longer interval between the onset of sexual maturity and marriage, increasing the likelihood that they will engage in premarital sexual relations and be exposed to the associated risks.[23]

Young women first experience sexual intercourse, on average, at age 15 in Niger, 19 in Indonesia, 16 in the United States and 17 in Italy. In Latin America surveys indicate that males have their first intercourse at a younger age than females, in some countries two years younger.[24]

Traditional customs and family ties that have discouraged pre-marital sex are being undermined by social developments such as migration to cities, which disrupts families and changes lifestyles. Attitudes on sexuality are increasingly shaped by the mass media.

Deteriorating economic conditions in many countries place young people at increased risk of abusive, exploitative and unsafe sexual encounters. Poverty is often a direct cause of prostitution among young people, some of whom are sold by their families.[25] Studies indicate that some 800,000 girls under age 20 work in prostitution in Thailand, 500,000 in Brazil and 400,000 in India.[26]

Among the major reproductive health risks that young people face are:[27]

- **Sexually transmitted diseases**, including HIV/AIDS. Although it is difficult to obtain detailed information on STDs in adolescents,

studies suggest they are on the rise. In Thailand and Singapore, for example, young people comprise up to 40 per cent of the clients treated for STDs in government clinics.[28] Each year, one in 20 teenagers world-wide contracts an STD. To date, at least half of those who have been infected with HIV were infected between 15 and 24 years of age.[29]

- **Unwanted pregnancy** and its consequences, including illegal abortion and related complications. Pregnancy has serious implications for young women's health but also for their plans for the future. Some 15 million adolescent females, married and unmarried, become pregnant each year.[30] A high percentage of these pregnancies are unwanted, leading many young women to seek refuge in abortion, whether it is legal or not. In Latin America almost 15 per cent of women hospitalized in the 1970s for abortion complications were younger than 19. More recent statistics from cities in Kenya, Liberia, Mali, Nigeria and Zaire show that 38 to 68 per cent of women hospitalized with abortion complications were 19 or younger.
- **Higher risks of maternal morbidity and mortality.** Mothers aged 15-19 are two to three times more likely to die in childbirth than those aged 20-24, those under 15 five times more likely.[31] During delivery, teenagers are also much more likely to suffer complications such as fistulas — an abnormal opening between the vagina and the rectum or urinary tract which often leads to lifelong disability.
- **Low birth weight and prematurity.** Children of very young mothers face higher risks of infant morbidity and mortality. Low birth weight, a major cause of death in infants, is common. Premature infants often experience persistent problems throughout early childhood.

Early pregnancy also has social consequences: compared with women who delay child-bearing until after age 20, teenage mothers are likely to have less education and lower-paying jobs or no jobs at all.

If youth knew, if age could... young people in Brazil.

MARK EDWARDS / STILL PICTURES

They are more likely to be separated or divorced from their partners.[32]

Young people need appropriate and effective education programmes on sexuality and gender relations, and access to reproductive health services and information. There is clear evidence that young people who have had some education on sexual health and social responsibility are less likely to engage in risky sexual behaviour before marriage.[33]

ICPD Programme of Action on Adolescents

The Programme of Action encourages governments and NGOs to establish programmes to meet adolescents' sexual and reproductive health needs and to substantially reduce adolescent pregnancies, "through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling...". [para. 7.44] Areas to address include gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, and prevention of STDs and HIV/AIDS. Legal and social barriers preventing adolescents from receiving reproductive health information and services should be removed. [paras. 7.45 and 7.47]

The Programme of Action recommends that youth be involved in the design, implementation and evaluation of the programmes that affect them. Young men need to be taught to respect women and to share responsibility with them in matters of sexuality and reproduction. [para. 7.41]

Information and Education

The lack of accurate information on reproductive health, and conflicting messages in the mass media are increasingly becoming problems for young people. Traditional means of acquiring information, through family and peers, have lost influence and have not been replaced by systematic education in or outside of schools.

Informing young people about sexuality and reproductive health is a delicate subject. It is often argued that giving them such information promotes early sexual activity and violates parents' rights. A survey by WHO's Global Programme on AIDS, however, found no evidence that sex education in schools leads to earlier or increased sexual activity in young people. It did indicate that sex education can help protect teenagers from the risks of sexual activity.

WHO recommends educating young people about a range of options, including postponing sexual activity, and for those already sexually active, non-penetrative sex and condom use for protected intercourse. The survey indicated that sex education is most effective when given before a young person becomes sexually active. Programmes that promoted both postponement of sex and protected sex were much more effective than those that promoted abstinence alone.[34]

Parents generally feel that they are the ones who should give their children sex education, but often feel uncomfortable doing so. Special programmes have been developed to help parents start discussions with their children about sexuality and reproductive health. Church-based agencies in Madagascar, Kenya and Malawi, for example, give parents basic information

'GENTE JOVEN', MEXICO

Gente Joven (Young People), is a sex education and family planning programme for young people developed by the Mexican Family Planning Foundation, Mexfam. In 52 cities, the programme reaches out to adolescents in schools, sports and recreational centres, work sites, on the streets and in other gathering places.

In 1986, Mexfam established special centres providing a range of educational activities and medical services to adolescents. This approach reached only a limited number of adolescents and costs per person served were high. After two years, Mexfam changed its strategy, taking the services into the community.

Gente Joven has five major components:

- **Peer promoters.** More than 1,500 volunteer promoters aged 16-20, supervised by 17 paid coordinators, provide information and condoms to young people in the communities. They can also make referrals to family planning clinics. Adolescents help to develop the information materials the promoters use, to ensure that they correctly reflect teenagers' needs and to appeal to their tastes.
- **Education in schools and factories.** Mexfam staff provide sex education courses in schools and lectures in workplaces. The 10-hour school programme, presented on five consecutive days, is not limited to providing information, but emphasizes debate and analysis.
- **Outreach to youth gangs.** Mexfam reaches out to teenagers in street gangs through music, theatre, group discussions and by training social workers who work with the gangs.
- **Radio.** Mexfam has produced more than 100 radio programmes for youth in cooperation with the Ministry of Public Education. The programmes provide information on sexuality, reproduction, family planning and human relationships.
- **Videos.** Films and videos developed by Mexfam are used to initiate discussions about sexuality. The videos, supplemented with teaching guides, address various complex issues.

Mexfam has recently begun to extend the programme's activities into rural areas and to incorporate gender issues in its materials.

In 1993, *Gente Joven* offered 4,264 2-hour talks on sexuality, communication, adolescence and AIDS; 109,867 young people took part. Ten-hour courses were given to 44,072 peer educators on family communication, puberty, sexuality and youth, STDs and AIDS, teenage pregnancy and contraception. As a result of the programme, 18,393 young people reportedly started using condoms.

An estimated 320,000 young people listened to the radio programme *Estrenando Cuerpo* (Using your Body for the First Time). This series combines music with personal accounts of young people's lives and problems. *Gente Joven* also uses street theatre, written, directed and performed by young people.

Sources: Marques, Magaly. 1993. "Gente Joven/Young People: A Dialogue on Sexuality with Adolescents in Mexico." Quality/Calidad/Qualité, No. 5. New York: The Population Council; José Ligilar (Mexfam). 1993. Personal communication.

Cairo Youth Declaration on Population and Development

Just prior to ICPD, more than 100 young men and women from all regions of the world came to Cairo for an International Youth Consultation on Population and Development. Discussion focused on two central priorities:

- The need to explicitly and consistently integrate population concerns with development, within a just and equitable international economic system;
- The need to educate and mobilize youth in regard to adolescent health, the environment and human rights.

The importance of individual commitment to take action at the organizational, national and international levels, and the need to mobilize youth as agents of change were recurrent themes.

In discussions on reproductive health, participants emphasized the value of education in promoting healthy relationships. They issued a Declaration which states that education and services facilitating safe sexual behaviour do not encourage promiscuity, but on the contrary help young people to better understand their responsibilities. The Declaration stresses that men need to take responsibility as a basis for equality between women and men. Prevention of teenage pregnancies is deemed crucial, especially to enable young women to continue their education.

As members of youth-NGOs, participants pledged to work within their organizations for the empowerment of women and to end all forms of sexual discrimination and violence against women. They further agreed that reproductive health and family planning are integral to the promotion of a healthy life .

The Declaration calls upon governments to provide family planning and sexuality education, to enforce laws prohibiting female genital mutilation and sexual exploitation, to provide care for women who are victims of sexual exploitation and violence, and to ensure that pregnant teenagers are not expelled from school.

Source: International NGO Youth Consultation for the International Conference on Population and Development. 1994. Cairo Youth Declaration on Population and Development, *31 August – 4 September 1994, Cairo, Egypt.*

and help them feel more confident discussing these issues. In other countries, parents are being involved in sex education programmes in schools.[35]

Population education, in schools or in other settings, is an important means of teaching young people that they can control events related to reproduction – when to marry, when to have the first child, how many children to have, etc. In some countries with a shortage of teachers, economic necessity has led to increased peer involvement in teaching; research shows that this has educational benefits for both those who are taught and the student teachers. In population education, peers can be especially helpful in a process that is more a matter of creating awareness than a pure transfer of knowledge.[36]

Some countries offer family life education to address issues of gender and adolescent reproductive health. Such programmes can start with age-appropriate curricula at the primary school level and proceed gradually through the secondary school level. Major aims include enabling young women to achieve good reproductive health, and educating young men and women about positive and responsible sexual and reproductive behaviour.

Education programmes for youth in many countries, however, generally have a narrow focus on teenage pregnancy. Family life education programmes often promote "responsible parenthood" within marriage and abstinence outside it; these programmes frequently ignore gender relations, rarely provide information on sexual feelings, attitudes and behaviour, and seldom address contraceptive use.[37]

The most effective programmes start by listening to young people's concerns, to understand how they perceive their own needs. Programmes such as *Gente Joven* in Mexico have done this by conducting community surveys and identifying interested and responsible young people to be trained as "peer promoters". All educational materials are geared towards the needs identified by young people.

Another example is the HIV/AIDS-prevention video *"No Rubber, No Way!"*, produced for street children in Brazil. Children were closely involved in writing the script, and a number of interviews with them are shown. The video provides information not only on HIV/AIDS and prevention, but also on other problems youth face while living on the streets.[38]

Sex Education as A Gradual Process

Ideally, sex education should be a progressive process, giving age-appropriate information in different stages. Programmes that involve young people in discussions and activities are found to work better than lectures. Though some subjects may be better dealt with in separate sessions for boys and girls, many providers have found there are advantages in mixed sessions, especially when discussing gender attitudes. Alongside classroom education, many adolescents need one-to-one counselling on particular problems.

Millions of young people world-wide do not attend school; to get information to them, other means must be used. Often living in social and economic misery, these young people are particularly at risk. To reach out-of-school youths effectively, communications efforts must address their basic survival needs, and be creative enough to attract their interest. Approaches used successfully in Latin America and the Caribbean include television soap operas, newspaper cartoons and comic strips produced especially for adolescents.[39]

Another creative example is a photo-comic, *Roxy: Life, Love and Sex in the Nineties*, produced for South African teenagers. It tells the story of an adolescent girl, Roxy, who discovers that her friend has committed suicide because she was HIV-positive. Roxy then starts gathering information about AIDS, and shares it with her peers. The comic had been distributed to more than 30,000 adolescents as of July 1993. Although some adults reportedly think the story is too explicit about sex, young people themselves have indicated that adolescents need such information because of the risks that they are exposed to if sexually active.[40]

ABORTION LAWS

In 173 of the world's 190 countries, abortion is permitted to save the life of a woman. It is permitted in 119 countries to preserve a woman's physical health, and in 95 to preserve mental health. Eighty-one countries permit abortion in cases of rape or incest, and 78 in cases of foetal impairment. Abortion is available for economic or social reasons in 56 countries and on request in 41 countries.

Most Eastern and Central European countries liberalized their abortion laws in the 1950s; most other industrialized countries and several developing countries – notably China and India – did so in the 1960s and 1970s. By 1986, abortions for health reasons were legal in all North American and European countries except Belgium and Ireland.

Other factors are often more important than laws in determining the availability of abortions. In countries where women have a legal right to abortion, many find it difficult to exercise this right due to strict medical requirements, inaccessibility or underfunding of services, a lack of information or referral networks, a shortage of trained providers, or local failure to enforce national laws.

On the other hand, where laws are interpreted flexibly or not strictly enforced, safe abortion services may be available despite legal constraints. Although abortion is restricted in Bangladesh, for example, clinics perform menstrual regulation (the use of an effective agent or procedure to induce menstruation) up to 10 or 12 weeks after a missed period. These are also performed in some areas of Indonesia and Malaysia – where abortion is only permitted legally to save a woman's life or preserve her health, and in case of foetal impairment, respectively.

The prevalence of abortion is not determined by its availability. The Netherlands, with Europe's most liberal abortion law, has an annual abortion rate of five for every 1,000 women, compared to the Western European average of 14. The United States in 1991 had 26 abortions per 1,000 women. In Latin America, where abortion is largely illegal, the rate is between 30 and 60 per 1,000 women.

More women resort to abortion where family planning services and sex education are not easily available or of poor quality. Restrictive laws do not prevent abortion but result in women seeking unsafe, "back-alley" abortions which account for a significant proportion of maternal deaths.

Sources: United Nations. 1994. World Abortion Policies 1994. *New York: Department for Economic and Social Information and Policy Analysis, Population Division, United Nations; Henshaw, Stanley K. 1990. "Induced Abortion: A World Review, 1990."* Family Planning Perspectives *22(2): 76-89; UNFPA. 1993. "Reducing Abortion."* Populi *20(7).*

Services for Adolescents

Providing reproductive health services to young people is often even more controversial than giving them information about sexual issues. But without access to services, young people cannot take care of their health, no matter how much education and counselling they have had. As with education and counselling programmes, proponents of service provision to adolescents need to gain support of community leaders, parents and teachers by stressing the consequences of *not* providing the services.

Which reproductive health services are appropriate for adolescents in a particular country depends on the sociocultural context. As the ICPD Programme of Action notes, they may include:

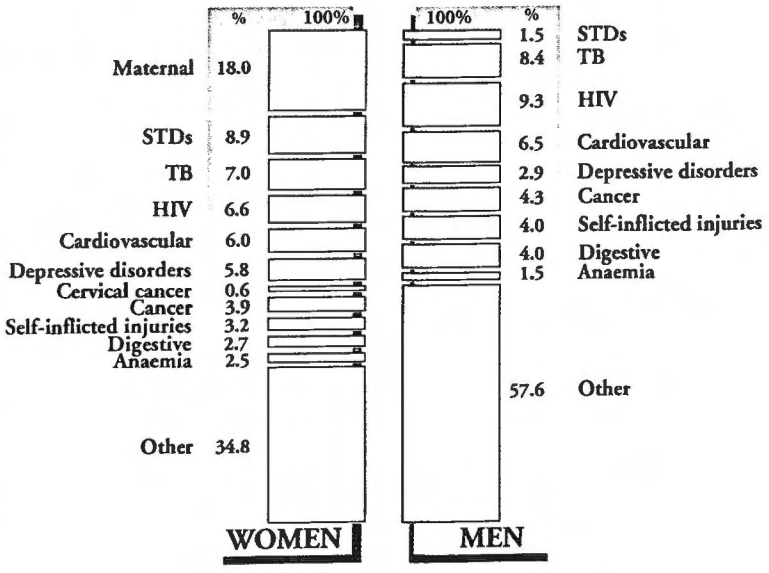
- family planning information, counselling and services for sexually active adolescents;
- counselling on gender relations, violence against adolescents, reproductive health and the prevention of STDs, including HIV/AIDS;
- prevention and treatment of sexual abuse and incest.

Some excellent programmes offering services for adolescents have been developed. The Philippines has three health centres especially designed for teenagers. Educational and clinic-based programmes in Antigua and Barbuda, Brazil, Chile, Ecuador, Guatemala, Indonesia, Jamaica, Mauritius, Montserrat, Nigeria and Peru focus on adolescents' needs.

Adolescents' Orientation Centres in Mexico City offer a broad variety of educational, medical, psychological and recreational activities and services for 11-19 year-olds, including family planning services and information and counselling. An outreach programme promotes young people's participation in local community-development projects.[41]

In Jamaica, a UNFPA-supported programme operates women's centres in seven cities to help young

DISEASE BURDEN IN MEN AND WOMEN AGED 15-44 YEARS



Source: Based on *World Development Report 1993 – Investing in Health* (New York, Oxford University Press, for the World Bank)

LIFE-CYCLE APPROACH TO REPRODUCTIVE HEALTH

PROBLEMS		SERVICES
	ELDERLY	
Circulatory diseases	POST MENOPAUSAL	(Affected by earlier reproductive experience)
Prolapse/Osteoporosis		Early diagnosis; information; treatment
Reproductive tract and breast cancers		STD prevention and treatment; early diagnosis; information; treatment
Malnutrition/Anaemia (all ages)		Supplementation; education
Infertility		Counselling; primary prevention
Complications of abortion		Treatment; counselling; family planning; education in responsible sexual behaviour
Maternal morbidity and mortality		Family planning; antenatal, delivery and post-partum care; emergency obstetric care; tetanus immunization
Regulation of fertility	REPRODUCTIVE AGE	Family planning; contraception; information and education
Commercial sex		Counselling; legal/social change
Substance abuse (alcohol, drugs, tobacco)		Education; treatment; counselling
Gender violence (all ages)		Counselling; legal/social change; education
Harmful traditional practices		Empowerment; legal/social change; education
STDs/HIV (and infants through vertical transmission)		Detection; treatment; counselling; education; prevention; appropriate contraception
Nutrition (all ages)		Supplementation; education
Unsafe sexual practices (and older ages)	ADOLESCENT	Family life education
Adolescent pregnancy		Family life education; counselling; family planning
Other diseases (all ages)		Environmental health; occupational health; primary health care; education; immunization
Neonatal morbidity and mortality	CHILD	Antenatal, delivery and post-partum care; breast-feeding
Low birth weight	BIRTH	Supplementation; education; antenatal care; health promotion; disease prevention

Source: World Health Organization, WHO/FHE/RHP7, WHO/FHE/RHP9

COMMUNITY BIRTHING HUTS IN TANJUNGSARI, INDONESIA

While fertility rates in Indonesia have been reduced substantially in recent decades by family planning, maternal mortality remains high, at 450 per 100,000 live births. A 1988-89 study in the West Java subdistrict of Tanjungsari revealed that most maternal deaths were caused by delays in obtaining services for obstetrical emergencies.

The most-reported reasons for this were: delays by pregnant women, their husbands and traditional midwives in deciding to seek a higher level of care; transportation problems preventing referral patients from reaching the appropriate level of care; and inadequate equipment and staffing at care facilities.

The University of Padjadjaran, with technical assistance from MotherCare, developed an operational research project to address the problems of referral and attendance for emergencies. Birthing huts were established in 10 of Tanjungsari's 27 villages, serving a population of 37,000. In the huts women receive prenatal care, referral and normal delivery services. The huts have access to emergency care via two-way radios and ambulances.

Research revealed that village midwives were ambivalent towards the birthing huts, strongly preferred home delivery, and were highly misinformed about the warning signs of obstetrical complications. A strategy was launched to educate the communities and midwives about the correct responses to danger signs and about the benefits of the birthing huts.

The result was a three-fold increase in referrals to the birthing huts (from 20 per cent to 64 per cent) between January 1992 and March 1993. In the same period:

- Referrals from traditional birth attendants for labour and delivery increased from 17 to 34 per cent;
- Perinatal mortality (deaths between the end of the 28th week of gestation and the seventh day of life of a newborn) decreased from 48 per 1,000 to 36 per 1,000 live births;
- Maternal mortality in the area decreased from 508 per 100,000 live births in 1989 to 225 per 100,000 in 1993.

However, many traditional birth attendants still believe referring clients to another facility discredits their professional standing in the community.

Source: MotherCare. 1994. "Tanjungsari, Indonesia: Community-Based Birthing Huts." In MotherCare Matters *4(2): 4.*

mothers cope with the consequences of early pregnancy. Daycare is provided to allow the women to continue their education. The centres also provide counselling, family life education and contraceptive services. Young fathers are encouraged to get involved in the programme, and many attend the weekly community workshops.[42]

In making existing reproductive health services available to adolescents, is important to ensure that programmes and health care providers' attitudes do not inappropriately restrict access. In a number of countries, regulations and laws prevent unmarried adolescents from using such services. Changing these laws (within sociocultural norms) would be an important first step to improving adolescent health.

ELEMENTS OF REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAMMES

The sections below examine the major components of reproductive health and family planning programmes. While each component is presented separately, they need to be seen as connected parts of a single, holistic approach which is implemented in the context of providing primary health care services. This approach coordinates, links or functionally integrates all the components and ensures continuity of care between different levels of service.

SAFE MOTHERHOOD

For the women of the Bariba tribe in Benin, having babies is a test of will. Enduring labour and childbirth alone and in silence is a sure route to social respect. Asking for help is considered a sign of weakness and shameful. As a result, many women who could easily have been saved die of complications during delivery.[43]

In parts of Ghana, prolonged obstructed labour is seen as a sign of infidelity. This belief delays the seeking of emergency care, as a woman has to make a confession to appease the gods before she delivers. Some women believe so strongly in this that they confess infidelity even if they have not committed it.[44]

In Papua New Guinea's Southern Highland Province, women are expected to give birth unattended. This tradition stems from a belief that a woman's blood is a source of contamination leading to illness or even death. Maternal and infant mortality rates in the region are exceptionally high.[45]

In many countries, pregnant women are told not to drink milk, or to eat eggs and other foods which are good sources of vitamins and protein.

Though women are valued in most societies principally for their reproductive role, their reproductive health has been poorly protected. According to the World Bank, fully one third of the total disease burden in developing country women aged 15-44 is related to pregnancy, childbirth, abortion, HIV and reproductive tract infections.[46]

The major factor in preventing maternal morbidity and mortality is access to appropriate health services. This is not determined by the health system alone; social, economic, cultural and political factors – particularly women's status and freedom to make their own decisions – strongly influence access to health care. In societies where women are disproportionately poor and illiterate, and politically powerless, high rates of maternal morbidity and mortality are common.

One of the most important aspects of safe motherhood is control over whether and when

pregnancy occurs. Pregnancy too early or late in life; too many pregnancies or pregnancies too close together greatly increase the risks. Women's low status in many countries, male dominance in sexual relations and the inadequacy of reproductive health services make preventing unwanted pregnancy – or protection against disease – difficult or even impossible for many women.

Certain traditional practices compound women's poor health status. On the other hand, some traditions or cultural beliefs associated with childbirth – such as encouraging women to rest more frequently during pregnancy – are beneficial to maternal health. Others, such as burying the placenta, have no impact on women's health.

Their health depends on their freedom to choose: youth and age in India.

MARK EDWARDS / STILL PICTURES

A Context for Reproductive Health and Family Planning

Some three fourths of maternal deaths world-wide can be attributed to five immediate causes: haemorrhage, sepsis (infection), pregnancy-related hypertension, obstructed labour, and complications of unsafe abortion. The remaining 25 per cent result from complications during pregnancy attendant to pre-existing illnesses like hepatitis, malaria and heart ailments.

Immediate medical causes conceal underlying social issues. High levels of maternal mortality and poor reproductive health generally are closely related to the low social and economic status of women. In many families, girls and women eat after men and boys, and often do not get enough to eat.

Poorly nourished, girls are more likely than boys to fall ill; when they do they are less likely to receive proper treatment. Malnutrition and childhood disease may hold back a girl's growth, making obstructed labour much more likely. Many women become anaemic because their diets lack sufficient iron to meet the demands of menstruation and pregnancy.[47]

Lack of attention to women's health and well-being translates into poor antenatal and perinatal care – to say nothing of family planning services, which could prevent much maternal mortality simply by avoiding unwanted pregnancy.

Complications during pregnancy or childbirth take the life of one woman every minute. Nearly 99 per cent of the 500,000 maternal deaths annually are in the developing world.[48] One in 21 African women will die from pregnancy- or childbirth-related causes; elsewhere the lifetime risk is one in 54 in Asia, one in 73 in South America, one in 6,366 in North America, and one in 9,850 in Northern Europe.[49]

In absolute terms, South Asia is the region with the most women of

GRASS-ROOTS AIDS EDUCATION IN NIGERIA

Early AIDS education programmes in Nigeria relied mainly on mass media which do not reach large segments of the population. To educate a wider audience, including illiterates, a number of grass-roots initiatives have since been started in and around Lagos:

Fathers' Club

The College of Medicine's Institute of Child Health and Primary Care operates a Family Health Clinic in a poor area of Lagos, providing comprehensive services to some 30,000 people. To help gain community support for its programme, the clinic started a Fathers' Club which meets each month to discuss health-related topics.

A meeting on AIDS was of particular interest to the participants. Each was asked to pass along what he had learned to at least 10 family members and co-workers. The club also began to distribute condoms, and other groups have followed suit.

Booths in the Marketplace

Inspired by the success of the Fathers' Club, students of the College of Medicine set up a booth in one of Lagos's biggest markets during national "Health Day". Services at the booth included family planning, blood pressure screening, counselling and treatment for minor ailments, and discussion on health topics. A discussion on AIDS lasted more than three hours. The use of condoms was demonstrated and condoms were distributed. This is now an annual activity, part of the required fieldwork for final year medical students.

Club Talks

StopAIDS, an NGO, initiated a lecture and discussion programme on AIDS in recreational clubs around Lagos. Participants are given pamphlets and other information materials. The meetings have generated a lot of interest; many of the male participants want to learn the right way to use condoms, and have many questions about AIDS.

Source: Olukoya, Adepeju A. 1993. "Approach to AIDS Education for the Grassroots in Nigeria." In Women and HIV/AIDS: An International Resource Book, *by Marge Berer and Sunanda Ray. London: Pandora Press.*

reproductive age and the highest number of maternal deaths, 300,000 annually. Six countries – Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka – account for 43 per cent of maternal deaths world-wide. Africa accounts for an estimated 150,000 maternal deaths each year, Latin America 34,000, and the industrialized countries 6,000.[50]

Women often have very limited knowledge about their own health and the symptoms of serious problems. In Senegal, for instance, a 1989 survey in six regions found that women lacked basic information on the signs and symptoms of obstetric complications. One quarter of the women interviewed could not name one single complication. Some women believed that fever, dizziness and pallor were signs of a normal pregnancy.[51]

Pregnancy-related Illness: the Hidden Scourge

For every woman who dies as a result of pregnancy, many more survive to suffer from chronic illness or physical impairment. In household surveys coordinated by Family Health International among 16,000 women in Egypt, Ghana, Indonesia, India and Bangladesh, seven out of 10 women reported either a health problem related to their last pregnancy, delivery or post-partum phase, or a chronic condition resulting from pregnancy or childbirth.[52]

Preliminary results from Egypt, Ghana and Indonesia indicate that for each maternal death, there are between 240 and 330 maternal morbidities; the number varies from country to country. This suggests the problem is much more serious than was previously thought; up to now, experts have used an estimate of 16 morbidities per maternal death, based on a small-scale study in India in 1980.

Men also suffer from reproductive health problems, particularly STDs. But the health risks are far greater for women, who alone are exposed to the risks of pregnancy and childbirth. Women also face higher risks in preventing pregnancy, as they are usually the ones using contraception, and suffer from the consequences of unsafe abortion. In addition, as the ICPD Programme of Action points out, "The social and economic disadvantages that women face make them especially vulnerable to sexually transmitted infections, including HIV." [para. 7.28] Women are often in no position to protect themselves from the risk of pregnancy or sex-related disease: they are expected to submit, and to take the consequences.

Data on maternal health and mortality are limited. While most governments compile statistics on infant mortality, only 20 out of 130 developing countries do so for maternal mortality.[53] Statistics for maternal morbidity are even weaker; it is an indication of how little importance has been assigned to women's health in the past that the true extent of such a serious problem can still only be guessed.

Abortion and Women's Health

Induced abortion has been used throughout history and in most countries to prevent unwanted births. But abortion is often legally restricted, and most women in developing countries do not have access to safe abortion services. Consequently, many women seek recourse to unsafe abortion, making it a major cause of maternal deaths and permanent injuries to women.

World-wide, it is estimated that women have more than 40 million abortions each year. WHO estimates that between 26 and 31 million are performed legally, and 20 million are performed under unsafe conditions. These figures imply that at least one in four pregnancies is terminated.[54]

Data on abortion are usually incomplete, especially where abortion is partly or completely illegal. Officially reported annual rates of abortion range from 192 per 1,000 women of reproductive age in Romania (about 76 per cent of pregnancies) to 5 per 1,000 women in the Netherlands (9 per cent of pregnancies). The actual figures are thought to be much higher than official records indicate.

Unsafe abortion is a serious public health concern, accounting for an estimated 67,000 deaths each year.[55] The risk of death from an abortion performed by an unskilled provider is 100 to 1,000 times greater than from one performed by a qualified provider. Recent studies have found that abortion accounts for 26 per cent of maternal deaths in Ethiopia, 47 per cent in Brazil and 50 per cent in Nepal.[56] Almost all abortion-related deaths occur in developing countries, and most are preventable.

An even larger number of women suffer long-term complications such as infection, pain and infertility. A study by the Alan Guttmacher Institute in Brazil, Colombia, Chile, Mexico, Peru and the Dominican Republic found that some 30-45 of every 100 women having an illegal abortion experienced complications, but only 20-30 were hospitalized for treatment.[57]

Young women tend to wait longer than older women to seek an abortion, increasing the risk of complications. In some countries, adolescents account for as much as 60 per cent of those hospitalized with abortion complications, according to data from 27 studies in Africa, Asia and Latin America.[58]

In many countries, complications of unsafe abortions put a major strain on hospital resources and budgets. In Sudan, for instance, half of all obstetrical and gynaecological admissions and 80 per cent of the emergency cases in that sector were due to incomplete and septic abortions.[59] A study in the Dominican Republic found that treating a case of abortion complications costs 12 times more than a normal birth.[60]

Action for Safe Motherhood

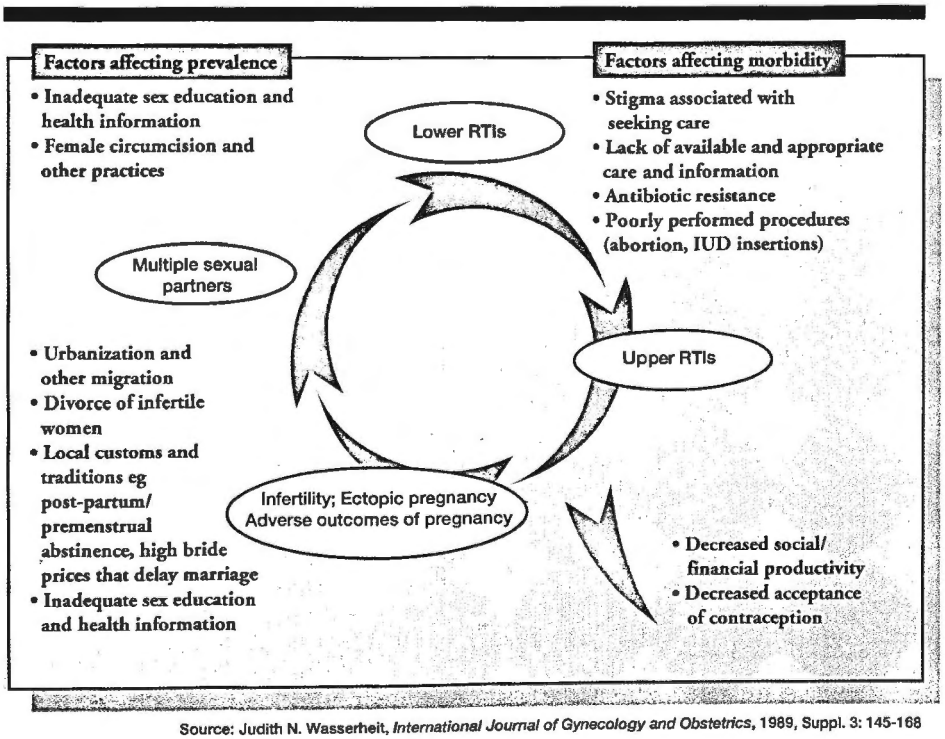
Pregnancy can be made much safer with technologies currently within reach of all countries. Providing emergency obstetric care, in particular, can save countless lives.

El Salvador is working to make motherhood safer by training health promoters and traditional birth attendants, strengthening the nutritional component of its health care system, and upgrading its maternal care referral system. In the Gambia, where maternal mortality rates are among the world's highest, the focus is on increasing the supervision and support of traditional birth attendants by health system personnel. And in Pakistan, the Family Health Project's safe motherhood strategy includes increasing the number of female nurses and health visitors and introducing a systematic training programme for primary health care staff.[61]

Making motherhood a lot safer will require an improvement in the socio-economic and political status of girls and women; high-quality family planning, pre-natal and delivery care for all women; and skilled obstetric care for high-risk and emergency cases. To work towards these goals, the Safe Motherhood Initiative was launched in 1987, as a global effort to improve women's health and to reduce maternal mortality by half by the year 2000.

The Initiative aims to raise awareness of the causes and consequences of maternal death and illness, and to stimulate action on a broad range of women's health issues and needs. It seeks to build active partnerships among governments, NGOs, intergovernmental organizations, private institutions, and individuals at

SELECTED FACTORS ASSOCIATED WITH FEMALE REPRODUCTIVE TRACT INFECTIONS (RTIs)



Source: Judith N. Wasserheit, *International Journal of Gynecology and Obstetrics*, 1989, Suppl. 3: 145-168

the local, national, and international levels. Leadership has been provided by UNDP, UNFPA, UNICEF, WHO, the World Bank, the International Planned Parenthood Federation and the Population Council.

From the beginning of the Initiative, participants have agreed that safe motherhood is linked to broader development goals and requires a wide range of development strategies.[62] Improving women's health requires mobilization of political and social will to allocate the necessary resources; collaboration among health, education, economic and social sectors; and participation and commitment from local communities, especially women.

Safe Motherhood Programme Strategies

An ideal safe motherhood programme would bring about immediate reductions in maternal morbidity and mortality, by providing access to a broad array of health services in an informed and participatory community.

Safe motherhood initiatives should always be part of a broader reproductive health approach, provided within the primary health care system. They need to recognize that women are not only mothers in need of maternal care. Indeed, since women's needs go beyond reproductive health care, an integrated life-cycle approach to their overall health is required.

To be implemented effectively, a safe motherhood programme must be designed to encourage coordination among the various medical and social agencies and organizations concerned. Finally, and most important, it must empower women to make their own choices.

ICPD Programme of Action on Maternal Mortality

The ICPD Programme of Action calls on governments to integrate safe motherhood interventions into reproductive health services, provided in the context of primary health care. Essential aspects include pre- and post-natal care, delivery assistance and emergency care, family planning and neonatal care. The objectives are for all countries to halve their 1990 levels of maternal mortality and morbidity by the year 2000 and halve them again by 2015, and to narrow disparities in maternal mortality within and between countries, geographical regions and ethnic groups.

All countries are further encouraged to reduce maternal mortality by preventing, detecting and managing high-risk pregnancies and births, particularly those to adolescents and older women. Education programmes are recommended to enlist men's support for maternal health and safe motherhood. [paras. 8.22 and 8.23]

The Programme of Action urges governments, intergovernmental organizations and NGOs to address unsafe abortion as a major public health concern. In all cases, it states, women should have access to quality services for the management of abortion-related complications. It further encourages governments to expand and to improve family planning services as the most effective means of preventing abortions. [para. 8.25]

Reproductive Tract Infections

Both women and men are vulnerable to a variety of reproductive tract infections. Most are transmitted via sexual intercourse,[63] but women may also be infected by the use of unclean menstrual cloths, the insertion of leaves or other materials in the vagina to prevent pregnancy or induce abortion, unsafe childbirth or abortion techniques, and harmful practices such as female genital mutilation.

The low status of women in many countries plays a major role in the prevalence of RTIs. Women are frequently subject to sexual exploitation at a young age, and men often have multiple sexual partners. These practices increase women's exposure to STDs and facilitate their spread.[64] Inequality in marriage or sexual relationships is also an important factor.

Biologically, women are more vulnerable than men to sexual transmission of infections. For example, the risk of acquiring gonorrhoea from a single act of intercourse with an infectious partner is about 50 per cent for women, compared to 25 per cent for men.[65]

Mary, a mother of three from a small town near Delhi, India, suffered from vaginal infections for several years. When she finally saw a doctor, she was diagnosed as having gonorrhoea. The doctor gave her antibiotics and suggested she send her husband in for a treatment. The husband was furious, and refused to see the doctor. As a result, the infections came back and Mary continues to suffer.[66]

Kanda, from Thailand, was more than four months pregnant with her second child when she tested HIV positive. She was infected by her husband, a quiet man whom she had never expected to have sex with other women. "He has ruined my life and my children's too," Kanda says.[67]

Traditional healers in several sub-Saharan African countries promote the belief that men suffering from a sexually transmitted disease can be cured by having sex with a virgin.[68] *The same belief is found among the lower castes in India.*[69]

Most sexually transmitted diseases are reproductive tract infections, although some STDs, such as syphilis, hepatitis B and HIV/AIDS also affect other parts of the body. RTIs in women originate in the lower reproductive tract. If untreated, RTIs can spread to the

STD/AIDS Education for Indian Sex Workers

Commercial sex workers in Bombay and other cities live under deplorable conditions; most of the young girls use drugs. The Indian Health Organization (IHO) provides assistance to female sex workers, including education about STDs and AIDS.

Sex Workers and STDs

IHO surveys indicate that Bombay has about 100,000 female sex workers out of a population of 10 million. When starting the AIDS education programme, the group was surprised to find that not more than 300 women a year visited an STD clinic in Bombay's largest red light district. The same clinic had an average of 100 male patients a day.

To provide health services to those who need them, IHO has organized health camps in the district since 1982 and has two mobile clinics serving the area. When the programme began, some 80 per cent of the women who visited the clinics were found to suffer from STDs; over half of them had two or more STDs at the same time.

Medical social workers who interviewed the sex workers concluded that their problems required socio-medical solutions, rather than purely medical ones. Since then IHO has provided social relief as well as medical care to women sex workers and their children, child prostitutes and eunuchs.

STD/AIDS Education

In 1992, HIV prevalence among Bombay's sex workers was estimated at 32 per cent. Generally, when sex workers are tested and found to be HIV positive, little is done for them and they continue in their profession; some are not even told about the test results, let alone counselled or educated about safer sex.

Over the past 10 years IHO has tried various strategies to prevent forced and child prostitution; conducted safe sex campaigns among sex workers and their clients; distributed free condoms; and provided counselling and treatment of STDs and minor ailments through the mobile units. Some of its specific activities include:

- A day-care centre for the daughters of sex workers;
- An education campaign about rape and incest;
- Social programmes to foster brother-sister relationships and get-togethers;
- Efforts to get the press to pay attention to issues related to sex workers and AIDS;
- Awareness creation among political representatives and ministers;
- The foundation of a union for female sex workers in Bombay.

The union has demonstrated against the harassment of sex workers by the police and the apathy of government officials. They have raised awareness and brought about some reduction in forced and child prostitution. Encouragement of self-protection and self-direction are probably the most important aspects of their programme.

In 1991 IHO launched a new project on AIDS control, run and managed by the sex workers themselves, with technical guidance of the IHO staff. The project is managed by a three-tiered cadre of caregivers — a Saheli (friend) for every 25 sex workers, a Tai (sister) for every 10 Sahelis, and a Bai (mother) for every eight Tais.

Source: Gilada, I.S. 1993. "AIDS and Sex Work: An Indian Perspective." In Women and HIV/AIDS: An International Resource Book, *by Marge Berer and Sunanda Ray. London: Pandora Press.*

upper tract and some can cause infertility or even death. This danger is greatest where services for diagnosis and treatment are limited, and where health workers and the public are not well-informed about RTIs.[70]

As a woman's status in her family and society is often directly related to her ability to bear children, the consequences of RTIs may be very far reaching.

Lower tract infections are common in most developing countries, according to the limited data available. Studies of women who visit obstetric and gynaecology clinics have found gonorrhoea, for example, among up to 12 per cent in Asia, 18 per cent in Latin America and up to 40 per cent in Africa.

A 1993 study in rural Egypt among 500 women found that 52 per cent of the women had a reproductive tract infection. A survey among 3,000 women in Matlab, Bangladesh, found that, of the almost 25 per cent of the respondents that reported symptoms of reproductive tract infections, about 70 per cent indeed had an infection. The actual number of women suffering from reproductive tract infections may be higher, as the survey only included women experiencing symptoms.[73]

RTIs are more common in developing countries than in industrialized countries for several reasons, including some factors characteristic of all societies in transition. Urbanization frequently results in a loosening of traditional norms and restrictions on sexual activity among young people. Further, education on sexuality and STD prevention is often limited; as a result, many people do not practise preventive measures.

Sexually Transmitted Diseases

STDs are a major cause of RTIs in women, along with poor obstetric care and unsafe abortion. Although men in most societies tend to have more sexual partners than women, women are often blamed for the spread of STDs. This stigma often results in infected women being left untreated, leading to ectopic pregnancy (foetal development outside the uterus, usually in the fallopian tubes), chronic pain, genital tract cancer, and complications during pregnancy and delivery.

There are some 250 million new cases of STDs per year world-wide.[72] At maternal and child health clinics in developing countries, as many as two women in 10 are infected with an STD. Research indicates that each year, 1 in 20 teenagers contracts an STD.[73]

Acquired Immune Deficiency Syndrome

AIDS is a sexually transmitted disease – although there are other means of transmission – but not a reproductive tract infection. The connection between RTIs and AIDS is still being explored. People infected with some RTIs appear to be at greater risk of transmitting and acquiring HIV infection, which is linked with AIDS. Some STDs can increase the efficiency of HIV transmission by 3 to 10 times.[74]

By the end of 1994, more than 1 million AIDS cases had been officially recorded. But AIDS cases in developing countries are frequently undiagnosed or underreported, and the actual total is thought to be as high as 4.5 million.

The United States accounted for 39 per cent of the reported AIDS cases but only 9 per cent of the

estimated actual total. Africa, with 34 per cent of the reported cases, probably accounts for 70 per cent of the actual total. Latin America, Europe and Asia respectively account for 12 per cent, 12.5 per cent and 2 per cent of reported AIDS cases.

A cumulative total of 19.5 million people have been infected with HIV, the virus that causes AIDS, since the late 1970s; this includes 1.5 million children. Between 13 and 15 million of those infected are believed to be still alive. The number of HIV-positive people is projected to reach 40 million by the end of the decade.[75]

WHO estimates that some 1.5 million people became infected with HIV in the second half of 1994. The vast majority were in less developed countries, where transmission is primarily through heterosexual intercourse and about the same numbers of men and women are affected.

Biologically, a woman is more likely than a man to be infected during heterosexual contact if other risk factors are the same. Socially, women are more at risk than men because they have less control over the timing and frequency of sexual encounters. Consequently, as the number of infections through heterosexual contact increases, it is expected that more women than men will be infected. Women are the fastest growing group of HIV-infected people. In parts of sub-Saharan Africa, more than 20 per cent of women of reproductive age are infected.[76] AIDS has become a leading cause of death among women of reproductive age in large cities in the Americas, Western Europe and sub-Saharan Africa.[77]

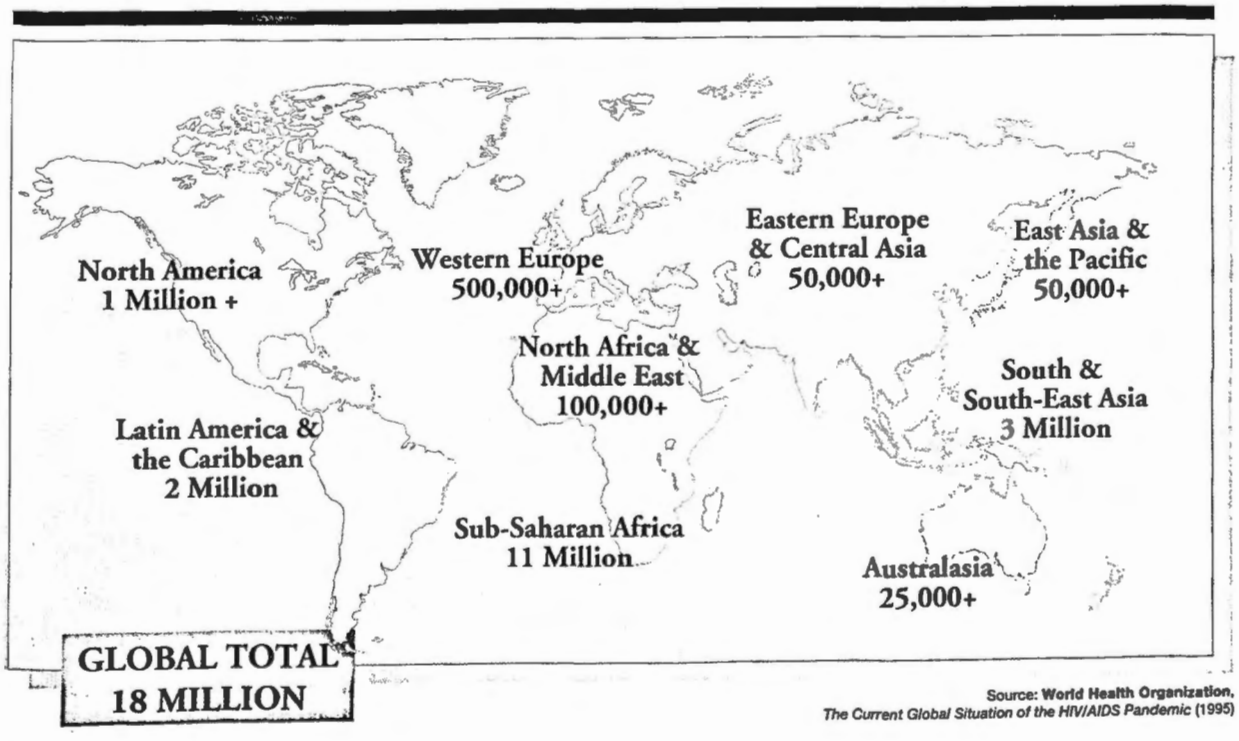
The AIDS epidemic has placed a serious strain on the already overstretched health care systems in several developing countries. By 1991 in some African cities almost half the hospitalized patients were HIV infected.[78] The challenge for the future will be to integrate programmes to control and prevent HIV with those for STD prevention and control, while strengthening the primary health care system.

To better meet the challenge posed by the HIV/AIDS pandemic, six UN agencies and organizations, including UNFPA, are working together to establish a joint and co-sponsored UN Programme on AIDS, scheduled to start in January 1996. The new programme is intended to ensure a united, coordinated effort and better integration of ideas and approaches among UN agencies in response to the needs of developing countries for policy, strategic and technical guidance and assistance.

ICPD Programme of Action on STDs and HIV/AIDS

The ICPD Programme of Action recognizes that social and economic disadvantages and the high-risk sexual behaviour of their partners make women

ESTIMATED DISTRIBUTION OF TOTAL ADULT HIV INFECTIONS
FROM LATE 1970s / EARLY 1980s UNTIL LATE 1994



Source: World Health Organization, *The Current Global Situation of the HIV/AIDS Pandemic* (1995)

especially vulnerable to infections. It seeks to prevent and reduce the spread of STDs including HIV/AIDS; and to provide treatment for STDs and their complications, such as infertility, with special attention to girls and women.

To meet these objectives, it states that all reproductive health programmes should increase efforts to prevent, detect and treat STDs and other RTIs, especially at the primary health care level. This implies giving care providers specialized training in the prevention, detection and counselling on STDs, including HIV/AIDS, and ensuring public access to preventive education and counselling and to high-quality condoms.

The ICPD agreement also indicates specific actions to prevent the spread of HIV/AIDS, and recommends that governments address the socio-economic ramifications of this pandemic as well as the health consequences.

RTIs and Reproductive Health Care

Many primary health care facilities do not adequately address RTIs and STDs in women. Early diagnosis and treatment of lower tract infections is the cheapest and most effective way to prevent upper tract infections. Without much additional cost, family planning and primary health care programmes can include routine RTI screening and treatment. Treatment for RTIs at facilities offering family planning and primary health care services is socially more acceptable for most women than at clinics specializing in STDs, which are often used only by men and commercial sex workers. When identifying strategies for effective prevention, diagnosis and treatment of RTIs, it is important to take the social position of girls and women into consideration.

As a first step, reproductive health and family planning programmes can undertake primary prevention through education and counselling about the causes, symptoms and consequences of STDs, and how their spread can be prevented. Clear instructions should be given about the use of condoms and their effectiveness when used consistently and correctly.

It may be more difficult for these programmes to include diagnosis and treatment of STDs; diagnosis may require laboratory work, and treatment requires antibiotics. Where laboratories are unavailable, treatment must be based solely on the patient's history and on the prevalence of different types of infection in the community.

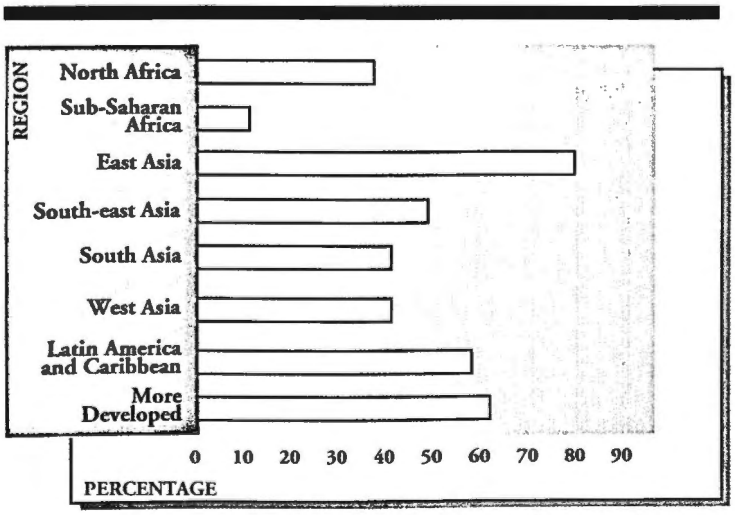
Family planning programmes can benefit greatly from including RTI management in their overall service package, particularly in areas where RTI-related infertility is common. Research indicates that the most common reason women discontinue using a contraceptive is the fear of side-effects. Users often attribute any symptom, particularly those in the reproductive tract, to their method of contraception – regardless of whether there is any actual connection between the two. In the absence of an accurate diagnosis, many women find it far easier and less threatening to blame vaginal discharges on their contraceptive method than on the possibility that their husbands have other sexual partners.[79]

STD Prevention

Male condoms are currently the most effective method for protection against STDs. Female condoms, although not yet widely available, may also be very effective; preliminary studies indicate that some women and their partners prefer these to male condoms. Researchers are also developing new barrier methods and working to improve existing methods.

For any barrier method to be effective, however, it must be used consistently and correctly. This requires motivation, training, partner cooperation and an uninterrupted supply. But many people, especially women, cannot meet these conditions.[80] Despite the very serious threat of STDs and AIDS, it remains difficult to convince many men to use condoms. But condom use has increased markedly in a number of countries. In Zimbabwe, for instance, only 3 million condoms were distributed in 1985. In 1992, an estimated 16 per cent of sexually active couples used condoms and 43 million were distributed. The total is projected to reach 120 million by 2002. Condom distribution in Zaire jumped from 500,000 in 1987 to 18 million in 1991. In Jamaica, it increased from 2 million to 8 million between 1989 and 1992. A similar pattern occurred in Mexico.[81]

AVERAGE PERCENTAGE OF COUPLES CURRENTLY USING CONTRACEPTION (c.1990)



Source: **United Nations Population Division,** Levels and Trends of Contraceptive Use as Assessed in 1994 (United Nations Publication, forthcoming)

Condoms for cash in Ghana.

With condoms, the main problem is that their use requires a rational decision that interrupts the spontaneity of love-making for many people. This objection may be countered by stressing that sex can be more enjoyable when worries about unwanted pregnancy and disease are removed.[82]

Consumer research and social marketing techniques can greatly increase the acceptance and use of condoms, by linking them to lifestyles with which people want to identify. A project in the Kabarole district in Uganda has done this successfully. Prior studies indicated that while 83 per cent of the population knew about condoms, less than 10 per cent of sexually active people had ever used them. Using focus groups, the district Health Team determined that many people wanted to use condoms, and that they preferred high-quality, readily available products. Based on their research, the team designed a package showing a man holding a spear and a shield. The implicit message was that if one must face an enemy (STDs/AIDS), it is wise to have protection. Early results indicate that condom sales have increased since the campaign began.[83]

The disadvantage of condoms is that women need the cooperation of men to use them. For many women – especially those at high risk of contracting STDs, like sex workers – obtaining this cooperation is not possible. A study among high-risk women in two New York AIDS-prevention programmes[84] found that a lack of social, cultural, sexual and technological options causes vulnerable women to concentrate on the more immediate risks in their lives, like poverty and homelessness, rather than address the issue of condom use. These findings have implications for STD/AIDS prevention programmes everywhere that one finds poverty and great imbalances in the power relationships between men and women.

Family Planning

In the past 20 years, many countries have dramatically expanded the availability of family planning services, accelerating a decline in fertility rates. An estimated 57 per cent of couples in developing countries (38 per cent excluding China) now use contraceptives compared to around 14 per cent in 1960-1965. The total fertility rate in

developing countries has declined from 6.1 children per woman in the 1950s to 3.7 today.

Contraceptive prevalence is estimated at over 70 per cent in the developed world, ranging from 58 per cent in Japan, to 74 per cent in the United States and 81 per cent in the United Kingdom. In most developing countries, contraceptive use is well below these levels. Among countries covered by demographic and health surveys, it ranges from below 10 per cent in seven sub-Saharan African countries to near or above 70 per cent in Brazil, Colombia, Costa Rica, Mauritius, South Korea and Thailand.[85]

In virtually every country surveyed, some combination of three methods – female sterilization, oral contraceptives and IUDs – accounted for most use of modern methods. Female sterilization is the method most widely used in the world, particularly in Latin America and Asia, but is hardly used in Africa and the Near East.

Family Planning and Women's Health

Practising family planning significantly reduces the risk of death or illness as a result of pregnancy. In most developing countries it is simply much safer for a woman not to be pregnant, given the current state of maternal care: but family planning also reduces the risks of pregnancy by allowing women to delay childbirth until they are ready, and to stop having children before age and many pregnancies make another one too risky. Spacing births permits women to recover their health between pregnancies. The World Bank estimates that "satisfying the expressed wish of women to space or limit future births might each year avert as many as 100,000 maternal deaths and 850,000 deaths among children under 5."[86]

Reducing the risk of unwanted pregnancies also reduces maternal deaths by reducing the recourse to abortion. Studies indicate that providing family planning services to all women who wish to avoid or delay their next pregnancy could reduce the number of deaths from unsafe abortion by more than 30 per cent.[87]

However, it is essential to understand that family planning services are not a substitute for comprehensive reproductive health care. For example, the Matlab family planning project in Bangladesh helped to increase contraceptive use, reducing both fertility rates and deaths from maternity-related causes; women who got pregnant, however, were as much at risk of dying as women in other parts of the country.[88] Family planning services should be provided wherever possible as an essential part of better overall reproductive health care services.

Family Planning as Part of Reproductive Health Programmes

Over 95 per cent of people in the developing world live in countries that directly support family planning programmes. These programmes were established with different motivations: to allow individuals and couples to regulate their fertility; to improve maternal and child health; and to reduce population growth in response to national and international concern. The preoccupation of some programmes with fertility reduction has adversely affected their design and the quality of services provided.[89]

The aim of family planning programmes should be to give people the widest possible freedom of choice in matters of procreation, within the broader context of

Influencing Attitudes About Family Planning

Studies show that **mass media** can be effective in raising awareness and influencing attitudes and behaviour regarding family planning.

The mass media provide information quickly and repeatedly to large audiences; their influence is spreading rapidly in developing countries. According to British Broadcasting Corporation surveys, the number of televisions in Africa doubled between 1985 and 1992 to 16.2 million, one for every 29 people – and few people watch alone. Radio receivers, which still outnumber televisions four to one, increased by 50 per cent.

During an intensive three-month mass media campaign in Turkey, for example, the percentage of married women of reproductive age who were aware of family planning increased from 69 to 86; 63 per cent of women said they had discussed family planning with their spouses as a result of the campaign; and modern contraceptive use increased from 39 to 42 per cent.

After a television campaign in Nigeria's Anambra state, 55 per cent of new family planning clients cited the campaign as their source of referral.

Media promotion of specific contraceptive methods has also been effective. In São Paulo, Brazil, a series of television, radio and magazine advertisements on vasectomy contributed in 1986 to a dramatic increase in the procedure, boosting prevalence to nearly 12 times the rate in Rio de Janeiro.

Information about development and health issues – including family planning, sexually transmitted diseases, AIDS, and empowerment of women – is increasingly making its way into popular entertainment such as soap operas, songs, dances, theatre and puppet shows.

For example, a Ugandan film drama, *It's Not Easy*, educates young people about HIV/AIDS. It portrays a successful young professional whose wife is expecting their first child. Even though he is aware of AIDS, the man has extramarital sex with many women. Soon he learns that he is HIV-positive and has infected his wife and the baby.

In many countries, **live drama** has traditionally been used both to entertain people and to inform them about important issues. In Nigeria, a local theatre group travels from village to village performing dramas with messages about family planning. In one area, clinic attendance increased by 80 per cent after performances by the group. In another area, family planning acceptance increased by 41 per cent.

Sources: Piotrow, Phyllis Tison, Opia Mensah Kumah, Karusa Kiragu and Miriam Jato. 1994. "Entertainment-Education in Africa: An Idea Whose Time Has Come." Unpublished paper; Bulatao, Rodolfo A. 1993. Effective Family Planning Programs. Washington D.C.: The World Bank.

attaining good reproductive health. Experience shows that family planning programmes work best when they are part of, or closely linked to, broader programmes which address closely related health needs, and when women are fully involved in the design, delivery, management and evaluation of services.

In much of the world, men usually dominate decision-making about family size and contraceptive use. Only relatively recently have family planning programmes recognized that men are therefore a critical target audience for family planning information and education. Such activities should focus mainly on increasing men's responsibility within sexual relationships.

Family planning opens up other options for these women in Zimbabwe.

Access to Reliable Services

Women who want to use family planning may be unable to do so if contraceptive supplies and services are inadequate. A lack of information may also result in a gap between the perceived and actual availability of family planning. Surveys indicate that nearly all women who can name a contraceptive method also know where to obtain it – but this does not mean that they are able to do so, particularly if long distances are involved. They may not be able to travel independently, or may lack the cost of transport or the time to make the trip (which often involves a wait of several hours in the clinic waiting room).

The distances that women must travel to the nearest clinic providing family planning services vary greatly. In 12 countries where demographic and health surveys were conducted, the median distance ranged from one kilometre in Egypt to 19 in Uganda; in most countries it was three or four kilometres. Women have much better access to family planning services in urban areas than in rural areas. In most of the countries surveyed, government clinics were the principal source of family planning supplies. Private, for-profit suppliers were also found to be an important source of contraceptives, especially in Latin America.

Women and Contraceptive Development

Being able to control their fertility is more directly important to women, who bear the burden of pregnancy, than to men. Enabling women to control their fertility gives them greater control of their lives, allowing young women to continue their education without the interruption of a pregnancy, for example. Women thus have a very real interest in the development of contraceptives that suit their personal and social situations.

The type of contraceptive a woman prefers depends on circumstances. Young women with more than one sexual partner require methods that protect against both pregnancy and STDs. Older women who have all the children they want may chose a long-acting or permanent contraceptive. Women living far from a health centre may also welcome long-acting methods.

Historically, women were the initiators of the international family planning movement, and they continue to be the majority of contraceptive users. Nevertheless, women have had only a marginal influence on the development of new contraceptives. While many women using contraception are satisfied with their method, others have encountered problems such as unpleasant side-effects. Others experience difficulties with the system that provides contraceptives, such as inadequate counselling and follow-up.

Women's health activists have brought these issues into the spotlight. At the same time, researchers and policy makers are increasingly recognizing the importance of taking consumers' views into account.[90] A first meeting to bring these two perspectives together was organized in 1991 by WHO's Special Programme of Research, Development and Research Training in Human Reproduction and the International Women's Health Coalition.

New contraceptives that protect against both pregnancy and infections are urgently needed to combat the current epidemics of STDs, including HIV/AIDS. This will require a concerted effort to develop such methods, involving both women activists and scientists.

ICPD Programme of Action and Family Planning

The ICPD Programme of Action addresses the need for family planning in the context of reproductive health. It stresses that family planning programmes should aim to help couples and individuals meet their reproductive goals, by providing them with the information and means to do so. The Programme emphasizes that informed free choice is essential to the long-term success of family planning programmes. While governments have an interest in making family planning services available, their use must be completely voluntary; coercion has no part to play. [paras. 7.12 and 7.16]

Substantially higher investments from governments and industry are needed to develop new, safe and affordable contraceptive methods to increase the options available to women and men, and to prevent, diagnose and treat sexually transmitted diseases, including HIV/AIDS, the Programme of Action states. It recommends social and cultural research to allow programmes to take users' views into account, and calls for their involvement in programme design, monitoring and evaluation. ■

COUNTRY RESPONSES TO THE ICPD

THE true test of the impact of the ICPD recommendations will be in the national awareness of and response to the Programme of Action. On this front, there have already been a large number and variety of activities. Several countries have issued "popular" versions of the Programme of Action so that the message of Cairo is more widely available, and, in a number of countries, educational versions have been published for use in schools.

In addition to actions to raise general awareness, numerous countries are reviewing their present policies and programmes to ensure that programmes are designed to conform with ICPD recommendations. Such activities are under way in, among others, Ethiopia, Uganda, United Republic of Tanzania, Brazil, Haiti, Panama, Mexico, Pakistan, the Philippines, Nepal, Thailand, Bangladesh and India. UNFPA will offer assistance to these and other countries at their request. National Preparatory Committees for the Conference have transformed themselves into "implementation committees" and have begun to delineate country implementation strategies.

In some countries, actions are already under way to restructure institutions in line with the Programme of Action recommendations. Mexico is merging its maternal and child health and family planning programmes under a high-level Director-General for Reproductive Health; the Ministry of Health is the first in the region to clearly adopt in the title of the office the new terminology endorsed at Cairo. Brazil is establishing a Council on Population and Development. This new mechanism will allow a role for NGO and community group participation in the formulation of population and development initiatives.

Non-governmental organizations in India, participants in the ICPD deliberations, are networking to allow them to collaborate with state and local governments in furthering an agenda which will seek to increase budgetary allocations to health and education sectors, encourage introduction of holistic reproductive health services in the context of primary health care and identify systems to assess programme performance other than those based on targets. The Ministry of Health and Family Welfare has met with NGOs and agreed in principle to work together on issues of priority to India and develop mechanisms for sustained interaction. The Government is also planning to organize discussions and workshops in each of the states to share the Cairo vision and plan for its implementation. A "Corporate Consultative Meeting on Planned Family Initiatives" has been organized to encourage corporate-sector support for population activities involving participation from 10 countries in the region.

Bangladesh has established a national committee for ICPD implementation headed by the Secretary of the Ministry of Health and Family Welfare which includes representatives from different ministries, leading NGOs, the donor community, media, UN agencies and academics. An NGO advisory group will work closely with the Government to enhance cooperation. Projects have been formulated in support of primary education for adolescent girls. The Government has agreed to UNFPA funding of a project with the Grameen Bank to address the empowerment of women, with special emphasis on adolescent girls.

The Islamic Republic of Iran has initiated a series of activities in furtherance of the Programme of Action. Seminars have been held with particular reference to women and to the girl child, as part of ICPD follow-up and in anticipation of the Fourth World Conference on Women. The Ministry of Health is planning to organize a national workshop on Family Planning Counselling. A pilot project is under way to strengthen community-based family planning programmes; a proposal to extend it to a nationwide level has been presented to UNFPA for support. The Government has recognized the vital role which NGOs can play. It is supporting reactivation of the Family Planning Association of Iran and has established a Women's NGO Coordinating Office to help coordinate NGO and government activities nationwide. The integration of maternal and child care and family planning service delivery administration was accomplished prior to the ICPD; the budget for these activities has since been increased.

Indonesia has organized a sequence of meetings involving NGOs, government ministries, national experts, regional planners and local experts. These meetings have sought to align population policies and programmes with the Programme of Action. Particular attention has been given to soliciting input for the design of a system of indicators for policy formulation and monitoring, especially concerning the empowerment of women. Indonesia has also

actively fostered international cooperation in the field of population.

Egypt has set up a committee to review the Programme of Action and assist the adjustment of national population policies in accordance with its recommendations. The NGO Steering Committee has met since the ICPD, and it is anticipated that its structure will be further strengthened.

These are just a few of the many examples of government cooperation with non-governmental organizations. Activities are being undertaken by NGOs in dozens of countries. Community organizations, medical associations, scientific institutes and societies, family planning associations, legal organizations, churches, women's groups, youth associations, labour organizations, mothers' leagues, entrepreneurial coalitions, theatre groups, education associations, volunteer groups, child welfare and other social service organizations are advocating and working towards implementing the Programme of Action. Many of these organizations were among the 1,254 officially accredited NGOs at the ICPD. Among the countries reporting post-Cairo NGO initiatives related to the Programme of Action are Cameroon, Ghana, Kenya, Mozambique, Namibia, Senegal, Zimbabwe, China, India, Pakistan, Bangladesh, Thailand, the Solomon Islands, Indonesia, Jamaica, Barbados, Mexico, Bolivia, Peru, Egypt, Morocco, and Tunisia. Regional groups including participants from various countries have also been active.

Many examples could be cited to show the range of activities being undertaken (by nations, donors and recipients alike, and by local, national, regional and international organizations) to translate the Programme of Action into reality and to monitor its implementation. The dynamic process which produced the momentous agreements reached in Cairo continues. The blueprint for action is in hand; the foundations are being painstakingly laid; the mobilization of financial, political, institutional and personal resources is under way. The promise of Cairo remains to be realized, however. The degree of success obtained will largely determine the quality of life the world will enjoy in the next century. ■

THE UN SYSTEM RESPONSE TO THE PROGRAMME OF ACTION

Many of the specialized agencies and organizations of the United Nations system are formulating and implementing strategies in response to the ICPD Programme of Action. To develop a coordinated approach to implementing the Programme of Action, the Administrator of the United Nations Development Programme, on behalf of the Secretary-General of the United Nations, requested that the UNFPA Executive Director convene an Inter-Agency Task Force. This Task Force will focus on policy development and coordination, and will monitor inter-agency coordination in implementing the Programme of Action. It met for the first time on 13 December 1994.

Additional discussions have been held with the aim of establishing greater collaboration in the national programmes of the various agencies, under the active supervision of the UN Resident Coordinators. These discussions and the Inter-Agency Task Force consultations are already mobilizing concerted action. The Task Force will utilize working groups to develop proposals for inter-agency collaboration in the following areas: a common national-level data system in the health field, notably in infant, child and maternal mortality; basic education, with special attention to gender disparities; policy-related issues, including the drafting of a common advocacy statement on social issues; and women's empowerment.

The Population Commission of the United Nations, under direction from the General Assembly and the Secretary General, is being renewed and revitalized as a Population and Development Commission. Bilateral assistance agencies have begun to revise their programmes of aid to reflect the priority to be placed on the empowerment of women, on primary health care including reproductive health and on the other recommendations of the Programme of Action.

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MONITORING ICPD GOALS – SELECTED INDICATORS

(see notes page 73)

Country	Indicators of mortality			Indicators of education				Reproductive Health indicators		Other Health indicators	
	Infant mortality	Life expectancy at birth M/F	Maternal mortality ratio	Primary enrolment (Gross) M/F	% last year primary M/F	Secondary enrolment (Gross) M/F	% Illiterate (>15 years) M/F	% knowing FP method/ source	Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
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**	**51.5/53.6**							**140**		
Africa	**85**	**52.7/55.7**							**136**		
Eastern Africa(1)	**99**	**48.6/51.2**							**151**		
Burundi	96	49.4/52.9		76/62	73/78	8/ 5	39/60	70/62	60	65	19
Eritrea	94	51.3/54.6							140		
Ethiopia	107	48.4/51.6	452	27/19	26/31	12/11		63/–	169	45	10
Kenya	66	53.0/55.4	510	93/91		30/24	20/42	96/88	144	19	50
Madagascar	93	57.5/60.5	350	77/74	36/41	15/15	12/27	62/45	155	65	58
Malawi	136	44.3/45.3	380	84/77	46/37	6/ 3	48/69	90/80	173	80	50
Mauritius(2)	16	68.3/75.0	99	107/108	97/97	56/57		100/–	46	100	85
Mozambique	136	45.4/48.3	300	69/ 52		9/ 6	55/79		131	30	25
Rwanda	105	45.2/48.0	300	76/74	50/50	12/10	36/63	98/86	60	60	22
Somalia	112	47.4/50.6	1100	113/113		68/80	64/86		208	20	2
Uganda	111	42.2/44.3	550	78/62		14/ 8	38/55	82/74	220	70	38
United Republic of Tanzania	81	50.2/52.9	342	71/69	72/74	6/ 5		74/66	134	73	53
Zambia	99	45.4/46.8	151	90/84	88/75	29/17	19/35	89/81	145	75	51
Zimbabwe	65	49.8/51.8	80	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	650	89/82		16/11	44/72		236	70	15
Cameroon	55	57.0/60.0	430	100/86	69/66	36/25	34/57	72/54	141	15	64
Central African Republic	96	47.8/52.5	600	99/62	65/53	18/ 7	48/75		161	13	66
Chad	112	47.9/51.1	700	80/38	76/56	16/ 3	58/82		192	30	15
Congo	83	47.8/52.0			57/48		30/56		146		
Gabon	85	53.9/57.2	190	126/123	46/41	32/37	27/52		163	87	79
Zaire	86	50.4/53.4	600	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	129	111/96	92/88	66/55	36/55	99/–	30	90	78
Egypt	54	64.7/67.3	266	102/87		82/68	37/66	100/93	73	99	35
Libyan Arab Jamahiriya	56	63.9/67.5		88/84		52/70	25/50		110	100	76
Morocco	56	63.9/67.5	327	85/60	75/76	40/29	39/62	99/94	37	60	31
Sudan	71	53.6/56.4	655	61/47		23/19	57/88	71/60	88	70	69
Tunisia	37	68.4/70.7	127	122/111	79/77	53/45	26/44	99/97	23	90	70
Southern Africa	**49**	**62.1/67.9**							**75**		
Botswana	37	65.3/69.2	90	113/120	71/88	49/55	16/35	95/95	100	85	77
Lesotho	69	60.5/65.5	220	94/111	61/39	21/31	38/16	79/–	85	80	60
Namibia	53	60.0/62.5		134/139	32/43	49/61		89/78	107		68
South Africa	48	62.3/68.3	84						72		90

Country	Indicators of mortality			Indicators of education				Reproductive Health indicators		Other Health indicators	
	Infant mortality	Life expectancy at birth M/F	Maternal mortality ratio	Primary enrolment (Gross) M/F	% last year primary M/F	Secondary enrolment (Gross) M/F	% Illiterate (>15 years) M/F	% knowing FP method/ source	Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
Western Africa[5]	**90**	**49.9/52.9**							**164**		
Benin	79	47.2/50.5	161	92/46	42/36	17/7	68/84	40/–	152	99	45
Burkina Faso	123	45.3/48.1	810	47/30	70/72	11/6	72/91	66/30	165	70	41
Côte d'Ivoire	88	48.6/50.5		79/57	75/64	34/17	33/60	26/–	228	60	40
Ghana	73	56.2/59.9	1000	82/70		43/28	30/49	76/70	127	25	40
Guinea	124	46.0/47.0	1247	57/27	70/59	17/6	65/87		241	32	25
Guinea-Bissau	129	43.9/47.1	760	71/40	8/7	15/7	50/76		189	80	
Liberia	113	56.0/59.0	173				50/71	72/48	230	34	58
Mali	149	46.4/49.7	2325	35/22		11/5	59/76	42/30	199	20	30
Mauritania	92	51.9/55.1	800	68/55	75/59	19/10	53/79	61/–	133	30	20
Niger	114	46.9/50.2	420	35/21	83/77	9/4	60/83	76/33	219	48	15
Nigeria	77	50.8/54.0	800	104/82	56/60	27/33	38/61	46/34	150	40	37
Senegal	62	50.3/52.3	530	67/50	91/78	22/12	48/75	74/44	155	40	41
Sierra Leone	154	39.5/42.6	450	59/40		21/12	69/89	78/–	212	36	25
Togo	77	55.2/58.8	476	149/97	67/44	35/12	44/69	94/81	126		42
Asia	**57**	**64.9/67.7**							**45**		
Eastern Asia[6]	**35**	**69.0/73.1**							**14**		
China	38	68.2/71.7	115	124/117		59/48	16/38		15		95
DPR Korea	22	68.7/75.2	41						12	100	99
Hong Kong	6	76.2/82.3	4	104/103	96/98	75/79	5/19	98/–	6		99
Japan	4	76.8/82.9	15	101/101	100/100	99/100			4	100	100
Mongolia	52	64.4/67.3	140	84/88		72/81			37	100	99
Republic of Korea	9	68.8/76.1	30	103/104	99/100	91/90	1/7	100/94	6	100	89
South-Eastern Asia	**47**	**63.5/67.6**							**47**		
Cambodia	102	52.6/55.4	9000				52/35		131		
Indonesia	48	63.3/67.0	450	116/112		48/39	16/32	95/93	64	64	40
Lao People's Dem. Rep.	86	52.0/55.0	561	119/89		30/18	8/24		51	67	20
Malaysia	11	69.9/74.3	20	93/94	95/96	58/62	14/30	99/94	29		98
Myanmar	72	58.5/61.8	150	110/106		25/25	11/28		32	48	70
Philippines	35	66.6/70.2	74	113/110	70/70	76/78	10/11	97/93	28		55
Singapore	5	73.5/78.6	10	108/104	100/100	69/70	7/21	98/95	8	100	99
Thailand	34	65.2/71.6	37	99/98		40/38	4/10	100/99	53	93	66
Viet Nam	37	64.9/69.6	105	111/106		33/31	8/16	95/–	18	97	90
South Central Asia	**74**	**62.1/63.1**							**73**		
Afghanistan	154	45.0/46.0		31/16	27/32	10/5	56/86	4/–	153		9
Bangladesh	96	58.1/58.2	400	94/81		26/14	53/78	100/98	133	38	7
Bhutan	107	51.6/54.9	1305				49/75		63	65	20
India	72	62.6/62.9	460	112/89	65/58	60/37	38/66	95/–	64	75	32
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	833	130/87		46/23	62/87	93/80	104	10	6
Pakistan	74	62.9/65.1	270	53/28	48/48	32/14	53/79	78/46	64	85	35
Sri Lanka	15	70.9/75.4	80	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	117	98/83	67/49	53/34	23/51		49	93	60
Israel	8	75.4/79.2	5	95/96	100/100	84/91	3/7		20	100	99
Jordan	30	67.7/71.8		94/95	84/91	52/54	25/30	100/95	49	80	87
Kuwait	15	74.1/78.2	6	60/60	90/90	55/55	39/33		41	100	97
Lebanon	29	68.1/71.7		117/113		71/76	12/27	91/-	32	95	
Oman	25	68.9/73.3		90/83	93/88	59/52			122	92	75
Saudi Arabia	23	69.9/73.4	52	78/73	87/89	54/44	27/52		124	93	90
Syrian Arab Republic	33	66.7/71.2	143	112/101		54/43	47/49	78/-	110	83	61
Turkey[8]	52	66.5/70.7	146	107/98	96/95	74/48	10/29	99/95	43	100	76
United Arab Emirates	15	73.9/76.5		111/109	94/95	78/89			84	100	99
Yemen	109	51.9/52.4	330		71/55		47/74	60/27	102	40	16

Country	Indicators of mortality			Indicators of education				Reproductive Health indicators		Other Health indicators	
	Infant mortality	Life expectancy at birth M/F	Maternal mortality ratio	Primary enrolment (Gross) M/F	% last year primary M/F	Secondary enrolment (Gross) M/F	% Illiterate (>15 years) M/F	% knowing FP method/ source	Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
Europe	**12**	**69.3/77.3**							**27**		
Eastern Europe	**17**	**63.7/74.1**							**38**		
Bulgaria	14	67.8/74.8	22	91/88	84/78	68/72			59	100	100
Czech Republic	9	67.8/74.9		98/101	93/93	77/79			46		
Hungary	15	64.5/73.8	28	95/94	92/94	79/81			41	62	99
Poland	13	66.7/75.7	12	99/97		81/85			28	100	
Romania	23	66.6/73.3	180	87/86	95/93	83/82			41	100	99
Slovakia	12	66.5/75.4		101/101		86/90			44		
Northern Europe[9]	**7**	**73.4/79.3**							**27**		
Denmark	7	73.0/78.7	4	98/98	99/99	112/115			10	100	
Estonia	16	63.8/74.8	41	86/85		90/95			34		
Finland	5	72.7/80.2	5	100/99	99/99	112/135			13	100	
Ireland	7	73.4/78.9	7	103/103	98/99	101/110			16	100	
Latvia	14	63.3/74.9	57	86/84		84/88			35		
Lithuania	13	64.9/76.0	29	93/90		78/81			32		
Norway	7	74.1/80.6		100/100		114/111			19	100	100
Sweden	5	76.2/81.9	4	101/101	100/100	96/97			13	100	100
United Kingdom	6	74.4/79.4	7	103/103		87/90			33	100	98
Southern Europe[10]	**10**	**73.9/80.0**							**17**		
Albania	26	70.0/75.8		99/100		85/73			14	100	
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	12	103/103	97/98	99/98	2/11		22		
Italy	7	75.1/81.4	13	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	
Slovenia	7	68.8/78.1		96/96		88/91			30		
Spain	7	75.3/81.0	10	105/105	97/97	105/115	3/7		12	95	96
Yugoslavia	18	70.3/75.3	27				3/12		43	100	
Western Europe[11]	**6**	**73.9/80.4**							**11**		
Austria	6	73.9/80.1	11	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	13	107/105		100/104			9		
Germany	6	73.5/79.8	11	97/98	98/98	102/100			13	100	
Netherlands	6	75.1/80.8	5	96/99		126/120			7	100	
Switzerland	6	75.4/81.7	5	103/104	100/100	94/89			5	100	
Latin America & Caribbean	**41**	**67.2/72.4**							**79**		
Caribbean[12]	**38**	**68.0/72.6**							**78**		
Cuba	11	74.2/78.0	39	103/102		77/87	5/7	100/-	92	100	99
Dominican Republic	34	68.9/73.1	300	96/98		64/84	15/18	100/96	91		92
Haiti	77	56.7/60.2	600	56/52	40/38	23/22	41/53	81/66	54	45	78
Jamaica	12	72.4/76.8	115	109/108	82/88	62/70	2/1	99/-	86		90
Puerto Rico	9	72.1/79.8	21						65		99
Trinidad & Tobago	16	70.5/75.3	89	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	18	105/104		45/47	7/7	100/99	93	97	97
El Salvador	39	65.8/70.8	148	78/79	24/23	25/28	24/30	98/-	131		85
Guatemala	40	64.7/69.8	300	84/74		25/21	37/53	70/64	123	60	89
Honduras	35	67.5/72.3	221	104/109	30/23	29/36	25/29	95/-	127		81
Mexico	33	68.9/75.0	200	115/111		56/56	11/15	91/72	77	91	69
Nicaragua	45	66.6/70.3	300	100/104		40/44		97/-	153		73
Panama	21	71.8/76.3	60	107/102	76/82	62/66	12/12	95/-	91	82	84

Country	Indicators of mortality			Indicators of education				Reproductive Health indicators		Other Health indicators	
	Infant mortality	Life expectancy at birth M/F	Maternal mortality ratio	Primary enrolment (Gross) M/F	% last year primary M/F	Secondary enrolment (Gross) M/F	% Illiterate (>15 years) M/F	% knowing FP method/ source	Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
South America[13]	**44**	**66.6/71.8**							**75**		
Argentina	22	69.7/76.8	140	104/109		66/74	5/5		61		92
Bolivia	66	59.8/63.2	48	104/95	47/41	42/36	15/29	73/66	82		55
Brazil	53	65.5/70.1	140	115/107		38/49	18/20	100/95	78		73
Chile	14	71.1/78.1	40	99/98	73/80	67/72	7/7		56	95	98
Colombia	34	67.4/73.3	110	116/117	53/59	56/67	13/14	98/94	71	97	71
Ecuador	46	67.3/72.5	170	117/116	63/65	58/61	12/16	89/88	79	80	84
Paraguay	35	69.4/73.1	180	111/108	57/60	34/35	8/12	98/90	92		66
Peru	59	65.5/69.4	165	120/115		69/62	9/21	96/89	60		60
Uruguay	17	69.7/76.2	36	109/107	91/94	72/93	3/4		60		96
Venezuela	21	70.0/75.7	200	95/97		29/41	13/14	98/68	101		97
Northern America[14]	**7**	**73.5/80.2**							**60**		
Canada	6	75.0/81.2	2	106/104	96/96	104/104			27		99
United States of America	7	73.4/80.1	9	104/106	89/87	95/94			64	100	100
Oceania	**24**	**71.3/76.4**							**28**		
Australia-New Zealand	**7**	**75.1/80.9**							**24**		
Australia[15]	6	75.4/81.2	11	108/108	99/100	83/86			21	100	99
Melanesia[16]	53	60.0/62.2							33		
New Caledonia	18	70.8/75.8							53		
New Zealand	8	73.4/79.4		103/101	96/97	95/95			35	100	99
Papua New Guinea	62	57.2/58.7	700	80/67		15/10	35/62		23	96	43
Vanuatu	38	65.5/69.5		105/107		23/18			75	80	
Countries with Economies in Transition of the Former USSR											
Armenia	20	70.3/76.3	35						61		
Azerbaijan	26	68.0/75.5	29	88/86		93/91			21		
Belarus	17	64.5/75.1	25	96/96		88/95			28	100	
Georgia	18	69.5/77.6	55						51		
Kazakhstan	27	66.5/75.0	53	87/87		81/82			35		
Kyrgyzstan	32	66.5/73.8	43						37		
Republic of Moldova	25	63.5/71.6	34						38		
Russian Federation	19	61.5/73.6	49	84/84		84/91			37		
Tajikistan	43	68.8 /74.0	39	87/84		89/84			34		
Turkmenistan	51	63.5/70.0	55						18		
Ukraine	16	64.2/74.2	33	91/90		84/94			43	100	
Uzbekistan	38	67.5/73.2	43						34		

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

(see notes page 73)

Country	Total population (millions) 1995	Projected population (millions) 2025	Average population growth rate % 1995-2000	% Urban (1995)	% Urban growth rate (1995)	Population per hectare arable land	Total Fertility Rate (1995)	Contraceptive prevalence Method Any/Modern	GDP per capita ($US 1992)	% central govt expenditure Educ/Health	External population assistance ($US/ 000s)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
World Total	**5,716.4**	**8,294.3**	**1.5**	**45**	**2.5**		**3.04**							
More developed regions(*)	**1,166.6**	**1,238.4**	**0.3**	**75**	**0.7**		**1.71**							
Less developed regions(+)	**4,549.8**	**7,055.9**	**1.8**	**38**	**3.3**		**3.38**							
Least developed countries(‡)	**575.4**	**1,162.3**	**2.7**	**22**	**5.2**		**5.59**							
Africa	**728.1**	**1495.8**	**2.7**	**34**	**4.3**		**5.58**				**172,453**			
Eastern Africa(1)	**227.1**	**494.6**	**2.8**	**22**	**5.3**		**6.22**							
Burundi	6.4	13.5	2.8	8	6.4	234	6.54	9/1	189		2,306	185/165	24	37
Eritrea	3.5	7.0	2.6	17	4.7		5.57					211/190		
Ethiopia	55.1	126.9	2.9	13	5.1	66	6.76	4/3	123	9.9 /3.0	4,628	216/194	21	18
Kenya	28.3	63.4	2.8	28	5.6	47	6.02	33/27	312	20.1/5.4	16,814	110/95	92	28
Madagascar	14.8	34.4	3.1	27	5.6	26	5.88	17/5	242	17.2/6.6	1,901	160/141	38	30
Malawi	11.1	22.3	1.8	14	4.6	215	6.94	13/7	204	10.4/7.8	2,662	238/215	40	53
Mauritius(2)	1.1	1.5	1.1	41	1.6	211	2.31	75/49	2,761	14.6/8.1	813	25/20	385	100
Mozambique	16.0	35.1	3.4	34	7.1	26	6.28		64		1,603	283/269	32	24
Rwanda	8.0	15.8	2.6	6	4.7	423	6.28	7/5	212		7,055	206/185	28	64
Somalia	9.3	21.3	3.1	26	4.7	15	6.76		110		6	205/186	7	56
Uganda	21.3	48.1	2.9	13	5.4	174	7.01	5/3	181		6,940	216/194	24	21
United Republic of Tanzania	29.7	62.9	2.8	24	5.7	57	5.69	10/7	105		12,874	158/139	30	52
Zambia	9.5	19.1	2.6	43	3.3	17	5.74	15/9	463	6.2/5.3	3,450	187/167	158	59
Zimbabwe	11.3	19.6	2.1	32	4.4	93	4.77	43/36	549	15.7/5.1	9,142	66/53	450	36
Middle Africa(3)	**82.3**	**189.1**	**3.0**	**33**	**4.5**		**6.23**							
Angola	11.1	26.6	3.3	32	5.6	21	6.94				1,531	220/198	96	50
Cameroon	13.2	29.2	2.8	45	4.7	47	5.50	16/4	849	15.3/4.3	2,457	124/109	77	34
Central African Republic	3.3	6.4	2.4	39	3.5	38	5.49		422		2,284	183/163	29	12
Chad	6.4	12.9	2.8	21	4.1	9	5.70		219		1,320	216/194	16	
Congo	2.6	5.7	2.7	59	4.2	14	6.08		1,160		862	175/157	131	20
Gabon	1.3	2.7	2.8	50	4.2	16	5.52		4,924		720	162/143	784	72
Zaire	43.9	104.6	3.0	29	4.3	113	6.47	8/2	220		4,203	156/138	48	34
Northern Africa(4)	**160.6**	**268.6**	**2.1**	**46**	**3.1**		**3.96**							
Algeria	27.9	45.5	2.2	56	3.5	16	3.63	47/43	1,721		1,109	80/66		78
Egypt	62.9	97.3	1.9	45	2.6	820	3.66	46/45	650	13.4/2.8	13,118	93/80	988	90
Libyan Arab Jamahiriya	5.4	12.9	3.3	86	3.9	4	6.16		4,492		7	91/76	7122	97
Morocco	27.0	40.7	1.8	48	2.9	30	3.42	42/36	1,084	18.2/3.0	3,897	84/69	794	61
Sudan	28.1	58.4	2.7	25	4.7	13	5.55	9/6			906	171/152	69	
Tunisia	8.9	13.3	1.72	57	2.6	20	2.95	50/40	1,878	17.5/6.6	1,668	63/51	4463	68
Southern Africa	**47.4**	**82.8**	**2.2**	**48**	**3.3**		**4.07**							
Botswana	1.5	3.0	2.9	28	6.3	2	4.65	33/32	2,719	21.0/4.7	1,529	49/37	395	56
Lesotho	2.1	4.2	2.6	23	5.8	61	5.03	23/19	365	21.9/11.5	1,114	73/61		46
Namibia	1.5	3.0	2.6	37	5.3	1	5.08	29/26	1,617	22.2/9.7	1,139	92/79		
South Africa	41.5	71.0	2.2	51	3.0	6	3.95	50/48	2,884		211	77/63	2487	

Country	Total population (millions) 1995	Projected population (millions) 2025	Average population growth rate % 1995-2000	% Urban (1995)	% Urban growth rate (1995)	Population per hectare arable land	Total Fertility Rate (1995)	Contraceptive prevalence Method Any/Modern	GDP per capita ($US 1992)	% central govt expenditure Educ/Health	External population assistance ($US/ 000s)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
Western Africa[5]	**210.7**	**460.6**	**2.9**	**37**	**4.9**		**6.32**							
Benin	5.4	12.3	2.9	31	4.6	127	6.85	9/1	432		2,117	193/172	19	50
Burkina Faso	10.3	21.7	2.5	27	8.9	59	6.28	8/4	306		3,025	205/186	16	67
Côte d'Ivoire	14.3	36.8	3.2	44	4.7	42	7.14	3/1	788		2,735	138/121	125	83
Ghana	17.5	38.0	2.9	36	4.4	101	5.75	20/10	436	25.7/9.0	7,347	138/120	96	56
Guinea	6.7	15.1	2.9	30	5.5	65	6.76		530		3,567	237/213	67	33
Guinea-Bissau	1.1	2.0	2.1	22	4.6	55	5.61		215	2.7/1.4	776	248/224	37	25
Liberia	3.0	7.2	3.2	45	4.5	31	6.57	6/6		11.0/5.1	301	223/201	45	54
Mali	10.8	24.6	3.0	27	5.4	24	6.85	5/1	315	9.0/2.1	3,381	212/189	22	49
Mauritania	2.3	4.4	2.5	54	4.3	4	5.22	3/1	573		502	207/186	108	66
Niger	9.2	22.4	3.3	17	5.8	57	7.25	4/2	287		6,899	218/196	39	59
Nigeria	111.7	238.4	2.8	39	4.8	103	6.21	6/4	300		15,539	192/174	128	46
Senegal	8.3	16.9	2.7	42.3	4.0	110.8	5.84		801		3,024	113/98	111	55
Sierra Leone	4.5	8.7	2.3	36.2	4.4	93.6	6.28		160	2.1/1.5	921	253/229	73	42
Togo	4.1	9.4	3.0	30.8	4.8	105.4	6.33	12/3	413		1,835	145/127	46	71
Asia	**3,458.0**	**4,960.0**	**1.5**	**35**	**3.2**		**2.96**				**210,520**			
Eastern Asia[6]	**1,424.2**	**1,745.8**	**0.9**	**37**	**2.9**		**1.91**							
China	1221.5	1,526.1	1.0	30	3.6	155	1.95	83/80	435		10,041	43/32	600	78
DPR Korea	23.9	33.4	1.6	61	2.3	349	2.30				738	32/26	1737	
Hong Kong	5.9	5.9	0.3	95	0.5	798	1.21	81/75	16,506		301	9/7	1946	99
Japan	125.1	121.6	0.2	78	0.4	132	1.50	64/57	29,497		74,752	7/5	3586	
Mongolia	2.4	3.8	2.0	61	2.9	5	3.41		559		1,006	88/73	1082	66
Republic of Korea	45.0	54.4	0.9	81	2.1	418	1.76	79/70	6,782	16.2/1.2	1,233	18/13	2569	93
South-Eastern Asia	**484.3**	**713.4**	**1.7**	**34**	**3.7**		**3.16**							
Cambodia	10.3	19.7	2.5	21	5.6	166	5.06		217		847	178/160	55	
Indonesia	197.6	275.6	1.5	35	4.1	240	2.77	50/47	686	9.8/2.8	18,732	98/82	303	42
Lao People's Dem. Rep.	4.9	9.7	2.8	22	5.7	184	6.36		273		251	168/149	41	29
Malaysia	20.1	31.6	2.0	54	3.4	110	3.43	48/31	3,094	19.6/5.9	1,965	20/14	1445	79
Myanmar	46.5	75.6	2.1	26	3.7	192	3.99	17/14	863	17.4/6.8	327	108/91	42	32.5
Philippines	67.6	104.5	2.0	54	3.7	321	3.75	40/25	816	15.0/4.1	14,941	56/44	302	81
Singapore	2.8	3.4	0.8	100	0.8	2570	1.73		16,332	22.9/6.2	101	7/6	4399	100
Thailand	58.8	73.6	1.0	20	2.8	138	2.10	66/64	1,903	21.1/8.1	4,294	36/26	614	72
Viet Nam	74.5	118.2	2.1	21	3.5	611	3.69	53/38	131		6,271	50/38	88	50
South Central Asia	**1,381.2**	**2,196.3**	**2.0**	**29**	**3.4**		**3.94**							
Afghanistan	20.1	45.3	5.6	20	7.7	27	6.63	2/2			760	254/230	119	21
Bangladesh	120.4	196.1	2.2	18	5.2	823	4.13	45/37	208	11.2/4.8	74,568	127/132	59	80
Bhutan	1.6	3.1	2.3	6	6.3		5.65		170	10.7/4.8	306	187/195	15	32
India	935.7	1,392.1	1.8	27	3.0	301	3.59	41/36	274	2.1/1.6	31,962	104/108	235	75
Iran (Islamic Republic of)	67.3	123.5	2.1	59	3.0	26	4.76	65/45	1,900	11.9/4.2	292	88/81	10883	89
Nepal	21.9	40.7	2.5	14	6.5	404	5.19	23/22	149	10.9/4.7	5,082	139/145	20	36
Pakistan	140.5	284.8	2.8	35	4.6	248	5.88	12/9	396	1.6/1.0	18,771	142/129	223	56
Sri Lanka	18.4	25.0	1.2	22	2.8	387	2.39	62/40	563	10.1/4.8	3,691	24/19	101	60
Western Asia[7]	**168.4**	**304.6**	**2.4**	**66**	**3.4**		**4.27**							
Iraq	20.4	42.7	3.0	75	3.7	39	5.47	14/10	2,539		148	76/62	586	93
Israel	5.6	7.8	1.5	91	1.6	36	2.77		13,631	11.1/4.4	171	13/10	1256	
Jordan	5.4	12.0	3.3	72	4.1	20	5.35	35/27	1,213	12.9/5.2	2,837	41/32	979	99
Kuwait	1.5	2.8	3.2	97	3.4	18	3.00	35/32	15,391	13.7/6.0	18	19/15	2367	100
Lebanon	3.0	4.4	1.8	87	2.3	71	2.92	53/23	1,467		1,059	47/36	813	98
Oman	2.2	6.1	3.9	13	7.4	59	6.93	9/8	6,990	11.0/5.7	196	28/20	2164	64
Saudi Arabia	17.9	42.7	3.5	80	3.9	7	6.16		6,615		612	38/29	3070	95
Syrian Arab Republic	14.7	33.5	3.3	52	4.3	23	5.63	36/28	1,330	8.6/1.9	1,665	50/38	14831	79
Turkey[8]	61.9	90.9	1.8	69	3.5	68	3.20	63/34	1,930	20.0/3.5	6,807	72/66	948	92
United Arab Emirates	1.9	3.0	2.0	84	2.5		4.06		20,928	15.0/6.9	1	27/22	823	100
Yemen	14.5	33.7	3.2	34	5.9	39	7.37	7/6	790		2,418	162/144	567	

Country	Total population (millions) 1995	Projected population (millions) 2025	Average population growth rate % 1995-2000	% Urban (1995)	% Urban growth rate (1995)	Population per hectare arable land	Total Fertility Rate (1995)	Contraceptive prevalence Method Any/Modern	GDP per capita ($US 1992)	% central govt expenditure Educ/Health	External population assistance ($US/ 000s)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
Europe	**727.0**	**718.2**	**0.1**	**74**	**0.5**		**1.59**				**6,269**			
Eastern Europe	**308.7**	**299.4**	**-0.1**	**70**	**0.5**		**1.63**							
Bulgaria	8.8	7.8	-0.4	71	0.3	16	1.50	76/8	1,275	2.7/2.1	39	22/17	2422	
Czech Republic	10.3	10.6	0.1	65	0.4		1.83	69/46	2,539		78	14/10	40	
Hungary	10.1	9.4	-0.3	65	0.4	17	1.71	73/62	3,415	3.3/7.9	308	21/15	2392	99
Poland	38.4	41.5	0.2	65	0.9	35	1.88	75/26	2,185		15	20/14	2407	89
Romania	22.8	21.7	-0.2	55	0.6	26	1.50	57/14	1,074	10.0/9.2	1,360	32/24	1958	
Slovakia	5.4	6.0	0.4	59	1.2		1.92	74/41	1,879			18/13	17	77
Northern Europe(9)	**93.5**	**98.6**	**0.2**	**84**	**0.4**		**1.85**							
Denmark	5.2	5.1	0.1	85	0.2	8	1.70	78/72	27,551	9.3/1.0	(28,247)	9/7	3729	
Estonia	1.5	1.4	-0.5	73	-0.1		1.61		276			18/13		
Finland	5.1	5.4	0.4	63	1.0	14	1.88	80/78	21,037	13.9/3.2	(20,863)	9/7	5560	100
Ireland	3.6	3.9	0.3	58	0.8	8	2.10		13,729	12.2/13.0		7/6	2881	
Latvia	2.6	2.3	-0.7	73	-0.2		1.64		1,925			25/17		
Lithuania	3.7	3.8	-0.0	72	0.7		1.83		1,310			23/16		
Norway	4.3	4.7	0.4	73	0.7	22	1.96	76/72	26,343	9.4/10.3	(54,940)	9/7	4925	
Sweden	8.8	9.8	0.4	83	0.5	10	2.10	78/71	28,489	9.3/0.8	(62,739)	8/6	5395	
United Kingdom	58.3	61.5	0.3	90	0.4	6	1.81	81/78	18,027	13.2/13.8	(50,665)	10/8	3743	100
Southern Europe(10)	**143.9**	**139.3**	**0.2**	**65**	**0.6**		**1.41**							
Albania	3.4	4.7	1.0	37	2.2	142	2.75				883	42/37	421	
Bosnia & Herzegovina	3.5	4.5	4.5	49	6.1		1.60					27/19		
Croatia	4.5	4.2	-0.3	64	0.9		1.65					17/12		
Greece	10.5	9.9	0.2	65	1.0	23	1.40		7,671		44	12/9	2173	
Italy	57.2	52.3	0.0	67	0.2	19	1.27	78/32	21,155"	5.5/7.5	(2,878)	12/9	2755	
Macedonia (Former Yugoslav Republic of)	2.2	2.6	0.8	60	1.5		1.97					40/30		
Portugal	9.8	9.7	-0.0	36	1.4	39	1.55	66/33	8,079	12.0/8.0	195	13/10	1816	58
Slovenia	1.9	1.8	-0.0	64	1.2		1.46		6,123			12/9		
Spain	39.6	37.6	0.1	76	0.4	12	1.23	59/38	14,708	5.3/7.0		11/9	2409	98
Yugoslavia	10.8	11.5	-0.3	57	0.9	31	2.03	55/12			52	38/29	29	75
Western Europe(11)	**180.8**	**180.9**	**0.2**	**81**	**0.4**		**1.51**							
Austria	8.0	8.3	0.4	56	0.7	10	1.56	71/56	23,498	9.4/13.0	(1,104)	11/9	3266	
Belgium	10.1	10.4	0.3	97	0.3		1.68	79/75	21,796	10.2/1.4	(879)	13/10	5100	92
France	58.0	61.2	0.4	73	0.5	8	1.74	80/64	23,006	6.1/14.1	(9,497)	11/8	4034	100
Germany	81.6	76.4	0.0	87	0.3	14	1.30	75/72	22,208	0.5/13.8	(62,862)	9/7	4358	
Netherlands	15.5	16.3	0.6	89	0.6	26	1.61	80/77	21,102	10.8/13.9	(43,007)	9/7	4560	100
Switzerland	7.2	7.8	0.8	61	1.3	11	1.63	71/65	34,961		(7,106)	9/7	3694	
Latin America & Caribbean	**482.0**	**709.8**	**1.7**	**74**	**2.3**		**2.96**				**96,821**			
Caribbean(12)	**35.8**	**49.6**	**1.2**	**62**	**2.0**		**2.71**							
Cuba	11.0	12.7	0.6	76	1.2	32	1.82	70/67			841	15/11	978	98
Dominican Republic	7.8	11.2	1.6	65	2.7	72	2.94	56/52	1,056	10.2/14.0	3,553	54/49	347	67
Haiti	7.2	13.1	2.1	32	4.1	283	4.69	10/9	393		4,560	160/141	48	41
Jamaica	2.4	3.3	0.8	54	1.7	152	2.22	62/57	1,375		2,000	19/15	1075	72
Puerto Rico	3.7	4.6	0.8	73	1.4		2.14	64/58	9,489		112	18/14	2018	
Trinidad & Tobago	1.3	1.8	1.1	72	1.8	70	2.33	53/44	4,249		395	21/15	4910	96
Central America	**126.4**	**197.5**	**2.0**	**68**	**2.6**		**3.32**							
Belize	0.2	0.4	2.6	47	2.6	59	3.92	47/42	2,285	16.8/6.6	129	58/45	436	73
Costa Rica	3.4	5.6	2.1	50	3.2	26	3.05	75/65	2,045	19.1/ 32.0	1,494	19/15	566	94
El Salvador	5.8	9.7	2.2	45	2.9	145	3.81	53/48	1,198	12.8/7. 5	5,491	52/47	225	43
Guatemala	10.6	21.7	2.8	42	4.1	148	5.13	23/19	1,071		10,589	84/76	161	61
Honduras	5.7	10.7	2.8	44	4.3	69	4.61	47/35	606		3,310	70/57	175	70
Mexico	93.7	136.6	1.8	75	2.4	26	3.00	53/45	3,872	13.9/1.9	12,388	49/37	1525	78
Nicaragua	4.4	9.1	3.1	63	4.0	22	4.77	49/45	477		2,925	75/68	253	53
Panama	2.6	3.8	1.6	53	2.4	26	2.76	58/54	2,386	16.1/21.8	478	28/23	520	83

Country	Total population (millions) 1995	Projected population (millions) 2025	Average population growth rate % 1995-2000	% Urban (1995)	% Urban growth rate (1995)	Population per hectare arable land	Total Fertility Rate (1995)	Contraceptive prevalence Method Any/Modern	GDP per capita ($US 1992)	% central govt expenditure Educ/Health	External population assistance ($US/ 000s)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
South America[13]	**319.8**	**462.7**	**1.6**	**78**	**2.2**		**2.86**							
Argentina	34.6	46.1	1.16	88	1.5	2	2.67		6,912	9.9/3.0	518	38/33	1351	
Bolivia	7.4	13.1	2.3	61	3.8	11	4.58	45/18	700	16.6/8.2	2,869	115/106	255	66
Brazil	161.8	230.3	1.5	78	2.3	15	2.77	66/57	2,569	3.7/6.9	8,329	76/70	681	87
Chile	14.3	19.8	1.4	84	1.6	9	2.49		3,030	13.3/11.1	1,645	24/18	837	86
Colombia	35.1	49.4	1.5	73	2.2	19	2.58	66/55	1,455		4,239	29/21	670	92
Ecuador	11.5	17.8	2.0	58	3.1	41	3.31	53/42	1,150	18.2/11.0	3,474	64/51	524	70
Paraguay	5.0	9.0	2.5	53	3.8	9	4.12	48/35	1,426	12.7/4.3	1,112	49/38	209	34
Peru	23.8	36.7	1.9	72	2.5	26	3.25	59/33	988		6,100	75/61	330	58
Uruguay	3.2	3.7	0.6	90	0.8	3	2.29		3,644	6.8/5.0	484	28/20	642	84
Venezuela	21.8	34.8	2.0	93	2.4	9	3.13	49/38	3,019		232	43/35	2296	89
Northern America[14]	**292.8**	**369.6**	**0.9**	**76**	**1.2**		**2.06**							
Canada	29.5	38.3	1.0	77	1.2	1	1.89	73/70	20,541	2.9/5.2	(28,111)	10/8	7912	
United States of America	263.3	331.2	0.9	76	1.2	1	2.08	74/69	23,179	1.8/16.0	(309,994)	12/9	7662	
Oceania	**28.5**	**41.0**	**1.4**	**70**	**1.4**		**2.48**							
Australia-New Zealand	**21.7**	**29.0**	**1.2**	**85**	**1.2**		**1.91**							
Australia[15]	18.1	24.7	1.2	85	1.2	0.2	1.87	76/72	16,860	7.0/12.7	(7,827)	10/8	5263	
Melanesia[16]	5.8	10.1	2.2	21	3.6		4.49							
New Caledonia	0.2	0.3	1.5	62	2.2	26	2.63					24/17	3377	
New Zealand	3.6	4.4	1.0	86	1.3	2	2.13	70/62	11,997	13.9/12.1	(889)	11/8	4284	97
Papua New Guinea	4.3	7.5	2.2	16	4.0	538	4.84		1,043	15.0/7.9	678	78/64	235	34
Vanuatu	0.2	0.3	2.5	19	3.9	42	4.52		1,171	14.8/7.6	254	64/51	288	71
Countries with Economies in Transition of the Former USSR														
Armenia	3.6	4.7	1.2	69	1.6		2.50		739			29/21	1092	
Azerbaijan	7.6	10.1	1.1	56	1.7		2.40		737			44/33		
Belarus	10.1	9.9	-0.1	71	0.8		1.65		2,926			21/15	4154	
Georgia	5.5	6.1	0.3	59	1.1		2.10		853			27/19		
Kazakhstan	17.1	21.7	0.7	60	1.4		2.43		1,677			43/32	4722	
Kyrgyzstan	4.7	7.1	1.6	39	2.4		3.50		816			52/40	1148	
Republic of Moldova	4.4	5.1	0.3	52	2		2.12		1,293			32/23	1600	
Russian Federation	147.0	138.5	-0.2	76	0.3		1.53	21/13	2,601		229	28/20	5665	
Tajikistan	6.1	11.8	2.7	32	3.2		4.70		683			70/57		
Turkmenistan	4.1	6.7	2.1	45	2.5		3.81					78/64		
Ukraine	51.4	48.7	-0.2	70	0.6		1.64		1,819			25/17	3885	
Uzbekistan	22.8	37.7	2.1	41	2.8		3.72		851			59/47		

SELECTED INDICATORS FOR LESS POPULOUS COUNTRIES/TERRITORIES

(see notes page 73)

Monitoring ICPD Goals – Selected Indicators

Country/territory	Indicators of mortality			Indicators of education		Reproductive Health	Other Health Indicators	
	Infant mortality	Life expectancy at birth M/F	Maternal mortality ratio	Primary enrolment (Gross) M/F	Secondary enrolment (Gross) M/F	Births per 1,000 women aged 15-19	% access basic care	% births with trained attendants
Bahamas	19	69.9/78.7	69	93/96	95/95	54	100	
Bahrain	16	71.1/75.3	34	109/111	97/101	25	100	97
Barbados	9	73.6/78.7	27	109/107	97/89	54	100	98
Brunei Darussalam	8	73.3/77.3		108/102	65/73	26	96	
Cape Verde	41	65.5/67.5	134	122/119	26/26	22	81	50
Comoros	79	57.5/58.5	500	78/70	20/14	166	82	24
Cyprus	7	75.6/80.0		101/102	93/96	36	95	98
Djibouti	106	48.7/52.0		39/30	13/10	31	37	79
East Timor	135	46.7/48.4				47		
Equatorial Guinea	107	48.4/51.6	430			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	45.4/48.7	1500	79/56	25/13	171	90	
Guadaloupe	11	72.1/78.9				39		
Guam	7	73.7/79.1				88		
Guyana	42	64.4/69.5	200	122/122	67/70	61	96	
Iceland	5	76.3/81.3	23	104/100	104/98	29	100	
Luxembourg	6	72.8/80.2	25	88/94	74/75	13	100	
Maldives	49	65.7/63.3	480			71	75	
Malta	8	74.6/79.1	33	116/100	87/81	12	100	
Martinique	7	73.8/80.1				31		
Micronesia[17]	35	67.5/71.7				64		
Netherlands Antilles	17	71.4/76.3				34		
Polynesia[18]	37	67.3/71.8				80		
Qatar	17	70.0/75.4	19	91/86	82/86	66	100	99
Reunion	7	70.8/78.7				67		96
Samoa	58	67.5/71.1				80		
Solomon Islands	23	69.7/73.9		97/83	19/12	99	80	
Suriname	24	69.0/74.0	82	129/128	56/67	62	91	91
Swaziland	65	57.7/62.3	129	120/114	54/52	79	66	55

SELECTED INDICATORS FOR LESS POPULOUS COUNTRIES/TERRITORIES

Demographic, Social and Economic Indicators

Country / territory	Total population (millions) 1995 (actual)	2025 (projected)	Urban % (1995)	growth (1995)	Total Fertility Rate (1995)	Contraceptive prevalence method Any/Modern	GDP per capita ($US 1992)	Under 5 Mortality M/F	Per capita Energy consumption	Access to safe water
Bahamas	0.3	0.4	86.5	1.9	2.00		12,563	33/28	6985	90
Bahrain	0.6	0.9	90.3	2.7	3.59	53/30	7,520	41/31		100
Barbados	0.3	0.3	47.4	1.7	1.83	55/53	6,721	14/11	1387	100
Brunei Darussalam	0.3	0.4	57.8	2.2	2.91		10,978	11/8	7341	
Cape Verde	0.4	0.7	54.3	5.5	4.11		903	56/44	290	74
Comoros	0.7	1.6	30.7	5.6	6.78		512	135/118	35	
Cyprus	0.7	0.9	54.1	1.9	2.41		9,331	15/12	2306	100
Djibouti	0.6	1.1	82.8	2.6	5.60			203/182	995	43
East Timor	0.8	1.2	7.5	1.7	4.55					
Equatorial Guinea	0.4	0.8	42.2	5.2	5.70		364	206/185	69	
Fiji	0.8	1.2	40.7	2.5	2.87	41/35	2,078	32/23	533	80
French Polynesia	0.2	0.3	56.4	2.2	3.10			31/22	1449	71
Gambia	1.1	2.1	25.5	5.3	5.40	12/7	361	234/211	60	77
Guadaloupe	0.4	0.6	99.4	1.6	2.27	44/31		16/13	643	
Guam	0.2	0.2	38.2	2.4	3.10			14/11	9676	94
Guyana	0.8	1.1	36.2	2.9	2.43	31/28	465	69/55	350	83
Iceland	0.3	0.3	91.6	1.2	2.23		25,451	8/6	4977	
Luxembourg	0.4	0.4	89.1	1.4	1.69		26,921	12/9	9722	
Maldives	0.3	0.6	26.8	4.3	6.47		578	80/66	144	70
Malta	0.4	0.4	89.3	0.9	2.05		6,839	13/10	1556	
Martinique	0.4	0.5	93.3	1.3	1.95	51/38		14/11	653	
Micronesia[17]	0.5	0.9	42.7	3.2	4.23			50/38		
Netherlands Antilles	0.2	0.2	69.5	1.3	2.10			17/13	8384	
Polynesia[18]	0.6	1.0	41.3	2.6	3.58					
Qatar	0.6	0.8	91.4	2.1	4.14	32/29	13,135	36/26	278	91
Reunion	0.7	0.9	67.8	2.3	2.21	67/62		10/8	689	
Samoa	0.2	0.3	21.0	2.4	4.25					
Solomon Islands	0.4	0.8	17.1	6.3	5.18		718	62/49	170	69
Suriname	0.4	0.6	50.4	2.5	2.54		4,804	51/39	1903	98
Swaziland	0.9	1.6	31.2	5.7	4.66	20/17	1,163	169/156	265	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, Europe, 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) 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.

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

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

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

(16) Including New Caledonia and Vanuatu.

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

(18) 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 introduces a new 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) will, therefore, be given special attention in our presentations. Relevant indicators will be 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 ongoing 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, forthcoming). 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: World Bank, *World Tables, 1994*, 1994, based on World Health Organization sources including *Maternal Mortality: A Global Factbook* (WHO, 1991). 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. Estimates of this quantity are based on a combination of national, small area and clinical data and are subject to considerable uncertainty; however, rough relative magnitudes are informative.

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. In so far as possible, data refer to the proportion who cannot, with understanding, 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, forthcoming). 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 average number of births per woman per year, one could multiply it 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: World Bank, *The World Tables 1994*, 1994, 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: WHO, *Coverage of Maternity Care: A Tabulation of Available Information, Third Edition*, 1993. This indicator presents WHO 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, forthcoming). These indicators present the size, projected future size and current period annual growth of national populations.

Per cent urban, urban growth rates: Source: United Nations Population Division, World Urbanization Prospects: the 1994 Revision, (United Nations publication, forthcoming). 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 1995: Source: United Nations Population Division, World Population Prospects: the 1994 Revision (United Nations publication, forthcoming). 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.

Contraceptive prevalence: Source: United Nations Population Division, Levels and Trends of Contraceptive Use as Assessed in 1994 (United Nations publication, forthcoming). 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: World Bank, *The World Tables 1994*, 1994, The World Bank, 1994. 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: World Bank, *The World Tables 1994*, 1994. 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 1992*, 1994. 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. This is the first inclusion of information on resource flows in *The State of the World Population* report. Future editions 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.

Under-5 mortality: Source: World Bank, *World Tables 1994*, 1994, based on information from UNICEF, *The State of the World's Children 1994*, 1994. This indicator relates to the incidence of mortality among 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 immunization 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: World Bank, *World Tables 1994*, 1994. 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: World Bank, *World Tables 1994*, 1994, 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. ■

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