

## New Population Policies: Advancing Women's Health and Rights

by *Lori S. Ashford*

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*New population policies address social development beyond family planning.*

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*Women's status is deemed central to population and development concerns.*

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*Greater civic participation is shaping new policies.*

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# New Population Policies: Advancing Women's Health and Rights

*by Lori S. Ashford*

Policies that address population issues touch on the most sensitive aspects of people's lives: sexuality, childbearing, and family relationships. Seeking an international consensus on population policies has often been a contentious process. The early 1990s marked a dramatic departure from conventional ideas about how governments should try to influence the size and well-being of the societies they govern, and brought an unparalleled consensus among national governments about population policy. This new perspective shifted the emphasis of population policies away from slowing population growth to improving the lives of individuals, particularly women. The policies spawned by this consensus continue to evolve.

The old focus on restraining population growth grew out of widespread concern that the unprecedented pace and volume of population growth after 1950 was a serious threat to economic development, public health, and the environment. Many governments supported family planning programs to reduce their birth rate and slow population growth. But national policies intent on "population control" met with increasing resistance and diminishing support by the mid-1990s. Women's health advocates in particular saw (and still see) these policies as infringing on women's basic rights to decide whether and when to have children.

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*Mexico is among the countries that have adopted a more comprehensive approach to population issues—which may improve the health and well-being of young Mexicans.*

A turning point in international discussions on population was the 1994 International Conference on Population and Development (ICPD), held in Cairo. The Cairo conference enlarged the scope of earlier population policies: Governments agreed that population policies should address social development beyond family planning, especially the advancement of women, and that family planning should be provided in the context of reproductive health care. This care includes ensuring healthy and safe childbearing; preventing sexually transmitted infections, including HIV/AIDS; and

addressing other factors that contribute to poor health, such as sexual trafficking and violence against women. Underlying this new emphasis was a belief that enhancing individual health and rights would ultimately lower fertility and slow population growth.

Many countries have attempted to implement the recommendations of the Cairo conference, although progress has been uneven. In many low-income countries, addressing such a wide range of health and social concerns requires greater resources and organizational capacity than are currently available. Also, funding from donor agencies to support these changes has fallen below expectations. In spite of these obstacles, a large number of countries have redefined policy and program objectives and adopted approaches that aim to meet individual needs rather than national demographic goals. The world's two most populous countries, India and China, embarked on new initiatives that reoriented their national family planning programs in the second half of the 1990s.

Debates continue about the importance of controlling population growth and whether the entire Cairo agenda is feasible. Because large numbers of young people are in or approaching their childbearing ages, world population will continue to grow well into the 21st century. Governments may differ in their thinking about whether and how to curb population growth, but a broad international consensus exists—along with a well-organized advocacy community—that calls for population policies that protect and enhance individual rights.

This *Population Bulletin* reviews the evolution of national population policies, particularly following the historic 1994 Cairo conference. It describes the new focus on improving reproductive health and women's rights and how governments have tried to incorporate this new approach in their policies and programs. The *Bulletin* also looks at possible new directions for population policies.

## Evolution of Population Policies

Population policies are government actions—laws, regulations, programs—that try to influence the three agents of population change (births, deaths, and migration) as a way to promote social and economic development. The stated intent of these policies often is to improve the quality of life, consistent with the available resources in a country. During the second half of the 20th century, a large number of countries developed policies that focused on slowing the unprecedented pace of population growth. By the dawn of the 21st century, most countries had changed their policies to correspond to new perceptions about population and the appropriate solutions for population problems.

International meetings on population provide a useful guide to how governments (and more recently, institutions outside government) view population issues. These meetings began on a small scale in the late 19th century and have convened roughly every 10 years since 1954, mainly under the auspices of the United Nations (UN). Since 1974, these international meetings have produced formal consensus agreements, which do not set national policies but reflect current thinking and attempt to guide national policies (see Box 1).

The UN held its first meetings on global population in 1954 and 1965, in collaboration with the International Union for the Scientific Study of Population. During this period, a growing number of scientists became concerned about the negative consequences of rapid population growth. In less developed regions, the introduction of modern medicine and increased access to health services helped bring down death rates sharply after 1950, but birth rates remained high. The result was the most rapid expansion of population in human history, sometimes called the “population explosion.” World

## What Purposes Do UN Conferences Serve?

When the UN convenes an international conference on population, the environment, or social development, governments are called on to consider policies on long-term issues that might otherwise receive little attention in their national agendas. Unlike the economy, national security, or natural disasters, effects of population trends may not be felt for many years, so national leaders focused on current problems tend to delay consideration of these trends. In addition, national governments are less likely to consider global issues unless they are in an international forum. UN meetings focus on global issues and sometimes generate mass media coverage and widespread public attention.

UN conferences are complex processes that span months and even years. Government representatives attend numerous formal and informal meetings to draft and review documents that represent a consensus among the nations involved. Delegates may attend a series of official preparatory committee meetings, or “prep-coms,” before the conference where national leaders formally adopt a consensus agreement. The population agreements forged in recent decades are not signed or ratified, and therefore are not enforceable under any country’s laws. They are nevertheless important for several reasons.

A UN conference document—sometimes called a platform, program, or plan of action—represents a common policy statement among all the nations that participate in the process.

As an “expression of the world’s conscience,” as the UN calls it, a consensus agreement can be a powerful tool for promoting change. It serves as a reference document or guidepost for professionals working on national policies and programs, both inside and outside of government. The document’s wording is critical because it is translated and quoted in scores of national and local planning documents around the world, as well as in training programs for practitioners.

Conference agreements can be a catalyst for national action in several ways:

- They can influence government policies through the international “peer pressure” that arises from the document drafting and review process.
- Advocates can use the documents to put pressure on governments and legislatures to fund or approve actions that would otherwise languish on the national policy agenda.
- The goals and benchmarks contained in the documents can serve as tools for monitoring national progress and encouraging greater action.
- The documents can be used to solicit donor agencies for more funds.

Also, advocates working on culturally or politically sensitive issues, such as adolescent sexuality or abortion, can refer to international agreements for standard, widely accepted approaches to deal with the issues, thereby helping to defuse local controversy.

population grew from 2.5 billion in 1950 to 3.7 billion by 1970, and the pace appeared to be accelerating (see Box 2, page 6). The early UN meetings warned that rapid population growth could exacerbate poverty and hinder development in countries with limited resources.

The earliest population policies and programs were developed during this period. Most attempted to slow population growth by encouraging

couples to have fewer children and providing access to family planning services. India initiated a national policy to slow population growth in 1952, and stepped up efforts to promote family planning after a famine struck many parts of the country in the mid-1960s.<sup>1</sup> The International Planned Parenthood Federation (IPPF), the largest private-sector organization devoted to family planning, was also founded in 1952.

## Is the 'Population Explosion' Over?

Recent international debates about population policy have downplayed the significance of world population growth, even though the population is still growing rapidly in many parts of the world. The earliest population policies were propelled primarily by fears that rapid population growth would hinder socioeconomic progress. These concerns surfaced during a period of unprecedented population growth that began in the 1950s in less developed countries—setting off what was often referred to as the “population explosion.” In these countries, the availability of modern health care, improved nutrition, and expanded transportation networks, among other factors, contributed to rapid declines in mortality. Fertility remained relatively high. As births outnumbered deaths by ever-larger margins, the population of less developed countries shot up from 1.7 billion in 1950 to 4.9 billion in 2000. The population in more developed countries rose from 0.8 billion to 1.2 billion over the same period. While the total for more developed countries is expected to fall slightly by 2050, the number is still rising for less developed countries and is projected to exceed 8 billion by 2050. World population will rise from 6 billion in 2000 to 9 billion by 2050 (see figure).

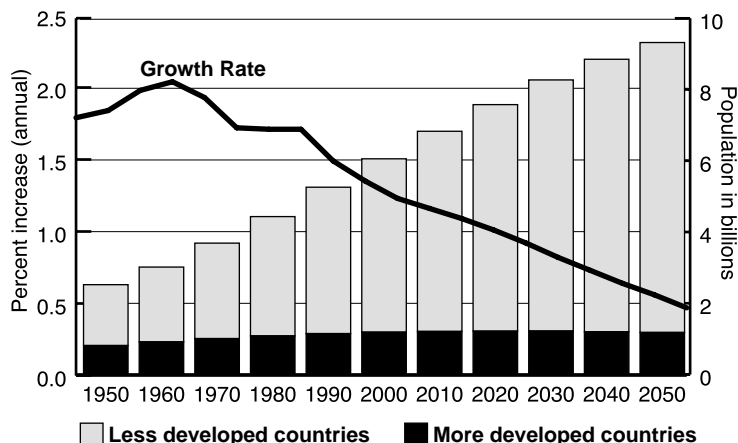
The world population growth rate peaked in the 1960s, then began a slow descent as fertility levels declined in many world regions. Between the 1960s and 1990s, social and economic advances reinforced the idea that couples could control their family size, and that smaller families were preferable. Expanding education and job opportunities for women encouraged later marriage and delayed childbearing—which also slowed the pace of population growth.

Population policies and family planning programs were important contributors to the widespread fertility declines. These programs fostered greater access to modern contraceptives and enabled couples to control the timing of their childbearing more effectively than ever before.

Some countries in East and Southeast Asia and in Latin America experienced robust economic development during this period. Governments in some of the largest countries—including China, Indonesia, Thailand, and Mexico—also had explicit policies to lower population growth by promoting smaller families. Fertility dropped rapidly in many of these countries.

The marked declines in fertility in some countries in Asia and Latin America, as well as in more developed coun-

**World Population and Population Growth Rate, 1950–2050**



Source: United Nations, *World Population Prospects: The 2000 Revision* (forthcoming 2001).



tries, have led some observers to declare that “the population explosion is over.”<sup>1</sup> But there are two parallel worlds: one world in which fertility is low and declining as economic development advances, and another world where fertility remains high and where much of the population is mired in poverty.

U.S. couples average about two children each—the number required to just replace each couple in the population and avoid long-term population growth. Most industrialized societies now have an average of less than two children per couple and some countries are headed for population decline. Some of the larger less developed countries—China, South Korea, Thailand, and Brazil, for example—also have fertility rates close to or below the two-child average. In the 1990s, the UN twice revised population growth projections downward to take into account unexpectedly rapid declines in fertility in several regions. This slowing of growth has contributed to commentary that “too few babies is emerging as a bigger worry in many countries—not all of them rich ones—than too many.”<sup>2</sup>

This perspective ignores the “second world” of population made up of countries in sub-Saharan Africa, South Asia, and elsewhere, where fertility (and mortality) are still relatively high. It also overlooks the effect of population momentum. Decades of rapid growth mean that there are now more young men and women of childbearing age than ever before; just behind them is another large generation of children who will enter childbearing age in the next decade. This huge generation of young people provides the momentum for continued population growth well into the 21st century, even though couples are likely to have fewer children than in earlier generations. The world’s population reached 6 billion in 1999 and could exceed 9 billion by 2050, assuming that the average family size

falls from 2.8 children per woman today to 2.1 by 2050.

The population will eventually stop growing if fertility falls to a two-child average worldwide (“replacement-level fertility”). Births would balance out deaths, yielding a stable population size. But reaching replacement-level fertility will require widespread access to family planning and major social transformations in some countries. In the poorest regions, women have five to six children on average. In India—the world’s second-largest country—fertility fell substantially over the past few decades, but remains well above replacement at 3.2 children per couple. Even after countries reach replacement level, population momentum ensures future growth. China, for example, has had a two-child average or less for about a decade, yet the momentum provided by the age structure means that 11 million more people were born than died each year in the 1990s. At current fertility levels, China’s population will continue to grow until about 2030, according to UN projections.

When media stories alternate between “the population explosion” and “birth dearth,” the public is likely to be confused and policymakers may question the need for population policies and programs. Recent UN conferences have sidestepped the issue of rapid population growth (and population momentum), framing the issue instead as that of enhancing individual health and well-being. A lingering question is whether policymakers will invest the sums required to improve individual health and well-being whether or not they perceive a population crisis.

#### References

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2. “The Empty Nursery,” *The Economist*, Dec. 23, 2000. Accessed online at: [www.economist.com](http://www.economist.com), on Jan. 26, 2001.

In the mid-1960s, the United States, Sweden, and several other industrialized countries launched large-scale aid programs to support national family planning efforts in less developed countries. The United States became—and still is—the largest single donor of population assistance. In 1969, the UN created the United Nations Population Fund (UNFPA), whose mission included the promotion of national family planning programs. From this time onward, “population programs” and “family planning programs” became almost synonymous.

### **Waxing and Waning Support**

Among the first critics of these programs were the very countries that received international population assistance. The idea that couples should limit their family size went against cultural values in many societies. Many governments in less developed countries were reluctant to promote family planning even if they were worried about rapid population growth. Some instead embraced the idea that fertility would fall and population growth would slow as living standards rose through economic development. At the 1974 UN World Population Conference, an Indian delegate expressed the views of leaders of many less developed countries when he declared that “development is the best contraceptive.”

During the late 1970s and the 1980s, attitudes began to change in many less developed countries. Government leaders grew increasingly concerned that their rapid population growth would interfere with economic development. An increasing number of countries accepted the idea that government actions could slow population growth, and they adopted national population policies to that end. An important factor contributing to this change in attitude was a growing body of data and research for less developed countries that showed high rates of population

growth, high rates of infant and maternal death, and a widespread desire by women to limit childbearing. By 1994, more than one-half of less developed countries had national population policies to slow growth.<sup>2</sup>

Criticism of population programs surfaced on many fronts. In the United States during the 1980s, the most serious challenge came from antiabortion activists, who linked family planning with abortion and opposed support for international family planning programs. In addition, conservative economists in President Ronald Reagan’s administration argued that governments should not try to curb population growth to promote economic development; government should instead allow free markets to work. These economists asserted that economic growth and technological innovations would bring about prosperity and overcome the resource limitations faced by growing populations.

At the 1984 World Population Conference in Mexico City, the U.S. government upset conference proceedings by announcing that it would withdraw funding from any organization that provided abortion services or counseling—even with funding from non-U.S. government sources. This restriction became known as the Mexico City Policy.

Most other governments at the conference reaffirmed the need for and effectiveness of family planning programs to slow population growth and to promote health. The formal declaration produced at the Mexico City conference called on governments “as a matter of urgency” to make family planning services “universally available.” UN planners, who had worked for years to increase awareness of demographic problems, regarded this consensus as a major achievement, in spite of the U.S. position.<sup>3</sup>

While governments in less developed countries were embracing population policies, and family planning in particular, women’s health and rights advocates became increasingly critical of population policies

and family planning programs in less developed countries.

The women's groups asserted that government-funded programs were distributing contraceptives with little regard for the health of women who used them. Especially in Asia, where governments are the largest providers of services, family planning programs were administered and evaluated based on targets and quotas for "family planning acceptors"—women or couples recruited by health workers to adopt a contraceptive method.

Women's rights advocates in more developed and less developed regions joined together to oppose top-down, target-driven approaches to slowing population growth. They maintained that these approaches promote coercion and violate women's right to reproductive freedom. Programs run according to targets and quotas, the groups argued, tend to emphasize numerical goals at the expense of service quality and women's reproductive choices.

Women's rights advocates also argued that the focus of many family planning programs—delivering contraceptives and related information—was too narrow. They asserted that family planning programs would be more effective if they took into account the social and cultural context surrounding sexual relations, childbearing, and the use of contraceptives.

## **The 1994 Cairo Conference**

When the UN brought together national leaders in Cairo for the International Conference on Population and Development in September 1994, sharp ideological disagreements divided participants on some issues, while a surprising consensus united them on other issues. Two years of difficult and unprecedented negotiations had preceded the ICPD; work to produce a meaningful agreement continued at a feverish pace during the conference. Women's health advocates within and outside national delegations argued strongly for incor-

porating the concepts of reproductive health and rights in the conference document. These terms had never been defined in an international context and negotiating a definition acceptable to all parties was difficult (see page 11 and Appendix, page 40). The Vatican and a small number of Catholic and Muslim countries took issue with how reproductive health and reproductive rights were defined. A central sticking point was whether abortion could be interpreted as a component of reproductive health to which women would have a universal right. The abortion debate brought wide media coverage to the ICPD, even though the conference addressed far more than women's reproductive health.

As the conference ended, the 180 nations that met in Cairo agreed to a new approach to population issues. The 20-year Programme of Action adopted at the conference enlarged the scope of earlier population policies. It avoided mention of specific population targets, but called on governments to take action in many areas to promote human development and to stabilize population growth. The program called for investments to improve individuals' health, education, and rights—particularly for women—and for family planning services to be provided in the context of comprehensive reproductive health care.

This landmark conference is credited with "reframing" population discussions. The heart of the new agenda is that responding to individual needs is a more humane and effective way to slow population growth than the old model that focused on family planning use. By placing the causes and effects of rapid population growth in the context of human development and social progress, governments and individuals of all political, religious, and cultural backgrounds could support the recommendations. Although there were ideological and religious differences over issues such as definitions of reproductive health, adolescent sexuality, and abortion, all

*The Cairo Programme of Action enlarged the scope of earlier population policies.*

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*The new population policies call for incorporating family planning and other reproductive health services into basic health care.*

but a few nations fully endorsed the final program.

Cairo's Programme of Action is ambitious: It contains more than 200 recommendations in the areas of health, development, and social welfare. A central feature is the recommendation to provide comprehensive reproductive health care, which includes family planning, safe pregnancy and delivery services, abortion where legal, prevention and treatment of sexually transmitted infections (including HIV/AIDS), information and counseling on sexuality, and elimination of harmful practices against women (such as genital cutting and forced marriage).

### **Factors Influencing the Cairo Consensus**

The Cairo conference was far larger and more inclusive than earlier world population conferences. It brought together 11,000 representatives from governments, nongovernmental organizations (NGOs), and international agencies, and citizen activists. The diversity of views contributed to the unprecedented international consensus achieved in 1994.

**Broad NGO participation.** The ICPD's emphasis on women's health and rights was driven, in part, by the

active participation of more than 1,200 NGOs. Previous international meetings involved a small number of NGOs in a limited capacity; the 1984 Mexico City population conference involved only 139 NGOs as observers, for example. In Cairo, NGO representatives participated as delegates or observers and worked closely with governments to craft the Programme of Action. For the first time, a wide range of interests—from the grassroots level to the highest levels of government—informed conference deliberations.

**The influence of women's networks.** By 1994, women's groups had emerged as a well-organized and potent force in UN meetings. Some women's groups began building active networks years in advance of the Cairo conference. They developed and distributed information materials that governments and NGOs used in preparing for the conference. A women's caucus that included more than 400 organizations from 62 countries lobbied delegates daily during the Cairo conference proceedings. The women's groups' consistent pressure on delegations was largely responsible for the strong language in the Cairo document promoting women's health, rights, and opportunities.<sup>4</sup>

**High-level leadership.** The head of the UNFPA, Nafis Sadik, worked tirelessly with governments and NGOs around the world to frame the population debate in terms of women's health and rights. President Clinton's administration strongly supported the Cairo program. The U.S. State Department and Agency for International Development (USAID) worked closely with women's groups and other NGOs in developing official positions and lobbied other governments to support the emerging consensus.

**Emphasis on human rights.** The UN has sponsored a number of treaties and conventions that provide a legal foundation for guaranteeing individual rights to freedom, privacy, and dignity. These conventions also called for equal rights for men and

women and for government action to end all forms of discrimination. The 1993 World Conference on Human Rights (held in Vienna) emphasized that the rights of women and girls are an integral part of human rights and stated that women should enjoy the highest standards of physical and mental health throughout their lives. Building on this history, the Cairo conference defined reproductive and sexual health as among these universally recognized rights.

**Reinforcement in subsequent conferences.** Other UN meetings in the 1990s helped solidify support for the Cairo consensus. These included the 1995 World Summit for Social Development in Copenhagen and the 1995 Fourth World Conference on Women in Beijing. Many of the same women's networks that had been prominent at Cairo were actively involved in shaping the agenda and ensuring the adoption of similar language on reproductive health and rights at these conferences.

### **Five-Year Review of Cairo**

Five years after the Cairo conference, in 1999, the UN once again brought together world governments for a series of meetings to discuss population and development policies. The review, nicknamed ICPD+5, or Cairo+5, involved a series of meetings that culminated in a UN General Assembly session in June 1999. This session focused on the key actions needed to reach the goals set out in 1994.

Many of the issues that were contentious at the Cairo conference, such as adolescent sexuality and abortion, also generated controversy during the five-year review. Once again, however, delegations overcame political, cultural, and religious differences and reached a consensus. The review ended with the adoption of a document of "Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development." This document includes new benchmarks for 2015 that sharpen the focus of the 1994 goals.

The review process uncovered a host of examples around the world of how new policy and program approaches have worked, as well as examples of obstacles encountered in implementing the program. The review process reinforced two important principles: that women's health and rights are central to population and development policies; and that nongovernmental actors play a critical role in local, national, and international deliberations on population issues.

## **Improving Reproductive Health**

Reproductive health is a relatively new concept in global discussions on population. During the 1990s, the term was widely adopted around the world, both as a description of a specific set of health concerns and as an overall approach to thinking about population issues.

### **Defining the Agenda**

The Cairo Programme of Action defined reproductive health for the first time in an international policy document. The definition states that "reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system ... ." It says that reproductive health care should enhance individual rights, including the "right to decide freely and responsibly" the number and spacing of one's children, and the right to a "satisfying and safe sex life." (See Appendix, page 40, for complete definition.) This definition goes beyond traditional notions of health care as preventing illness and death, and it promotes a more holistic vision of a healthy individual.

Reproductive health takes into account notions of rights, equity, dignity, and responsibility in relationships.<sup>5</sup> If a woman is unable to control

Table 1

**Selected Aspects of Reproductive Health for Women and Men Worldwide, 1990s**

Health concern	Total	Women	Men
Maternal deaths (from complications of pregnancy and childbirth), annual	515,000	515,000	—
Serious injury from pregnancy or childbirth, annual	15 million–20 million	15 million–20 million	—
Unsafe abortions, annual	20 million	20 million	—
Adults living with HIV/AIDS (in 2000)	34.7 million	16.4 million	18.3 million
New HIV infections among adults (in 2000)	4.7 million	2.2 million	2.5 million
New cases of curable STIs, annual	333 million	166 million	167 million
Prevalence of STIs	250 million	175 million	75 million
Infertile men and women	50 million–80 million	—	—
New cases of cervical cancer, annual	470,000	470,000	—
Women who have undergone genital cutting	130 million	130 million	—
Couples with unmet family planning needs	100 million–150 million	—	—

— Not applicable or not available.

Note: STIs are sexually transmitted infections; unmet family planning needs arise when couples want to delay or avoid pregnancy, but are not using contraception.

Sources: C. AbouZahr, "Background Paper on Reproductive Health" (Prepared for the World Bank Institute, Washington, DC, 1999); UNAIDS, *Report on the Global HIV/AIDS Epidemic* (December 2000); B. Robey, J. Ross, and I. Bhushan, *Population Reports Series J*, no. 43 (September 1996): 3-6; unpublished estimates of unmet need from the Center for Population, Health, and Nutrition, U.S. Agency for International Development; J. Ferlay, F. Bray, P. Pisani, and D.M. Parkin, *Globocan 2000* (WHO International Agency for Research on Cancer, forthcoming); United Nations, *The World's Women 2000: Statistics and Trends* (2000); and UNICEF, "Maternal Health." Accessed online at: [www.childinfo.org/eddb/maternal.htm](http://www.childinfo.org/eddb/maternal.htm), on March 6, 2001.

basic aspects of her relationships, such as having sex free of coercion, this is a reproductive health issue, even though the health care system will likely only deal with the consequences—an unintended pregnancy or a sexually transmitted infection (STI—also commonly referred to as sexually transmitted disease or STD).

Improving reproductive health involves more than providing care during a woman's reproductive years.<sup>6</sup> Poor nutrition in childhood and adolescence, for example, is a major cause of poor health for women during pregnancy and childbirth. This poor health status can be transferred to their babies, especially when babies are low birth weight (less than 2,500 grams at birth). Harmful practices such as female genital cutting (practiced mainly in Africa), domestic violence, and sexual trafficking violate women's physical health and sexual and reproductive rights. Disabilities caused by childbirth or STIs can affect women in their older years.

While men suffer from reproductive health problems, particularly STIs, women bear the greatest burden

of ill health (see Table 1). Pregnancy and childbirth, including unsafe abortion, account for the largest health burden for women in their reproductive years. In addition to maternal causes, sexually transmitted infections, including HIV, are a major cause of disability and death among women worldwide.

Reproductive health care encompasses many elements, including:

- Contraceptive information and services;
- Prenatal care;
- Safe childbirth and postnatal care;
- Prevention and treatment of STIs, including HIV/AIDS;
- Abortion (where legal) and postabortion care;
- Prevention and treatment of infertility;
- Elimination of harmful practices such as female genital cutting, sexual trafficking, and violence against women; and
- Other women's health services, such as diagnosis and treatment for breast and cervical cancers.

The Cairo Programme of Action calls for all countries to provide these

services, mainly through the primary health care system, by 2015.

Although the Programme of Action defined reproductive health broadly, it set numerical goals and provided cost estimates in only three major areas: increasing the use of family planning, reducing maternal deaths, and preventing sexually transmitted infections. The following sections outline the policy and program issues related to these three areas, as well as a fourth critical area, the special needs of adolescents.

## Increasing Family Planning Use

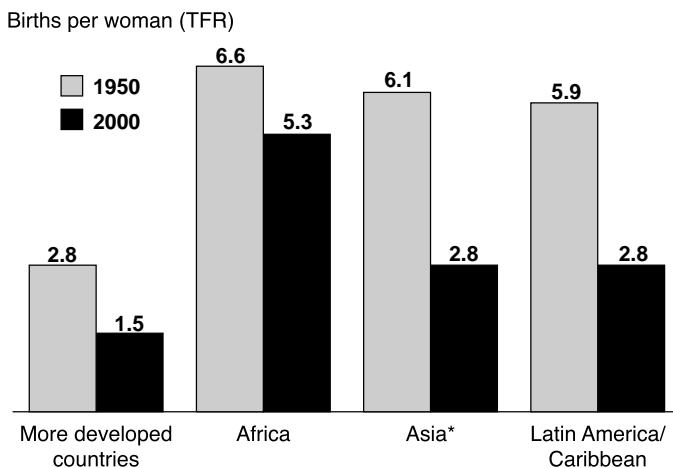
Family planning has long been a core element of population policies and programs and is a central component of reproductive health. In addition to allowing couples to limit the number of children they have, family planning helps lower fertility rates and slow population growth by helping women to space their pregnancies. Family planning also promotes healthier mothers and babies when women wait until they are out of their teens to have a baby and space subsequent pregnancies at least two years apart. Family planning can help protect older women and women with specific health problems who would face health risks from another pregnancy.

Although more people use family planning than ever before, more people than ever may need or want to use family planning. The number of people who need access to family planning is growing even more rapidly than the population of reproductive age because an increasing share of this age group want to limit their family size.

More than half of the couples in the less developed world use family planning today, compared with only 10 percent in the 1960s. This dramatic increase in family planning use has caused fertility to decline much more rapidly in less developed countries than it did in more developed countries. The shift from larger to smaller families in the United States and

Figure 1

## Fertility in World Regions, 1950 and 2000



Note: The TFR (total fertility rate) is the average total number of children born per woman given prevailing birth rates.

\*Excludes Japan, which is included in the average for more developed countries.

Sources: United Nations, *World Population Prospects: The 1998 Revision* (1998): tables A.1 and A.20; and C. Haub and D. Cornelius, *2000 World Population Data Sheet* (Population Reference Bureau, 2000).

Europe occurred over 100 to 150 years, yet average family size dropped almost as much in less developed countries in only a few decades (see Figure 1).

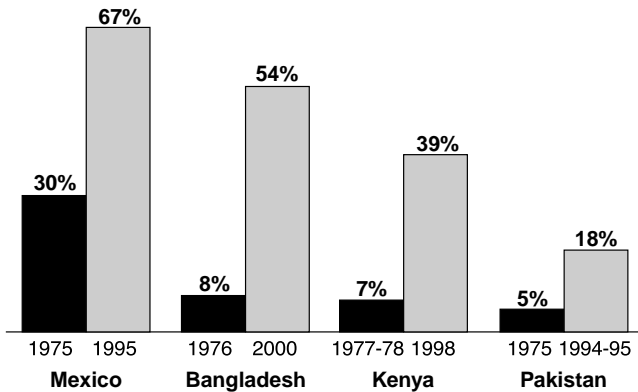
The smaller family sizes reflect a transformation in attitudes about childbearing. As countries have modernized and become more urban, and as women have achieved higher levels of education and have begun to marry later, couples want fewer children. In the 1970s in Kenya, for example, women reported wanting seven or more children, on average. In the 1990s, Kenyan women said they wanted fewer than four children, on average. In Colombia and Indonesia, women want fewer than three children today, compared with just over four in the 1970s.<sup>7</sup>

In the last 30 years, the growing availability of modern contraceptive methods, such as pills, injections, intrauterine devices, and sterilization, has made it possible for women and couples to space the births of their children and to have smaller families if they want them. Organized family planning programs and government

Figure 2

## Contraceptive Use in Selected Countries, Mid-1970s and Mid-1990s or Later

Percent of married women ages 15-49 using contraception



Sources: United Nations, *Levels and Trends of Contraceptive Use as Assessed in 1998* (1999); and Demographic and Health Surveys from 1994 to 2000. Accessed online at: [www.measuredhs.com](http://www.measuredhs.com), on Jan. 23, 2001.

promotion of family planning also play an important role. Some demographers credit family planning programs with 40 percent to 50 percent of the fertility decline in less developed countries since the 1960s.<sup>8</sup> Even couples living in low-income, rural communities in countries like Bangladesh and Kenya have gained access to modern contraception, thanks to organized programs that brought information and services closer to the communities (see Figure 2).

### Unmet Need for Family Planning

In spite of these advances, large disparities remain in the use of family planning. The percentage of women of childbearing age using contraception ranges from less than 10 percent in many countries of sub-Saharan Africa to more than 60 percent in Brazil and Thailand, and more than 80 percent in China. Within countries, family planning use often is much higher in urban than rural areas and among the wealthy than the poor.

Many women, especially in less developed countries, still get pregnant before they expect to and have more children than they intend. Experts estimate that between 100

million and 150 million women in the less developed world have an “unmet need” for family planning.<sup>9</sup> These estimates are based on surveys that include questions about women’s reproductive intentions. Demographers define a woman as having an unmet need if she says she would prefer to avoid a pregnancy but is not using a contraceptive method. In some countries, more than one-quarter of married women of reproductive age have an unmet need for family planning (see Figure 3). If sexually active, unmarried women were included in the surveys, these figures would almost certainly be higher.

The Cairo Programme of Action calls for providing universal access to “a full range of safe and reliable family planning methods and related reproductive health services.” At the five-year review, governments agreed on a more specific benchmark: reducing the unmet need for family planning without the use of targets or quotas.<sup>10</sup>

### Barriers to Family Planning Use

Although the vast majority of people everywhere know about family planning, studies have uncovered a number of reasons why women do not use contraception even when they say they would prefer to avoid a pregnancy.<sup>11</sup> Many women (and their husbands) fear the side effects of contraceptive methods. Other women are dissuaded by their husbands’ disapproval or by family pressure to have more children. Some couples oppose contraceptive methods for religious reasons. Difficulties in obtaining contraceptives and a shortage of trained health personnel can also restrict access to family planning. Young people in particular face such economic, social, political, and cultural barriers to family planning.

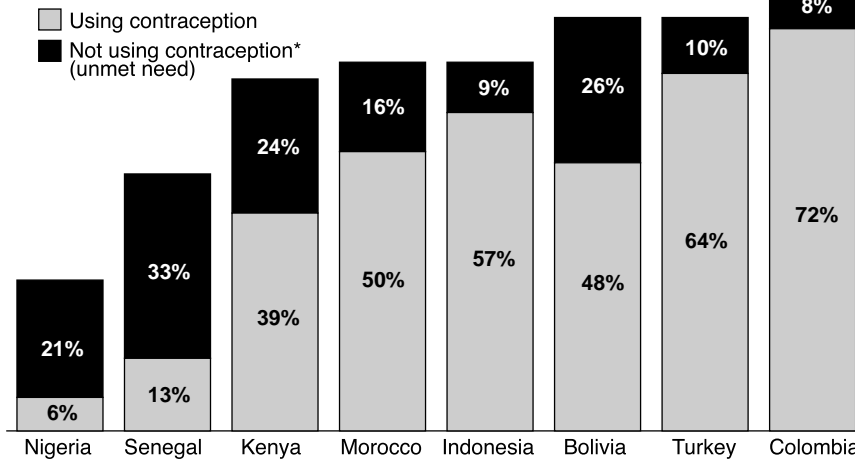
Family planning experts are increasingly concerned about whether there is an adequate supply of affordable contraceptives for those who need them. Governments and non-profit service providers in less developed countries typically have access to reduced-price or donated contracep-



Figure 3

### Contraceptive Use Among Women Who Prefer to Avoid Pregnancy, Selected Countries, 1990s

Percent of married women ages 15-49 who prefer to avoid a pregnancy



\* Women who want to avoid a pregnancy but are not using contraception are referred to as having an “unmet need” for family planning.

Source: Demographic and Health Surveys, Final Country Reports. Available online at: [www.measuredhs.com](http://www.measuredhs.com).

tives, which allows them to serve low-income populations that could not afford to buy contraceptives on the retail market. The price discounts and donations have been possible because of funding from governments in more developed countries (notably the United States) and multilateral institutions such as the World Bank and the United Nations.

The UN estimates that the number of contraceptive users will increase by more than 40 percent, from 525 million to 742 million, between 2000 and 2015. Given current levels of aid, supplies may not keep up with growing needs. Already, reports of “stockouts” of contraceptives are widespread in some countries—in part because of poor management of supply networks and shortfalls in government purchasing of contraceptive supplies.<sup>12</sup>

### Reducing Maternal Deaths

Complications of pregnancy and childbirth are major causes of disability and death among women of reproductive age in less developed countries. More

than 500,000 women die each year from pregnancy-related causes; more than 95 percent of these deaths occur in the less developed world, particularly in Africa and Asia. Of all the adult health statistics monitored by the World Health Organization (WHO), maternal death rates show the largest discrepancy between more developed and less developed countries. The ratio of maternal deaths to live births varies from an average of 10 maternal deaths per 100,000 live births in more developed regions to 880 maternal deaths per 100,000 live births in Africa (see Figure 4, page 16).

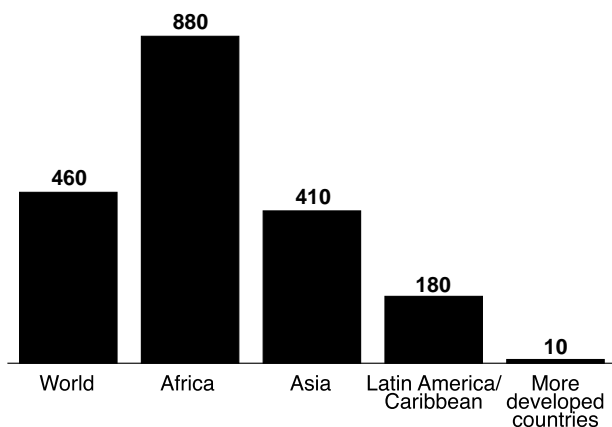
Because high-quality health care is accessible to most women in more developed countries, women rarely die in childbirth in these countries. Childbirth is much more risky in less developed countries. Maternal deaths are strongly associated with substandard health services and a lack of medical care during and immediately after childbirth.

Most births in less developed countries—about 60 percent—occur outside health facilities. Births at home

Figure 4

## Maternal Mortality Ratios in World Regions, Early 1990s

Maternal deaths per 100,000 live births



Source: L. Parikh and B. Shane, *1998 Women of Our World* (Population Reference Bureau, 1998), based on data from WHO, UNICEF, and the United Nations.

are not necessarily unsafe if a woman's family and her birth attendant can recognize the signs of complications during labor and delivery and, if complications occur, can move her quickly to a facility where she can obtain adequate care.

Families may not be able to transport her to a medical center in time, or they may not take her because they fear patronizing treatment, high fees, or poor quality care. Deliveries in health facilities can still be risky because of poor medical care.

A mother's death can have profound consequences for her family: In some less developed countries, if the mother dies, the risk of death for her children under age 5 can increase by as much as 50 percent.<sup>13</sup> Also, because these women are stricken during their most productive years, their deaths affect the wider society and economy.

For every maternal death, many more women suffer from injuries, infections, and disabilities related to pregnancy and childbirth. As a consequence of childbirth, some women have ruptures of the uterus, pelvic inflammatory disease, and damage to

the reproductive tract, which can lead to incontinence if not repaired. WHO estimates that more than 20 million women per year suffer from untreated injuries that occur during pregnancy and childbirth.

The Cairo Programme of Action called on governments to close the gap in maternal death ratios between less developed and more developed countries, and to aim for maternal mortality ratios below 60 deaths per 100,000 live births in all countries. The five-year review added a new benchmark for high mortality countries: to ensure that at least 60 percent of births are assisted by trained health personnel (see Figure 5).

All pregnancies involve some risks, even for healthy women: An estimated 15 percent of pregnancies result in complications requiring medical care. In life-threatening cases, women need emergency obstetric care, which includes surgery and anesthesia, blood transfusions, and other specialized care. Special medical care is also needed for complications of abortions such as incomplete abortions, infections, hemorrhage, and injuries to the cervix and uterus. Family planning reduces women's exposure to pregnancy and its health risks.

In 1987, a coalition of international agencies launched the Safe Motherhood Initiative to raise awareness about maternal deaths and to find ways to reduce them. Progress has been slow, however, because of insufficient funding and political commitment, weak health care systems, lack of awareness, and logistical hurdles for families in rural areas. Major donor agencies such as the World Bank have renewed their commitment to safe motherhood in recent years and made it a core component of women's health programs.

### Unsafe Abortions

The WHO estimates that 13 percent of maternal deaths, or about 80,000 annually, result from complications of abortion. These complications arise from unsafe procedures, which

usually occur where abortions are illegal or inaccessible. About 400 deaths occur for every 100,000 abortions, but this figure masks substantial regional variation: Unsafe abortions in Africa are at least 700 times more likely to lead to death than safe abortions in more developed countries.<sup>14</sup>

In countries where abortion is illegal or where safe abortion services are not available, women with an unwanted pregnancy may seek clandestine abortion services or abortion drugs and other means of self-induced abortion. When these abortions lead to injury, women often go to hospitals for emergency treatment. According to estimates in some countries, up to 50 percent of hospital beds used by gynecology patients are occupied by women with abortion complications.<sup>15</sup>

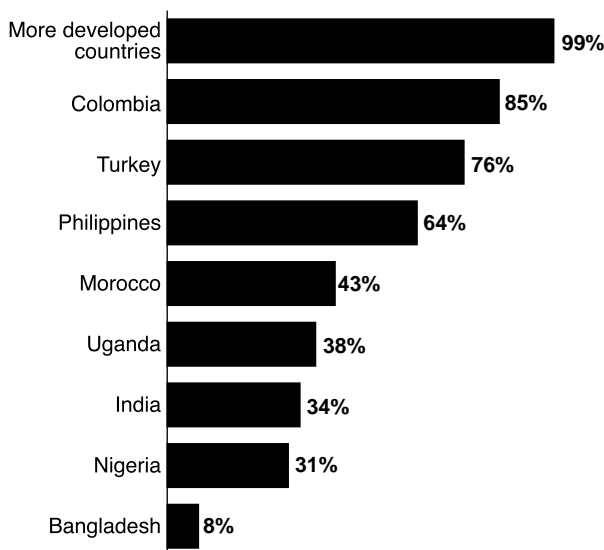
Abortion is possibly the most divisive women’s health issue that policy-makers face. Every recent global conference on population and reproductive health has confronted some protest related to abortion, within or outside the meeting. The current international consensus—hammered out at the Cairo conference and refined during its five-year review—is that unsafe abortion should be addressed to reduce its adverse health impacts. The consensus documents made clear that “in no case should abortion be promoted as a method of family planning.”<sup>16</sup> Whether or not abortions are performed legally, delegates agreed, women should receive care for complications arising from abortion. Where abortion is legal, “health systems should train and equip providers and take other measures to ensure that abortion is safe and accessible.”<sup>17</sup>

## Preventing Sexually Transmitted Infections

The global rise in sexually transmitted infections (STIs), most notably HIV, opened up a new area of public discourse in the 1990s. Discussions on population and health trends

Figure 5

### Births Attended by Trained Health Personnel, Selected Countries, 1990–1997



Source: UNICEF, *State of the World’s Children 1999* (1999): table 7.

used to focus on fertility, but now the growing incidence of HIV/AIDS and other STIs has brought the act of sex itself into the limelight. In the interest of saving lives, many national leaders have begun to talk openly about the formerly taboo subject of sexual activity.

Worldwide, more than one adult in 10 acquires an STI each year, and some 333 million new infections occur annually (see Table 1, page 12). Risky sexual behaviors are mainly responsible for the spread of STIs. These behaviors include sexual activity at a young age, sex with multiple partners, commercial sex, and specific sexual practices.<sup>18</sup>

Two common STIs, chlamydia and gonorrhea, do not show symptoms in women but can spread into the uterus and fallopian tubes, where the infection, called pelvic inflammatory disease, may greatly reduce a woman’s chances of becoming pregnant. For this reason, STIs are a major cause of infertility in the less developed world. Also, STIs in pregnant women can be passed to a fetus or infant with serious

## Combating HIV/AIDS in Uganda

The HIV/AIDS epidemic in Uganda has posed a major challenge to social and economic development and prompted an unprecedented government response. The openness of the Ugandan government in dealing with AIDS—discussing sexuality and its consequences publicly—stands in stark contrast to the governments of other African countries that avoid public debates on topics related to sexuality.

Uganda was one of the first countries to record a high prevalence of HIV infection. In 1992, just 10 years after the first AIDS cases were identified, about one-third of the pregnant women in Uganda's urban areas were infected with HIV. The number of reported AIDS cases was growing at an alarming rate.

By the early 1990s, the Ugandan government recognized the devastating impact that AIDS would have on development. Public health officials also understood that other sexually transmitted infections (STIs) fueled the spread of HIV. With financial support from major donor agencies, the government instituted a far-reaching, multipronged strategy involving the Ministries of Health, Labor, Gender, Defense, Education, Information, and Agriculture. Programs include public information campaigns, research, voluntary testing and counseling, safe blood for transfusions, school health programs, home-based care of people living with AIDS, and a nationwide campaign to treat STIs. The STI/HIV control program, supported by the World Bank, emphasizes outreach to

vulnerable groups—especially young people—and the involvement of parents and communities. A national AIDS commission also coordinates policies and programs throughout the country and collaborates with parliamentarians, government officials, and religious leaders.

The HIV/AIDS epidemic continues in Uganda. Almost 1 million people—out of a population of 23 million—were living with HIV/AIDS at the end of 1999; 1.7 million children have been orphaned by AIDS deaths. Yet the far-reaching national efforts have produced promising results. Nearly all adults in Uganda now are aware of the dangers of HIV. The percentage of men who report having casual sexual partnerships fell substantially during the 1990s. Overall, rates of infection have declined, from a peak of almost 14 percent of adults ages 15 to 49 in the early 1990s to around 8 percent in 1999.

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Florence Mirembe, Freddie Ssengooba, and Rosalind Lubanga, *Reproductive Health in Policy and Practice: Uganda* (Washington, DC: Population Reference Bureau, 1998); UNAIDS, *Report on the Global HIV/AIDS Epidemic June 2000* (Geneva: UNAIDS, 2000); and Rand Stoneburner, Daniel Low-Beer, Tony Barnett, and Alan Whiteside, "Enhancing HIV Prevention in Africa: Investigating the Role of Social Cohesion on Knowledge Diffusion and Behavior Change in Uganda" (Paper presented at the International Conference on AIDS, Durban, South Africa, July 2000.)

health consequences for the newborn child.<sup>19</sup>

Other sexually transmitted infections also facilitate the transmission of HIV. Governments and health systems have stepped up efforts to raise awareness about "unsafe sex" and to slow the spread of STIs through prevention and treatment programs. Aside from abstaining from sex, the most effective way to prevent STIs is to use

a condom. In some countries, such as Uganda, governments have aggressively promoted condom use, with some positive results (see Box 3); in others, such as Kenya and Zambia, religious institutions or political leaders have opposed public campaigns promoting condoms.<sup>20</sup> In particular, many Catholic leaders have been reluctant to support the use of condoms because they consider absti-

nence and monogamy to be the only forms of protection that are consistent with Catholic doctrine.

Strategies to control the spread of STIs are often two-pronged: intensive prevention and treatment efforts aimed at “core groups” (such as sex workers and men with multiple partners) that account for most of the transmission of infections, and the incorporation of STI programs into existing family planning and other health services. In practice, detecting STIs is difficult because several STIs do not show symptoms and lab tests are expensive. Treating large numbers of high-risk people with antibiotics whether or not infections are detected may not be effective and is prohibitively expensive in most places.

## The HIV/AIDS Epidemic

HIV/AIDS is the most devastating of all sexually transmitted infections. There is no cure, and the disease is nearly always fatal. Because there is a long delay between infection and onset of disease symptoms, an infected person can pass the disease to many others before knowing he or she is carrying HIV. At the end of 2000, an estimated 36 million adults and children around the world were living with HIV/AIDS, with the majority (more than 25 million) in sub-Saharan Africa (see Table 2).<sup>21</sup> In the early 1990s, experts warned of a growing health crisis brought on by HIV/AIDS, but few predicted the enormity of the crisis. In Southern Africa, an estimated one-fourth to one-third of the adult population is infected with HIV.

In sub-Saharan Africa, HIV is spread mainly through heterosexual contact. High-risk behaviors and the presence of other sexually transmitted infections fuel its spread. In other regions, including parts of Asia, Latin America, Eastern Europe, and Central Asia, HIV is transmitted through intravenous drug use and men having sex with men, as well as through heterosexual relations. National rates of infection are far lower in these re-

Table 2

### Adults and Children Living With HIV/AIDS, 2000

Region/country	Number of adults and children with HIV/AIDS	Percent of adults infected, ages 15-49
World	36,100,000	1.1
Sub-Saharan Africa	25,300,000	8.8
<i>South Africa</i>	4,200,000	19.9
<i>Botswana</i>	290,000	35.8
South and Southeast Asia	5,800,000	0.6
<i>India</i>	3,700,000	0.7
Latin America	1,400,000	0.5
North America	920,000	0.6
<i>United States</i>	850,000	0.6
Eastern Europe & Central Asia	700,000	0.4
East Asia and Pacific	640,000	0.1
<i>China</i>	500,000	0.1
Western Europe	540,000	0.2
North Africa & Middle East	400,000	0.2
Caribbean	390,000	2.3
Australia & New Zealand	15,000	0.1

Note: Estimates for countries are for December 1999; estimates for regions are for December 2000.

Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic* (June 2000 and December 2000). Accessed online at: [www.unaids.org/epidemic\\_update/report](http://www.unaids.org/epidemic_update/report), on Jan. 22, 2001.

gions than in Africa, although infection rates are high and rising among some population groups.

In most world regions, men are more likely than women to have HIV/AIDS. In sub-Saharan Africa, however, women—particularly young women—are more likely than men to contract the disease. An estimated 12 women have HIV/AIDS for every 10 men with HIV/AIDS in sub-Saharan Africa. Among people in their early 20s, the rates are three times higher in women than men, and among teenagers, girls are five times more likely than boys to be infected.<sup>22</sup>

Young women are more susceptible than young men to HIV infection for biological and social reasons. Girls are more easily infected during vaginal intercourse with an infected partner than are boys. Girls are also more likely to have sex with an older partner who has been exposed to HIV. Young girls often have difficulty resisting sexual advances from older men or persuading older partners to use a condom, which makes them vulnerable to infection.

Young women with HIV/AIDS may become infertile or many die prema-

*HIV/AIDS  
is creating a  
generation of  
“missing  
adults.”*

turely and leave behind orphan children; they may also pass HIV to their infants, who in turn will have little chance of survival.

The demographic, social, and economic consequences of AIDS are profound in countries with high infection rates. In some societies, HIV/AIDS is killing so many young adults that it is creating a generation of “missing adults”—men and women in their 20s and 30s today who will not be around to support their families in middle-age. Households and communities must care for growing numbers of orphans and elderly who have lost their income-earning family members. Since AIDS strikes adults during their most productive years, its effects are felt in the military, education, industry, agriculture, transportation, and the economy in general. These potentially destabilizing effects led the UN Security Council to declare in 2000 that AIDS is a global security concern. This was the first time this world body defined a health concern as a security threat.

In the short term, there is little hope for survival for those already infected with HIV in low-income countries. Treatment therapies are too expensive for the vast majority of citizens of these countries, and an HIV/AIDS vaccine is many years away. Prevention strategies are the most effective and realistic way for developing-country governments to combat the HIV/AIDS epidemic. Aggressive prevention efforts in Uganda (see Box 3, page 18) have brought the adult prevalence rate down to single digits, compared with rates in the double digits in many neighboring countries.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that a combination of strategies can be effective in combating the epidemic. These strategies include a comprehensive national AIDS plan; social openness and willingness to increase the visibility of the disease; the engagement of all sectors (not just the health system); support for community-level programs; and special

interventions for those who are most vulnerable, including young people.<sup>23</sup>

## **The Needs of Young People**

Young people are more vulnerable than adults to HIV, other STIs, and unplanned pregnancies for a variety of reasons, and recent world conferences have called for special attention to their needs. Policymakers have good reason to pay attention to this group: More than one-fourth of the world's 6 billion people are between the ages of 10 and 24. Their decisions about marriage, sexual activity, and childbearing have major implications for their societies and for the future world population.

Today's young people are generally healthier and more educated than their parents, but they still face serious risks to their reproductive health. Complications from pregnancy, childbirth, and unsafe abortion are the major causes of death for women ages 15 to 19 in less developed countries. Young men and women ages 15 to 24 have the highest rates of sexually transmitted infections, including HIV.

Young people are also marrying at later ages than did their parents, which is one reason for declining levels of childbearing. But later marriage combined with increased premarital sex puts young people at greater risk of unplanned pregnancies, unsafe abortion, births out of wedlock, and STIs. Although premarital sex is generally less common in less developed countries than in industrialized countries, it is on the rise in all regions.<sup>24</sup> When adolescents do become sexually active, they tend to have multiple, short-term relationships, use condoms and other contraceptives inconsistently, and lack the knowledge to protect their well-being.

Teenage women are especially vulnerable to reproductive health problems. Teens are more likely than older women to die from problems related to pregnancy and childbirth. Childbirth is riskier for young women who have not completed their growth and who may have less information

and access to prenatal, delivery, and postpartum care than older women. Also, young women are more likely than older women to resort to an unsafe abortion if faced with an unwanted pregnancy. In addition, girls are more vulnerable than boys or older women to coerced sex and sex in exchange for gifts or money. When young girls have sex with older, more experienced partners, they risk contracting an infection, including HIV.

### **Protecting Adolescent Health**

Discussions on adolescent sexual health in international meetings have been contentious. Several governments, particularly from Muslim countries, expressed formal reservations on (that is, opted out of) portions of the Cairo program that deal with adolescent sexuality because premarital sexual activity is not condoned in their societies. Many other governments do not explicitly oppose the UN discussions but are reluctant to address the issues directly in their national policies.

In countries with conservative values and traditions, including the United States, many parents and policymakers are concerned that providing contraceptive information and services will promote promiscuity among unmarried teens. There is little evidence that such programs promote greater sexual activity among young people. Reviews of sex education programs worldwide, for example, have concluded that sex education does not encourage early sexual activity, but can delay first intercourse and lead to more consistent contraceptive use and safer sex practices.<sup>25</sup>

In spite of the controversies surrounding adolescent sexuality at recent world conferences, governments agreed to a comprehensive set of measures to improve adolescents' health at the Cairo conference, which were expanded at the Beijing conference and the Cairo five-year review. These include providing sexual and reproductive health information to adolescents; encouraging parental involvement; using peer educators to reach out to young people; provid-

Photo removed for copyright reasons.

*Reproductive health risks of teens—including unplanned pregnancies and sexually transmitted infections—are of increasing concern to policymakers.*

ing integrated health services that include family planning for sexually active teens; and taking measures to eliminate harmful practices and violence against young women.

### **Ending Harmful Practices**

World conferences have recently addressed the harmful practices that affect young women: sex trafficking, female genital cutting, and violence against women (see Box 4, page 24). The UN estimates that 2 million girls under age 16 are introduced into the commercial sex market each year.<sup>26</sup> Many of them are lured by promises of jobs or a better life. The greatest volume of sex trafficking is in Asia, where, for example, thousands of girls are brought into the sex trade in India and Thailand every year. Eastern European women are also increasingly vulnerable to sex trafficking.

The international community has recently spoken out against these practices and taken steps to strengthen enforcement measures against traffickers. Ending sex trafficking, however, is complicated. It is a lucrative trade that crosses international borders—and therefore legal jurisdictions.

Female genital cutting, also known as female circumcision and female genital mutilation, affects an estimated 2 million girls each year.<sup>27</sup> About 130 million women have undergone the practice, mostly in Africa

*No government could deny that women deserve higher status and better opportunities.*

and among African immigrants in other countries. Female genital cutting is a long-standing cultural practice that involves removing part or all of the external genitalia. Its main purpose is to curtail women's sexual desire and ensure virginity before marriage and fidelity in marriage. Female genital cutting has serious health effects, including hemorrhage, shock, chronic pain, and infections and other complications that can cause lasting damage. Ending the practice involves confronting deeply held values of women, their families, and communities. Community efforts in several countries are contributing to a growing body of knowledge about how best to end the practice.

## **Empowering Women**

Thanks to the growing activism and influence of women's rights advocates around the world, the situation of women has moved to the forefront of both national and international population policy debates. Since the Cairo and Beijing conferences, there has been greater discussion of gender issues, and of the differences in men's and women's socially defined roles. Governments and donor agencies increasingly acknowledge that women's inferior status hinders development and support policies and programs to reduce gender inequalities. Those concerned about the negative effects of population growth also see a connection between enhancing a woman's status within the family and society and increasing her control over childbearing.

The agreements adopted at the population and development conference (ICPD) in Cairo and the women's conference in Beijing called for equal participation and partnerships between men and women in nearly all areas of public and private life. As innovative—even revolutionary—as these notions seem, they met with little dissent during the confer-

ences themselves. In spite of the diversity of cultures represented, no government could deny that women deserve higher status and better opportunities. Beyond the conference halls, however, putting these ideas into practice requires overcoming deeply rooted cultural values and ways of life.

## **Understanding Gender**

Gender refers to the different roles that men and women play in society, and the relative power they wield. Gender roles vary from one country to another, but almost everywhere, women face disadvantages relative to men in the social, economic, and political spheres of life. Where men are viewed as the principal decision-makers, women often hold a subordinate position in negotiations about limiting family size, contraceptive use, managing family resources, protecting family health, or seeking jobs.

Inequalities between men and women are closely linked to women's health—making the issue of gender pertinent to discussions on how to improve reproductive health. Gender differences affect women's health and well-being throughout the life cycle:<sup>28</sup>

- Before or at birth, parents who prefer boys may put girls at risk of sex-selective abortions (where technology is available to identify the sex) or infanticide.
- Where food is scarce, girls often eat last, and usually less than boys.
- Girls may be less likely than boys to receive health care when they are ill.
- In some countries, mainly in Africa, girls are subjected to female genital cutting.
- Adolescent girls may be pressured into having sex at an early age—within an arranged marriage, by adolescent boys proving their virility, or by older men looking for partners not infected with STIs.
- Married women may be pressured by husbands or families to have more children than they prefer, and women may be unable to seek or use contraception.



Table 3

## Fertility and Access to Reproductive Health Care Among the Poorest and Richest Women, Selected Countries, 1990s

Country	Births per woman (TFR)*		Prenatal care (Percent of pregnant women)		Births attended by skilled staff (Percent of deliveries)	
	Poorest fifth	Richest fifth	Poorest fifth	Richest fifth	Poorest fifth	Richest fifth
	Bolivia	7.4	2.1	39	95	20
Cameroon	6.2	4.8	53	99	32	95
Guatemala	8.0	2.4	35	90	9	92
India	4.1	2.1	25	89	12	79
Indonesia	3.3	2.0	74	99	21	89
Morocco	6.7	2.3	8	74	5	78
Vietnam	3.1	1.6	50	92	49	99

\*TFR (total fertility rate) is the average total number of births per woman given prevailing birth rates.

Note: Women were ranked according to their household assets.

Source: A. Tinker, K. Finn, and J. Epp, *Improving Women's Health: Issues and Interventions* (World Bank, June 2000): 10.

- Married and unmarried women may be unable to deny sexual advances or persuade partners to use a condom, thereby exposing themselves to the risk of STIs.
- In all societies, women are more likely than men to experience domestic violence. Women may sustain injuries from physical abuse by male partners or family members, and the fear of abuse can make women less willing to resist the demands of their husbands or families.

A mixture of cultural and social factors explain women's lack of power in protecting themselves or their daughters from these health threats. These factors include women's limited exposure to information and new ideas, ignorance of good health practices, limited physical mobility, and lack of control over money and resources.<sup>29</sup> In some South Asian and Middle Eastern countries, for example, women's use of health care services is inhibited by cultural restrictions on women traveling alone or being treated by male health care providers.

### The Poverty Connection

Gender disadvantages intertwine with poverty. Poverty is strongly linked to poor health, and women represent a disproportionate share of the poor. In all regions of the world, including wealthier regions, reproductive health is worse among the poor (see Table 3). Women in the poorest households

have the highest fertility, poorest nutrition, and most limited access to skilled pregnancy and delivery care, which contribute to higher maternal and infant death rates. Women's disadvantaged position also perpetuates poor health, an inadequate diet, early entry into motherhood, frequent pregnancies, and a continued cycle of poverty.<sup>30</sup>

Women's low socioeconomic status also makes them more vulnerable to physical and sexual abuse. Unequal power in sexual relationships exposes women to coerced sex (see Box 4, page 24), unwanted pregnancies, and sexually transmitted infections. Impoverishment can also lead some women into commercial sex.<sup>31</sup> Thus, women's access to and control over resources can give women greater control of their sexuality, which is fundamental to controlling their fertility and improving their health.

### Reducing Gender Inequalities

Recent reports from the World Bank show that reducing gender inequalities can bring about greater economic prosperity and help reduce poverty. One study found that a 1 percent increase in women's secondary schooling results in a 0.3 percent increase in economic growth.<sup>32</sup> In addition, the strong links between women's status, health, and fertility rates make gender equality a critical

## Violence Against Women

Violence against women is the issue that perhaps best illustrates the connection between women's rights and women's health, and the tragic consequences of women's inferior position. Once thought to be only a private matter, violence against women has gained visibility as a serious public policy and public health concern.

Violence against women (also referred to as gender-based violence) occurs in nearly all societies, within the home or in the wider community, and it is largely unpoliced. It may include female infanticide, incest, child prostitution, rape, wife-beating, sexual harassment, wartime violence, or harmful traditional practices such as forced early marriage, female genital cutting, and widow or bride burning. A recent study published by the Center for Health and Gender Equity and Johns Hopkins University estimated that one in three women worldwide suffers from some form of gender-based violence.

Domestic violence is the most common form of gender-based violence, and it is most often perpetrated by a boyfriend or husband against a woman (see figure). Psychological abuse almost always accompanies physical abuse, and the majority of women who are abused by their partners are abused many times. Many women tolerate the abuse

because they fear retaliation by their spouse or extended family, or both, if they protest. Women's vulnerability to violence is reinforced by their economic dependence on men, widespread cultural acceptance of domestic violence, and a lack of laws and enforcement mechanisms to combat it.

Although women's control over their sexuality is central to population and health concerns, the extent to which sexual activity is forced or coerced has only recently been addressed. Most coerced sex takes place between people who know each other—spouses, family members, or acquaintances. One-quarter to one-half of domestic violence cases involve forced sex. Coercion also takes place against children and adolescents in more developed and less developed countries. Statistics on rape suggest that between one-third and two-thirds of rape victims around the world are younger than 16.

What is the connection between gender-based violence and reproductive health? Violence against women is rooted in unequal power between men and women. It affects women's physical, mental, economic, and social well-being. It can lead to a range of health problems. Since girls are more often subjected to coerced sex than boys, they are at risk of becoming infected with sexually transmitted infections

strategy for policies to improve health and stabilize population growth.

The empowerment of women is seen as a key avenue for reducing the differences between the sexes that exist in nearly all societies. Empowerment refers to "the process by which the powerless gain greater control over the circumstances of their lives."<sup>33</sup> It means not only greater control over resources but also greater self-confidence and the ability to make decisions on an equal basis with men. Empowerment of women also requires that men are aware of gender inequalities and are willing to question traditional definitions of masculinity.

In many societies, these concepts may be threatening to men, who are accustomed to having authority in the household, the community, the economy, and national politics. The concepts may also be frightening to women, who may fear the implications of these changes for their personal lives.<sup>34</sup> For these reasons, and because concepts of women's rights, empowerment, and gender equality are still relatively new in many places, progress in advancing women's rights has been modest.

### Women's Education

The World Bank calls women's education the "single most influential

*Women's control over their sexuality is central to population and health concerns.*

(STIs) at a younger age than are boys. Some STIs can lead to pelvic inflammatory disease, infertility, and AIDS. Forced and unprotected sex also leads to unintended pregnancies, abortions, and unwanted children. The experience of abuse puts women at greater risk of mental health problems, including depression, suicide, and alcohol and drug abuse. Ultimately, these outcomes have negative consequences for the whole society, not just the women who are victims of such violence.

After a series of international conferences and conventions in the 1990s called for eliminating all forms of violence against women, many countries strengthened laws and enforcement mechanisms related to domestic violence. Much of the pressure to change laws and community standards has come from nongovernmental organizations, and particularly women's groups. These groups are at the forefront of efforts to combat violence against women through grassroots activism, lobbying, and working with women survivors of violence. Ending the violence requires community-level action and, ultimately, changes in the values that lead to the subjugation of women.

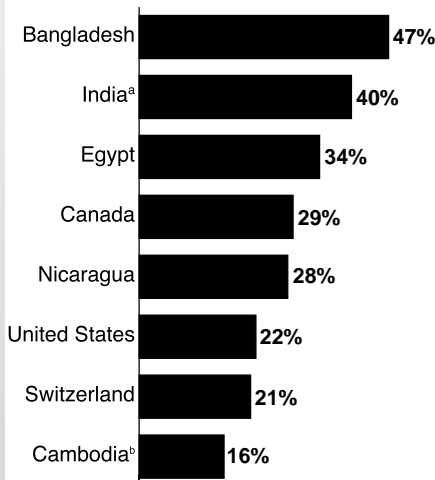
#### References

Lori Heise, Mary Ellsberg, and Megan Gottemoeller, "Ending Violence Against

investment that can be made in the developing world." Many governments now support women's education not only to foster economic growth, but also to promote smaller families, increase modern contraceptive use, and improve child health. Educating women is an important end in itself, and it is also a long-term strategy for advancing women's reproductive health. The Cairo conference called for universal access to and completion of primary education, and for reducing the gender gap—differences in boys' and girls' enrollment—in secondary education.

Worldwide, more men than women are literate (80 percent, compared

### Women Reporting Physical Assault by Male Partner, Selected Studies, 1990s



<sup>a</sup> Six states only.

<sup>b</sup> Phnom Penh and six provinces.

Source: L. Heise, M. Ellsberg, and M. Gottemoeller, *Population Reports Series L*, no. 11 (1999): table 1.

Women," *Population Reports Series L*, no. 11 (Baltimore: John Hopkins University, 1999); UNFPA, *The State of World Population 2000: Lives Together, Worlds Apart* (New York: UNFPA, 2000); and Yvette Collymore, ed., *Conveying Concerns: Women Report on Gender-Based Violence* (Washington, DC: Population Reference Bureau, 2000).

with 64 percent). While nearly all boys and girls in more developed countries are enrolled in both primary and secondary school, women in less developed countries complete fewer years of education than men, on average, and are more likely to be illiterate.

According to the UN, primary and secondary school enrollments increased for both girls and boys during the 1990s in almost all world regions. The gender gap in school enrollments closed somewhat in recent years but remains pronounced at the secondary school level (see Table 4, page 26). Girls are more likely than boys to discontinue their schooling for a number of reasons:

Table 4

### Secondary School Enrollment by Sex in World Regions, 1980 and 1990s

Region	Percent enrolled*			
	1980		1990s	
	Boys	Girls	Boys	Girls
More developed countries	88	89	99	102
Less developed countries	43	30	57	48
Northern Africa	47	29	63	57
Sub-Saharan Africa	19	10	29	23
Western Asia	49	31	63	48
South-Central Asia	38	20	55	37
Southeast Asia	40	35	53	49
East Asia	59	45	77	70
Central America	46	42	56	57
Caribbean	—	—	49	55
South America	38	42	—	—

— Not available.

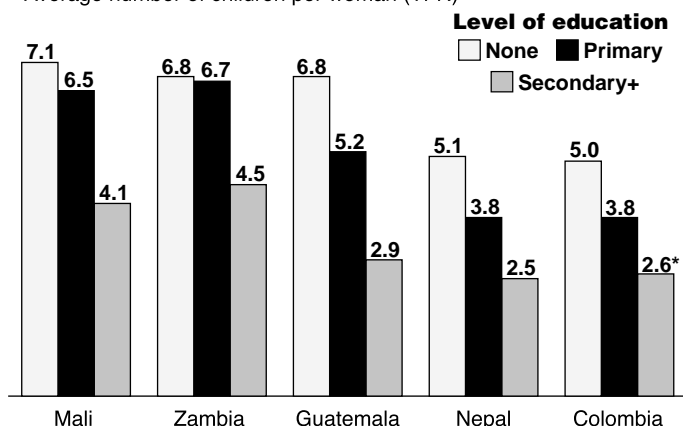
\* The percent enrolled is the ratio of the total number enrolled in secondary school (regardless of age) to the number of secondary-school-age children, or the gross enrollment ratio. Data from the 1990s are the latest available, generally between 1990 and 1996.

Source: A. Boyd, C. Haub, and D. Cornelius, *The World's Youth 2000* (Population Reference Bureau, 2000), based on national figures from UNESCO, *Statistical Yearbook 1999* (1999).

Figure 6

### Women's Education and Childbearing, Selected Countries, 1995–1999

Average number of children per woman (TFR)



\*Secondary level only.

Note: The TFR is the average total number of children born per woman given prevailing birth rates.

Source: Demographic and Health Surveys, Final Country Reports. Available online at: [www.measuredhs.com](http://www.measuredhs.com).

household duties; early marriage and childbearing; parents' perceptions that education is more beneficial for sons; worries about girls' safety as they travel to schools away from their villages; and limited job opportunities for women in sectors that require higher education. In some settings, gender bias among teachers and sexual harassment may lead to higher dropout rates among young women.<sup>35</sup>

During the 1990s, the countries seeing the greatest gains in closing the gender gap were regions that had the lowest enrollments in the past: Northern Africa, sub-Saharan Africa, Southern Asia and Western Asia. Nevertheless, in the regions where almost a third of the world's women live (Southern Asia and sub-Saharan Africa), girls are much less likely than boys to attend secondary school. The populations of these two regions are among the world's fastest growing, which suggests that the number of illiterate women in these regions will continue to grow.<sup>36</sup>

Research over the last 20 years has shown that women with more education make a later transition to adulthood and have smaller, healthier families. Women with more education usually have their first sexual experience later, marry later, want smaller families, and are more likely to use contraception and other health care than their less educated peers (see Figure 6). In many less developed countries, women with no schooling have about twice as many children as do women with 10 or more years of school.<sup>37</sup> Expanding educational opportunities for women has been embraced as a means to lower national fertility rates and to slow population growth.

### Women's Work

Employment is another way that women can elevate their status: It enables them to earn income and have more control over resources. It can also increase women's involvement in the public sphere and help enhance decisionmaking skills. Women's participation in the labor

force increased during the 1990s, but they are still at the lower end of the labor market in pay and authority.

Women make up an increasing share of the labor force in almost all regions of the world (see Table 5). Several factors explain this: Women's improved ability to limit and space pregnancies has enabled them to spend less time on child care and more on work outside the home; attitudes toward the employment of women have become more accepting; and new policies on family and child care ensure more flexibility and therefore favor working women. In addition, economic growth, and particularly the expansion of service industries (like finance, communications, and tourism), which tend to employ large numbers of women, has increased women's labor force opportunities. And finally, programs that have made credit available for small enterprises have benefited women.<sup>38</sup>

These trends are positive, but equality in the work force is still a long way from reality. Women typically occupy lower-paid and lower-status jobs than men; women's unemployment rates are higher than men's; and far more women than men work in the "informal sector," occupations like street vending and market work, where wages are very low. Even when women work in the same sector as men, wages are typically lower (see Figure 7).

In addition, more women are remaining in the work force during their reproductive years, leading to a "dual burden": working outside the home while at the same time doing a larger share of work in the home than men—such as childrearing, cooking, and cleaning. The few studies that are available on how women's time is used (in more developed countries) show that women spend 50 percent to 70 percent as much time as men on paid work, but almost twice as much or more time as men on unpaid work.<sup>39</sup> A multicountry study on women's lives and family planning in less developed regions found that many women reported

Table 5

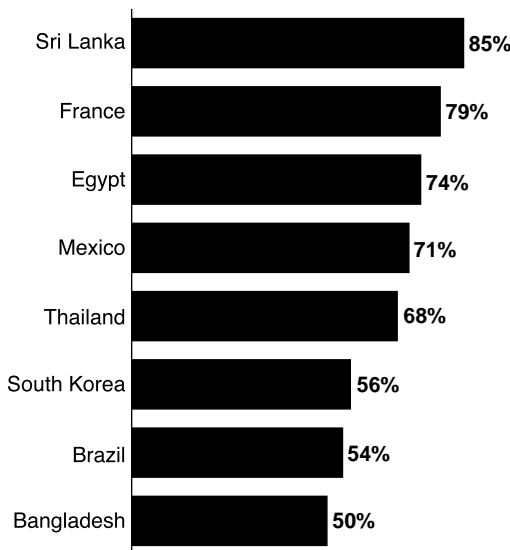
**Women's Share of the Labor Force, 1980 and 1997**

Region	Women as percent of labor force	
	1980	1997
<b>Africa</b>		
Northern Africa	20	26
Sub-Saharan Africa	42	43
<b>Latin America &amp; Caribbean</b>		
Caribbean	38	43
Central America	27	33
South America	27	38
<b>Asia</b>		
East Asia	40	43
Southeast Asia	41	43
Southern Asia	31	33
Central Asia	47	46
Western Asia	23	27
<b>More developed regions</b>		
Eastern Europe	45	45
Western Europe	36	42
Other more developed regions	39	44

Source: United Nations, *The World's Women 2000: Trends and Statistics* (2000): 110.

Figure 7

**Women's Wages as a Percentage of Men's Wages, in Manufacturing, Selected Countries, 1992–1997**



Source: United Nations, *The World's Women 2000: Trends and Statistics* (2000): chart 5.23.

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copyright reasons.

*Women who earn incomes outside the home often carry a dual burden of family and work responsibilities.*

additional stress because of these dual responsibilities, and that many women in these situations would prefer not to work outside the home.<sup>40</sup>

The Cairo population and development conference and the Beijing women's conference called on governments to reduce disparities between men and women in the work force and to provide additional support to working women, such as maternity leave, child-care assistance, and other flexible arrangements. One area that has received much visibility and high-level political support is that of providing microcredit—small low-interest loans—that allow women to start their own small businesses. Experience has shown that women are good “credit risks” and repayment rates are high. These programs tend to be small, however, and they do not address the underlying social and cultural reasons for women's economic disadvantages.

### **Changing Family Dynamics**

Women's strong attachment to family and responsibility for the household define much of their adult lives. Women usually marry at a younger age than do men, and the age gap between spouses tends to be wider in low-income countries. The age differ-

ences between spouses help perpetuate women's weaker authority. In societies where childbearing starts soon after marriage, women's opportunities to pursue careers or additional schooling, or to develop contacts beyond the family, are limited.

In many societies, laws pertaining to the family put women at a disadvantage and reinforce their dependence on men: Women may be unable to inherit land or other property, divorce their husbands, or get custody of their children if they can divorce. The gender gap in legal rights is gradually narrowing in some countries. Egypt revised its laws in 2000 to allow women similar divorce rights as men, for example, and Morocco revised its personal status laws in the 1990s to enhance women's rights in marriage—including polygamous marriages—and divorce.<sup>41</sup>

### **Women's Political Leadership**

Women's right to equal participation in political life is guaranteed by a number of international conventions, most notably the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which was adopted in 1979 but has not been ratified by all governments. In practice, in all countries, women are underrepresented at every level of government, especially in high-level executive positions and legislative bodies.

Worldwide, women held only 11 percent of seats in parliaments and congresses in 1999, up from 9 percent in 1987.<sup>42</sup> In the United States, sub-Saharan Africa, Latin America and the Caribbean, and East and Southeast Asia, these percentages ranged between 10 percent and 13 percent in 1999. In Northern Africa and South and West Asia, women held just 3 percent to 5 percent of seats in legislative bodies (see Figure 8). There are some exceptions: Women in Vietnam, South Africa, Mozambique, Cuba, and Argentina hold 25 percent to 30 percent of parliamentary seats.

In the 1990s, a number of countries, including India, Uganda, Brazil,

and the Philippines, formally set aside a percentage of seats on national and local bodies to be held by women. In South Africa, the proportion of women in parliament rose from 1 percent to 30 percent following the establishment of a new constitution.

One drawback of mandated quotas is that women may be placed on election ballots and voted into office before they have developed the political and technical skills necessary to govern effectively. Until these reforms become more widespread and meaningful, women's lack of political power will limit their influence on laws and policies that affect their rights, as well as on priority-setting in health care and other public services.

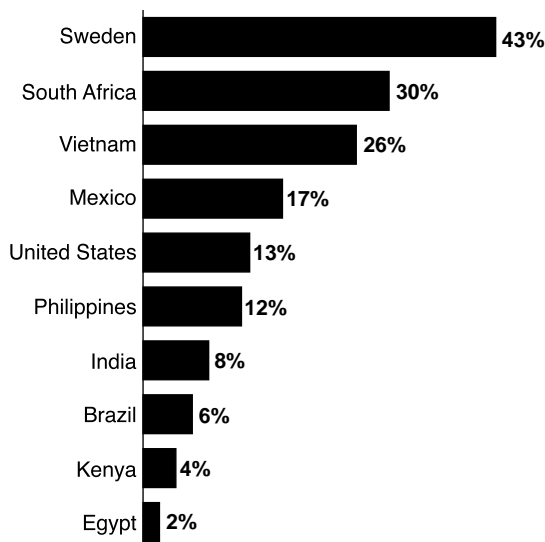
## Putting Policies Into Practice

Recent world conferences have produced an astounding array of recommendations for governments and private organizations. The Programme of Action from the 1994 Cairo conference includes 16 chapters with 243 proposed actions that cover many aspects of population, health, gender equality, other areas of social policy, socioeconomic development, and the environment. It is not realistic for governments to implement all of the proposed actions. Most governments set national priorities that reflect the needs they perceive to be most critical. And, given resource limitations in less developed countries, most governments can afford only limited actions. The poorest countries need support from donor agencies to make any progress at all.

The five-year review of the Cairo program, in 1999, provided information on how well governments are meeting the commitments of the Programme of Action. Government and NGO reports documented a wide range of challenges and obstacles as well as some surprising successes—

Figure 8

### Legislative Seats Held by Women, Selected Countries, 1999



Source: United Nations, *The World's Women 2000: Trends and Statistics* (2000): table 6.A.

and a great deal of interest in and momentum toward change.

### Challenges For New Policies and Programs

The centerpiece of the Cairo program—making reproductive health care universally available—requires considerable time to implement. A “reproductive health approach” means offering women and their families more comprehensive services, which rely on the broader health system as well as on other social sectors.

### Health System and Government Capacity

Governments in less developed countries face enormous challenges in delivering basic services to their citizens. Roads, communication systems, and other infrastructure typically are rudimentary and strained to capacity; health centers and hospitals face overcrowding and a shortage of trained medical staff. People living in small villages or remote areas have little access to modern health care or other

## Brazil: Health Reform Enhances Reproductive Health

In Brazil, a comprehensive approach to women's reproductive health was developed in 1984 that included nearly all of the elements called for 10 years later at the ICPD in Cairo. The program remained isolated and underfunded, however. It was never integrated into the national health system. Political turmoil and economic crises, up until 1995, also hampered progress in reproductive health.

From 1995 on, Brazil had greater institutional stability and a political climate favorable to the Cairo agenda. Reproductive health and rights also gained greater visibility as a result of Brazil's active participation in the 1995 Fourth World Conference on Women, in Beijing. This renewed political interest, combined with reform of the health system, paved the way for substantial progress in making reproductive health services widely available. These reforms have been critical for addressing the wide inequalities in health status and access to care among the country's citizens.

The national health system in Brazil (called the "unified health system" or SUS) has undergone major reforms in management and structure since 1995. The government has advanced primary health care through community-based strategies that emphasize family health,

and has pushed for the decentralization of health services. Decentralization of the health system has put municipalities in control of budgets and the provision of services, which they can accomplish either through public health providers or contracts with private providers. Under the SUS, all individuals are guaranteed access to a minimum package of basic health services, which include family planning, prenatal care, maternity assistance, and other preventive services.

Is Brazil a model for other countries? No health system can be replicated easily in another country because each country has unique social, political, and economic circumstances. Nevertheless, reproductive health experts in Brazil have observed that the major principles underlying health reform—universal access, comprehensive care, equity (among different population subgroups), decentralization, and public accountability—have all proved to be necessary elements of a comprehensive approach to reproductive health.

### Reference

Adapted from Sonia Correa and Sergio Piola, *Reproductive Health in Policy and Practice: Brazil* (Washington, DC: Population Reference Bureau, 1998).

*Progress on national reproductive health objectives is usually uneven across localities in any given country.*

social services. Governments often concentrate health resources in hospitals in big city centers, which starves outer-lying areas of resources.

Many less developed countries have initiated dramatic reforms in their health care systems—often as a condition for receiving funds from international institutions such as the World Bank. The basic thrust of these reforms has been to improve how health care resources are allocated so that more citizens benefit from at least basic levels of health care. The reforms have involved decentralizing the management of health services by giving managers in states, provinces, cities, and rural districts more authority over how resources are raised and spent.

The reforms have also tried to reorganize how services are delivered, with an emphasis on primary and preventive health care, including reproductive health.<sup>43</sup> Reforms also attempt to contain costs and to use the private sector (both for-profit and nonprofit), which often can provide services more efficiently and cheaply than governments. Beginning in the mid-1990s, for example, health reforms in Brazil have aimed to make low-cost, preventive services universally available through a reorganized health system that includes both public and private health care providers (see Box 5).

The reform of health systems and the delivery of reproductive health services, in principle, should be rein-



forcing goals. Reforms often are designed to channel public funds to the neediest citizens and emphasize low-cost health services over expensive high-tech services—goals consistent with the Cairo agenda. Family planning and prevention of STIs, for example, are among the least costly of all health services.<sup>44</sup>

In striving to allocate health resources more effectively, however, government planners must weigh the various components of reproductive health care (for example, family planning, prevention of STIs, and maternity care) against many other health needs, such as combating malaria, tuberculosis, and serious childhood diseases. Reproductive health may not receive priority attention in government budgets if other health needs appear urgent and affect a larger proportion of the population. When reproductive health becomes part of a much larger pool of health services, it may lose some of its focus. Also, reforms can take many years to complete, leaving many programs on hold until health systems are reorganized.

Decentralization, the transfer of authority to lower levels of government, is also a common trend in less developed countries today. It affects not only health care but many other aspects of development. In a decentralized system, communities participate more directly in setting priorities, developing programs, and allocating resources. If such decisionmaking works well, it should make programs and policies more responsive to local needs. But, in some cases, responsibilities have been transferred before local governments have the capacity to manage them. Some communities may not consider reproductive health a high priority, even if it is a national concern. As a result, progress on national reproductive health objectives is usually uneven across localities in any given country.

How much any system can deliver—nationally or locally—depends in part on the total resources available. Spending per person on health care in less developed countries is far lower

Table 6

### Per Capita Spending on Health Care by Region, 1990s

Region	US dollars per year (PPP) <sup>a</sup>
<b>World</b>	<b>\$561</b>
<b>Low- /middle-income countries</b>	<b>182</b>
South Asia	69
Sub-Saharan Africa	84
East Asia & Pacific	154
Middle East & North Africa	237
Europe & Central Asia <sup>b</sup>	355
Latin America & Caribbean	461
<b>High-income countries</b>	<b>2,505</b>

<sup>a</sup> PPP is purchasing power parity: dollar amounts adjusted by the World Bank to account for differences in living costs among countries.

<sup>b</sup> Includes the former Soviet republics and low- and middle-income countries in Eastern and Southern Europe.

Source: The World Bank, *World Development Indicators 2000* (2000): 92.

than in industrialized countries (see Table 6). These striking differences must be kept in mind when reviewing progress toward international goals. In Uganda, reproductive health care consumes about 60 percent of the government's primary health care budget—a relatively high percentage largely because of the HIV/AIDS crisis.<sup>45</sup> But the reproductive health budget amounts to only a few dollars per person annually, which buys little modern health care or drugs. Resource constraints are similar in most of Africa and South Asia.

### Shortfalls in Donor Funding

The world is far from meeting the resource needs outlined in Cairo's Programme of Action. In 1994, the UN projected that in less developed countries and countries in transition to a market economy (such as in Eastern Europe and the former Soviet Union), population and reproductive health programs would cost nearly \$17 billion annually by 2000 and \$22 billion by 2015, in 1993 dollars. The cost estimate for 2000 included \$10.2 billion for family planning programs (about double the amount spent in 1990), \$6.3 billion for other reproductive health care (such as prenatal

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*China has expanded family planning options for women in some areas, and is less stringent about enforcing its one-child policy.*

and delivery care as well as the prevention of HIV and other STIs), and another \$0.5 billion for research and policy activities.

The Cairo Programme of Action called for one-third of the proposed spending to come from international donors, about the same proportion as in earlier programs. Generally, governments in less developed countries pay for most of the local costs of providing services; donors typically help pay for contraceptives and other supplies and technical services. Under the Cairo guidelines, the donor/developing country breakdown would have translated to \$5.7 billion and \$11.3 billion, respectively, in 2000. In fact, UN estimates of 1997 spending showed that donor countries were providing only about \$1.9 billion to \$2.0 billion annually—one-third of the amount called for—and the less developed countries were spending about \$7.7 billion from domestic resources.<sup>46</sup>

The shortfalls in spending apply only to the estimated costs included in the Cairo Programme of Action for providing family planning and basic elements of safe motherhood and preventing sexually transmitted infections. The estimates did not include

the cost of meeting additional goals supported in principle in the Cairo document, including improving overall health care systems, providing emergency care for childbirth complications, closing the gap between girls' and boys' education, eliminating harmful practices against women, improving women's job opportunities, or the costs associated with the treatment of STIs, including HIV/AIDS.

Part of the reason for the shortfall in funding is an overall decline in official development assistance (ODA). ODA includes grants and low-interest loans from governments and multilateral organizations, such as the World Bank, that are financed by governments. ODA peaked in 1992 at almost \$61 billion and has since declined. It was \$48 billion in 1997.<sup>47</sup> Total ODA for population-related activities increased during the 1990s, but this also reflects the fact that "population" was redefined to include reproductive health activities beyond family planning.

Only three donor countries, Denmark, the Netherlands, and Norway, have met or exceeded the financial commitments they made in Cairo. Several major donor countries, including the United States, Germany, and Japan, lag far behind in their commitments. The United States is the largest source of population assistance funds, but it ranks last among donor countries in the percentage of gross national product that it spends on development assistance.<sup>48</sup>

As a whole, the less developed countries fared better than the donor countries in meeting the commitments made in Cairo, in spite of the economic crisis in Southeast Asia and the widespread effects of HIV/AIDS in sub-Saharan Africa. But overall levels of spending were low, particularly in the poorest countries. The UN estimated that in 56 of the poorest countries, annual per capita expenditures on reproductive health were only about \$0.35 per capita in 1996.<sup>49</sup>

Expenditures for reproductive health are more difficult for the inter-

national community to monitor than was spending for the old-style population programs, which mainly consisted of family planning services and information, research, and other technical activities. Reproductive health care is embedded in a broad array of services, making attribution of expenses extremely complicated. These complications will make future reporting and monitoring of the Cairo agenda difficult.

### **Political Opposition in the United States**

As the largest single contributor of population and reproductive health funding among industrialized countries, the United States has a major influence on the amount of donor assistance available. In 1994, the Clinton administration significantly increased U.S. support for family planning assistance and was a major supporter of the Cairo conference.

A few months after the Cairo conference, however, the Republican Party won a majority in the U.S. Congress, and the balance of power shifted toward those opposed support to for international family planning activities. In the 1996 budget, Congress cut foreign aid programs significantly as part of efforts to reduce all government spending. Family planning assistance was cut disproportionately, by 35 percent.<sup>50</sup> From the mid-1990s through 2000, international family planning programs suffered repeated attacks in Congress. Conservative members of Congress called for additional abortion-related restrictions on funding for international family planning programs.

In the 2000 budget, Congress enacted the so-called “global gag-rule” amendment, which denies U.S. funding to private organizations overseas if they use other, non-U.S. government funds to provide abortion services or if they lobby for changes in abortion laws in their country. Immediately after taking office in January 2001, President George W. Bush reinstated the Mexico City Policy (see page 8). These policies force

overseas organizations to give up U.S. funding or to abstain from public debates on abortion.

### **Promising Areas of Change**

Given the enormous challenges faced in less developed countries and the limited resources devoted to population and reproductive health activities, even small progress toward the international community’s goals would be noteworthy. In fact, the five-year review of the ICPD documented a great deal of commitment and progress, perhaps in part because of the widespread appeal of the concepts in the Cairo agreement and the activism of NGOs.

### **Greater Civic Participation**

Since the beginning of the 1990s, greater openness in political decision-making can be seen at all levels—international, national, and local. NGOs, religious and community leaders, and the private sector—what the UN calls “civil society”—are now active partners with governments in deliberations on new policies and programs. During the 1994 Cairo conference and its aftermath, nongovernmental actors helped mold the latest generation of population policies.

Increased NGO-government partnerships can be found in many countries. In Mexico, the National Forum of Women and Population Policy, a network of 70 women’s organizations, works closely with the national and state governments to ensure that policies and services reflect the 1994 Cairo mandate.<sup>51</sup> In Morocco, 76 NGOs—one-third of which were established after 1994—work on issues related to women and development. The Moroccan government now regularly consults with these NGOs, which is a marked departure from its usual highly centralized decisionmaking style.<sup>52</sup>

A women’s health expert from Brazil characterized the greater participation of civil society in her country: “Since the 1980s, democratization has definitely lengthened the policy-

*Nongovernmental actors helped mold the latest generation of population policies.*

*South Africa's  
new Constitution  
calls for free  
primary health  
care for women  
and for children  
under age 6.*

making process. But it has also given voice to the advocacy community and allowed for debate of the reproductive health and rights agenda. The adoption of this agenda would not have occurred without open political debate about its meanings.”<sup>53</sup> In Brazil, and in South Africa, women’s rights organizations have played a prominent role in reshaping the national health agenda.

The involvement of civil society in government policymaking may prolong debates and complicate the planning process, but it is important for several reasons. It brings legitimacy to policies that address the needs of women and other vulnerable groups in society (such as adolescents or indigenous groups) by listening to representatives of grassroots organizations. NGOs play an important role in mobilizing public interest and action

on particular issues. Also, in an era of decentralized management of health and social services, NGOs and commercial organizations can fill gaps in government-supported services.

### **Changing Laws and Policies**

National laws and policies provide important impetus and guidance for action at the local level, which can affect individual lives. But creating policies are just one step in the process. Continuing the momentum that began during the Cairo process, governments around the world have drafted an impressive array of new legislation and strategy documents. The UN reported in 1999 that, since the Cairo conference, more than 40 countries had taken concrete policy actions toward the goal of providing universal access to reproductive health care.<sup>54</sup> In some cases, these

#### *Box 6*

### **India: From Family Planning Targets to Reproductive Health<sup>1</sup>**

Almost 50 years ago, India became the first country in the less developed world to initiate a state-sponsored family planning program to slow population growth. From the early 1960s until the 1990s, the management of India’s program was driven by government-determined targets for contraceptive acceptance. The government’s zeal to achieve these targets met with increasing criticism. After the Cairo conference in 1994, a major national policy shift occurred: The “Target-Free Approach,” announced in 1996, eliminated nationally mandated targets for contraceptive acceptance, while continuing to allow for locally determined targets. The new approach called for planning at the community level, where grassroots workers would set targets for their service areas after assessing the needs of clients.

Several factors contributed to India’s “paradigm shift.” Government health workers often were apprehensive about reaching numerical targets and over-reported the number of contraceptive acceptors in their district

(which led to inflated national figures). Their preoccupation with targets fostered a lack of concern for the quality of care they provided or for other health services. Women’s groups and other nongovernmental organizations repeatedly voiced concerns about the apparent overemphasis on family planning acceptance and disregard for women’s needs. The 1994 Cairo conference provided these groups with an opportunity to pursue a family planning reform agenda with the national government, and the evidence generated from several years of discussions provided the impetus to overhaul the program.

The new approach was implemented first in selected districts and states of India that were most amenable to change. Two years after the new approach was announced, a case study carried out in two states, Rajasthan and Tamil Nadu, assessed the government’s new approach. The study found that both state governments were committed to implementing the target-free approach to family plan-

actions included developing comprehensive national reproductive health policies; in others, governments redesigned aspects of national family planning or other health programs to address reproductive health. The following are examples:

- In 1996, the Indian government replaced a decades-old policy that required states to meet national family planning targets with a “target-free approach” that called for meeting individual reproductive needs (see Box 6).
- South Africa’s 1996 Constitution (developed after white-minority rule ended) included universal rights to reproductive choice and reproductive health care, to be implemented in a reorganized health system that provides free primary health care for women and for children under age 6.<sup>55</sup>

- As part of health care reform, Brazil made reproductive health care a component of primary health care to which all citizens would have equal access (see Box 5, page 30).
- In Bangladesh, a consortium consisting of the government, donors, and NGOs developed a new health and population strategy in 1997 that mirrors the comprehensive approach called for at Cairo.

It would be an exaggeration to say that these governments revised their policies as a result of a UN conference. Nevertheless, debates in these countries took place around the same time as national governments and NGOs were preparing for the Cairo and Beijing conferences. Sometimes national events influenced the international consensus. Brazilian and Indian advocacy groups, for example,

ning, but were still in the early stages of developing a broader approach that would include other aspects of reproductive health care.

Interviews with health workers revealed that, while they still had to develop targets and report their performance to higher authorities, they were not reprimanded for failing to meet the targets, as they had been in the past. Focus group discussions also showed that couples in both states perceived less pressure to accept sterilization, and that health workers informed couples about a variety of contraceptive methods. Annual service statistics showed that, in the year following the introduction of the new approach, the number of family planning users declined in the country as a whole, possibly because the pressure to distort the statistics had disappeared. By 1998, however, use of all methods had increased, which allayed the fears of many skeptics that contraceptive use would decline in a target-free environment.

The new approach is not implemented uniformly throughout India,

and the government still maintains demographic targets at the national level. India’s 2000 national population policy calls for a reduction in the average family size to 2.1 children per couple by 2010 (from 3.2 in 1999), which would require a rapid decline in birth rates. To achieve this goal, the national policy also calls for meeting the unmet needs for family planning and other health care and for integrated service delivery of basic reproductive and child health care.<sup>2</sup> Providing high-quality, reproductive health services to all women and men will require substantial increases in resources and human capacity in this country of more than 1 billion people.

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are credited with influencing the dialogue in Cairo. In all of these cases, the Cairo conference was one of several catalysts for national action.

### **Improving Reproductive Health Services**

Improvements in reproductive health services have involved reorganization, resetting priorities, and retraining service providers. Government reports and independent studies conducted for the five-year review of the Cairo Programme of Action provided scores of examples of such improvements.<sup>56</sup> While relatively few, albeit prominent, countries established comprehensive reproductive health policies and programs, many introduced or expanded certain elements of health care.

Two popular initiatives have been the integration of health services—to meet a broader array of health needs in a single health visit—and improvements in service quality, particularly efforts to improve health care

providers' technical and counseling skills. Quality of care initiatives aim, among other things, to make health care providers more sensitive to the needs of their clients. These initiatives are groundbreaking in countries where institutions have never placed high priority on patients' or consumers' rights.

In China, a country known for its strictly enforced population policy, the government took steps in selected counties to improve the quality of family planning services and introduce more comprehensive reproductive health care. The leaders of the experiment believed that a client-centered, reproductive health approach could help revitalize the government's family planning program.<sup>57</sup> If successful, these initiatives may be expanded to the whole country (see Box 7).

In Thailand, a national public health initiative has integrated HIV/AIDS education, testing, and counseling into existing family health serv-

#### *Box 7*

### **China's Population Policy Put to the Test**

China's national population policy provides a unique example of the clash between a society's objectives and individual rights. The national policy, in place since 1979, is credited with slowing growth in the world's most populous country (nearly 1.3 billion). China's policy is also notorious for restricting individual rights and for heavy-handed enforcement methods. Reports of forced abortions and other coercive practices have plagued the program and brought condemnation from the United States and other governments.

China's current population policy limits most urban couples to one child—two if both parents are only children—and allows rural residents two children if the first child is a daughter. These limits are implemented unevenly throughout China and are widely evaded, making enforcement a key political issue.

In 1995, the Chinese government called for reorienting the family plan-

ning program to be “driven by people's interest” and to emphasize more comprehensive services. China's interest in improving the quality of family planning services and providing more comprehensive care was sparked by the 1994 International Conference on Population and Development in Cairo, which stressed the value of the more comprehensive approach. The State Family Planning Commission introduced the reforms by selecting six rural counties and five urban centers with relatively good economic conditions to test the new approaches. The UN Population Fund (UNFPA) and the Ford Foundation became involved in the reform effort in the late 1990s.

Family planning service centers in selected areas of China now offer counseling on method choices, reproductive health services, prenatal care, and premarital counseling. Although local officials still set family planning targets, the concept of “informed choice” has gained acceptance in some

ices. Other pilot projects are testing innovative approaches to HIV prevention, including training women to negotiate safer sex with their husbands, premarital counseling, and “life skills” education for young people.<sup>58</sup> Also in response to the HIV/AIDS crisis, many African countries have started integrating STI prevention into existing family planning and health services. Uganda has made great strides in incorporating HIV prevention into health, education, and other social programs (see Box 3 on page 18).

Reproductive health care has improved even in countries where traditions and religious beliefs are, on the surface, at odds with some aspects of the Cairo agenda. In Algeria, for example, a Muslim country where open discussion of sexuality is taboo, a project designed by the country’s family planning association and youth volunteers provides young people with information about unsafe abor-

tion, unwanted pregnancies, and STIs. In Iran, couples are required to attend government-sponsored classes on family planning and other aspects of reproductive health before obtaining a marriage license.<sup>59</sup>

## Future Population Policies

The Cairo agreement provided the world community with an abundance of information about population and health challenges, a framework for viewing these challenges, and a range of possible policy and program responses. There has been progress on many fronts; nevertheless, the profound changes called for will take years, even decades, to accomplish. Along the bumpy road to implementation, doubts about the appropriateness of some of the proposed actions are likely to surface.

places. The government estimates that 660 of China’s 3,000 counties have participated in the movement so far, which marks a sizable shift in how population goals are pursued in some areas.

The family planning reforms are consistent with changes taking place throughout China. As China’s economy has shifted from state planning to free markets, coercive approaches to family planning appear less workable. The erosion of the government’s control has been particularly pronounced in the countryside, where the majority of China’s population lives. Increasingly affluent parents can often afford to pay the fines or bribes necessary to have more children than allowed under their quota, or to move to a new area to escape scrutiny. As a result, while the government claims that the national fertility rate is 1.8 children per woman, some Chinese demographers believe the real number lies between 2.0 and 2.3 children. With traditional controls looking ineffective, the government

appears to hope that a more customer-oriented approach will fit better into China’s changing society.

The true test of the government’s commitment to the population policy will be its reaction to the 2000 Census results. The official goal is a total population of less than 1.3 billion. If the census total surpasses that figure, some experts believe the government will step up pressure to limit births.

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*Critics questioned whether the Cairo agenda struck the right balance among competing interests.*

## **Cracks in the Cairo Consensus**

Not long after the ink was dry on the Cairo agreement, academics and advocates from a range of disciplines began to debate the significance of the conference and whether the agreement struck the right balance among competing interests. The Cairo agreement has had many supporters, but also some detractors. Cracks in the consensus started to appear after 1994, and could well reappear in 2004, when the UN may call the next population conference. For example:

- Demographers and other scientists have called for renewed emphasis on the problem of population growth.<sup>60</sup> In their view, the Cairo agreement dismissed demographic concerns because of pressure from women's rights advocates, although population growth still threatens the well-being of millions of people and therefore merits attention in government policies. They point out that little evidence exists to show a direct link between improvements in reproductive health and a desire for smaller families. They fear that diverting resources to a broad range of services might dilute efforts to increase family planning use.
- Some environmental scientists have been disappointed by the lack of focus on sustainable development, in particular on links between population growth, pollution, and the depletion of natural resources.<sup>61</sup> Both the increasing size of populations and increasing per capita consumption threaten the world's environmental health. With less emphasis on population growth, a major cause of environmental degradation may be fading from the public consciousness.
- Some conservatives in less developed countries have questioned whether well-organized Western feminists and the groups they support in less developed countries have too much control over the international population agenda.<sup>62</sup> They argue that women from less

developed countries, acting on their own, would have portrayed the issues in a more culturally sensitive way and defined their rights differently.

- Still others call for more emphasis on reducing socioeconomic inequalities. Underlying many of the concerns outlined in this *Bulletin* about health and human rights is the problem of persistent poverty in much of the less developed world. Until the world's poorest citizens can be lifted from the day-to-day struggle for survival, progress in other areas of human rights may be elusive.<sup>63</sup>

In addition to the views expressed above, a number of factors could influence future discussions on population. The HIV/AIDS epidemic (particularly in Africa) could dwarf other health and development concerns and require massive infusions of new funds to save lives and salvage communities. In Asia and other regions where birth rates have fallen, governments face the problem of aging populations and a critical lack of social and economic support for the elderly. In Asia, Latin America, and countries of the former Soviet Union, frequent financial crises have drained government treasuries of funds needed for social development. These crises, combined with the persistent poverty and indebtedness of many of the world's nations, may lead to calls for greater financial support from more developed countries. It is not clear whether the donor countries will be willing to increase funding for international population, health, and development efforts.

A further influence on future population discussions is the sheer cost and effort associated with UN conferences. Given logistical and financial constraints, the UN might defer until 2014 a full reassessment of Cairo's 20-year goals. In the meantime, the UN may convene meetings on poverty, social development, children, aging, or other development concerns. For population and reproductive health and rights advocates,



however, any deferment or merging of Cairo-related issues into other conferences may mean a loss of policy momentum and of opportunities to push for increased funding for family planning, reproductive health, and women's advancement.

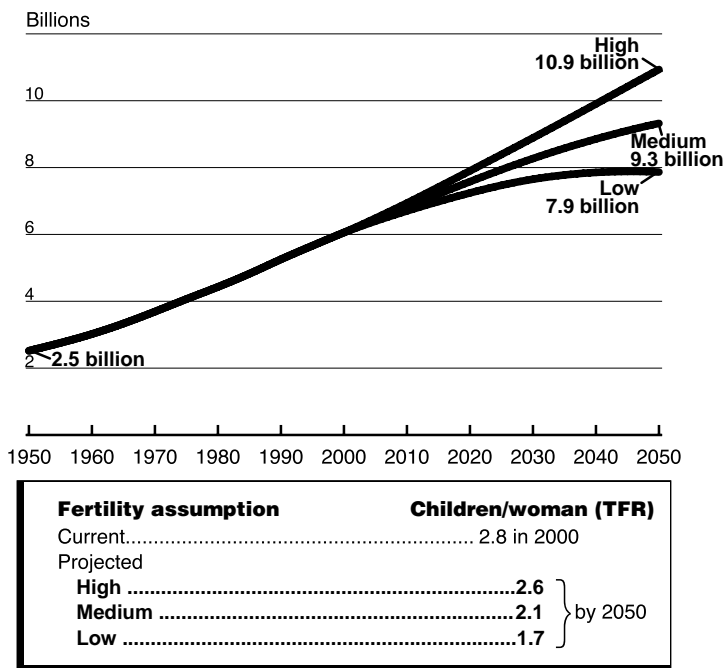
## Balancing Societal Goals and Individual Rights

One of the most positive outcomes of the 1994 Cairo conference was a new sense of optimism that world population growth could stabilize without coercive measures that limit individual freedoms and restrict childbearing. Whether this optimism is well founded might depend on how successfully countries can implement policies based on the "new paradigm"—the focus on reproductive health and rights. This *Population Bulletin* has reviewed many of the challenges faced in implementing these policies. Progress so far has been impressive given the enormous obstacles to success.

As long as couples continue to favor smaller families, supporting individual choices and rights does not conflict with the societal goal of slowing population growth. If population growth is higher than expected in large countries such as India and China, however, some governments could return to the more rigid family planning policies and enforcement practices of the past. Recent survey data from Bangladesh and Egypt show that average family size hardly declined at all in these countries in the second half of the 1990s. These findings were surprising given that the drop from 5 or 6 children to 3.5 children on average occurred fairly rapidly between the 1970s and 1990s. It is possible that the two-child average is still a long way off, or will never be reached, in some societies.

Advancing women's health and rights may well contribute to the transition to smaller families, but it may also require long-term efforts in the poorest societies. After all, women in the poorest societies suffer

Figure 9  
World Population Projections to 2050 Under Three Assumptions of Fertility



Note: The TFR (total fertility rate) is the average total number of children born per woman given prevailing birth rates.

Source: United Nations, *World Population Prospects: The 2000 Revision* (forthcoming 2001).

the greatest health problems and have the most limited opportunities. These efforts are of no small consequence for world population: Population projections show that a small difference in average family size worldwide—an average of 2.6 children versus 2.1 children—translates into a difference of 1.6 billion people in the world's population total in 2050 (see Figure 9).

Many governments continue to maintain demographic goals as part of their development plans. These goals will likely coexist with policies that promote the advancement of women and individual welfare. These goals are desirable in their own right regardless of their effect on population growth. The emphasis placed on one set of goals over another may depend on a combination of factors: high-level leadership, scientific evi-

dence, and the influence of grassroots organizations.

In the 21st century, continued population growth presents many of the same challenges to development as the rapid growth of the last century. But governments' responses to growth (in particular, their public stances) are dramatically different from a decade ago: Policies aimed at population control are no longer acceptable in most countries. An important lesson from the Cairo process is that national population goals cannot be pursued without some form of public scrutiny, either at home or abroad. If individuals' perspectives and needs are disregarded,

policies will likely meet with evasion or open resistance. Now that NGOs and citizen activists have taken on a prominent monitoring role in international agreements, they are likely to continue to pressure governments to respect individual rights.

Given the growing body of evidence showing the links between women's status and population and development trends, and the growing influence of women's groups, it is hard to imagine that women's health and rights issues will disappear from population policy debates. Issues related to sexuality and childbearing are value-laden and complex, ensuring that policy debates will continue.

## Appendix

### Reproductive Health and Rights as Defined in the Cairo Programme of Action

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

...Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the

recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the areas of reproductive health, including family planning. As part of their commitment, full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

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63. See Harriet B. Presser, "Demography, Feminism, and the Science-Policy Nexus," in *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*, ed. Harriet B. Presser and Gita Sen (New York: Oxford University Press, 2000): 399.

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- Ashford, Lori, and Carolyn Makinson. *Reproductive Health in Policy and Practice: Case Studies from Brazil, India, Morocco and Uganda*. Washington, DC: Population Reference Bureau, 1999.
- Bayer, Ronald, ed. "Health Policy and Ethics Forum: The Population Debate," *American Journal of Public Health* 90, no. 12. December 2000: 1838–1847.
- Bouvier, Leon F., and Jane T. Bertrand. *World Population: Challenges for the 21st Century*. Santa Ana, CA: Seven Locks Press, 1999.
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- Presser, Harriet, and Gita Sen. *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*. New York: Oxford University Press, 2000.
- Tsui, Amy, Judith Wasserheit, and John Haaga, eds. *Reproductive Health in Developing Countries*. Washington, DC: National Academy Press, 1997.

## Websites

- United Nations Population Fund  
[www.unfpa.org/icpd](http://www.unfpa.org/icpd)  
(Contains the ICPD Programme of Action and documents related to ICPD+5)
- PopNet—Global Population Information, Population Reference Bureau  
[www.popnet.org](http://www.popnet.org)  
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