INDES Working Paper

Bridging the Gender Gap

In Developing Regions

Alessandro Magnoli
Research Associate, Department of Population and International Health,
Harvard School of Public Health (HSPH), Boston, MA, USA.

Harvard University

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ABSTRACT

According to conventional wisdom, health and education are important factors for economic and social development: they improve productivity and income distribution, and the poor gain the most. Nonetheless, in many regions of the world not all members of society receive these services equally. To a large extent, women are left out of health and education systems; as a consequence, they constitute an economically and socially disadvantaged group.

Disproportionate poverty, low social status, and their reproductive role expose women to high health risks, resulting in needless and largely preventable suffering and death. A woman's health and nutritional status is not only an individual welfare concern, but also a national one, because it has an impact on her children and her economic productivity.

Similarly, women's education still lags far behind men's in most developing countries, with far-reaching adverse consequences for both the individual and national well being. Indeed, more schooling increases the incomes of males and females, but educating girls generates much larger social benefits. Why? Because women will use both the newly acquired knowledge and related extra income for the benefit of the family.

This article analyzes the gender gaps within health and education in six regions of the developing world: Sub-Saharan Africa; South Asia; East and Southeast Asia; The Middle East and North Africa; Latin America and the Caribbean; Eastern Europe and Central Asia. In all of these regions, there is an unfinished agenda in terms of access and equity.

Three substantial reasons support an active government interest in the field of women's health and nutrition and justify public expenditure in gender-targeted educational policies: equity, economic development and social cohesion. On the one hand, investment in women's health and nutrition promotes equality, widespread benefits for this generation and the next, and economic efficiency because many of the interventions that address women's health problems are cost-effective. On the other hand, educating women brings about the potential benefit of educating the population. The failure to educate women can result in the loss of raised productivity, increased income, and improved quality of life.

In general, the exclusion of women from health and education delivery can act as a severe constraint on the achievement of higher development levels. Hence, it is a high priority to invest more in these social services and to remodel their delivery systems.

If we educate a boy, we educate one person. If we educate a girl, we educate a family -- and a whole nation.

-- African proverb

A very simple statistic, the demographic composition of the population, reveals a very surprising truth – namely, that more than 100 million[1] women are missing worldwide. In theory, the proportion of females in a given population should be slightly higher than 52 percent.[2] A survey of international indicators, however, reveals that in fact there exist large regional discrepancies from this figure. Women do constitute 52.5 percent of the population in the industrial world, but they account for only 51 percent of the population in Sub-Saharan Africa, less than 48 percent in East Asia, and less than 47 percent in South Asia. What happened to these missing 100 million women? This question has a rather sinister-sounding answer: excessive female mortality.

The disproportionate rate of early death of females worldwide is caused by specific gender-linked problems they face. Violence against women is common in most developing countries and ranges from injury associated with dowry demands to marital abuse. In some areas of Asia, gender selection through abortion[3] and through female infanticide is a widespread practice. Throughout the developing world, female mortality is high partially as a result of insufficient access to contraceptives and to basic prenatal care. In the nations with the highest maternal death rates, relatively few births are attended by trained personnel (Population Reference Bureau 1998). Moreover, many governments have largely ignored other problems to which women are highly vulnerable, such as malnutrition and sexually transmitted diseases.

In all developing regions, women are not a social priority. Their inferior status is evident in their lower rates of school enrollment and graduation. The resultant lack of education makes them less apt to recognize health problems for which they need to seek care. In respect to the labor market, girls begin working at an earlier age than boys and -- throughout their lives -- spend more hours working each day (UN 1991). Their earnings for the same or similar work are substantially lower than men's wages, and much of their work is outside the formal sector and not financially remunerated. Consequently, women are in a continued cycle of poverty that circularly reduces their access to health and education services.

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[1] As calculated by Amartya Sen (1987).

[2] This is a biologically determined constant. Under optimal conditions for both men and women, a woman's life expectancy at birth is 1.03 times that of men (Coale and Demeny 1983, World Bank 1993b). In many parts of the world the statistics are even more favorable for females. In most industrial countries their life expectancy is more than 1.06 times that of men, and up to 1.10 times higher in Canada. In most developing countries, however, the ratio is much lower, dropping below 1.00 in parts of Asia, with a low of 0.97 in Buthan – a sign of socioeconomic conditions particularly inimical to women and girls (Keyfitz and Flieger 1990).

[3] In Bombay, India, of the abortions performed after parents learned the gender of the fetus, only one among 8 thousand averted the birth of a male (UN 1991, World Bank 1994b).

In general, women's status is affected by complex biological, social, and cultural factors that are highly interrelated. In many countries in South Asia, Africa, Latin America, and the Middle East, one-third to one-half of women are mothers before the age of 20 (World Bank 1994b). In a few developing countries, as many as one in four girls is married before her fifteenth birthday (World Bank 1994b). Worldwide, women receive less information than do men and have less control over decision making and family resources (World Bank 1993a). In short, they are in a handicapped social position, often as a result of the economic value placed on their familial roles. As a result, they are trapped in a vicious cycle the main consequences of which are poor health, insufficient education, inadequate diet, and early and frequent pregnancy.

1. Principal Health Issues

Infant mortality rates have been reduced by one-half[4] in the past thirty years, but improvements in maternal mortality rates have lagged behind, with little evidence of any progress at all in the least developed countries.[5] In Bangladesh, the total fertility rate declined by one-third and child mortality by almost one-half in two decades, but the maternal mortality ratio remained virtually unchanged (Khan, Jahan, and Begum 1986, World Bank 1992 and 1993c, Population Reference Bureau 1998). Maternal mortality ratios[6] and rates[7] constitute the area of widest human-development indicator disparity between developing and industrial countries. In Sub-Saharan Africa, where the ratio is 980 maternal deaths per 100 thousand live births, a woman's lifetime risk of dying from pregnancy-related complications is one in 48[8] (Population Reference Bureau 1998). In industrialized nations, on the other hand, maternal death ratios are much lower, ranging from 3 to 11 per 100 thousand live births, and in Northern Europe, the risk of dying from pregnancy-related causes is only one in 10 thousand (UN 1993, Herz and Measham 1987, Population Reference Bureau 1998).

[4] Infant mortality rates and population fertility rates have dropped substantially in developing countries over the past three decades. From 1962 to 1992, infant mortality in the developing world decreased by 50 percent, and fertility rates fell by 40 percent (UN 1993). Fertility regulation has contributed to women's health by reducing the number of pregnancies – and the associated risks – and thereby giving women more control over their lives.

[5] Except in the countries with relatively low maternal mortality ratios (fewer than one hundred maternal deaths per 100 thousand births), the World Health Organization has found scant evidence of any progress at all in reducing maternal mortality in recent years (WHO 1992b).

[6] The maternal mortality ratio is the number of women who die in pregnancy and childbirth per 100 thousand live births. It measures the risk women face of dying once pregnant.

[7] The maternal mortality rate is the number of women dying in pregnancy or childbirth per 100 thousand women ages 15 through 49. The rate reflects both the maternal mortality and the fertility rate.

[8] According to the World Bank (1994b), in Sub-Saharan Africa the ratio is 700 maternal deaths per 100 thousand live births and a woman runs a 1-in-22 risk of dying from pregnancy-related causes during her lifetime.

Progress has been even slower in other areas significant to women's health. For instance, female physical fitness and nutrition have largely been ignored, despite their specific and cumulative impact on health and longevity.[9]

Biological factors. It is generally believed that women are sturdier than men given that their life expectancy is higher. This, however, is not true. Albeit they live longer, women are more prone to diseases because of their more complex physiology. The major health risks related to pregnancy are well known, but other health problems associated with women's reproductive biology may be less recognized.

- *Anemia.* Menstruation renders women more susceptible to iron deficiency anemia. Anemia is highly prevalent throughout the developing world and appears to be worsening in South Asia, where it affects at least 60 percent of all women ages 15 to 49.

Table 1. Anemia among Women Ages 15 to 49 (% anemic), 1990

	ALL WOMEN	PREGNANT WOMEN
Africa	42	51
Asia	44	58
Latin America	33	41
Industrial countries	12	17

Sources: WHO 1992, World Bank 1994b.

- *Sexually transmitted diseases.* Because of their physical make-up, women are at a higher risk (per exposure) of contracting sexually transmitted diseases. In the case of human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS), women are more likely than men to contract the disease from an infected partner, and young girls are the most vulnerable.

  Of all HIV-infected women, 70 percent are between the ages of 15 and 25 (World Bank 1995). Furthermore, because women with sexually transmitted diseases are more likely to have no immediate symptoms, they may delay treatment until an advanced stage and suffer more severe consequences. In developing countries, one of the major consequences is cervical cancer,[10] which peaks in women ages 40 to 50 and annually accounts for more new cases of cancer than any other type.

[9] Many of the health problems that affect women of reproductive age and older begin in childhood and adolescence. For instance, inadequate diet in youth and adolescence can lead to anemia or stunting. An estimated 450 million adult women in developing countries are stunted as a result of protein-energy malnutrition during childhood (World Bank 1993b). Calcium insufficiency can lead to osteoporosis later in life. Such problems also have detrimental effects on these women's newborns -- underweight babies with health complications in childhood.

[10] Human papillomavirus infection results in genital cancer much more frequently in women than in men. It is the single most important risk factor for cervical cancer (Parkin, Laara, and Muir 1988).

Table 2. Estimated Cumulative HIV Infections in Women, as of early 1994

Sub-Saharan Africa	> 7,500,000
South Asia and Southeast Asia[a]	> 1,500,000
East Asia and the Pacific	50,000
The Middle East and North Africa	75,000
Latin America	> 1,000,000
Eastern Europe and Central Asia	50,000
Western Europe	500,000
North America	> 1,000,000

a. Including Australasia.

Sources: WHO 1993, World Bank 1994b.

- *Pregnancy and its complications.* Pregnancy can exacerbate certain conditions, including anemia, malaria, and tuberculosis. Approximately 80 percent of maternal deaths result from obstetric problems in delivery, including infections (Population Reference Bureau 1998).

  Complications during pregnancy may also cause permanent damage, such as uterine prolapse and obstetric fistulae. Worldwide, one out of four pregnancies is unwanted. Abortions outnumber live births in parts of Eastern Europe and the former Soviet Union. Complications from unsafe abortions are a major cause of maternal death in many developing regions, particularly in Latin America.

Table 3. Maternal Mortality Ratio (per 100 thousand live births)[11]

	1980	**1990**	**1992**
Sub-Saharan Africa	634.3	na	999.8
South Asia	1047.5	na	887[b]
East Asia and Southeast Asia	223.5[a]	267.2[a]	na
The Middle East and North Africa	408.7[a]	na	126.3[a]
Latin America and the Caribbean	125.4	204.7[a]	na
Eastern Europe and Central Asia	47.1	37.2[c]	na

a. Data available for less than 75 percent of countries in the sample. b. Bangladesh only. c. Data 1989.

Source: Author's calculation based on World Bank Social Indicators of Development (1997). Averages country-wWeighted. Selected sample, countries by geographical area.

[11] According to the Population Reference Bureau (1998), the following are the maternal deaths per 100 thousand live births, by region: Sub-Saharan Africa 980; South-Central Asia 560; Southeast Asia 440; North Africa 340; West Africa 320; Latin America & Caribbean 190; and East Asia 95.

- *Cardiovascular conditions.* Women of reproductive age receive some protection against cardiovascular disease from the hormone estrogen; accordingly, their cardiovascular risk increases after menopause. By age 65, a higher proportion of women than men dies as a consequence of cardiovascular problems (Lopez 1993).

Socioeconomic factors. The social environment and their economic role expose women to disease and injury and affect their diet, their access to and use of health services,[12] and the disease manifestations and consequences experienced by females.

- *Unequal power.* Women's low status can expose them to physical and sexual abuse and mental depression. Unequal authority in sexual relationships[13] makes them subject to unwanted pregnancies and sexually transmitted diseases, including HIV and AIDS. Domestic violence, rape, and sexual abuse are a significant cause of permanent disability among women.

- *Familial roles.* Indoor cooking is one of the most serious occupational health and environmental hazards in the developing world because of accidental burning and the acute and chronic -- and sometimes fatal -- consequences of inhalation of smoke and toxic gases (WHO 1986, World Bank's World Development Report 1992). Moreover, because of their multiple tasks and responsibilities within the family, women face high opportunity costs for any time spent caring for their own health[14] or attending school.

- *Culture.* Access to health services is inhibited by certain cultural factors, such as restrictions in some Middle Eastern countries on a woman's traveling alone or on her being treated by male health care providers. One cultural practice in Africa makes an estimated 2 million young girls subject to genital mutilation (removal of parts or all of the external female genitals).

Poor public policies. Public policies have not done much to help. In general, targeting needs to be redesigned. Women's health initiatives that are in place are inadequate and tend to focus on married women of childbearing age. All other females -- girls, adolescents, older women, and unmarried or childless women of reproductive age -- rarely receive the attention of public health administrators.

National economic development level. A country's overall economic underdevelopment may pose additional health risks for women. For instance, poor roads and lack of transportation, as well as inadequate obstetric facilities, hinder women from receiving

[12] The strongest evidence of gender differentials in health status and the use of health services has been documented for both children and adults in South Asia. A study in India found that protein-energy malnutrition was four to five times more prevalent among girls, and yet boys were fifty times more likely to be hospitalized for treatment (Das Gupta1987). Studies in other countries have also found that even where there is no apparent gender difference in the prevalence of infectious disease, women may be less likely than men to seek care. In Colombia and Thailand, for example, about six times as many adult men as women attend malaria clinics for treatment (Vlassof and Bonilla 1992, Ettling and others 1989).

[13] With changing social values and economic pressures, girls are engaging in sexual relationships at earlier ages. The worst manifestation of this phenomenon is the growing number of young girls forced into prostitution, especially in Asia.

[14] Studies in Kenya and in Peru confirm that user fees and distance are a decisive obstacle to women more than to men against seeking medical care (Mwabu, Ainsworth, and Nyamete 1993, Gertler and van der Gaag 1990).

timely medical treatment for pregnancy-related complications. Furthermore, inadequate water supply, lack of electricity, and poor sanitation impose extra burdens on women as they fulfill their household responsibilities.[15]

2. Main Problems in Education

Evidence from many countries points to strong causal links between the average education levels of women and increased levels of national economic development. Nonetheless, several indicators -- including measures of literacy, enrollment, and years in school -- reveal a large and generalized gender gap[16] and other significant negative patterns in women's education in developing countries. In most of the low-income countries, with just a handful of exceptions the level of female education is low, and the gender gap is, by any measure, the largest. Considerable disparities exist between boys and girls in terms of their enrollment and primary school completion rates.

Illiteracy.[17] In many countries low literacy rates prevail among women.[18] There are 900 million illiterate people in the developing world, and the women still outnumber the men two to one in this category. In 1990 there were only 74 literate women for every 100 literate men worldwide.

In fourteen of the fifty-one developing countries for which school data or estimates are available for the 1980s, female adult literacy was less than 20 percent. In none of these countries was the male literacy rate as low (World Bank 1994a). In Afghanistan, Burkina-Faso, Nepal, Somalia, and Sudan, where fewer than 10 percent of adult women are literate, the percentage of men who are literate is three to four times larger (World Bank 1994a).

Table 4. Female Illiteracy Rate (% of females age 15+)

	1985	1990	1994
Sub-Saharan Africa	68.3	67.6	58.6
South Asia	70.6	67	59.3
East Asia and Southeast Asia	29	27.6	24.2
The Middle East and North Africa	51.7	45.1	42.7

[15] Taking care of children and the elderly, cooking, fetching water and fuel wood, and the like.

[16] In general, educational gaps between genders have been decreasing over time. Nevertheless, there is still inadequate female educational performance. Public expenditure in education is not getting to everyone, and the average data mask unequal gender achievements.

[17] Literacy is the first step in the educational process and one of the principal goals of education around the world. The ability to read and write could be considered almost a basic human right, but it also is a necessary condition for communicating common values and fostering economic growth. By consolidating cooperative principles and common values, education reinforces the social contract and strengthens democracy.

[18] Among those countries with male literacy rates greater than 70 percent, the gender gap is notably large -- Libya (30 percentage points), China (28), Zaire (26), Turkey (23), and Botswana (21). In contrast, the literacy rates for men and women are about equal in Colombia, the Dominican Republic, and the Philippines (World Bank 1993). Low adult literacy rates are a result of past underinvestment in the education of women and thus do not necessarily reflect recent progress.

Latin America and the Caribbean	20.3	18.5	16
Eastern Europe and Central Asia	na	2.2 [a b c]	na

a. Data available for less than 75 percent of countries in the sample. b. Total illiteracy rate (% of population age 15+). c. Data 1989.
Source: Author's calculation based on World Bank Social Indicators of Development (1997). Averages country -weighted. Selected sample, countries by geographical area.

Low enrollment. Without question, enrollment rates[19] at all school levels have been rising in the developing world for both sexes. But this expansion has not substantially diminished gender disparities: the enrollment rates of girls remain much lower, with the widest gap evident in the poorest countries.

- *Primary level.* Enrollment at the primary level is an important indicator. Worldwide, in 1990 there were 77 million girls between the ages of 6 and 11 who were not attending school, compared with 52 million boys. Hence, of the 129 million[20] children who did not go to primary school, girls represent 59.6 percent. For the group of forty low-income countries -- defined as those with a GNP per capita below US$500 in 1988 -- the gap in primary school enrollment between boys and girls averages 20 percentage points. This gap has persisted in large part since 1960 (World Bank 1993a).

  Enrollment rates and gender disparities in enrollment differ dramatically by region. Except for Sub-Saharan Africa, all regions have achieved nearly universal primary school for boys. South Asia[21] did so during the 1990s, and the region comprising the Middle East and North Africa is on its way. But in only three of the regions -- East Asia; Latin America/the Caribbean; and Eastern Europe/Central Asia – have enrollment rates for girls approached similar levels. In the other three regions, female enrollment rates continue to lag behind.

Table 5. Primary: Average of Gross Enrollment Ratio (% school age population)

	1965	**1970**	**1975**	**1980**	**1985**	**1990**	**1991**	**1992**	**1993**	**1994**
Sub-Saharan Africa										
Males	58.9	61.0	69.3	78.6	80.1	79.9	80.5	74.1	85.4	73.8 [a]
Females	37.4	41.2	50.1	60.0	63.4	65.4	66.5	63.0	70.3	58.3 [a]
South Asia										
Males	60.3	63.0	83.8	89.4	79.2	97.2	115.0	116.0	111.3	81.0 [a]

[19] For this analysis, we use gross enrollment ratios since they are the only available data. Gross enrollment rates are computed as the ratio (expressed as a percentage) of total enrollment in primary education to total population in the appropriate age group. Because of intake from younger or older (adult education) age groups into the primary grades, or grade repetition, gross enrollment rates can exceed 100 percent. Despite of this shortcoming, gross enrollment rates are a favored measure of educational progress because they reflect the admission capacity of the system.

[20] The data do not take into account repetition, absenteeism, and dropout rates, which would make the gap even wider.

[21] Over the period 1960-1988, in South Asia policies to expand the education system improved access for boys more than for girls; however, universal primary school for boys was not achieved before 1990. Over same the period (1960-1988), moreover, the gender gap in primary enrollment has widened.

Females	33.2	36.0	46.2	57.8	54.5	73.6	90.3	93.3	86.9	60.0 [a]
East Asia and Southeast Asia										
Males	93.7	87.0	109.6	109.8	111.9	106.1	109.6	108.8	109.0	na
Females	81.5	77.6	101.2	104.0	105.7	105.0	101.8	102.2	100.8	na
The Middle East and North Africa										
Males	96.0	93.3	90.0	98.6	101.2	93.2	91.5	92.6	97.7	na
Females	62.9	61.8	61.6	79.0	85.2	80.3	79.7	83.4	89.0	na
Latin America and the Caribbean										
Males	95.5	101.3	100.6	102.6	104.9	100.7	100.1	104.1	101.8	na
Females	90.0	97.2	97.8	100.0	103.5	100.3	99.8	104.3	100.3	na
Eastern Europe and Central Asia										
Males	103.5	103.3	102.0	99.6	101.2	98.0	93.5	92.9	90.3 [a]	97.3 [b]
Females	101.0	102.3	101.0	99.4	100.6	97.4	92.5	91.7	89.0	96.7 [b]

a. Data available for less than 75 percent of countries in the sample. b. Poland only.

Source: Author's calculation based on World Bank Social Indicators of Development (1997). Averages country-weighted. Selected sample, countries by geographical area.

- *Secondary level.* The gender gap in enrollment becomes more apparent beyond the primary level, as countries approach universal basic education. In 1960, average secondary school enrollment rates did not exceed 25 percent in all developing regions, with the exception of Eastern Europe and Central Asia, where it was higher. Sub-Saharan Africa's rate was the lowest, at 3 percent. Luckily, progress at the secondary level since 1960 has been dramatic in many parts of the developing world, and enrollment of females rose faster[22] than did that of males. Gross enrollment rates for females have increased from an average of 12 percent in 1960 to 44 percent in 1988 in lower-middle-income countries,[23] and from 25 percent to 70 percent in upper-middle-income countries. Nevertheless, the regional pattern in enrollment rates has grown more diverse, especially for females.

  Although the gender difference in secondary enrollment has narrowed in East Asia, it has widened in Sub-Saharan Africa and in the Middle East and North Africa, as well as in South Asia after 1965. Average enrollment rates in Africa and South Asia in 1988 lagged behind those of East Asia by about 40 percentage points. Indeed, the averages for Sub-Saharan Africa were still below the rates that East Asia had achieved twenty-five years earlier.

Table 6. Secondary: Average of Gross Enrollment Ratio (% school age population)

	1965	**1970**	**1975**	**1980**	**1985**	**1990**	**1991**	**1992**	**1993**	**1994**
Sub-Saharan Africa										
Total	4.9	7.5	11.6	15.3	17.8	19.1	20.9	20.9	19.4	15.0 [a]
Females	2.9	4.8	8.5	11.0	13.6	16.2	18.5	19.0	17.7	12.0 [a]

[22] The average female enrollment rate for this group of countries has quadrupled since 1960.

[23] A few low-income countries experienced major setbacks in enrollment in the early 1980s. China, for instance, shows a decline of 5 percentage points for females and 8 percentage points for males.

South Asia										
Total	15.4	19.4	21.5	27.6	27.3	37.8	50.0	52.3	40.8	na
Females	11.6	14.2	14.6	20.6	21.0	30.8	43.3	46.0	34.3	na
East Asia and Southeast Asia										
Total	28.1	32.6	43.6	51.8	56.5	59.9	47.6 [a]	57.7	62.8	na
Females	24.2	21.1	43.3	50.4	53.6	51.2	38.6 [a]	54.1	60.2	87.0 [b]
The Middle East and North Africa										
Total	23.3	28.8	32.8	46.1	51.2	49.3	51.3	53.9	54.3	na
Females	15.0	20.0	25.5	39.3	42.8	43.3	45.7	48.7	50.3	na
Latin America and the Caribbean										
Total	23.6	30.5	38.2	48.4	52.0	54.6	55.1	58.8	52.2 [a]	na
Females	23.3	31.0	38.2	46.9	54.5	54.6	58.2	59.8	49.2 [a]	na
Eastern Europe and Central Asia										
Total	54.1	62.0	72.5	84.3	89.7	86.4	83.8	84.6	84.9	79.1 [c]
Females	51.9	52.7	66.0	79.4	86.8	85.0	81.0	87.2	88.1	82.6 [c]

a. Data available for less than 75 percent of countries in the sample. b. Mongolia only. c. Poland only.

Source: Author's calculation based on World Bank Social Indicators of Development (1997). Averages country-weighted. Selected sample, countries by geographical area.

High dropout rates. The recent gains in enrollment in developing countries may overstate the progress in education since the 1960s. Gross enrollment rates, which are usually reported for all primary and secondary classes, tend to mask some other important measures of educational progress because they do not account for other factors. One of these factors is the dropout rate, an indicator that reflects the number of students that do and do not remain in school, the number that are promoted to the next grade, and the number that complete each cycle.[24] If high dropout rates prevail even in the lower primary grades, it is doubtful whether all those who enter school ever achieve functional literacy.[25]

Dropout rates vary considerably from country to country. On the average, 9.6 percent of girls in low-income countries leave primary school before finishing as compared with 8.2 percent of boys.[26] In Sub-Saharan Africa and in the Middle East and North Africa the dropout rate is higher for girls than for boys. But in Latin America and the Caribbean and in Congo, Lesotho, Madagascar, and the Philippines, girls are less likely than boys to drop out of primary school.

[24] Primary-school completion rates declined in the 1980s in the poorest countries: data indicate that fewer than 60 percent of those who entered school in low-income countries, and only about 70 percent in lower-middle-income countries, reach the final year of the primary cycle (World Bank 1995).

[25] For instance, in Latin America, although most of the countries of the region have good education coverage (gross primary school enrollment rates greater than 100 percent), only six have achieved adult literacy rates of more than 90 percent.

[26] Why? Simply walking to and from a distant school each day can be a challenge for a young girl and threaten her safety. In households where both parents must do full-time agricultural work, school can seem like a questionable luxury. Most girls end up staying home to care for younger siblings, cook, and help wherever else they are needed.

Table 7. Primary: Dropout Rates (%) by Country Group and Region, 1988

	GIRLS	BOYS
Country group		
Low-income countries	9.6	8.2
Lower-middle-income countries	6.1	5.9
Upper-middle-income countries[a]	6.2	6.3
Region		
Sub-Saharan Africa	8.6	7.3
South Asia (Sri Lanka only)	1.5	1.5
East Asia (Philippines only)	6.6	6.7
Latin America and the Caribbean	7.8	8.8
Middle East and North Africa	6.0	4.3

a. Data are available for only five countries in this group: Algeria, Gabon, Iran, Iraq, and Uruguay.

Source: World Bank 1993.

Few years of schooling. This indicator illustrates the effect of dropout rates on the average level of education attained.[27] The gender gap in educational attainment, measured by years of schooling, tends to fall as one moves from low-income to middle-income countries. Data for 1985 show that in low-income countries, the expected years of schooling averaged from 2.7 years (females) to 4.8 years (males), while in upper-middle-income countries, they averaged from 10.2 years (females) to 10.5 years (males). In the low-income group, the expected length of schooling for males exceeds that for females. In Nepal and Benin, girls average 4.4 and 3.5 fewer years of schooling than boys. In the middle-income group, besides Bolivia, only countries in the Middle East and North Africa show a significant gender gap: girls there can expect to be in school two or three years less than boys.

Table 8. Years of Expected School Attendance (average 6-year-old child), 1990

	GIRL	BOY	DIFFERENCE
Low-income or middle income country	7.7	9.3	1.6
South Asia	6.0	8.9	2.9
Middle East	8.6	10.7	2.1

Source: World Bank 1997.

Rural-versus-urban discrepancies. There also exists a wide gap in terms of educational services made available to the urban versus the rural populations. In Indonesia, only 3 percent of the urban population received no schooling at all, as opposed to10 percent in

[27] Enrollment rates -- once more -- could be tricky if interpreted without attention. Indeed, even if they have increased in most countries, the expected attainment levels in the poorest countries remain low, especially for females For example, a 6-year-old girl entering school in Nepal in 1985 was expected to complete only 3.1 years of schooling by the time she was eighteen. For a girl in Burkina-Faso, the figure was lower still: 1.5 years. Since 1965 the primary school enrollment rate for girls has increased fivefold in Nepal and almost threefold in Burkina-Faso. But of all the girls enrolled in primary school in Nepal in 1985, almost 45 percent were in grade one and only about 10 percent were in grade five (the final year of the primary cycle). In Burkina-Faso, 26 percent were in grade in grade one and 13 percent in grade five. In both countries the rate at which boys stayed in school, called the retention rate, was higher (World Bank 1995).

rural areas (World Bank 1995). Within rural areas, gender disparities are also acute. As shown in Table 9, in Pakistan the proportion of female and male children ages 7 to 14 who ever attended school were 73 percent and 83 percent in urban areas as opposed to 40 percent and 70 percent in rural areas.

Table 9. Pakistan: School Attendance by Gender (children ages 7 to 14), 1990

	URBAN	RURAL
% of females	73	40
% of males	83	70

Source: UNESCO 1997.

3. Health and Education Data by World Region

Although women throughout the developing world experience similar health and education problems, the key concerns vary from region to region. The present paper analyzes the situation of 100 countries, divided into six regions, as follows: 38 countries from Sub-Saharan Africa, 6 from South Asia, 13 from East Asia and Southeast Asia, 7 from the Middle East and North Africa, 24 from Latin America and the Caribbean, and 12 from Eastern Europe and Central Asia.

Sub-Saharan Africa. Most Sub-Saharan African countries[28] can be characterized as being among the world's poorest economies. The median GNP per capita for the region in 1987 was US$300, ranging from a low of US$130 in Ethiopia to a high of US$2,700 in Gabon.

- *Health.* Female genital mutilation is practiced in several countries of the region. Sub-Saharan Africa also has the world's highest fertility rate[29] and some of the highest adolescent pregnancy rates in the world. By age 18, more than 40 percent of females in Côte d'Ivoire, Mali, and Senegal have already given birth (Population Reference Bureau 1992).

  Maternal mortality rates are the highest in the world. Poor prenatal and delivery care exacerbates maternal health problems. Unsafe abortions account for 20 percent to 40 percent of all maternal mortality in the region. Sexually transmitted diseases, including HIV/AIDS, are a major cause of disability and death among African women. Furthermore, sexually transmitted diseases among African women constitute more than half of all such cases among women in the entire

[28] Sub-Saharan African countries divided by income levels: low-income (ascending order, from 130 to 450 US$ per capita, GNP 1987): Angola, Ethiopia, Chad, Zaire, Malawi, Mozambique, Guinea-Bissau, Tanzania, Burkina Faso, Madagascar, Mali, The Gambia, Burundi, Zambia, Niger, Uganda, Somalia, Togo, Rwanda, Sierra Leone, Benin, Central African Republic, Kenya, Sudan, Lesotho, Nigeria, Ghana, Mauritania, Liberia, and Guinea. Middle-income (ascending order, from 520 to 1490 US$ per capita, GNP 1987): Senegal, Zimbabwe, Swaziland, Côte d'Ivoire, Congo, Cameroon, Botswana, and Mauritius.

[29] The median of fertility was 6.5 children per woman in 1987, with a range from 2.1 in Mauritius to 8.0 in Rwanda.

developing world. Infertility and cervical cancer, often caused by sexually transmitted diseases, are common in some of the countries of this region.

Table 10. Sub-Saharan Africa: Maternal Mortality Ratio (per 100 thousand live births), 1992

Benin	2500 [f]	Sierra Leone	800 [e]
Somalia	1725	Tanzania	748
Chad	1594	Ghana	742
Angola	1562	Madagascar	660 [d]
Ethiopia	1528	Central African Republic	649
Mozambique	1512	Kenya	646
Burundi	1327	Togo	626
Rwanda	1324	Malawi	620 [d]
Mali	1249	Sudan	607
The Gambia	1050 [e]	Lesotho	598
Nigeria	1027	Niger	593 [c]
Burkina-Faso	939	Uganda	550 [c]
Zambia	923	Liberia	544
Guinea-Bissau	914 [a]	Cameroon	511
Congo	887	Senegal	510
Guinea	880 [d]	Botswana	220
Zaire	876	Mauritius	99 [b]
Cote d'Ivoire	822	Zimbabwe	80 [d]
Mauritania	800 [d]	Swaziland	na

a. Data 1986. b. Data 1987. c. Data 1989. d. Data 1990. e. Data 1993. f. Data 1994.

Source: Author's elaboration based on World Bank Social Indicators of Development (1997). Selected sample, countries by geographical area.

- *Education.* Education in this vast, diverse group of nations has been shaped by a mix of influences, among them indigenous cultures, Christianity, Islam, and a network of Western-type schools set up by missionaries and colonial governments. Given its cultural and economic diversity and despite the widespread poverty, Sub-Saharan Africa has made spectacular progress in expanding education since the countries achieved independence. Literacy rates have risen from a mean of 9 percent in 1960 to 42 percent in the mid-1980s. Despite this dramatic improvement, Sub-Saharan Africa is still plagued by some of the world's highest illiteracy rates;[30] a great deal of variation across countries remains, and the differences between men and woman persist.[31] Gross primary school enrollment was only 36 percent in 1960, half the rates of Asia and Latin America at that time. Between 1960 and 1983, striving to meet the needs of independence and economic growth, the region quintupled student enrollment in

[30] Despite the high fertility rates, the median annual rate of growth -- in the number of children of primary and secondary school age in the region as a whole -- increased only slightly, from 2.7 percent in 1960-70 to 2.8 percent in 1970-80. This growth rate declined in nearly half of the countries.

[31] In Burkina-Faso the most recent data indicate that fewer than 5 percent of women are literate, compared with 15 percent of men. In Swaziland, literacy rates are much higher for both women and men, although women's literacy still lags by about 4 percentage points.

schools at all levels to 63 million, a higher growth rate than in any other developing region. Even so, males and females have not benefited equally[32] in any of these countries. During the following years, fast-growing populations and adverse economic conditions caused enrollment to stagnate and educational quality to decline.

South Asia. South Asian countries have one of the world's richest mixes of religion[33] and cultural influences. Economic growth rates in the 1980s were fairly vigorous, and GDP rose faster in these countries than in the middle-income and high-income country groups.[34] Despite this rise, gross domestic product per capita is still very low.[35]

- *Health.* Throughout most of the countries of South Asia, women of all ages suffer the effects of gender discrimination. Discrimination and neglect are estimated to cause one in six deaths of female infants in Bangladesh, India, and Pakistan. Common forms of discrimination include giving less food to female household members, restricting their access to health services, and imposing more physical work on them. Hence, South Asia has a higher proportion of physical underdevelopment among girls and anemia among pregnant women than does any other region. Many women lack access to health care, especially maternity care, contraceptives, and safe services for abortion management. Only one in three women receives prenatal care or has a trained attendant at delivery. Consequently, the death and disability rates associated with pregnancy and childbirth are high. Sexually transmitted diseases are widespread, and HIV infection is on the rise.

- *Education.* In South Asia, as in Sub-Saharan Africa, the education of girls lags dramatically behind that of boys. Overall, primary school enrollments in these countries grew significantly between 1960 and 1987, increasing from 51 percent to 78 percent. Nevertheless, at the primary level all South Asian countries except Sri Lanka[36] have sharply lower enrollment rates for girls than for boys. In 1987 the difference ranged from 15 percentage points in Bhutan to more than 50 percentage points in Nepal. Furthermore, at the secondary and tertiary levels South Asia has the largest gender gap of any developing region, despite steep increases in female enrollments in the past several decades.[37]

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[32] Disparity exists within the region. For instance, in Chad and the Central African Republic, women constitute less than 10 percent of the students in institutions of higher learning, while in Lesotho, women make up more than 60 percent of such students. In Nigeria school enrollment of girls in the Muslim north is lower than in the rest of the country, whereas in Sudan, school enrollment of girls in the Muslim north is higher than in the Christian and traditional south.

[33] India is prevalently Hindu (about 80 percent) with Muslim, Buddhist, and Christian minorities. Pakistan and Bangladesh are predominantly Muslim. Bhutan, Tibet, and Burma are mainly Buddhist. Nepal is largely Hindu. Sri Lanka is part Buddhist and part Hindu.

[34] But except in Pakistan, GDP growth in the region was slower than the average for low-income countries.

[35] Five of the countries covered in this analysis fall in the low-income group—namely, (ascending order, from US$160 to US$400 per capita GNP 1987) Bangladesh, India, Nepal, Pakistan, and Sri Lanka.

[36] Sri Lanka far surpasses the other four countries in literacy, with 80 percent of the rural population and 90 percent of the urban population able to read as of 1981. Sri Lanka is also an exception in the region not only in primary but also in secondary schooling.

[37] Even so, the absolute gap at the secondary level is actually smaller than it is at the primary level; this is explained by the much lower overall enrollment rates for secondary education.

Table 11. South Asia: Illiteracy Rate, Female (% of females age 15+), 1994

Bangladesh	73.9
Bhutan	71.9
India	62.3
Nepal	86.8[a]
Pakistan	75.6
Sri Lanka	12.8

a. Data 1990.

Source: World Bank Social Indicators of Development (1997). Selected sample, countries by geographical area.

East Asia and Southeast Asia. East Asian and Southeast Asian countries account for more than 30 percent of the world's population. They vary enormously in geographic size and economic development levels.[38] Indeed, developing East Asia[39] --- comprising about a dozen large and small countries (Japan excluded) and a few tiny Pacific islands -- enjoys the highest economic growth rate and the highest level of education of any developing region.[40]

- *Health.* Women's health status is influenced by discriminatory practices such as sex selection in China and the Republic of Korea and female genital mutilation in parts of Indonesia and Malaysia. In certain countries, such as Laos and Cambodia, women's health conditions resemble those of women in South Asia or Africa. In other parts of East Asia and Southeast Asia, women are attaining levels of health, education, and social status typical of middle-income countries. In East Asia, 95 percent of women benefit from trained assistance during delivery, although less than half of all deliveries take place in institutions. Nevertheless, there exist considerable regional differences and urban-rural gaps. Lifestyle and economic status influence disease patterns. For rural women, infectious diseases are a major cause of death, while urban women have higher rates of cardiovascular and cerebrovascular diseases and cervical and breast cancer. East Asia has the highest incidence of cervical cancer among the developing regions. In several countries in the region, adequate maternity care is not widespread, and consequently maternal morbidity and mortality rates remain high (WHO 1991a). The use of contraceptives is relatively high in Indonesia, the Republic of Korea, Malaysia, and Thailand, but in some countries, such as the Philippines, a full range of birth control methods is not available. Increasingly, girls in their early teens are entering prostitution, often by force or because of economic hardship. Not surprisingly, HIV/AIDS is growing more rapidly in Southeast Asia than in any other part of the world (USAID 1991). Smoking and alcohol abuse among women are growing concerns in some parts of East Asia. Part of the blame for this

[38] Namely (in ascending order, from US$290 to US$7,940 per capita GNP 1987), China, Indonesia, Philippines, Thailand, Malaysia, Republic of Korea, Taiwan (China), and Singapore. As a curiosity, Hong Kong – then independent – had a GDP of US$8,070 per capita in 1987.

[39] Includes Cambodia, China (and former Hong Kong), Indonesia, the Republic of Korea, the Democratic Republic of Korea, the Lao People's Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore, Taiwan (China), Thailand, and Viet-Nam.

[40] The two achievements are linked because economic growth is affected by, and in turn affects, the rapid expansion of education.

problem lies with multinational tobacco firms, which increasingly are targeting women with their advertising.

- *Education.* The region has achieved almost universal primary school enrollment. The gender gap in education is less pronounced here than in most of the developing world, and women constitute a larger share of the labor force than in any other developing region. Overall, more than half the adult women in East Asia are literate, and in Korea, the Philippines, and Thailand four out of five women can read. Even so, literacy rates (uneven throughout the region) are substantially lower for women than for men, except in the Philippines. The problem is most acute in China, where nearly half the women are illiterate. Yet this is still much lower than the 70 percent to 80 percent illiteracy rates in neighboring South Asian countries. Throughout the region, illiteracy is higher in rural than in urban areas.

The Middle East and North Africa. The Middle East and North Africa region[41] includes opulent oil exporters such as Kuwait and Saudi Arabia and lower-middle-income countries such as Egypt and Morocco. The economic diversity is extreme: the seven countries included in this review had GNP per capita that ranged from a high of US$14,610 in Kuwait to a low of US$610 in Morocco. Life expectancy varies widely as well, from a low of sixty-one years in Morocco and Egypt to a high of seventy-three years in Kuwait. The countries are predominantly Muslim, but differences exist: Tunisia and Turkey have comparatively liberal laws on women and family matters, whereas Saudi Arabia follows a much stricter interpretation of Islamic laws.

- *Health.* Access to health care is poor. Cultural norms prevent many women from using existing health services. Moreover, female genital mutilation is practiced in some areas. In the Middle East and North Africa, contraceptive prevalence rates are low and fertility rates are among the highest in the world, almost equal to those of Sub-Saharan Africa. High fertility and early childbearing contribute to poor health among women. Women's low status and low literacy levels, as well as their lack of information and data on health issues of concern to them, are major obstacles to improving female health.

- *Education.* The region's economic and cultural diversity is reflected in its educational systems[42] and in its attitudes toward education. As measured by enrollment rates, literacy rates, and years of schooling, the gender gap in education, despite recent gains, is wider in this region than in many other parts of the developing world, with the exception of South Asia. Schools for males are more numerous and of better quality than schools for females. Girls are less likely than boys to enter primary school and are, when enrolled, less likely to complete

[41] Middle Eastern and North African countries are divided by income levels as follows: middle-income countries are (ascending order, from US$610 to US$1,560 per capita GNP 1987) Morocco, Egypt, Tunisia, Turkey, and Jordan; high-income oil exporters (in ascending order, from US$6,200 to US$14,610 per capita GNP 1987) are Saudi Arabia and Kuwait.

[42] The education systems developed at different times. Public education for girls in Egypt dates from the mid-nineteenth century, but in Saudi Arabia it began only in 1960.

the cycle or to continue to secondary school. Primary female school enrollment, on average 41 percent in 1960 and 45 percent in 1987, is nearly universal in Tunisia and Turkey, but more than a third of school age girls do not attend primary school in Morocco and Saudi Arabia.

Overall, female literacy and educational attainment have been lower in the Middle East and North Africa than in Latin America and East Asia. National illiteracy rates for women in the 1980s ranged from about 30 percent to more than 70 percent. The most recent data available suggest that Kuwaiti females have the lowest illiteracy rates, whereas Egyptian and Moroccan women have the highest.

Table 12. The Middle East and North Africa: Illiteracy (% of females age 15+), 1994

Egypt, Arab Republic of	61.2
Jordan	20.6
Kuwait	25.1
Morocco	69
Saudi Arabia	49.8
Tunisia	45.4
Turkey	27.6

Source: World Bank Social Indicators of Development (1997). Selected sample, countries by geographical area.

Latin America and the Caribbean. The population of Latin America and the Caribbean[43] exceeds 400 million and is more than 70 percent urban, reflecting heavy migration into the cities. A growing share of Latin American households is headed by women; estimates range from 15 percent to more than 40 percent for the region as a whole (World Bank 1993). Gender inequities prevail[44] in those countries where poverty is pervasive and in some rural areas where indigenous Indian populations[45] are not integrated because of indigence or language barriers.

[43] Latin American and Caribbean selected countries by income (ascending order, from US$360 to US$3,230 per capita GNP 1989): Haiti, Bolivia, Dominican Republic, Cuba, Honduras, Nicaragua, El Salvador, Guatemala, Paraguay, Ecuador, Colombia, Chile, Peru, Costa Rica, Mexico, Brazil, Uruguay, Panama, Argentina, and Venezuela. The analysis includes The Bahamas, Barbados, Jamaica, and Trinidad and Tobago from the English-speaking Caribbean.

[44] In Haiti, one of the poorest countries in the region, with a per capita GNP of US$360 in 1987, illiteracy rates were close to 63 percent for men and 68 percent for women. In Bolivia, with a large, poor Indian population and a GNP per capita of US$580 in 1987, 29 percent of men and 49 percent of women were illiterate. But in Argentina, which underwent early industrialization and educational expansion and which had a GNP per capita of US$2,390 in 1987, fewer than 6 percent of the population was illiterate, with no significant difference between men and women.

[45] The indigenous population constitutes a large and distinct portion of Latin America's population: it is estimated that about 40 million live in the region (about 10 percent of the total population). To define the term "indigenous" is a difficult task. A report published by the UN's Latin American Demographic Center (*Demographic Bulletin* 50 of 1992) compiled summary statistics on indigenous people from the national census data collected in a number of Latin American countries. There is not one clear definition of what "indigenous" means: definitions differ from country to country due to the use of different survey instruments. In the commonly used approach three different variables -- language spoken, self-perception and geographic concentration -- identify indigenous respondents. Language defines the indigenous population in Bolivia, Honduras, Mexico, Panama, and Peru. In some countries, such as Bolivia, it is possible to distinguish between monolingual and bilingual (Spanish and indigenous language) individuals, while in others, such as Peru, only monolingual indigenous or Spanish speakers can be identified. In most cases, the indigenous population is identified with a single indicator, be it language, identity, or location. The scarce available data come from household surveys.

- *Health.* In many Latin American nations, health services are often inefficient and of poor quality.[46] Fertility is moderately high in most of the countries,[47] and unwanted pregnancy, particularly among adolescents, is a serious problem. Maternal mortality ratios in the region are higher than in other areas of comparable income levels, owing in large part to unsafe abortions. The risk of disease among women is increased by such factors as high rates of smoking, obesity, and anemia, and nearly one-third of the region's women are anemic (PAHO 1993). Violence against women is increasingly recognized as a source of reduced mental and physical well-being. As the proportion of older adults rises, problems such as cardiovascular and cerebrovascular diseases are becoming more significant among women. Breast cancer is increasing, particularly in the higher-income countries, and cervical cancer is on the rise. In general, noncommunicable diseases cause more deaths and disability to women than do communicable diseases and maternal and perinatal causes combined. Nevertheless, sexually transmitted diseases are becoming a concern. Although the AIDS epidemic is still in its early stages, the number of cases among women is projected to rise sharply during the early part of the new century (PAHO 1993).

- *Education.* As a whole, Latin American countries have markedly improved the education of their populations in the past three decades. Since 1960, most of these countries have achieved universal or nearly universal primary education -- with the exception of the lower-income nations (Bolivia, El Salvador, Guatemala,[48] and Haiti) -- and have among the highest enrollment rates in secondary education in the developing world. Nevertheless, in some countries average levels of education are still low and deficiencies still exist.[49]

  In general, women have benefited, and the figures for educational attainment show small gender differences. At the primary, secondary, and tertiary levels,[50] the broadening of women's opportunities has been a consequence of the general expansion of both the education systems and the economies of Latin America. Even so, gender disparities arise in the transition from the formal school system to the labor market.

Table 13. Brazil: Average Number of Years of Schooling, 1960-1995

	1960	1970	1980	1990	1995

[46] Tertiary and higher-level health facilities are overutilized for maternity care, and some countries have abnormally high rates of cesarean section deliveries, which adds to women's health risk.

[47] Fertility rates have declined substantially in all countries in recent decades, yet they remain high in Bolivia, Ecuador, Guatemala, and Honduras, among others. In Chile, Cuba, and Uruguay, however, total fertility rates compare to those in industrial nations.

[48] Overall, 60 percent of Guatemalan women are illiterate, and 80 percent of these are from the country's rural indigenous areas. When families feel they can afford to send a child to school, they send a boy; slightly less than half of all Guatemalan girls do not enroll in elementary school at all. Even among girls in rural Guatemala who do enroll in first grade, 66 percent drop out before reaching third grade. In 1991 some 500 thousand girls between 7 and 15 were estimated to be missing school, compared with only 300 thousand boys.

[49] The gender gap in illiteracy is widest in countries with large indigenous populations and low per capita incomes.

[50] Women are not as well represented at the tertiary level as at the secondary.

Gender					
Male	2.4	2.6	3.9	5.1	5.4
Female	1.9	2.2	3.5	4.9	5.7
Ethnicity					
White	2.7	na	4.5	5.9	na
Black	0.9	na	2.1	3.3	na
Mixed	1.1	na	2.4	3.6	na
Asian	2.9	na	6.4	8.6	na
Area of Brazil					
North / Center-West	2.7	na	4	na	5.6
Northeast	1.1	1.3	2.2	3.3	4.1
Southeast	2.7	3.2	4.4	5.7	6.2
South	2.4	2.7	3.9	5.1	6

Sources: Relatório sobre o Desenvolvimento Humano no Brasil, 1996; PNUD/IPEA, 1996; and Evolução da Educação Básica no Brasil, 1991-1997, Ministério da Educação e do Desporto, Brasília, 1997. Note: Data for 1995 were calculated by MEC/INEP/SEEC.

Eastern Europe and Central Asia.

- *Health.* Women's health status in Eastern Europe and Central Asia is not as good as might be expected given the region's high levels of female education and its reasonably well-developed health care infrastructure. Shortages of drugs and supplies are common, as are outdated health care practices that are not always cost-effective. Although almost all women receive prenatal care, excessive emphasis is placed on diagnostic tests and not enough on counseling and prevention. Abortion, which is legal in many countries in the region, is the most common method of fertility regulation, because contraceptives are largely unavailable; in fact, there are more abortions than live births (World Bank 1994b). The needs of divorced, widowed, and elderly women require greater attention.

- *Education.* On the whole, educational opportunities for women in Eastern Europe and Central Asia are better than in other developing regions. Literacy and school enrollment among girls and women are high and often comparable to levels in industrial countries. The Eastern European and Central Asian economies differ significantly, however, in their individual social economic, political, demographic, and educational characteristics.

4. Health Agenda

The key issues on the health agenda call for preventive policies as well as curative policies, because better health requires both health awareness and health services.

Preventive policies. The countries need to stress the importance of preventive care and must increase the availability and delivery of preventive health services. The need for such services is particularly strong among the young and adolescent because of the large number of at-risk girls. Much disease would be prevented by ensuring increased

availability of information on healthy behaviors -- such as good nutrition, regular exercise, safer sex practices, and postponement of childbearing – and on the dangers of unprotected sex, of tobacco use, and of substance abuse. At the same time, preventive care services should be made easily accessible. Health programs need to give greater attention to the nutritional status of young females. Likewise, it is important to train more female health providers and to conduct community health education campaigns. Intersectorial programs are needed to address early marriage, to promote the use of contraceptive methods, and to increase access to family planning, to maternity care, and to safe services for abortion management. Furthermore, public policies must address the issue of violence against women.

Curative policies. It is essential to expand services for the treatment of sexually transmitted diseases, including HIV infection. Greater attention should be given to the timely detection of pregnancy-related complications More emergency care and improved obstetric attention in clinics would go a long way toward saving lives (Population Reference Bureau 1998). Adequate assistance should be provided to women beyond reproductive age, including, whenever resources permit, the management of cervical and breast cancer (cancer screening and treatment).

Regional health-related priorities. All regions throughout the developing world share widespread health problems, but crucial issues are not the same everywhere.

- *Sub-Saharan Africa.* Requirements for improving women's health in Africa include preventing genital mutilation and promoting special initiatives for adolescents, because of the large number of young females at risk. Great potential exists for improving health through the postponement of sexual activity and childbearing, through use of safer sex practices, and through good nutrition. A special effort has to be made to increase access to family planning, maternity care, and safe services for abortion management. Public policies must address the issue of violence against women. Moreover, it is essential to expand services for the treatment of sexually transmitted diseases, including HIV infections.

- *South Asia*. The key component of an agenda for women's health is to combat the effects of discrimination by expanding access to health care services. It is imperative to train female health care providers and to conduct community education campaigns. Health programs need to give greater attention to the nutritional status of young girls and adolescents, as well as to the detection and prompt referral of pregnancy-related complications. Intersectorial initiatives are needed to address the problems of early marriage and violence against women.

- *East Asia and Southeast Asia.* Priorities for women's health services are likely to vary considerably in this region, depending on the existing health infrastructure and policy. In countries with limited services, health agencies will need to concentrate on expansion and improvement in order to ensure access to maternity care, family planning, and safe abortion services. Most countries need to give additional attention to early prevention of disease among young and adolescent

girls, stressing the dangers of unprotected sex, tobacco use, and substance abuse. Where resources permit, cancer screening and treatment should be provided.

- *The Middle East and North Africa.* The main priority in the region is to increase women's access to health care by better meeting their needs for female health care providers, convenient locations, and information on healthy behavior. Improved maternity care is another pressing need in most countries. Women could also benefit substantially from broader access to contraception and a more ample choice of methods.

- *Latin America and the Caribbean.* The agenda for improving women's health in Latin America includes developing strategies to promote healthy behaviors, such as good nutrition, safer sex practices, and avoidance of smoking and obesity. It is also important to meet the reproductive and sexual health needs of adolescents and to address the problems of unwanted pregnancy and unsafe abortion. Some countries will need to give more attention to specific problem areas such as overuse of high-technology health care facilities, unnecessary medical procedures, HIV/AIDS, violence against women, and inadequate assistance to women beyond reproductive age, including management of cervical and breast cancers.

- *Eastern Europe and Central Asia.* Key initiatives in the women's health agenda for the region include making family-planning information and services more widely available, in order to reduce reliance on abortion. Regional health policy must provide for more training in support of improved clinical practice and must ensure that adequate drugs and supplies are available. It should also increase the emphasis on preventive health care (particularly the avoidance of tobacco and the value of exercise and good nutrition) and address the needs of women beyond reproductive age.

Table 14. Health Agenda

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Preventive and Curative)*	TARGET POPULATION
BIOLOGICAL FACTORS	Iron-deficiency	Menstruation (SSA - SA)	Anemia	Access to iron supplements and encourage a balanced diet	Young girls
	Sexually transmitted diseases (including HIV)	Sexual activity	Cervical Cancer, AIDS (SSA)	Access to contraception and wider choice of methods Expand services for prompt detection of diseases and treatment (SSA) Address HIV/AIDS explicitly (LAC) Address cervical cancer (LAC)	Young girls, adolescents
	Pregnancy and its complications	Early sexual activity (SSA) Early marriage (SA)	Early childbearing (SSA) Uterine prolapse, obstetric fistulae (SSA)	Special initiatives for adolescents: postponement of sexual activity and childbearing, safer sex practices, maternity care (SSA - LAC) Access to contraception and wider choice of methods (MENA) Expand emergency care: detection and prompt referral of pregnancy-related complications (SA) Improve obstetric and maternity care (ESA - MENA) Address early marriage (SA)	Adolescents
			Abortion (EECA) Death from unsafe abortion (LAC)	Family planning; (SSA - ESA - EECA) Safe abortion services (SSA - ESA - LAC)	Adolescents
	Cardiovascular conditions	Menopause (SSA)	Cardiovascular complications		Women over 45, elderly

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Preventive and Curative)*	TARGET POPULATION
SOCIOECONOMIC FACTORS	Nutrition	Poverty Lack of information	Stunt physical growth Obesity (LAC)	Promote good nutrition (SSA – LAC) Greater attention to nutritional status (SA)	Young girls, adolescents
	Domestic violence (physical and sexual abuse)	Unequal power	Unwanted pregnancies Sexually transmitted diseases (incl. HIV) Permanent disability Depression	Inter-sectorial initiatives Address early marriage Address violence explicitly (SSA - SA - LAC)	Young girls, adolescents
	Hazards of indoor cooking	Familial roles	Chronic repercussions	Information policy on dangers of inhalation of smoke and toxic gas and accidental burning	Young girls, adolescents, women, elderly
	Poor access to health services	Familial Roles	Impossibility to attend care	Diminish opportunity cost for time spent in health care	Adolescents, women
		Culture	Restrictions to traveling alone (MENA) Restrictions to be treated by males (SA - MENA)	Train female health providers (SA - MENA) Conduct community education campaigns (SA)	Young girls, adolescents, women, elderly
	Genital mutilation	Culture (SSA)	Immediate: pain, hemorrhage, tetanus. Long-term: scarring, urinary tract infections, complication in urination, menstruation, childbirth	Initiatives for preventing genital mutilation (SSA)	Young girls

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Preventive and Curative)*	TARGET POPULATION
INSTITUTIONAL FACTORS	Biased public policies	Poor policy design Insufficient preventive health Lack of information campaigns Inefficient management of resources (LAC) (EECA)	Poor health performance Unprotected sex (ESA) Tobacco abuse (ESA - LAC)	Redesign targeting: initiatives not only on married with children; assistance to women beyond reproductive age (LAC - EECA) Cancer screening and treatment (ESA) Address breast cancer (LAC) Information on healthy behavior – good nutrition, the value of exercise -and their promotion (MENA - LAC - EECA) Information policies: stress dangers of unprotected sex, tobacco abuse, and substance abuse (ESA - LAC - EECA) Limit overuse of tertiary health care, limit unnecessary medical procedures (some of LAC) Ensure adequate drugs are available (EECA)	Young girls, adolescents, women, elderly
	Poor country development	Poor roads Lack of transportation Inadequate obstetric facilities Lack of infrastructure	Poor access to health Impediment to receiving timely medical treatment	Expansion and improvement of infrastructure to ensure access to emergency care, maternity and obstetric services, family planning and safe abortion (some of ESA) Provide convenient locations (MENA) Provide training to improve clinical practice (EECA)	Young girls, adolescents, women, elderly

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia

5. Education Agenda

Providing education to women benefits not only females but also society as a whole. Educated women wait longer before they get married, tend to have fewer children, and are more likely to obtain prenatal, delivery, and postnatal care -- factors that lead to lower rates of infant[51] and maternal mortality. Therefore, a clear mandate to reach gender equity in education is urgent. The key concerns in the public-policy agenda include increasing female enrollment levels and promoting women's transition from education to the labor market. These goals can be achieved through increased spending and also through special policies.

Increased educational spending. Reforms should include improved infrastructure (mainly the expansion of educational facilities in rural areas) and adoption of school-related strategies such as diversification of school curricula, modification of the school calendar, preschool education, revision of promotion procedures, and improvement of teaching methods. In many cases additional policies are also required, such as providing transportation, lunches, textbooks, and child care and carrying out broad media campaigns. Many of the benefits of educating women in developing countries are public, whereas many of the costs are still private. This situation leads to underinvestment in women's schooling and thus to the persistent gender gap.

Spending should also be gender targeted in order to lower girls' opportunity cost of time spent in acquiring education. The barriers that prevent girls from attending school and from staying enrolled could be removed through parent outreach and through reducing parents' need for their girls to work (inside or outside the home). Training women in skills useful to get a job or to develop profitable activities should reinforce the link between education and access to the labor market.

[51] A study (World Bank 1993) of 25 countries found that an increase of one to three years in a mother's schooling reduced infant mortality in the first year of life by 15 percent. Among fathers, a similar increase in schooling resulted in only a 6 percent reduction in infant mortality rates. The children of women with as little as three to six years of formal education tend to be better nourished, and they are more likely to enroll and stay in school than the children of uneducated mothers.

Table 15. Female Labor Force (% of total)

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994
Sub-Saharan Africa	43.1	43.0	43.1	43.1	43.1	43.0	43.0	43.0	43.1	43.1
South Asia	24.8	24.6	27.6	34.0	34.4	35.0	35.1	35.2	35.4	35.5
East Asia and Southeast Asia	38.1	39.2	40.4	41.7	42.3	42.9	43.0	43.0	43.1	43.1
The Middle East and North Africa	12.0	13.2	16.9	22.8	23.7	24.9	25.3	25.7	26.2	26.6
Latin America and the Caribbean	23.8	25.0	27.2	29.7	31.5	33.4	33.6	33.9	34.2	34.5
Eastern Europe and Central Asia	46.6	47.6	47.8	48.0	47.6	47.2	47.3	47.3	47.3	47.4

Source: Author's calculation based on World Bank Social Indicators of Development, 1997. Averages country-weighted. Selected sample, countries by geographical area.

Special educational policies. Raising female enrollment is not merely a matter of increased spending. Cultural norms across different ethnic groups should be taken into account with the objective of changing parental attitudes toward their children's education. In the case of women's education, strategies for expanding girls' enrollment include not only reserving places for girls, establishing single-sex schools or classrooms, and recruiting more female teachers but also designing school facilities to conform to the cultural standards of the community. In some countries, it may also be necessary to reduce the direct and indirect costs of education in order to persuade parents to send their daughters to school. Scholarships for girls, flexible hours to allow them to complete home chores before or after school, and the provision of child care for younger siblings have proved successful in raising attendance among girls. Projects that improve home technologies and reduce the time required to provide the household with water or fuel have also freed girls to go to school. These measures need to be complemented with policies that encourage community participation.

Regional educational priorities. All regions of the developing world share certain problems in the field of female education, but depending on the region, these problems' individual precedence varies, and the key issues on the agenda are not the same ones.

- *Sub-Saharan Africa.* An increase in female enrollment is likely to result from a given amount of spending in specific policy areas. Apart from expenditure in the usual strategies (such as lunches, textbooks, child care, and broad media campaigns), consideration must be given to removing the barriers that prevent girls from going to school. Gender-targeted strategies -- such as counseling for parents on the importance of their daughters' schooling and distribution of vouchers or cash transfers to cover opportunity costs -- could narrow the educational gap between men and women. The challenges are to diversify the means of financing, to maximize the efficiency and quality of the existing system, and to expand the educational infrastructure.

- *South Asia.* The growth of education delivery has been less impressive here than in other regions, and public spending has been comparatively low. Infant

mortality rates and life expectancy are significantly linked to literacy rates here, and therefore the need clearly exists for greater public intervention in the education sector. It is suggestible either to offer day care centers where girls, in order to attend classes, could drop off younger siblings or to allow girls bring younger siblings into the classroom. Cultural norms across different religions and racial clusters should be carefully taken into account, and didactic materials in students' own language need to be developed. Participation of local communities should be stimulated.

- *East Asia and Southeast Asia.* Variations in social, economic, cultural, political, and historical conditions explain to some extent the differences in levels of female education among this region's countries. Official policies should take such variables into account. Textbooks, curricula, and differentiated teaching methods are relevant but cannot overcome gender inequality. Efforts to form parents' committees and to reduce families' direct costs for schooling could also have a very significant positive effect on female enrollment.

- *The Middle East and North Africa.* Reforms should include not only expansion of educational facilities in rural areas, diversification of curricula, and modernization of teaching methods but also an explicit political and social commitment to the enhancement of gender equity in education, in order to benefit both women and the overall development of the region's societies. To date, no Middle Eastern or North African country has issued policies designed specifically to promote gender equity, such as the affirmative-action policies of the United Kingdom and the United States. In this area, there needs to exist greater coordination among the activities and initiatives f students, parents, teachers, community leaders, and high-level government officials.

- *Latin America and the Caribbean.* Governments have assigned priority to women's issues in broad plans and programs, but they have rarely defined gender-specific strategies and policies for implementation.[52] Among the necessary school-related strategies are improvements to the infrastructure, changes to the school calendar, provision of preschool education, outreach to parents, revision of promotion procedures, and supplying of school lunches and transportation. These measures need to be complemented with policies that change parental attitudes toward their children's education, as well as with efforts to diminish girls' opportunity cost, easing the constraints imposed by the need for girls to work inside or outside the home. Additionally, where needed, [53] it is essential to develop didactic materials in indigenous languages and to hire indigenous women to work as education aides.

[52] Even education projects undertaken by international development agencies have given little consideration to strategies directed to women.

[53] There are approximately 400 different indigenous languages throughout Latin America, and every country has from 7 to 200 languages. In some countries, the indigenous population is substantial; Uruguay is the only country in the continent that is Spanish-monolingual. In many respects, the Latin American indigenous peoples are extraordinarily diverse; they are indeed a multi-ethnic and multilingual population. The scarce available data come from household surveys.

- *Eastern Europe and Central Asia.* In several countries, the educational status of women is becoming worse, and their access to such services as state-subsidized instruction is being threatened. Policy should provide for scholarships to individual students and for the training of government officials, teachers, and parents. Reorganization of the existing resources and implementation of more-efficient policies that require no new resources may accomplish as much as, if not more than, large and expensive new programs. One key action should be the inclusion of women on teams entrusted with planning, monitoring, and evaluation of education projects. The link between education and access to the labor market should be reinforced through the support of income-generating projects for women.

Table 16. Education Agenda

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Increased spending and Special policies)*	TARGET POPULATION
LITERACY	Low literacy rates Gender disparities in literacy attainments	Lack of gender policies Inefficient education delivery Lack of vision and information	High maternal mortality rates High infant mortality rates High number of children Poor childcare Dropout at primary level Low secondary enrollment Low life expectancy	Clear mandate to enhance gender equity (MENA) Training for government officials, teachers and parents (EECA) More public intervention: increase girls' primary enrollment Promote retention and prevent dropout through the sixth grade Encourage preschool education (LAC) Hire indigenous women to work as education aides (LAC) Form parents committees (ESA)	Parents, young girls,

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Increased spending and Special policies)*	TARGET POPULATION
ENROLLMENT	Low enrollment rates (Primary, Secondary, University) Gender disparities in enrollment Urban-rural gap	Poor policy design Lack of financing High opportunity costs Inadequate instruction Lack of infrastructure Inefficient management of resources	Educational gap between men and woman Early marriage Lower access to job-market for women	Define gender-specific strategies to promote equity (e.g. affirmative action) and policies for implementation (MENA - LAC) Expand education infrastructure, particularly in rural areas (SSA - MENA - LAC) Increase expenditure in providing lunches, free textbooks, transportation, arranging for childcare and broad media campaigns (SSA - LAC) Develop didactic materials in students' language (SA - LAC) Diversify school curricula and reform teaching methods (ESA - MENA) Counseling parents on importance of their daughters' schooling (SSA - LAC) Gender-targeted strategies: vouchers or cash transfers to cover opportunity costs (SSA - ESA - LAC) Diversify means of financing (SSA) Take into account cultural norms across different ethnic groups and religions (SA) Encourage participation of local communities (SA) Technical assistance for Education Ministries, NGO's and schools	Parents, young girls, adolescents, women

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

	PROBLEM	MAINLY CAUSED BY	MAIN CONSEQUENCES	SUGGESTED ACTIONS *(Increased spending and Special policies)*	TARGET POPULATION
SCHOOLING	Low schooling Gender disparities in average level of education	High dropout rates Inadequate policy design Inadequate school calendar, promotion procedures, materials and curricula High opportunity costs Lack of transportation	Gender gap in educational attainment Failure in achieving functional literacy Low female labor force	Maximize the efficiency and quality of education system Changes to the school calendar (LAC) Reduce first grade repetition Revision of promotion procedures (LAC) Offer scholarships to individual students (EECA) Lower girls' opportunity costs through parent outreach and by reducing their need to work (LAC) Offer day care centers where girls - while attending class - can drop off younger siblings or let bring them into the class room (SA) Reinforce link between education and access to labor market Coordinate the activities of students, parents, teachers, community leaders and high-level government officials (MENA) Support income-generation projects for women (EECA) Reorganization of resources and more efficient management (LAC - EECA)	Parents, young girls, adolescents, women

Legend: All items are characteristic of all regions, and particularly prevalent (when problems) or needed (when actions) in regions indicated in brackets. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

Conclusions

A man asked his gardener how long it would take for a certain seed to grow into a tree. The gardener said it would take a hundred years. The man replied, "Then plant the seed this morning. There is no time to lose."

--- A favorite John F. Kennedy story

In developing countries the challenge ahead is to invest more in both women's health and education. Moreover, there is an imperative to remodel the delivery systems -- tailoring them in favor of women's needs -- with the final objective of achieving more equity and efficiency. In order to even up opportunities, expanding and improving the quality of social services for women is a worldwide priority.

Improved health care for women. It is a *sine qua non* to increase access of low-income women to health care services, especially maternity care and family planning. It is urgent to prevent violence against females and to control the spread of HIV/AIDS within their number. Furthermore, it is indispensable to publicize the importance of protecting the health of women. Many countries need to strengthen their health care infrastructure if they want to deliver the necessary preventive and clinical services, especially in rural areas.

- *Equity.* Investment in health is fundamental in improving human welfare and reducing poverty (World Bank 1993b). Women are at particularly high risk for certain health problems, largely because of their low socioeconomic status and their reproductive role. Initiatives to improve women's health could save millions of women from unnecessary pain or premature death.

- *Economic development.* Investing in women's health has multiple payoffs: one of them is sustainable economic growth. Good health standards enable women to lead fully productive lives, conferring widespread benefits to the national economy. In particular, women's health has a major impact on the health and productivity of the next generation.

- *Social cohesion.* In addition to improving women's well-being and productivity, such investments yield significant benefits for families, communities, and society as a whole. To reach women effectively, health systems must take into account the biological, cultural, socioeconomic (such as age at marriage), and psychological (such as depression arising from gender violence) factors that increase the risks to their health.

Improved education for women. The same is true in education. The educational performance of women is still inadequate even though large investment in the field has achieved some progress. The expansion of education has not reached all members of society equally, and in many cases the type of instruction offered is inappropriate for women. Furthermore, the quality of schooling has been lower than expected.

- *Equity.* At the moment, many women are excluded from the delivery of education. Educating girls offers the best hope of breaking the cycle of female hardship. Moreover, instruction is one of the main ways of equalizing opportunities in later adult life: it enables people to take change into their own hands. Education would provide women with the ability to shape their future. In addition, schooling means lower child and maternal mortality rates and reduced fertility rates.

- *Economic development.* Education is a means of both training and allocating the future workforce. While acquiring knowledge, women would develop the skills and self-confidence that would allow them to gain employment. Moreover, education for girls has an important effect on every dimension of development -- increased educational attainment for their daughters and sons, higher productivity, and improved environmental management. Together, these can mean faster economic growth and, equally important, wider distribution of the fruits of this growth.

- *Social cohesion.* Educating girls opens the door to economic and political opportunity for future generations. When schools open their doors wider to include girls and women as well as boys and men, the benefits multiply. Educated women can have a higher impact than educated men on the development and well-being of their societies because of their multiple roles in the marketplace, the community, and the home. In addition, education builds human capital and propitiates the conditions for social stability: educated women tend to be more active and more effective participants in local governments, particularly in issues involving social services.

Policy integration. It is necessary to integrate the two policy areas -- the health-related and the education-related. Over the long term, broader efforts (particularly toward increasing female education) will help reduce many of the detriments to women's health, and society will gain as a whole. For instance, education lowers the risk of birth-related health problems for both infants and mothers.

The improvement of women's health and educational status is one of the most cost-effective investments available to developing countries. Redirecting public spending through highly cost-effective interventions will improve overall allocative efficiency.

Appendix

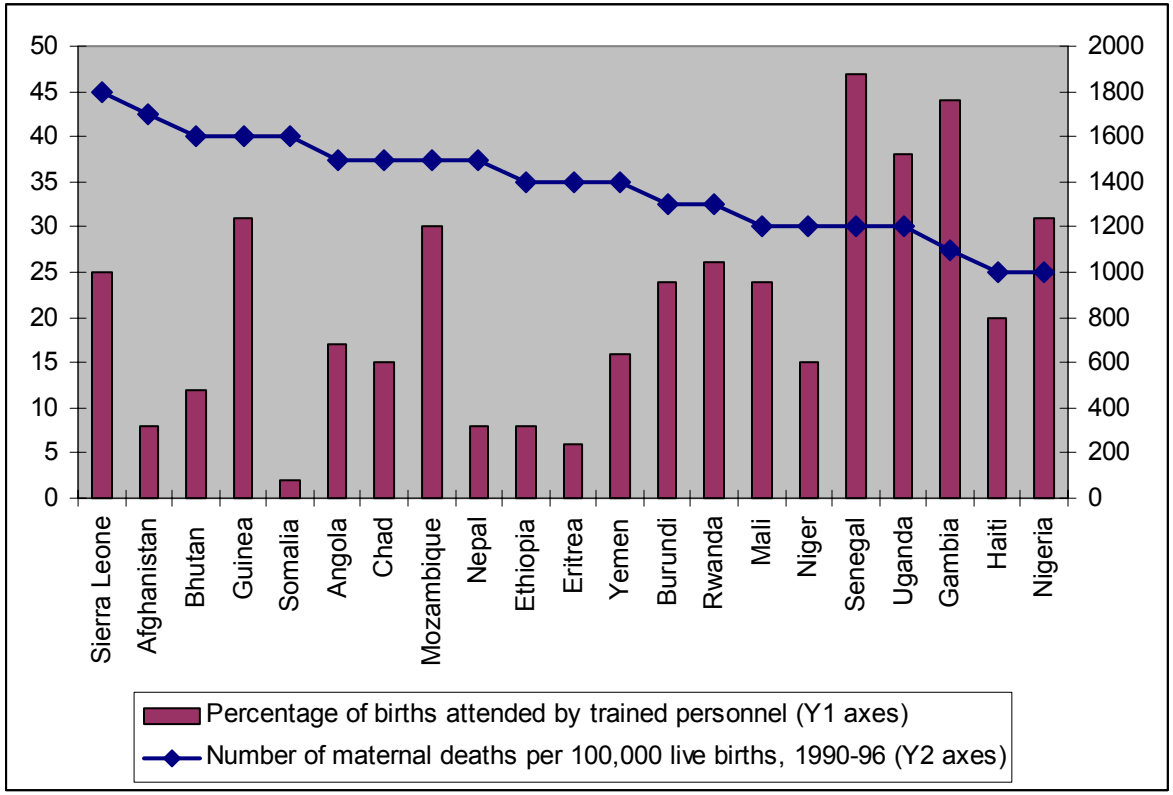
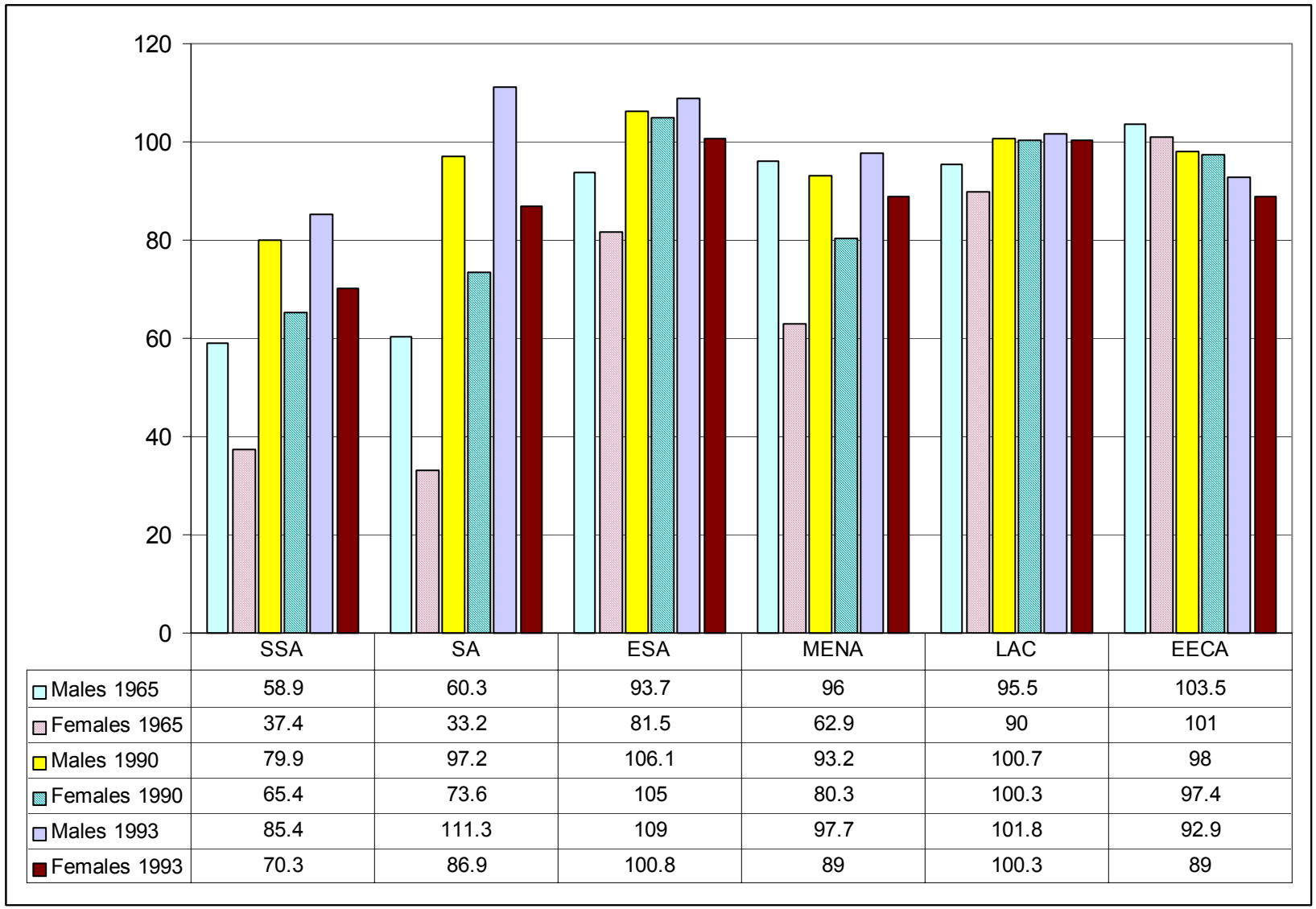


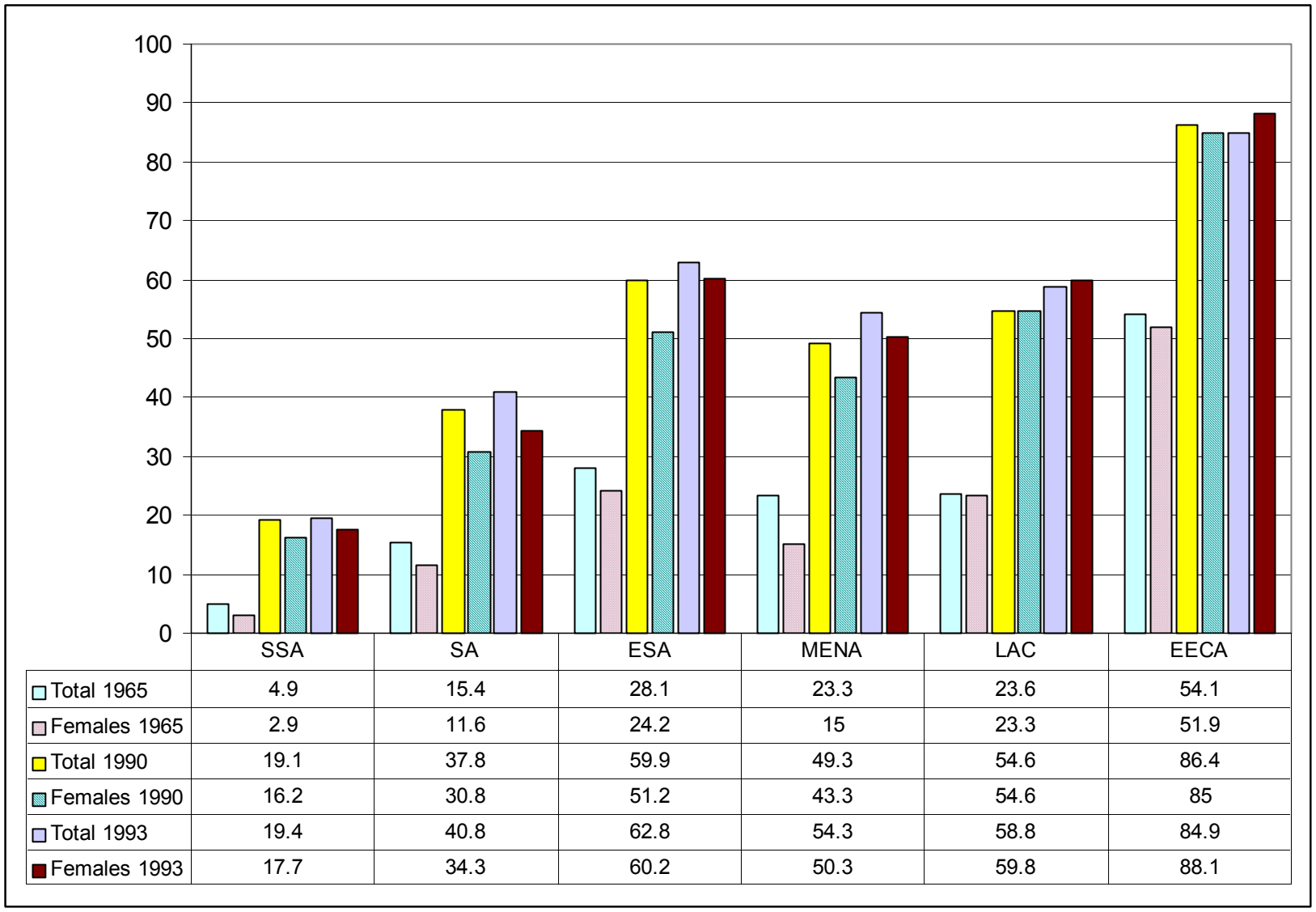
Figure 1 Nations with the highest maternal mortality ratio (descending order), and births attended by trained personnel.

Note as a reference: maternal mortality ratios in industrialized countries range from 3 to 11 per 100,000 live births and the rate of professionals attending births is close to 100%.

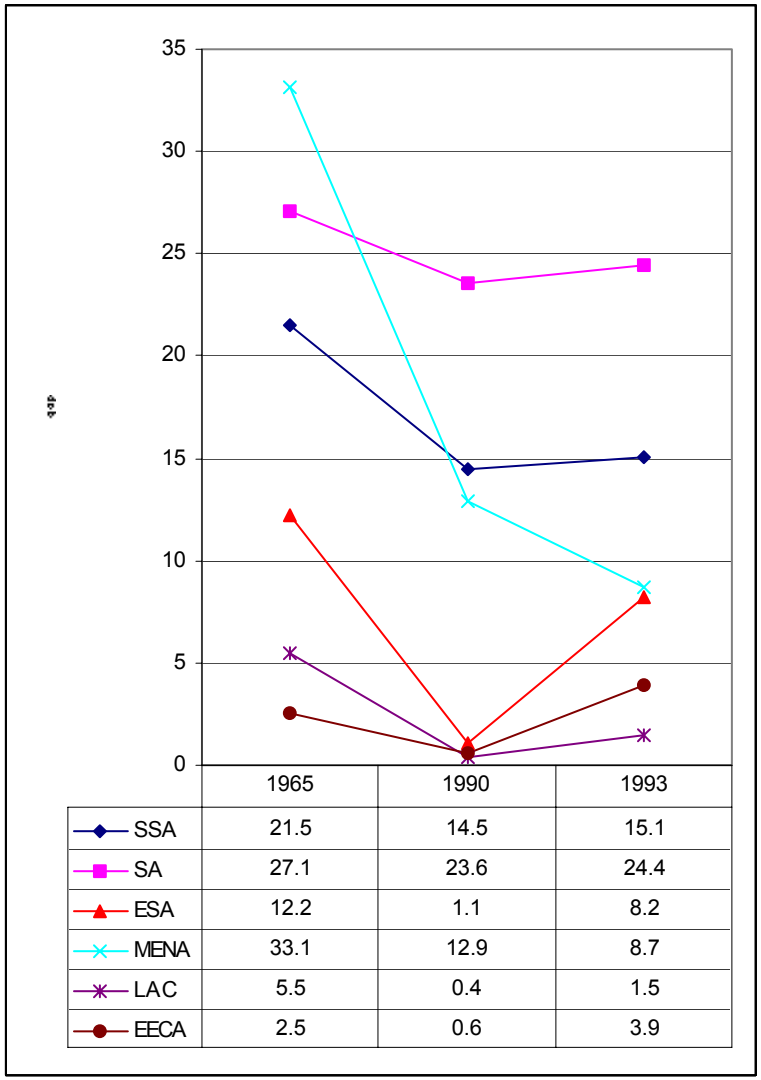
Source: Population Reference Bureau, 1998.



	SSA	SA	ESA	MENA	LAC	EECA
Males 1965	58.9	60.3	93.7	96	95.5	103.5
Females 1965	37.4	33.2	81.5	62.9	90	101
Males 1990	79.9	97.2	106.1	93.2	100.7	98
Females 1990	65.4	73.6	105	80.3	100.3	97.4
Males 1993	85.4	111.3	109	97.7	101.8	92.9
Females 1993	70.3	86.9	100.8	89	100.3	89

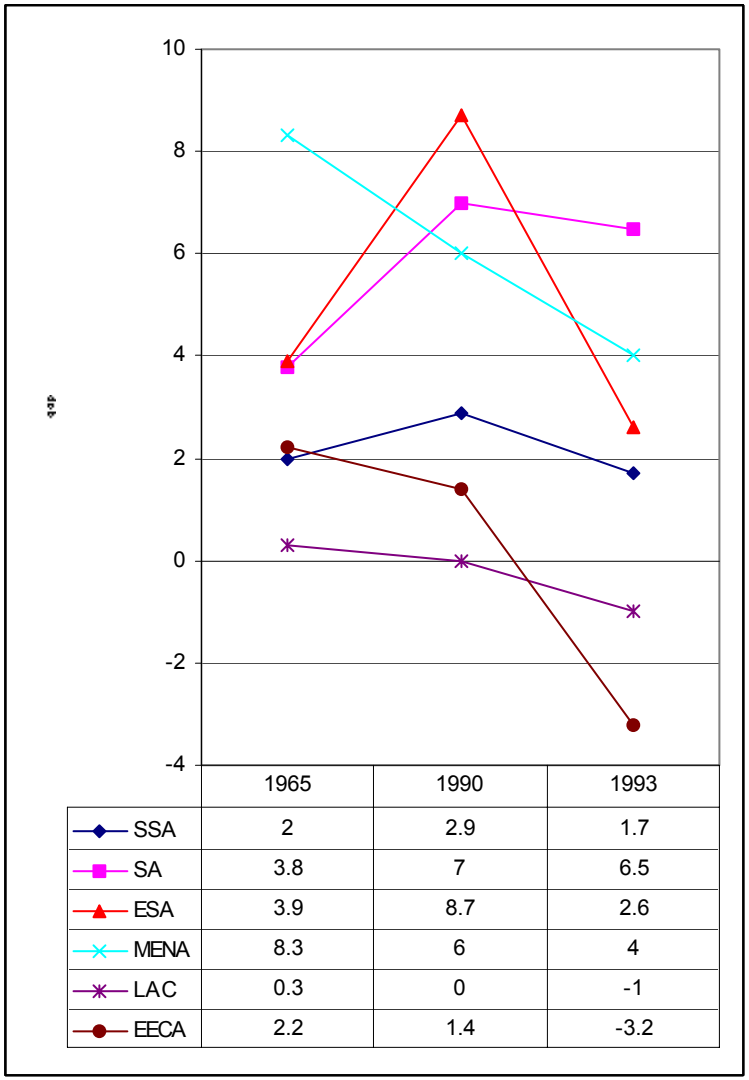


	SSA	SA	ESA	MENA	LAC	EECA
Total 1965	4.9	15.4	28.1	23.3	23.6	54.1
Females 1965	2.9	11.6	24.2	15	23.3	51.9
Total 1990	19.1	37.8	59.9	49.3	54.6	86.4
Females 1990	16.2	30.8	51.2	43.3	54.6	85
Total 1993	19.4	40.8	62.8	54.3	58.8	84.9
Females 1993	17.7	34.3	60.2	50.3	59.8	88.1



	1965	1990	1993
SSA	21.5	14.5	15.1
SA	27.1	23.6	24.4
ESA	12.2	1.1	8.2
MENA	33.1	12.9	8.7
LAC	5.5	0.4	1.5
EECA	2.5	0.6	3.9

Figure 4 Women's Gap in Primary, Average of Gross Enrollment Ratio (% of school population). Source: Author's calculation based on World Bank Social Indicators of Development, 1997. Averages Country Weighted. Selected sample, countries by geographical area. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia. **Note:** EECA Males 1993 is a 1992 datum.



	1965	1990	1993
SSA	2	2.9	1.7
SA	3.8	7	6.5
ESA	3.9	8.7	2.6
MENA	8.3	6	4
LAC	0.3	0	-1
EECA	2.2	1.4	-3.2

Figure 5 Women's Gap in Secondary, Average of Gross Enrollment Ratio (% of school population). Source: Author's calculation based on World Bank Social Indicators of Development, 1997. Averages Country Weighted. Selected sample, countries by geographical area. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia. **Note:** LAC Total 1993 and Females 1993 are 1992 data.

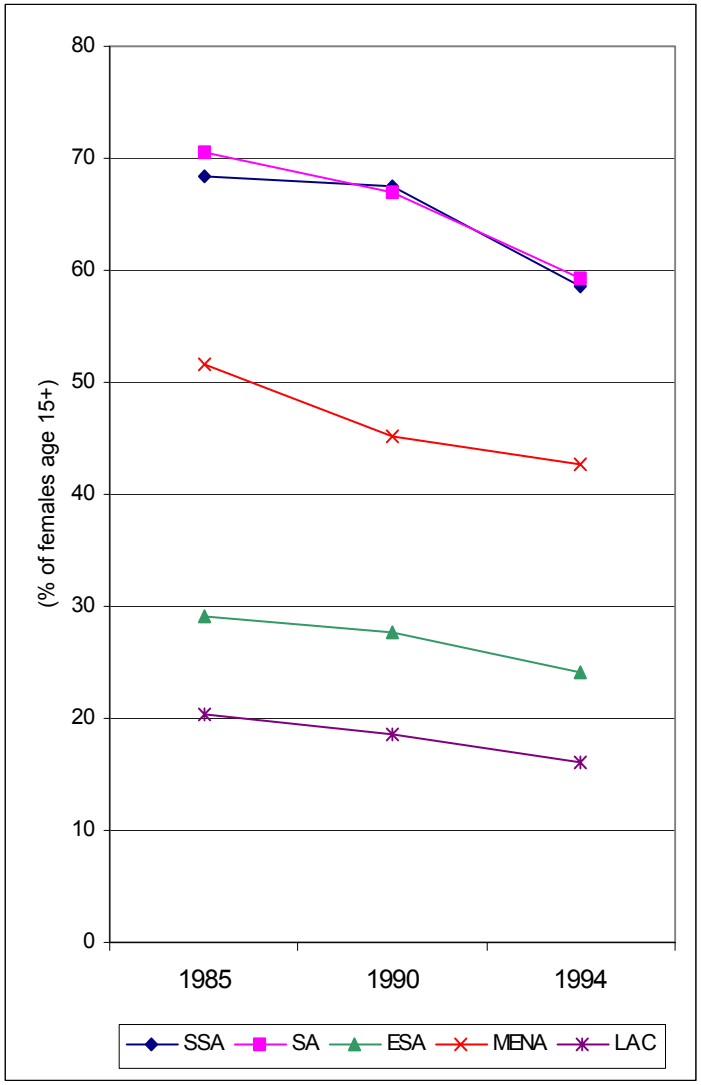


Figure 5 Female Illiteracy Rate, (% of females age 15+). Source: Author's calculation based on World Bank Social Indicators of Development, 1997. Averages Country Weighted. Selected sample, countries by geographical area. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean.

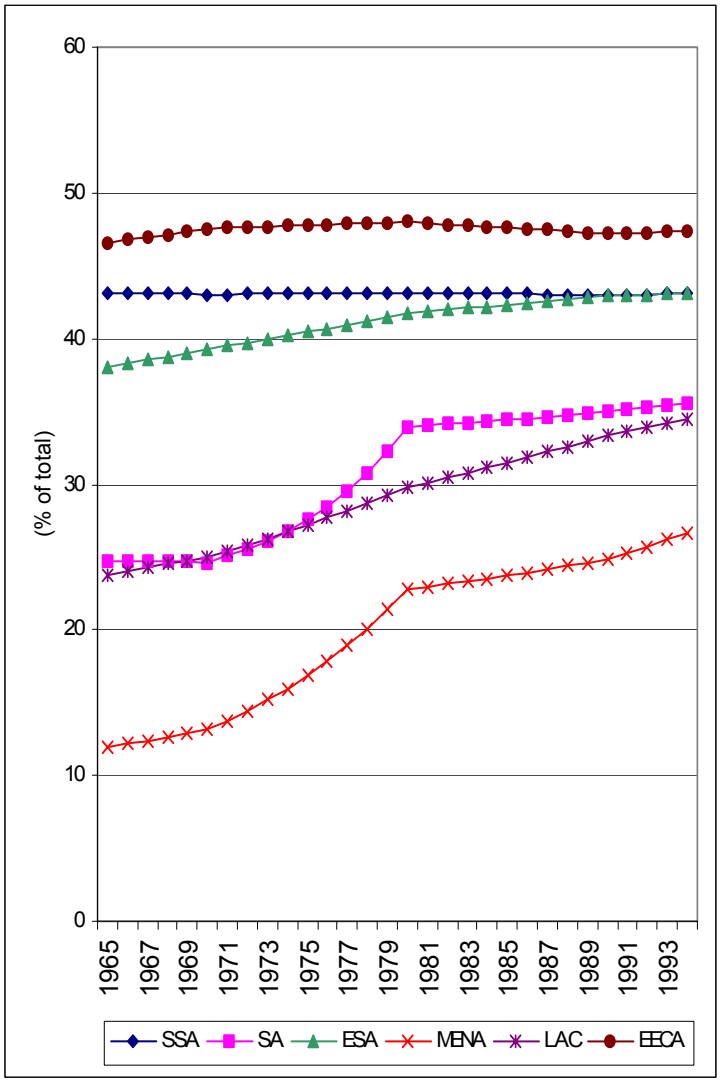


Figure 6 Female Labor Force (% of total). Source: Author's calculation based on World Bank Social Indicators of Development, 1997. Averages Country Weighted. Selected sample, countries by geographical area. Acronyms: (SSA), Sub-Saharan Africa; (SA), South Asia; (ESA), East and Southeast Asia; (MENA), The Middle East and North Africa; (LAC), Latin America and the Caribbean; (EECA), Eastern Europe and Central Asia.

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